CASE MANAGEMENT COMMITTEE MEETING

Wednesday, June 22, 2016
10:00 am – 2:00 pm

CALIFORNIA HOSPITAL ASSOCIATION
BOARD ROOM
1215 K Street, Suite 800
Sacramento, CA 95814

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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

CASE MANAGEMENT COMMITTEE MEETING AGENDA

Wednesday, June 22, 2016
10:00 AM - 2:00 PM

CALIFORNIA HOSPITAL ASSOCIATION
1215 K Street, Suite 800 – Board Room
Sacramento, CA

Call-in: (800) 882-3610; Passcode: 0523939#
Adobe Connect: http://connectpro16666225.adobeconnect.com/cm062216

ITEM	SUBJECT	REPORTING	TIME	PAGE
**Action Item*				
I.	**CALL TO ORDER/INTRODUCTIONS**	Brown	10:00	
II.	**MINUTES OF PREVIOUS MEETING** – March 30, 2016 Meeting Minutes ***Recommendation: approve meeting minutes***	Brown	10:05	 3
III.	**CHAIR REPORT** A. Membership Update – Case Management Committee Roster	Brown	10:10	7 9
IV.	**OBSERVATION** – MOON – SB 1076 – CHA Comments	Rogers	10:20	13 15 17 23
V.	**UNREPRESENTED PATIENTS/DECISION MAKING**	Richardson	10:30	27
VI.	**DISCHARGE DELAY/RESEARCH**	Lowe	10:45	29
VII.	**DURABLE MEDICAL EQUIPMENT**	Blaisdell	11:15	33

VIII.	**CURRENT ISSUES** A. MediCal Managed Care/CCI B. State Legislative Update – California Legislation C. Federal Update – CJR D. TSF/HASC Person-Centered Care Pilot	Blaisdell/ Rogers	11:30	35 37 41
IX.	**LUNCH**		12:30	
X.	**WORKFORCE** – CM Syllabus – Module Outline	Martin	1:00	43 45 53
XI.	**NEW BUSINESS** A. Communications/List-Serve B. Member Topics	All	1:30	
XII.	**NEXT MEETING** **WEDNESDAY, SEPTEMBER 28, 2016** 10:00AM – 2:00PM CHA- Board Room 1215 K Street, Suite 800 Sacramento, CA 95814	Brown		
XIII.	**ADJOURNMENT**	Brown	2:00	

CALIFORNIA HOSPITAL ASSOCIATION
Center for Post-Acute Care

CHA CASE MANAGEMENT COMMITTEE MEETING

California Hospital Association
Sacramento, CA

Wednesday, March 30, 2016
10:00 am – 2:00 pm

Present: Marcy Adelman, Laura Biscaro, Diane Brown, Tammy Hoeffel, Theresa Kurtinaitis, Cindy Laughton, Elizabeth Miller, Terri Scott, Lisa Stroud

By Phone: Regina Berman, Mary Cummings, Karen Dunning, Heather Esget, Martha Mleynek, Jill Schuyler

Staff: Pat Blaisdell, Beth Demeter, Jackie Garman, Dietmar Grellmann, Alyssa Keefe, Debby Rogers, Susan Lowe

RVPs: T Abraham, Julia Slininger, Judith Yates

I. CALL TO ORDER

Staff Blaisdell and Rogers called the meeting to order at 10:03 am.

II. MINUTE OF PREVIOUS MEETING

The minutes of the January 20, 2016 conference call were reviewed and approved.

III. CHAIR REPORT

A. Membership Update

Staff Blaisdell reported that four individuals have agreed to serve on the Committee: Laura Biscaro, Director of Care Management, Santa Barbara Cottage Hospital; Michael-Anne Browne, Associate CMO for Accountable Care, Stanford Children's Health; Mary Cummings, Manager, Case Management/Denial Recovery Unit, Fresno Heart and Surgical Hospital; and, Martha Mleynek, Executive Director, Case Management Services, Riverside Community Hospital. The nomination of all four individuals was unanimously approved by the Committee.

- *Members were asked to review the membership roster and let Beth Demeter know of any changes or updates.*

IV. FEDERAL UPDATE

A. Government Accountability Office (GAO)

Staff Blaisdell reported that the GAO has requested input from hospital-based discharge planners related to SNF Quality Measures and the Five-Star. CHA staff is working to schedule a call with three-to-five such individuals.

- *Committee members should let Staff Blaisdell know if they would like to participate in this call.*
- *Staff Blaisdell will arrange for Terri Scott to conduct a presentation, during a future meeting, on naviHealth and the score card system they have implemented.*

B. DME

Alyssa Keefe provided an update on DME. A memo was distributed last week that includes all contact info, including the 1-800-MEDICARE number.

- *Members are strongly encouraged to call 1-800-MEDICARE to report any DME issues.*
- *Staff Blaisdell will provide members with a data collection form to track the status of any issues reported to 1-800-MEDICARE.*
- *Members are requested to pull up a list of suppliers that should be in your area, according to CMS, and provide feedback on their level of availability, helpfulness, etc.*

C. Informed Choice

Staff Blaisdell reported that she has been getting a lot of questions on how to preserve informed choice. Feedback was requested from members on how best to balance the requirements.

V. WORKFORCE

A. Recruitment and Training Needs

Staff Blaisdell provided background on the CHA Workforce Planning Committee. Cathy Martin, CHA's Vice President of Work Force Policy, will be on the agenda for the June meeting to discuss next steps. In preparation, members provided feedback on current workforce needs.

VI. PERSON-CENTERED CARE MODELS GRANT

Julia Slininger reported that HASC is collaborating with CHA to manage a newly-funded project from the SCAN Foundation. The goal of the project is to look at models of care to

manage high-risk patients, within the continuum, to decrease readmission and improve functional status and quality of life scoring.

- *Members should let Ms. Slininger or Staff Blaisdell know if they are interested in participating in this opportunity.*

VII. STATE UPDATE

A. End of Life Option Act

Staff Garman provided background and information on the End of Life Option Act, which goes into effect on June 9, 2016. CHA conducted an informational webinar on April 18, and will be repeating the webinar soon.

B. State Legislative Update

Staff Rogers provided an updated on CHA priority legislation, including SB 1076.

C. State Regulatory Update

Staff Blaisdell provided an update on Discharge Planning. As requested, AARP has revised their wallet cards for patients and their families which provide information on the California Hospital and Family Caregiver Law.

- *Members who would like to obtain hard copies of these wallet cards should contact Staff Blaisdell or Nina Weiler at AARP.*

D. MediCal Managed Care/CCI

Staff Blaisdell reported on a recent court case in Alameda County regarding unrepresented patients. CDPH is appealing the case, which buys time to address this issue through legislation. Hospitals are advised to issue notifications to any patients they deem as lacking capacity.

Harbage Consulting has developed a final version of the PowerPoint, which will be distributed to members. The first presentation will be conducted with Molina at Cindy Laughton's facilities.

VIII. HOSPITAL DISCHARGE DELAY/NETWORK ADEQUACY

Staff Rogers introduced Susan Lowe, who will be interning at CHA. Ms. Lowe's goal is to help CHA better understand hospital discharge delay and to collect data to support CHA's position. Once the data is collected, Ms. Lowe will draft a whitepaper to explain the problem.

- *Ms. Lowe and Staff Rogers will convene a small workgroup to develop survey questions for data collection.*

IX. NEXT MEETING

WEDNESDAY, JUNE 22, 2016
10:00AM – 2:00PM
CHA- Board Room
1215 K Street, Suite 800
Sacramento, CA 95814

X. ADJOURN

Staff Blaisdell and Rogers adjourned the meeting at 2:03 pm.

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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

June 22, 2016

TO: Case Management Committee Members

FROM: Diane Brown, Chair

SUBJECT: Chair Report

SUMMARY

CHA has established a Case Management Committee to provide representation on behalf of CHA member organizations on issues related to case management.

ACTION REQUESTED

- To provide members with updates on committee membership.

DISCUSSION

The goals of the committee are to provide support for member hospitals and to solicit input for CHA advocacy on key issues, including care coordination, transition planning, and case management. The establishment of an effective forum for case managers also contributes to CHA's ongoing work on the transformation of our health care system. The committee coordinates with other CHA and regional committees and centers and will serve in an advisory capacity to the CHA leadership.

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CALIFORNIA HOSPITAL ASSOCIATION
Providing Leadership in Health Policy and Advocacy

CASE MANAGEMENT COMMITTEE

2016 Membership Roster

CHAIR	CHAIR-ELECT
Diane Brown, PhD, RN, CPHQ, FNAHQ, FAAN **Executive Director, Care Coordination** Kaiser Permanente, Northern California 1950 Franklin Street, 19th Floor Oakland, CA 94612 O: 510-987-3769 *Diane.brown@kp.org*	**Elizabeth Miller, RN, MSN** **Executive Director, Care Management** Adventist Health 1025 Creekside Ridge Drive, Suite 100 Roseville, CA 95678 O: 916-783-2542 *MillerEA@ah.org*
MEMBERS	
Marcy Adelman, RN, CCM, MSN **Clinical Resource Management** Palomar Health 456 E. Grand Ave. Escondido, CA 92025 O: 442-281-5551 *Marcy.adelman@palomarhealth.org*	**Regina Berman, RN, MA,** **Vice President, Population Health Management** Memorial Care Health System 17360 Brookhurst Street Fountain Valley, CA 92708 O: 714-377-3016 *rberman@memorialcare.org*
Laura Biscaro, RN **Director of Care Management** Santa Barbara Cottage Hospital PO Box 689 Santa Barbara, CA 93102 O: 805-367-2115 *lbiscaro@sbch.org*	**Michael-Anne Browne, MD** **Associate CMO for Accountable Care** Stanford Children's Health 725 Welch Road Palo Alto, CA 94304 O: 310-704-2601 *mbrowne@stanfordchildrens.org*
Mary Cummings, RN, MSN, ACM **Manager, Case Management/Denial Recovery Unit** Fresno Heart and Surgical Hospital 15 E Audubon Dr. Fresno, CA 93720 O: 559-433-8030 *mcummings@fresnoheartandsurgical.org*	**Karen Dunning** **Vice President, Care Management Operations** Sutter Health System Offices 2890 Gateway Oaks Drive, Suite250 Sacramento, CA 95833 O: 916-649-4077 *dunninkl@sutterhealth.org*

Heather Esget, RN, BSN, ACM **Director of Case Management** Shasta Regional 1100 Butte St. Redding, CA 96001 O: 530-229-2841 *hesget@primehealthcare.com*	**Tammy Hoeffel, RN, BSN** **Director of Case Management, Social Services and Palliative Care** John Muir Medical Center-Cross Campus 1601 Ygnacio Valley Blvd Walnut Creek, CA 94596 O: 925-941-5097 *Tammy.hoeffel@johnmuirhealth.com*
Theresa Kurtinaitis, MSN, RN **Vice President, Case Management** SHARP Healthcare 8695 Spectrum Center Blvd. San Diego, CA 92123 O: 858-499-3106 *Theresa.kurtinaitis@sharp.com*	**Cindy Laughton, RN, MA** **Regional Director, Care Coordination** UHS 36485 Inland Valley Dr. Wildomar, CA 92595 O: 951-200-8885 *Cynthia.laughton@uhsinc.com*
Martha Mleynek, RN, BSN, MBA **Executive Director, Case Management Services** Riverside Community Hospital 4445 Magnolia Avenue Riverside, CA 92501 O: 951-788-8324 *martha.mleynek@hcahealthcare.com*	**Elizabeth Polek, MBA, LCSW** **Director of Patient Transition Management** UCSF Medical Center 505 Parnassus Avenue San Francisco, CA 94143 O: 415-353-2650 *elizabeth.polek@ucsf.edu*
Jill Schuyler **Regional Director, Care Management** Providence Health & Services, Southern California 501 S. Buena Vista Burbank, CA 91505 O: 818-847-4558 *Jill.schuyler@providence.org*	**Terri Scott, RN, BSN** **Regional Senior Director, Care Coordination** Dignity Health/Greater Sacramento Service Area 10901 Gold Center Drive Rancho Cordova, CA 95670 O: 916-631-3066 *Terri.scott@dignityhealth.org*
Ricki Stajer, RN, MA, CPHQ **Vice President, Care Coordination** PIH Health 12401 Washington Blvd Whittier, CA 90602 O: 562-698-0811x12780 *rickistajer@pihhealth.org*	**Lisa Stroud, RN, MS, PhD (c)** **Director of Care Management** Santa Clara Valley Medical Center 751 South Bascom Avenue San Jose, CA 95128 O: 408-885-4489 *Lisa.stroud@hhs.sccgov.org*
Tessie Sulit Wagoner, RN-BC, MHA, BSN, CCM, IQCI **Regional Senior Director, Case Management** Kindred Healthcare/West Region 200 Hospital Circle Westminster, CA 92783 O: 714-899-5020 *Tessie.wagoner@kindred.com*	

REGIONAL ASSOCIATION REPRESENTATIVES	
T Abraham **Regional Vice President** Hospital Council 1215 K Street, Suite 730 Sacramento, CA 95814 O: 916-552-7534 *tabraham@hospitalcouncil.net*	**Ivonne Der Torosian, MPA, BSM** **Regional Vice President** Hospital Council 1625 E. Shaw, Suite 139 Fresno, CA 93710 O: 559-650-5694 *idertorosian@hospitalcouncil.net*
Julia Slininger, RN, BS, CPHQ **Vice President, Quality and Patient Safety** Hospital Association of Southern California 515 Figueroa Street, Suite 1300 Los Angeles, CA 90071 O: 213-538-0766 *jslininger@hasc.org*	**Judith Yates** **Senior Vice President** Hospital Association of San Diego & Imperial Counties 5575 Ruffin Road, Suite 225 San Diego, CA 92123 O: 858-614-1559 *jyates@hasdic.org*
STAFF	
Patricia L. Blaisdell, FACHE **Vice President, Continuum of Care** California Hospital Association 1215 K Street, Suite 800 Sacramento, CA 95814 O: 916-552-7553 *pblaisdell@calhospital.org*	**Boris Kalanj** **Director, Cultural Care & Patient Experience** Hospital Quality Institute 1215 K Street, Suite 900 Sacramento, CA 95814 O: 916-552-7694 *bkalanj@hqinstitute.org*
Debby Rogers, RN, MS, FAEN **Vice President, Clinical Performance and Transformation** California Hospital Association 1215 K Street, Suite 800 Sacramento, CA 95814 O: 916-552-7575 *drogers@calhospital.org*	**Susan Lowe** **Policy Analyst** California Hospital Association 1215 K Street, Suite 800 Sacramento, CA 95814
Beth Demeter **Administrative Assistant** California Hospital Association 1215 K Street, Suite 800 Sacramento, CA 95814 O: 916-552-7546 *bdemeter@calhospital.org*	

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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

June 22, 2016

TO: Case Management Committee Members

FROM: Pat Blaisdell, VP Continuum of Care
Debby Rogers, VP Clinical Performance and Transformation

SUBJECT: Observation Status & Patient Notification

SUMMARY

Recent legislation at both the state and federal level implement new requirements regarding patients admitted to the hospital under observation status, including requirements for notification.

ACTION REQUESTED

- To provide an update on the federal NOTICE Act
- To provide an update on current state legislation, SB 1076, and
- To discuss implications for hospitals

DISCUSSION

The federal Notice of Observation and Implication for Care Eligibility (NOTICE) Act will take effect in August of this year. The NOTICE Act requires hospitals and critical access hospitals to notify Medicare beneficiaries receiving observation services as outpatients for more than 24 hours. CMS has developed a standardized form with required elements and associated instructions.

Requirements for observation services, including staffing, patient notification, and other issues are also the subject of SB 1076, currently progressing through the California state legislature.

1215 K Street, Suite 800, Sacramento, CA 95814 • *Telephone:* 916.443.7401 • *Facsimile:* 916.552.7596 • www.calhospital.org
Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

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Department of Health & Human
Services Centers for Medicare &
Medicaid Services OMB Approval No.
xxxx-xxxx

Patient Name:_____ Patient ID:_____ Physician: _____

Date:_____ Time: _____

Medicare Outpatient Observation Notice (MOON)

On *[Date]* at [*Time]*, you began receiving observation services at *[Hospital Name]*. You're a hospital outpatient receiving observation services, also called an observation stay. You are not an inpatient.

Observation services:

- Are given to help your doctor decide if you need to be admitted as an inpatient or discharged;
- Are given in the emergency department or another area of the hospital; and
- Usually last 48 hours or less.

How being an outpatient affects what you may have to pay: Being a hospital outpatient affects the amount you may have to pay for your time in the hospital and may affect coverage of services after you leave the hospital.

Medicare Part B covers outpatient hospital services, including observation services when they are medically necessary. Generally, if you have Medicare Part B, you may pay:

- A copayment for each individual outpatient hospital service that you get; and
- 20 percent of Medicare-approved amount for most doctor services, after the Part B deductible.

Part B copayments may vary by type of service. In most cases, your copayment for a single outpatient hospital service won't be more than your inpatient hospital deductible. However, your total copayment for all outpatient services may be more than the inpatient hospital deductible.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage are determined by your plan. Check with your plan about coverage for outpatient observation services.

If you are a Qualified Medicare Beneficiary through your state Medicaid program you cannot be billed for Part A or Part B deductibles, coinsurances, and copayments.

Your costs for medications:

Generally, prescription and over-the-counter drugs, including "self-administered drugs," given to you by the hospital in an outpatient setting (like an emergency department) aren't covered by Part B. "Self- administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow patients to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs in certain circumstances. You'll likely need to pay out-of- pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, if inpatient hospital services become necessary for you and the hospital admits you as an inpatient based on a doctor's order, generally Medicare Part A will cover inpatient services. Generally, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital. Medicare Part B covers most of your doctor services when you're an inpatient. You may have to pay 20 percent of the Medicare-approved amount for doctor services after paying the Part B deductible.

Patient Name: _____ Patient ID: _____

How observation services may affect coverage and payment of your care after you leave the hospital:

If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you have a prior qualifying inpatient hospital stay. A qualifying inpatient hospital stay means you've been a hospital inpatient (you're admitted to the hospital as an inpatient after your doctor writes an inpatient admission order) for a medically necessary stay of at least 3 days in a row (not counting your discharge day) within a short time before you enter a SNF.

If you have a Medicaid, Medicare Advantage or other health plan, Medicaid or the plan may have different rules about qualifying for SNF services after you leave the hospital. Check with Medicaid or your plan.

Additional Information:

If you have any questions about your observation services, please ask the hospital staff member providing this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department. In addition, you can call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

If you have a complaint about the quality of care you're getting during your outpatient stay, you may contact the Quality Improvement Organization (QIO) for this hospital.

QIO Name: _____ QIO phone number: _____

If you have a Medicare Advantage or other health plan, you can make your complaint about quality of care by filing a grievance with your plan. Review your plan materials or contact your plan for information on how to file a grievance. You can also make a complaint about quality of care to the QIO listed above.

Please sign and date here to show you received this notice and understand what it says.

Signature of Patient or Representative	Date/Time

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Form CMS-XXXXX (expiration date xx-xx-xxxx)

AMENDED IN SENATE APRIL 18, 2016

SENATE BILL No. 1076

Introduced by Senator Hernandez

February 16, 2016

An act to amend Section 128740 of, and to add Section 1253.7 to, the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 1076, as amended, Hernandez. General acute care hospitals: observation services.

(1) Existing law establishes the State Department of Public Health and sets forth its powers and duties, including, but not limited to, the licensing and regulation of health facilities, including, but not limited to, general acute care hospitals. A violation of these provisions is a crime.

Existing law authorizes the department to issue a special permit authorizing a health facility to offer one or more special services when specified requirements are met. Existing law requires general acute care hospitals to apply for supplemental services approval and requires the department, upon issuance and renewal of a license for certain health facilities, to separately identify on the license each supplemental service.

This bill would require a general acute care hospital that provides observation services, as defined, to comply with the same ~~staffing standards~~ *licensed nurse-to-patient ratios* as supplemental emergency services, as specified. The bill would require that a patient receiving observation services receive written ~~notice immediately upon admission for observation services or placement into observation status, or immediately following a change from inpatient status to observation status,~~ *notice, as prescribed,* that his or her care is being provided on

an outpatient ~~basis.~~ *basis, which may affect the patient's health coverage reimbursement.* The bill would require observation units to be identified with specified signage, and would clarify that a general acute care hospital providing services described in the bill would not be exempt from these requirements because the hospital identifies those services by a name or term other than that used in the bill. Because a violation of these provisions by a health facility would be a crime, the bill would impose a state-mandated local program.

(2) Existing law requires a hospital to report specified summary financial and utilization data to the Office of Statewide Health Planning and Development (OSHPD) within 45 days of the end of every calendar quarter.

This bill would require hospitals to include certain data relating to observation service visits and total observation service gross revenues in the reports filed with OSHPD.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1253.7 is added to the Health and Safety Code, to read:

1253.7. (a) For purposes of this chapter, "observation services" means outpatient services provided by a general acute care ~~hospital,~~ *hospital and that have been ordered by a provider,* to those patients who have unstable or uncertain conditions potentially serious enough to warrant close observation, but not so serious as to warrant inpatient admission to the hospital. Observation services may include the use of a bed, monitoring by nursing and other staff, and any other services that are reasonable and necessary to safely evaluate a patient's condition or determine the need for a possible inpatient admission to the hospital.

~~(b) Notwithstanding subdivisions (d) and (e) of Section 1275, observation services provided by the general acute care hospital in an outpatient observation unit, including the services provided~~

~~in a freestanding physical plant, as defined in subdivision (h) of Section 1275, shall comply with the same staffing standards, including, but not limited to, licensed nurse-to-patient ratios, as supplemental emergency services.~~

~~(c) A patient receiving observation services shall receive written notice immediately upon admission for observation services or placement into observation status, or immediately following a change from inpatient status to observation status, that his or her care is being provided on an outpatient basis, and that this may affect reimbursement by Medicare, Medi-Cal, or private payers of health care services, or cost-sharing arrangements through his or her health care coverage.~~

~~(d) Observation units not provided in inpatient beds or attached to emergency services~~

(b) When a patient in an inpatient unit of a hospital or in an observation unit, as defined in subdivision (c), is receiving observation services, or following a change in a patient's status from inpatient to observation, the patient shall receive written notice, as soon as practicable, that he or she is on observation status. The notice shall state that while on observation status, the patient's care is being provided on an outpatient basis, which may affect his or her health care coverage reimbursement.

(c) For purposes of this chapter, "observation unit" means an area in which observation services are provided in a setting outside of any inpatient unit and that is not part of an emergency department of a general acute care hospital. A hospital may establish one or more observation units that shall be marked with signage identifying the *observation unit* area as an outpatient area. The signage shall use the term "outpatient" in the title of the designated area to indicate clearly to all patients and family members that the observation services provided in the center are not inpatient services. *Identifying an observation unit by a name or term other than that used in this subdivision does not exempt the general acute care hospital from compliance with the requirements of this section.*

~~(e) Observation services shall be deemed outpatient or ambulatory services that are revenue-producing cost centers associated with hospital-based or satellite services locations that emphasize outpatient care. Identifying an observation unit by a name or term other than that used in this subdivision does not~~

~~exempt the general acute care hospital from compliance with the requirements of this section.~~

(d) Notwithstanding subdivisions (d) and (e) of Section 1275, an observation unit shall comply with the same licensed nurse-to-patient ratios as supplemental emergency services. This subdivision is not intended to alter or amend the effect of any regulation adopted pursuant to Section 1276.4 as of the effective date of the act that added this subdivision.

SEC. 2. Section 128740 of the Health and Safety Code is amended to read:

128740. (a) Commencing with the first calendar quarter of 1992, the following summary financial and utilization data shall be reported to the office by each hospital within 45 days of the end of every calendar quarter. Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal or calendar year. The quarterly summary financial and utilization data shall conform to the uniform description of accounts as contained in the Accounting and Reporting Manual for California Hospitals and shall include all of the following:

(1) Number of licensed beds.

(2) Average number of available beds.

(3) Average number of staffed beds.

(4) Number of discharges.

(5) Number of inpatient days.

(6) Number of outpatient visits, excluding observation service visits.

(7) Number of observation service visits and number of hours of services provided.

(8) Total operating expenses.

(9) Total inpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(10) Total outpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(11) Total observation service gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(12) Deductions from revenue in total and by component, including the following: Medicare contractual adjustments, Medi-Cal contractual adjustments, and county indigent program contractual adjustments, other contractual adjustments, bad debts, charity care, restricted donations and subsidies for indigents, support for clinical teaching, teaching allowances, and other deductions.

(13) Total capital expenditures.

(14) Total net fixed assets.

(15) Total number of inpatient days, outpatient visits excluding observation services, observation services, and discharges by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, self-pay, charity, and other payers.

(16) Total net patient revenues by payer including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(17) Other operating revenue.

(18) Nonoperating revenue net of nonoperating expenses.

(b) Hospitals reporting pursuant to subdivision (d) of Section 128760 may provide the items in paragraphs (8), (9), (10), (12), (16), and (18) of subdivision (a) on a group basis, as described in subdivision (f) of Section 128760.

(c) The office shall make available to any person, at cost, a hard copy of any hospital report made pursuant to this section and in addition to hard copies, shall make available at cost, a computer tape of all reports made pursuant to this section within 105 days of the end of every calendar quarter.

(d) The office shall adopt guidelines, by regulation, for the identification, assessment, and reporting of charity care services. In establishing the guidelines, the office shall consider the principles and practices recommended by professional health care industry accounting associations for differentiating between charity services and bad debts. The office shall further conduct the onsite validations of health facility accounting and reporting procedures and records as are necessary to ensure that reported data are consistent with regulatory guidelines.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or

infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

CHA Comments on MOON

CHA has developed the following draft comments in response to the Centers for Medicare & Medicaid Services' (CMS) proposed rule updating the inpatient prospective payment system (IPPS) for federal fiscal year (FFY) 2017, including the proposed Medicare Outpatient Observation Notice (MOON). Following are excerpts from the June 17, 2016 letter.

CHA:

- *Urges CMS to significantly revise the proposed Medicare Outpatient Observation Notice (MOON) to ensure that the information provided is accessible to beneficiaries. Further, we believe CMS and hospitals need additional time to prepare for implementation and therefore ask for a period of non-enforcement — up to six months from the date of a final notice — to allow time for beneficiary, contractor and hospital staff education.*

MEDICARE OUTPATIENT OBSERVATION NOTICE

CMS proposes regulations to implement the NOTICE Act which would require hospitals and critical access hospitals, as a Medicare condition of participation, to provide individuals receiving outpatient observation services for more than 24 hours both a written notice and an oral explanation that the individual is an outpatient receiving observation services and the implications of that status. CHA agrees that hospitals and physicians should communicate clearly with Medicare beneficiaries and their families about their status in the hospital. Many hospitals in California have provided similar information to beneficiaries on a voluntary basis for quite some time. In addition, the California state legislature is currently considering a law, similar to those in other states, that would require notification of all patients in outpatient observation status. Through both the voluntary experience of providing notice, and in careful review of pending state legislation as well as the current notice under review at the Office of Management and Business (OMB), we offer the following detailed comments for CMS' consideration as it moves forward in implementing the Notice Act.

Timing of Notification

CMS proposes that notice must be given to individuals who receive observation services as an outpatient for more than 24 hours and no later than 36 hours after observation services begin. Further, the MOON must be provided sooner if the individual is to be transferred, discharged or admitted as an inpatient before the end of the 36-hour period. CMS indicates that observation services are initiated when ordered by a physician — or a non-physician practitioner authorized by state licensure law and hospital staff bylaws to admit patients or to order outpatient services — as documented in the patient medical record. In the case of a Condition Code 44 situation, CMS proposes that the MOON be provided within the time frames described above and the period for outpatient observation services begins upon the physician order.

While not explicitly stated, CHA is concerned that one interpretation of the proposed rule as written would be that the hospital could only present and explain the MOON within a 12-hour period between 24 and 36 (or less) hours after observation services have been initiated. While a reasonable interpretation of the statue, we believe the statue does provide additional flexibility and we urge CMS to utilize its regulatory authority as such.

Such a narrow time frame poses a number of challenges for hospitals in California, as well as other states with existing state law on this matter. The California state legislature is currently considering SB 1076 Hernandez (D-Azusa), which requires notification of all patients who are on observation status (with the exception of those that remain in the emergency department). The bill, as currently drafted, would require that hospitals provide a written notice to a patient on observation status being cared for in an inpatient unit

of a hospital or in an observation unit, or following a change in a patient's status from inpatient to observation, *as soon as practicable*. The notice shall state that while on observation status, the patient's care is being provided on an outpatient basis, which may affect his or her health care coverage reimbursement. If enacted, the provisions of SB 1076 would take effect January 1, 2017, and be applicable to all patients.

Timing of the state requirement and a narrow reading of the 24-36 hour window will create duplicative and unnecessary notices to beneficiaries. In addition, the narrow window of time would pose significant logistical and operational challenges for hospitals as they try to distinguish when the clock starts**. CHA recommends that CMS clarify that hospitals are permitted to provide the beneficiary with the MOON and its explanation at any point after outpatient observation services are initiated, as long as it takes place within 36 hours or prior to discharge, transfer or inpatient admission, whichever occurs first. For California hospitals as well as other states, it would allow the notice to be provided in a timely manner, compliant with state law and would not disrupt the normal workflow within the facility.**

Further, the regulation states that observation begins "when treatment starts pursuant to the order." It is not clear if this includes only services after the order for observation is written, or related services that commenced before the order was executed but after the patient occupied an outpatient bed count. While the order has a very definitive date and time, this may start the clock later than when services actually began. If CMS intends for these services to be included, an alternative would be to rely on the documentation of when nursing care began. **Either way, CMS should make the standard very clear in the final rule, so that differing interpretations across various survey agencies do not cause inconsistent application of the standard, resulting in varying audit protocols by surveyors.**

Accessibility and Clarity of Language in the MOON
CMS submitted the English language version of the MOON to OMB for approval, and notes that a Spanish language version will also be made available. **While CHA appreciates CMS' approach to standardizing the MOON as requested by many stakeholders, we are very concerned about the proposed language. In addition, once the language is refined, we respectfully request that CMS make it available in at least the top 10-15 languages for providers to download and use as appropriate.**

In reviewing the proposed MOON with hospital and health system case management leadership from across the state of California, many significant issues were raised. **First, nearly every case manager we spoke to noted that the language used by CMS is not understandable to most beneficiaries and, without additional clarification to make the MOON more accessible, will require significant explanation by hospital personnel adding to beneficiary confusion and unnecessary administrative burden that could be avoided.**

The language most problematic and in need of greater clarity includes, but is not limited to, the cost sharing sections, the discussion of self-administered drugs and the definition of observation services. **CHA urges CMS to conduct focus groups and beneficiary testing of the MOON prior to implementation. Moreover, we ask that CMS streamline the MOON and limit unnecessary and confusing language while leaving space for providers to add additional information as needed.**

Second, CHA is very concerned that the first time beneficiaries will have heard about the differences between outpatient observation services and inpatient is during their hospital stay, when they are most vulnerable and least likely to understand fully the implications. **CHA believes that CMS has a significant obligation to engage beneficiaries through education and outreach long before a hospital stay. This may be accomplished by direct mailers, online advertisements or beneficiary education**

and outreach groups, among other means. CHA urges CMS to make this a priority for the fall of 2016, leading up to 2017, and to engage stakeholders — including hospital case management and financial services personnel who have experience in providing this notice to beneficiaries — to inform this work.

Beneficiary education is particularly important in light of our third area of concern in the MOON — the compliant and grievances section. **CHA supports CMS providing information on this important topic, but unfortunately the information currently provided in the MOON will likely cause additional confusion and frustration for beneficiaries.** More specifically, we understand that the QIOs are routinely asked by beneficiaries to appeal their observation status so that they may be converted to inpatient, for any number of reasons. At the present time — and as the MOON describes — the QIOs only provide quality of care reviews for outpatient services; there is no process for appealing an outpatient level of care service. Alternatively, the QIOs routinely review the level of care review for inpatient services. **The MOON illustrates a gap in the beneficiary appeals process that may not be well understood by beneficiaries, and it puts providers in a difficult position of trying to explain this gap. For example, beneficiaries may appeal their discharge status and raise concerns when they believe they are being discharged to early or being recommended transfer to a SNF when they wish to be transferred to an inpatient rehabilitation facility. However, no comparable appeals process exists for patients who are in observation and believe they should be inpatient. The language currently provided in the MOON does not address this gap specifically, likely leading to confusion and frustration for Medicare beneficiaries. CHA again encourages CMS to reconsider this language to further clarify this point and to make this a focus of beneficiary outreach in the near future.**

Implementation Timeline
Unfortunately, while we understand that the law requires the notice procedures to be effective on August 6, 2016, we are concerned that it is unrealistic for a number of reasons. **CHA urges CMS delay enforcement of this requirement until no earlier than six months after the issuance of a final standardized notice.**

As noted above, we believe the current MOON requires significant modification and beneficiary testing for it to be understood by beneficiaries. In addition, hospitals and health systems will need adequate time to develop and operationalize policies and procedures for the NOTICE Act requirements, update and test their medical record system to include the notice requirements and provide extensive education about the requirements to their staff. This implementation period also would also allow CMS time to issue clear and detailed guidance to hospitals and Medicare contractors.

Enforcement
The NOTICE Act amends the provider agreement provisions of the Social Security Act. However, the proposed rule does not describe how the agency intends to enforce the Act's provisions or the penalties for noncompliance. It is our understanding that violations of requirements in this section can lead to the termination of a hospital's Medicare provider agreement, which we find to be too egregious of a penalty. **CHA encourages CMS to develop clear instructions for contractors on how to assess compliance and consider an appropriate phased process that begins with notifying and educating the provider about the regulatory requirements prior to any type of deficiency citation. Similar to other requirements, we believe this would include, but not be limited to, allowing a hospital to develop and carry out a corrective action plan.**

Qualified Personnel
CHA believes that hospitals are best equipped to determine which staff is most appropriate to deliver the notice and provide beneficiary information. Further, we are concerned that CMS has not provided an

opportunity for notice and comment regarding the oral notification. **It is our hope that CMS will allow for comment on any future proposed provider manual updates to ensure shared understanding between CMS and providers about expectations of compliance. For example, when a translator provides the oral notification, we believe it would be appropriate to check a box noting that this requirement was fulfilled.**

Beneficiary Signature Requirement

The Act provides that, if a beneficiary refuses to provide a signature, the notification must be signed and dated by the hospital staff member who presented the written notification. CHA recommends that CMS also apply this process in other situations that are outside of the hospital's control, such as when a beneficiary is unable, due to his or her medical or mental condition, to receive and sign the notification and no patient representative is available.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

June 22, 2016

TO: Case Management Committee Members

FROM: Pat Blaisdell, VP Continuum of Care
Debby Rogers, VP Clinical Performance and Transformation
Lois Richardson, VP Privacy and Legal Publications

SUBJECT: Unrepresented Patients Lacking Capacity

SUMMARY

A 2015 court decision declared unconstitutional a California statute that permits skilled nursing facilities (SNFs) to use an interdisciplinary team to make medical decisions for a patient who lacks capacity and has no family or other representative to make these decisions.

ACTION REQUESTED

- To provide an update on the current status of state action in response to the court decision in ***California Advocates for Nursing Home Reform (CANHR) v. Chapman (Director of the Department of Public Health).***
- To discuss current and future implications for informed consent, transitions of care, for hospitals and health systems.

DISCUSSION

CDPH has appealed the case, and the decision is not effective until the appeal is heard. However, CHA has advised health care providers to provide written and oral notification to patients that have been determined to not have capacity to make decisions regarding medical care.

CDPH has also indicated that they will pursue legislation to address the issue. CHA, in coordination with other key stakeholders, is in communication with CDPH to provide input to the proposed legislation. Language currently under consideration, in addition to addressing the notification issue, includes significant new requirements regarding the administration of psychotropic medications to patients/residents in skilled nursing facilities.

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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

June 22, 2016

TO: Case Management Committee Members

FROM: Susan Lowe, Policy Analyst
Pat Blaisdell, VP Continuum of Care
Debby Rogers, VP Clinical Performance and Transformation

SUBJECT: Hospital Discharge Delay/Network

SUMMARY

As CHA continues its work on the issue of discharge delays, there is need to develop and collect more detailed and comprehensive information on the scope, nature and implications of discharge delays, including impact on costs of care. Thanks to the involvement and input of the Case Management Committee, we have been able to clarify further the issues surrounding discharge delays. From those interactions as well as other sources, including the National Hospital Case Management Survey 2015, we have assembled a tool that can be utilized going forward to survey CHA members regarding barriers unique to their organizations and allow CHA to better frame the issues California hospitals face regarding discharges.

ITEMS FOR DISCUSSION

- Appropriate measures (attached below)

- Recommendations on the following
  - How to quantify the number of days with delayed discharge (average/median?) and total number of days (timeframe?)
  - How to quantify cost/lost revenue to the hospital (advocacy math)
  - Prevalence (pick 1 day and call all hospitals/SNF and ask how many patients on that date being held because of discharge delays)
  - Identify outliers – i.e. > 25 days and obtain descriptive data

- Best way to collect data
  - Direct survey monkey-link sent to CHA Members or their designated participants
  - Written document (Excel, or something else) sent to CHA Members to be completed and returned to CHA case management committee staff

- When should data collection begin?

Location of Hospital	Number of Beds	Average Daily Census
Average staff FTE's {RN}	**Average CM FTE {Licensed}**	**Number of CM Vacancies**

Tier 1 Discharge Delays

Issue Affecting Discharge	Description	Type of Issue	# of Incidents
Insurance Status			
Commercial	Private Insurance/group health/employer sponsored		
MediCal			
Medicare			
Uninsured			
VA			
Level of Care Needed			
Alzheimer's/Dementia			
Ambulatory/OP services	Chemotherapy/radiation		
Bariatric			
Behavioral Health			
Dialysis			
Home Care			
Hospice	End of life needs		
Infectious Disease	TB		
Intermediate Long term care			
Long Term Acute Care			
Tracheotomy			
Ventilator			
Social Issues			
Criminal History			
Homelessness			
Substance Abuse	Alcohol/drug history		
Legal Issues			
5150/5250 hold			
Adult/child Protective services			
Guardianship/conservatorship			

Family/Patient Issues			
Patient refuses placement			
Patient Age			
Tertiary/acute inpatient external transfer			
Undocumented	Citizenship issues		

Tier 2 Discharge Delays

Issue Affecting Discharge	**Description**	**Type of Issue**	**# of Incidents**
Attending Refusal to discharge			
Availability of Resource Contact	Are you able to complete contact with necessary parties to transfer care or discharge patient		
Availability of DME	Is delay in discharge due to delay in obtaining needed equipment such as walkers or other devices.		
Friday discharge			
High Cost/Non-covered Medications			
Inpatient Rehab Needs			
SNF refusal to re-admit			
Transportation			
Wound Care Needs			

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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

June 22, 2016

TO: Case Management Committee Members

FROM: Pat Blaisdell, VP Continuum of Care
Debby Rogers, VP Clinical Performance and Transformation

SUBJECT: Durable Medical Equipment

SUMMARY

CHA continues its work to address member concerns regarding delays and other issues encountered when ordering medically necessary durable medical equipment (DME) since the initiation of the CMS Competitive Bidding Program for the durable medical equipment prosthetics, orthotics and supplies (DMEPOS).

ACTION REQUESTED

- To provide committee members an update on the Medicare competitive bidding program for durable medical equipment prosthetics, orthotics and supplies (DMEPOS) and request additional information to support continued advocacy.
- To solicit input from committee members regarding content for a forum/webinar on ordering DME, to be developed and coordinated by CMS Region IX personnel.

DISCUSSION

CHA continues its work to address member concerns regarding delays and other issues encountered when ordering medically necessary durable medical equipment (DME) since the initiation of the CMS Competitive Bidding Program for the durable medical equipment prosthetics, orthotics and supplies (DMEPOS). As a result of the most recent round of competitive bidding, the list of designated suppliers changes on July 1, 2016.

CHA is engaged in ongoing communication on this issue with CMS personnel at both the regional and federal level. CMS Region IX has agreed to facilitate a conference call/webinar to review DME policies and procedures, and will develop the content in coordination with CHA. Topics to be addressed in the call:

- Criteria, required documentation, resources (presented by representative from Noridian)
- Identification of suppliers, policies and procedures for suppliers (Palmetto)
- Problem Resolution, 1-800-Medicare, etc. (CMS)

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CALIFORNIA HOSPITAL ASSOCIATION
Providing Leadership in Health Policy and Advocacy

June 22, 2016

TO: Case Management Committee Members

FROM: Pat Blaisdell, VP Continuum of Care
Debby Rogers, VP Clinical Performance and Transformation

SUBJECT: Current Issues

SUMMARY

Several current activities at the state and federal levels have significant implications for CHA member case managers.

ACTION REQUESTED

- To provide an update on state legislation, including CHA's priority bills SB 1300 and SB 1076
- To provide an update on the implementation of Cal MediConnect and the Coordinated Care Initiative (CCI)
- To provide updates and status reports on other areas of interest

DISCUSSION

State Legislation
Several bills of interest to hospitals and post-acute care providers will be addressed in the current legislative session. CHA is sponsoring SB 1300, legislation to modernize sections 5150, 5151 and 5152 of the Welfare and Institutions Code or Lanterman-Petris-Short Act, and to make clarifying changes to define the various steps of a 5150 detention process.

CHA is also monitoring SB 1076, which addresses staffing, patient notification and other issues association with hospital observation status.

MediCal Managed Care/Coordinated Care Initiative
CHA is working with the Department of Health Care Services (DHCS) and individual health plans to address several concerns identified by member hospitals regarding care coordination, care authorizations and access to care for beneficiaries enrolled in managed care, including Cal MediConnect and the coordinated care initiative (CCI), the California dual demonstration.
At CHA's request, Harbage Consulting has developed presentation materials and a case manager "tool-kit". Members of the CHA Case Management Committee provided input to the materials, and a regional presentation will be held in the next several months.

Pre-Admission Screening and Resident Review (PASRR)
CHA is working with the Department of Health Care Services (DHCS) to facilitate the implementation of new procedures and policies associated with requirements for completion of the pre-admission screening and resident review (PASRR). The purpose of the PASRR is to ensure that individuals with mental illness or intellectual disability receive appropriate services. Completion of PASRR is required for certain individuals prior to admission to a skilled nursing facility. DHCS personnel have shared with CHA staff a draft form and additional information regarding the proposed process. CHA has advanced several questions regarding the scope of the screening form/information gathering and other issues.

Comprehensive Care for Joint Replacement (CJR)
Effective April 1, 2016, CMS implemented the CJR in several geographic areas. Under CJR, acute hospitals are at risk for post-hospital spending for patients who have undergone lower extremity joint replacement. CJR has significant implications for discharge planning. CHA is monitoring the implementation and has developed resources for CHA members.

KEY STATE ISSUES
CONTINUUM OF CARE LEGISLATION
June, 2016

Details on all of our high-priority health care-related bills CHA is tracking this legislative session may be accessed at the CHA website at www.calhospital.org/key-state-issues.

AB 1300
Ridley Thomas (D-Los Angeles)
Will modernize sections 5150, 5151 and 5152 of the Welfare and Institutions Code or Lanterman-Petris-Short Act. This bill makes clarifying changes to better define the various steps of a 5150 detention process to ensure consistent statewide application and to ensure that patients receive the most appropriate care in the least restrictive environment appropriate to their needs.
To be heard in Senate Health Committee
CHA-Sponsored
Sheree Kruckenberg/Judy Wolen

AB 1306 *(Two year bill)*
Burke (D-Inglewood)
Would remove the physician supervision requirement for certified nurse midwives (CNMs) by allowing them to manage a full range of primary health services, perform peripartum care, provide emergency care when a physician is not present, and perform and repair episiotomies in all practice settings. As amended May 28, the bill subjects CNMs to a ban on corporate practice. Such a ban would be an unwarranted and precedent-setting expansion of the corporate practice ban and would create an artificial and unnecessary barrier to employment options for CNMs.
To be heard in Senate Business, Professions and Economic Development Committee.
Oppose unless amended
Jackie Garman/David Perrott/Connie Delgado

AB 1518 *(Two year bill)*
Assembly Committee on Aging and Long Term Care
Would require the Department of Health Care Services to seek authorization for additional slots for the Nursing Facility/Acute Hospital Waiver, and to expedite processing of waiver applications for individuals in the acute care hospital awaiting SNF placement, or those in the community at imminent risk of admission to a hospital or skilled nursing facility.
Senate Inactive
Support
Pat Blaisdell/Barbara Glaser

AB 2079
Calderon (D- Whittier)
Would require the Department of Public Health to develop regulations for staffing in skilled nursing facilities that include separate staff-to-patient ratios for certified nurse assistants in

skilled nursing facilities. Specifies minimum ratios for CNAs for each eight hour shift, as well as posting requirements. Hospital based skilled nursing facilities are excluded
To be heard in Senate Health 6/22
Neutral
Pat Blaisdell/ BJ Bartleson/Barbara Glaser/Connie Delgado

AB 2341
Lackey (R – Palmdale)
Would include dialysis, peritoneal, and infusion services as "special services" that may be approved for nursing facilities and skilled nursing facilities if licensee can demonstrate that the service is provided in accordance with a minimum standard for quality of care, defined as equivalent to, or greater than, that of current community standards for quality of care for that type of service".
Gut and amend to bill dealing with judgeships
Patricia Blaisdell/Barbara Glaser
Drop

AB 2743
Eggman (D-Stockton)
Would require CDPH to establish and administer a web-based electronic real time registry, known as the acute psychiatric bed registry, to collect, aggregate, and display information on the availability of acute psychiatric beds in health facilities. Amended to provide for pilot program.
Held in Assembly Appropriations
Oppose
Sheree Lowe/Alex Hawthorne

SB 323 *(Two year bill)*
Hernandez (D-Azusa)
Would allow nurse practitioners to practice to the full extent of their education and training to ensure access to health care delivery systems for millions of Californians who now have access to coverage under the Affordable Care Act.
To be heard in Assembly Business and Professions Committee.
Support
BJ Bartleson/Connie Delgado

SB 547
Liu (D- La Canada Flintridge)
Would require the Department of Health and Human Services to create an Aging and Long Term Care (LTC) Services Coordinating Council, which will develop a state-and system-wide LTC plan.
To be heard in Assembly Aging & LTC Committee 6/21
Follow, Hot
Pat Blaisdell/Barbara Glaser

SB 938
Jackson (D- Santa Barbara)
This bill would replace references to the term dementia with major neurocognitive disorders (MNCDs), and would establish new requirements for conservatorship of individuals with MNCD, including extensive new requirements for documentation to support a request for authorization of the administration of medications appropriate for the care and treatment of MNCD, and psychotropic medications
To be heard in Assembly Judiciary 6/28
Follow, Hot
David Perrot/Alex Hawthorne

SB 982
McQuire (D – Healdsburg)
Would require the Department of Developmental Services to develop and conduct a three year longitudinal study to assess the quality of life and outcomes of developmental residents that relocate from the Sonoma State Hospital as a result of the closure of that center.
To be heard in Assembly Human Services Committee 6/28
Follow
Sheree Lowe/Barbara Glaser

SB 1076
Hernandez (D-Azusa)
Would require a general acute care hospital that provides observation services to comply with the same staffing standards as supplemental emergency services. The bill would require that a patient receiving observation services receive written notice immediately upon admission for observation services or placement into observation status, or immediately following a change from inpatient status to observation status, and that the care being provided is on an outpatient basis.
To be heard in Assembly Health
Neutral Debby Rogers/Connie Delgado

SB 1252
Stone (R-Murrieta)
Would require a hospital to provide 1) written notification to a patient, in advance of treatment, if any of the physicians providing medical services to the patient are not contracted with the patient's health plan, and 2) the net costs to the patient for the medical procedure.
Held in committee
Oppose
Deepa Prasad/Alex Hawthorne

SB 1401
McGuire (D – Healdsburg)

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Would require CDPH to establish a pilot program in three counties targeted to increase access to in-home, private duty nursing care of children receiving Medi-Cal benefits. Would provide increased reimbursement rates for participating home health care agencies, and requires a report on the effectiveness of the pilot program no later than April 1, 2019.
Held in Suspense
Follow, Hot
Pat Blaisdell/Barb Glaser

CJR Bulletin

June 2016: Edition 2

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Frequently Asked Questions

Q: When can we begin utilizing the SNF 3-day stay waiver?

A: The SNF waiver will be available for use by Comprehensive Care for Joint Replacement (CJR) hospitals beginning on January 1, 2017 until the model ends on December 31, 2020. CJR hospitals may only use the SNF waiver to discharge a beneficiary without a qualifying 3-day inpatient stay to a SNF that meets the quality requirement, a 3-star rating or higher for 7 of the last 12 months. CMS will post a list of qualifying SNFs on our public website prior to January 2017 so hospitals are aware of which SNFs meet this requirement.

Q: Can we utilize the SNF waiver to discharge a beneficiary to a Critical Access Hospital (CAH) or other facility with swing beds? Currently CAHs do not have a star rating.

A: There is no star rating for swing beds or CAHs. The SNF 3-day stay waiver may only be utilized for discharge to a SNF that meets the quality requirements laid out in the CJR final rule.

Q: Can a CJR hospital that dropped out of BPCI continue using the SNF 3-day waiver (as they were using it in BPCI)?

A: The SNF waiver for CJR is not available until January 1, 2017. A hospital that is in CJR, regardless of whether or not they used to be in BPCI Model 2, is not able to begin using the CJR SNF waiver until it is available in January 2017.

CJR Model Reminders and Tips

➢ ***Voluntary patient-reported outcome (PRO) data submission***

The deadline for the CJR Performance Year (PY) 1 voluntary PRO data is October 31, 2016. If hospitals choose to submit data, they must report pre-operative data on at least 50 eligible patients or 50% of a hospital's eligible patients. Materials to assist with PRO data submission, such as the PRO data collection template and data dictionary, are available on CJR Connect under the Libraries tab. Use the content search bar to search for "PRO Data."

Also, don't forget to obtain your hospital's QualityNet account login information so that you are able to submit data using the Secure File Transfer File Exchange (Contact the QualityNet Help Desk if you have questions at: qnetsupport@hcqis.org or Phone: (886) 288-8912; TTY: (877) 715-6222).

➢ ***Beneficiary notification***

The CJR model requires providers to notify beneficiaries about their rights in the CJR model, including that beneficiaries retain their freedom to choose which hospital, physician, or other providers to use in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) has provided beneficiary notification documents for hospitals, physicians, physician group practices, and post-acute care providers/suppliers that should be used to notify beneficiaries about their rights under the CJR model. Beneficiary notification letters are available in English and Spanish through CJR Connect in the Libraries tab. Use the content search bar to search for "Beneficiary Notification Letters." The documents are also available on the CMS website at https://innovation.cms.gov/initiatives/cjr.

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In Case You Missed It

- ✓ "*CJR Webinar – Topic: Understanding and Working with CJR Claims Data: An Introduction*" (May 5, 2016)
- ✓ "*CJR Webinar – Topic: CJR Claims Data Office Hours"* (May 12, 2016)

Materials from both events, including updated tutorial videos, are available for download on CJR Connect through the Libraries tab. Use the content search bar to search for "Webinar Understanding and Working with CJR Claims Data 05 05 2016," "Data Analysis Webinar Transcript 05 05 2016," and "Data Analysis Videos and Transcripts 05 05 2016" for materials from the May 5th webinar and "Webinar Data Analysis Office Hours 5 12 2016" and "Data Analysis Office Hours Transcript 05 12 2016" for materials from the May 12th webinar.

Fast Fact about CJR Connect

CJR Connect provides an online forum for CJR participants to access model documents, as well as to interact with one another, ask questions, and share resources and experiences. Busy schedules may make it difficult to check the CJR Connect site frequently; however, changing your profile settings is a quick way to ensure that you do not miss the helpful reminders, peer-to-peer sharing, and resources that are available on the Connect site. Here are 6 quick steps to change your email settings so that you can receive weekly email digests of CJR Connect activity:

1. Log into CJR Connect using your username and password.
2. On the top right of the screen, click your name. A dropdown menu will appear.
3. Click "My Settings" from the dropdown menu.
4. Select "Email Settings" on the top right.
5. Check the boxes in each category to receive emails for posts, messages, and comments.
6. Select "Weekly Digests" from the dropdown menu at the bottom (there is also an option to select "Daily Digests" if you would like to be updated more frequently).

As a reminder, CJR Connect is intended for collaboration and sharing among CJR participants. Technical questions about the model should be directed to CJRSupport@cms.hhs.gov.

What's Trending on CJR Connect?

Here is what's trending in the CJR Connect Library:

- Most Recently Uploaded Documents:
  - Data Analysis Office Hours Transcript 05 12 2016
  - Webinar Learning System Kickoff Transcript 04 06 2016
  - Data Analysis Webinar Transcript 05 05 2016
- Most Downloaded Documents:
  - CJR 101 Webinars Content Pack
  - CJR PRO Data Content Pack
  - CJR - FAQ (Last Updated February 22, 2016)

A Request of CJR Participants

One of your CJR colleagues is looking for ideas on how to educate front line staff about the CJR model. If you have strategies, ideas, or resources related to educating front line staff about CJR, please log into the CJR Connect site, go to the Chatter tab, search for "Provider Engagement," and enter a comment.

CJR Contact Info

For questions, assistance, suggestions for Learning System events or to be added to the CJR Bulletin distribution list, please contact CJRSupport@cms.hhs.gov.

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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

June 22, 2016

TO: Case Management Committee Members

FROM: Cathy Martin, VP Workforce Policy
Pat Blaisdell, VP Continuum of Care
Debby Rogers, VP Clinical Performance and Transformation

SUBJECT: Workforce Planning

SUMMARY

CHA member hospitals report significant challenges in recruiting case management personnel. Workforce development was identified as a priority issue for committee work for 2016.

The goal of the CHA Workforce Committee is to lead a statewide, coordinated effort to develop, support and implement strategic solutions to address the shortage of allied health professionals. The CHA Workforce Committee is staffed by Cathy Martin, CHA, VP, workforce policy. Martin will participate in the current meeting.

ACTION REQUESTED

- To discuss and review current challenges associated with the recruitment and /or development of case management staff
- To discuss current models for training and orientation
- To identify potential issues or objectives for CHA advocacy efforts
- To discuss the potential for working with California State University (CSU) to develop customized training to meet the needs of California hospitals and health systems

DISCUSSION

During the meeting held on March 30, committee members discussed current challenges recruiting and/or developing qualified case management staff. Members reported that current vacancy rates are high, and identified possible issues and actions for further investigation, including:

- Many hospitals are working to recruit and develop incumbent staff as case managers.
- Development ideally includes accessing additional educational resources to expand knowledge base, combined with on-the job training/mentorship.
- Several education programs exist, but may not meet the specific needs of the hospital case manager, and may be costly.
- A defined career ladder is helpful to reward and retain staff.

- In addition to workforce development for case managers, there is a growing need to develop individuals to provide leadership to case managers and to their organizations.
- It would be desirable to advocate for case management to be included in curriculum for entry level professionals, e.g., for BSN students.
- Additionally, it would be desirable to advocate for case management be included as a component of "on-boarding" or orientation procedures.

The CSU Institute for Palliative Care has developed a modular training program for health plan case managers. Training is provided either on-line or in-person. An outline of the current curriculum and list of modules is attached. Committee members are requested to review the materials and be prepared to discuss. Among the questions:

- Is the described curriculum appropriate?
- What additional topics would need to be added?
- Is this format/mode of delivery a good "fit" for hospitals?
- What price point is acceptable?
- Is the described curriculum appropriate?
- Could these modules be used to support a career ladder and/or leadership development?

CSU The California State University
Institute for Palliative Care

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Foundational Care Management Curriculum

Submitted: February 29, 2016 by C. Lovci, RN, and R. Montano, PhD

I. Case Management Principles: Theory and Practice
  A. Care Management Concepts
    1. History of Care Management
      a. 1869-1982
        1. Case Work The Charity Organization Society
        2. Contributing Factors to Case Work
        3. Purpose of Case Work
        4. Outcome of Case Work
      b. 1955-1979
        1. Case Workers evolved to Case Managers
        2. Contributing Factors to Case Management
        3. Purpose of Case Management
        4. Outcome of Case Management
      c. 1980-2012
        1. Case Managers evolved to Care Managers+
        2. Contributing Factors to Care Management
        3. Purpose of Case Management
        4. Outcome of Case Management
    2. Basic Building Blocks Care Management
      a. Assessment
        1. What is it?
        2. Micro Levels of Assessment
        3. Meso Levels of Assessment
        4. Macro Levels of Assessment
        5. What is Involved?
      b. Plan/Coordinate
        1. What is it?
        2. Micro Levels of Planning/Coordinating
        3. Macro Levels of Planning/Coordinating
        4. What is Involved?
      c. Link/Refer
        1. What is it?
        2. Making a Successful Referral-What is Involved?
      d. Monitor

a. What is it?
b. Ensuring success

3. Care Management Function and Driving Forces
   a. Professional Designations
   b. Professional Roles and Responsibilities
   c. Understanding and Accounting for Driving Forces
4. Crisis Management
   a. Assess for potential crisis
   b. Preventing Potential Crisis
   c. When Crisis Occurs

B. Principles of Practice
1. Ethics
   a. Defining Concepts
   b. Principles and Relationships-Transference and Countertransference
   c. Principles and Relationships-Dual Relationships
   d. Principles and Practice-Value Conflict Awareness
   e. Best Practices for Value Conflict Prevention
   f. Practicing Motivation through Values
   g. Principles of Ethics
   h. Client Rights
   i. Informed Consent
   j. Confidentiality
   k. HIPPA
2. Protected vs. Vulnerable Populations
   a. Profiles of Protected Populations
   b. Profiles on Vulnerable Populations
   c. The “Legality” of Working with Protected and Vulnerable Populations
3. Care Management and Other Helping Professions
   a. Professionals within the Care Management Industry
   b. Care Management Specific to SPDs and Duals
   c. Psychotherapy vs Care Management
   d. Nursing vs. Care Management
4. Interventions for Positively Modifying Behavior
   a. Communication and Sharing
   b. Confronting Elements of Collateral Damage
   c. The Care Manager Perspective
   d. Empowerment

C. Healthcare Management and Delivery
1. Health Care Management
   a. Health Care Structures
   b. Health Care Origins
   c. Health Promotion
   d. Health Prevention

e. Healthcare Management Goals
f. Healthcare Management Risks
g. Healthcare Management Success

2. Healthcare Delivery
   a. Health Care Plans
   b. Health Care Settings
   c. Insurance/Managed Care Settings
   d. Health Care Continuum
   e. Managed Care Evolution

D. Managed Care Principles
1. Utilization Management
   a. Defining Concepts
   b. Categories
   c. Goals
2. Resource Management
3. Adherence
   a. Defining Concepts
   b. Non-adherence
   c. Strategies for adherence
4. Quality
   a. Access
   b. Defining Concepts
   c. Barriers to Access
   d. Results of Barriers to Access
   e. Responsiveness
   f. Principles for Member-centered care

E. Face to Face vs. Telephonic Care Management
1. Roles and Responsibilities Introduction
2. Care Management Roles
3. Roles and Responsibilities Continued
4. Face to Face
   a. Benefits
   b. Barriers
5. Case Management Technology
   a. Defining Concepts
   b. Benefits
   c. Barriers
6. Telephonic Case Management
   a. History
   b. Roles and Responsibilities
   c. Benefits
   d. Barriers
   e. Overcoming Barriers

f. Technology

F. Care Management Teams, Ancillary Services, and Partnerships
1. Care Teams
a. Models of care
b. Practice implications
c. Selection Criteria
d. Regulations
2. Ancillary Services and Partnerships
a. Categories of services
b. Partnership types
c. Roles and Responsibilities

G. Peer Support, Burnout Prevention, and Safety
1. Peer Support Groups
a. Defining Concepts of Peer Support
b. Maintaining Successful Peer Support Groups
c. Corollaries of Peer Support Groups
d. Organizational Support Groups
e. Professional Support Groups
2. Burnout Prevention
a. Defining Concepts of Burnout
b. Contributors of Burnout
c. Signs and Symptoms of Burnout
d. Neutralizing Burnout
e. Recovering Coping with Burnout
f. Physical Health Resilience Tactics to Prevent Burnout
g. Emotional Health Resilience Tactics to Prevent Burnout
3. Safety
a. Prevalence of Violence
b. Etiology of Violence
c. Risk Factors for Potential Violence
d. Warning Signs of Potential Violence
e. Techniques for Diffusing Violence
f. Conducting Home Visits

H. Critical Thinking
1. Critical Thinking Fundamentals
a. History
b. Contemporary Critical Thinkers
c. Central Concepts
2. Critical Thinking in Practice
a. Practicing Self-Disciplined Reasoning
b. The Importance of Questions
c. Socratic Questioning

d. Strategies for Developing Socratic Questions
e. Cultivating an Attitude of Inquiry
f. Engaging Reflective Thinking

II. Motivational Interviewing
A. Motivational Interviewing Concepts'
1. Self-Assessment
2. Defining Motivation
3. Motivation and Culture
4. Choices
5. Defining Motivational Interviewing
6. The Case for Motivational Interviewing
7. Limitations of Motivational Interviewing
B. The Spirit of Motivational Interviewing
1. Aligning Motivational Interviewing with Healthcare
2. Ineffective Motivational Techniques
3. Dynamics to Watch Out For
C. Applying Motivational Interviewing
1. Motivational Interviewing Language
2. Motivational interviewing Techniques
3. OARS
4. Affirmations
5. Reflections
6. Menu of Options
7. Rolling with Resistance
8. Developing Discrepancies
9. Decisional Balance
10. Additional Motivational Interviewing Strategies
11. Motivational Interviewing for Exploring Person-Centered

III. Relationship Building
A. Interdisciplinary Care Teams
1. Key Professionals and Roles
2. Collaboration and Information Sharing
3. Conducting Care Team Meetings
B. Member Relationship and Engagement
1. Know Yourself
2. Interpersonal Skills
3. Proactive Communication
a. Active Listening
b. Proactive Communication
c. Acknowledging Feeling and Emotions
4. Problem Identification and Goal Setting

a. Problem Identification
b. Decision Making
c. Intervention Planning
d. Resource Utilization

C. Community Partners
1. Identifying viable community partners
a. Private Industry Partnerships
b. Public Entity Partnerships
2. Creating win-win relationships
3. Developing joint taskforces for resource development

D. Patient Activation Principles
1. Defining Patient/Client Roles
2. Advocating Knowledge, Skills, and Confidence
3. Encouraging Active Engagement and Self-Advocacy
4. Promoting Long Term Empowerment and Resilience

IV. Getting the Whole Picture

A. Trauma Informed Care
1. Understanding Trauma Informed Care
a. Event or period of events of physically or emotional trauma or death which impact physical, emotional, mental, spiritual well-being.
b. Ask-What happened to you?
2. Recognizing Trauma Effects/Complex Issues of Trauma; Look at patterns of utilization for complexity of issues. Trauma results in health problems, detrimental social outcomes increased cost to social services.
a. ACE Surveys
b. Physical Health and Behavioral Patterns
c. Domains of Care Planning
3. Building a Trauma Workforce
a. Three Principles
b. Do's and Don'ts
c. Behavioral Interviewing-Use language of Trauma Informed Care-No labeling
d. Workforce Skills for Trauma Informed Teams

B. Evaluating Meaning in Communication and Documentation
1. Understanding and Interpreting Verbal Communication
2. Understanding and Interpreting Non-verbal Communication
3. Improving Communication to Enhance Meaningful Communication
4. Documenting for Problem Solving
5. Documenting for Collaboration

C. Assessing Capacity and Literacy
1. Understanding Capacity:
2. Determining Capacity:
3. Understanding Literacy

4. Determining Literacy

D. Evaluating Mandatory Reporting Protocols

1. Protected Populations
2. Vulnerable Populations
3. Privileged Information vs. Professional Responsibility

E. Psychosocial Aspects of Care

1. Environmental Factors
2. Support Systems
3. Risk Factors

F. Managing Multiple Chronic Conditions

1. Understanding Multiple Chronic Conditions
2. Assessing Patients with Multiple Chronic Conditions
3. Assessing Functional Status and Performance
4. Managing and Coordinating Care for Multiple Chronic Conditions
5. Managing Multiple Providers

G. Special Populations Overview

1. Mental Illness
2. Homelessness and Poverty
3. Substance Abuse
4. Pain Management & Chronic Opioid Use
5. Domestic Violence
6. Jail and Forensic Health
7. People with Physical Disabilities
8. Intellectual and Developmental Disabilities
9. LGBTQ
10. Alzheimer's/Dementia
11. TBI
12. Transplant
13. Pregnancy
14. Pediatrics

H. Completing Effective Home Visits

1. The Client at Home
2. The Living Space
3. Support Systems
4. Community and Environmental Factors

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Mentorship, Supervisor, and Management Curriculum

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I. Best Practices for Improved Outcomes
  A. Collaboration and Brainstorming
    1. Motivating Collaborative Participation
      a. Support
      b. Skills
    2. Understanding and Practicing Brainstorming
      a. Ideas-Good, Bad, and Ugly
      b. Promoting Idea Development and Sharing
      c. Creating Individualized Plans
    3. Resource Development
      a. Identification
      b. Safety in Sharing
      c. Relationship Building across Resources
  B. Understanding and Utilizing Quality and Performance Standards Data
    1. Understanding Quality Performance Standards
      a. Outcomes
      b. Patient/client Satisfaction
      c. Functional Status
      d. Cost Effectiveness.
    2. Utilizing Quality Performance Standards
      a. Professional Development
      b. Quality Improvement
  C. Problem Solving and Critical Thinking
    1. Problem Solving
      a. Problem Identification
      b. Decision Making Strategies
      c. Creativity and Alternatives
    2. Critical Thinking in Practice
      a. Practicing Self-Disciplined Reasoning
      b. Socratic Questioning
      c. Cultivating an Attitude of Inquiry
      d. Engaging Reflective Thinking
  D. Communication: Open Dialogue and Cross Discipline Learning
    1. Improving Communication with Care Managers
    2. Encouraging Open Dialogue with Clients
    3. Building Cross Discipline Interaction
    4. Promoting Cross Discipline Learning

II. Mentorship
- A. Knowledge Mentoring vs. Wisdom Mentoring
  1. What is Knowledge Mentorship
  2. What is Wisdom Mentorship
  3. Cultivating a Knowledge and Wisdom Mentorship Environment
- B. Bi-Directional Mentoring
  1. What is bi-directional mentoring
  2. Benefits of bi-directional mentoring
  3. Cultivating a Bi-directional Mentorship Environment
- C. Creating Assurances for Success
  1. Getting to Known Your Staff
     a. Identifying strengths
     b. Determining weaknesses
     c. Creating opportunities for alternative mentoring partnerships
  2. Benefits of Open Door Policies
  3. The Telephonic Mentorship Paradigm
     a. Identifying strengths
     b. Determining weaknesses
     c. Creating opportunities for alternative mentoring partnership
- D. Informal vs. Formal Mentoring
  1. What is Informal Mentorship
  2. What is Formal Mentorship
  3. Promoting Mentorship Partnerships in any form.
- E. Role Modeling
  1. Walking the Talk
  2. Walking the Walk

III. Leadership
- A. Influence, Power, and Persuasion
  1. How do influence, power and persuasion work in leadership?
  2. What is Leadership?
     a. Myths
     b. Reality
     c. Leadership Components
  3. Developing Leadership Skills
     a. Building technical competence
     b. Fostering effective relationships with superiors & peers
     c. Building credibility, expertise, and trust
     d. Reaching beyond the comfort zone
     e. Learning from experience
        1. Be open to receiving feedback from others
        2. Create a self-development plan
- B. Hiring Practices: Screening for Potential
  1. Essential Skills for Care Managers
  2. Assessing for Potential

3. Value of Critical Thinking
4. Evaluating Values, Reactions, and Adaptability

C. Improving Job Satisfaction and Reducing Turnover
1. Understanding Case Manager Needs
2. Promote Stress Management
   a. Triggers
   b. Thinking and Feelings
   c. Reactions
3. Provide Consistent Constructive Feedback
4. Create Opportunities for Empowerment

D. Provisions for a Supported Care Manger
1. Enhancing Resilience
   a. Importance of Resilience
   b. Promoting Emotional Resilience
   c. Promoting Physical Resilience
2. Reducing Burnout
   a. Recognizing Burnout
   b. Assessing Contributors within the Work Environment
   c. Neutralizing Burnout Contributes
   d. Encouraging Healthy Outlets
   e. When Burnout Occurs….

E. Creating a Culture of Learning and Growth
1. Peer Support, Mentorship Programs, Reflective Partners
   a. Starting and Maintaining Successful Support Groups
   b. Benefits of Mentoring
   c. Supporting Reflective Partnerships
2. Promoting Learning
   d. Identifying Education Needs
   e. Encouraging Questions/Promoting Safe Learning Environments
   f. Informal Learning Program
   g. Formal Education Programs

IV. Innovation

A. Fostering Innovation
1. Quality
2. Communication
3. Resources
4. Community Partnerships

B. Education
1. Informal
2. Formal

C. Resource Advocacy
1. Organization: Identifying, Sharing, and Housing Resources
2. Community: Identifying, Sharing, and Housing Resources
3. Industry: Identifying, Sharing, and Housing Resources

D. Collaboration

1. Team Collaboration
2. Organizational Collaboration
3. Community Collaboration
4. Industry Collaboration