NEW YORK STATE OF OPPORTUNITY.
Office of the State Long Term Care Ombudsman

# New York State
# Long Term Care Ombudsman Program

## Educating, Empowering, Advocating

March 3, 2022

- Mission and Values of the Long Term Care Ombudsman Program (LTCOP)
- Administration and Structure of LTCOP
- Role of Certified Ombudsman (paid staff and volunteers)
- Ombudsman Complaint Investigation Philosophy and Process
- Resident Rights: Overview
- Resident Rights: Care Planning and Discharge Planning
- Involuntary Discharge

# Ombudsman Program Mission

To serve as an advocate and resource for older adults and persons with disabilities who live in long-term care facilities

# Ombudsman Program Values

- Resident-Centered Focus
- Confidentiality
- Accessibility
- Prevention
- Resident Empowerment & Autonomy
- Complaint Resolution
- Objectivity

# Administration of the LTCOP Program

- The Older Americans Act, administered by the Administration on Community Living (ACL), requires each state to establish an Office of the State Long-Term Care Ombudsman.
  - In **New York**, the program is administratively housed within the State Office for the Aging (NYSOFA) and provides advocacy services through a network of regional programs.
    - The NYS LTCOP has 3 Assistant State Ombudsmen who supervise all regional programs and who are overseen by both a Senior Assistant State Ombudsman and the New York State Ombudsman.
      - To manage the 15 regional LTCO Programs from the State LTCOP Office, each ASO is individually assigned to 5 separate regional LTCO Programs.
        - Each regional ombudsman program has a designated ombudsman coordinator who recruits, trains and supervises a corps of volunteers that provide a regular presence in nursing homes and adult care facilities.

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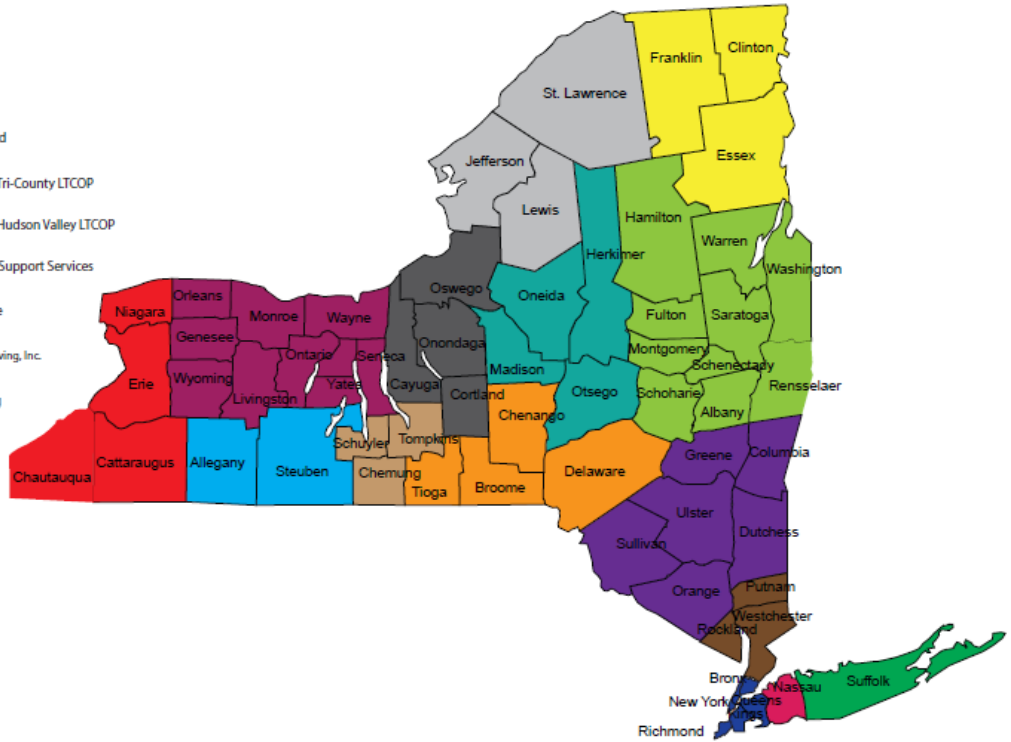
# LTCOP Regions

- 1 Family Service League
- 2 Family and Children's Association
- 3 Center for Independence of the Disabled
- 4 Long Term Care Community Coalition : Tri-County LTCOP
- 5 Long Term Care Community Coalition : Hudson Valley LTCOP
- 6 Catholic Charities Senior and Caregiver Support Services
- 7 North Country Center for Independence
- 8 Northern Regional Center for Independent Living, Inc.
- 9 Resource Center for Independent Living
- 10 ARISE Child and Family Services, Inc.
- 11 Action for Older Persons
- 12 Tompkins County Office for the Aging
- 13 Lifespan
- 14 AIM Independent Living Center, Inc.
- 15 People, Inc.

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# LTCOP by the Numbers

- Approximately 1,400 Long Term Care Facilities
- Over 160,000 beds
- Includes Skilled Nursing Facilities, Adult Care Facilities and Family Type Homes
- Approximately 35 Full Time and 15 Part Time Staff Statewide
- Approximately 250 Certified Volunteer Ombudsmen

# Certified Ombudsman Requirements

- All Ombudsmen (staff and volunteers) must complete a 36-hour certification training

- All Ombudsmen (staff and volunteers) must complete 18 Continuing Education credit hours each program year.

- Volunteers commit to 2-4 hours weekly in a facility

# Responsibilities and Authorities of a Long-Term Care Ombudsman under the Older Americans Act

- Investigate & Resolve Complaints
- Educate consumers/providers on residents' rights
- Advocate for quality care in LTC facilities
- Promote development of resident/family councils
- Access to all LTC facilities without interference
- Access to residents and medical records with consent

# Ombudsman Roles

- Listener/Investigator- gathers information, then evaluates facts
- Educator- on resident rights, responsibilities and regulations, on how to choose a nursing home, on staffing, and on resources in the community
- Negotiator/Mediator/Collaborator- helps to improve communication and find acceptable solutions, act as a 3rd party facilitator between roommates/other residents and staff
- Referral Agent/Broker - to other agencies who may be better able to help
- Problem Solver – is thoughtful and assists in resolving resident problems/issues by providing options and resources
- Systems Change Agent- advocating for concerns of residents and the need for change on a systems level. Working on broader, underlying problems for residents of LTC facilities

# The LTCOP's primary focus is to be resident-centered at all times.

- The resident is always the first person with whom an Ombudsman must discuss any complaints or concerns.

- A resident's wishes always remain the focus and priority of any action taken by an Ombudsman

# Permission to Act

- Before beginning any investigative work on behalf of a resident, an Ombudsman must receive verbal permission to do so from the resident, or their representative.

- A resident, or their representative, is always first fully informed about how the Ombudsman program can help them.

- The resident, or their representative, then needs to give the Ombudsman Program verbal permission to work on their behalf to resolve their complaints, to review their records if needed, and to reveal their identity and/or information in order to help resolve their complaint. The Ombudsman must then document that verbal permission was granted in their own documentation.

# How does an Ombudsman Resolve Complaints on behalf of Residents?

1. Ombudsman meets with the resident/complainant, clarifies the issues, looks at root causes, and brainstorms potential resolutions with the resident

2. If permission obtained from resident/complainant, Ombudsman will gather information about the concerns presented by interviews with staff, observation, and/or review of records

3. Bring all key staff together with the resident and the Ombudsman. Again determine root cause of the concern

4. Brainstorm and define potential solutions consistent with resident wishes

5. Mutually agree on a solution

6. Define a solid plan and timeline to implement the solution

7. Execute the solution, and evaluate the solution over time

8. After trying out the resolution, if it doesn't work, can go back to step 4 to renegotiate an alternative solution with staff to develop and execute a new plan

| Role of the New York State Department of Health (DOH) | Role of the LTCOP |
| --- | --- |
| Quality of Care | Quality of Life |
| Regulatory compliance based on minimum standards. | Goes above and beyond minimum standards to address ANY expression of dissatisfaction. |
| DOH's presence is for shorter intervals at least once a year for routine surveys or periodically in response to called in complaints | LTCOP has a regular and more routine presence. |
| Sanctions facilities with a deficiencies | Ombudsmen works with facility staff to resolve complaints. |

# *"Similar, but Different"*

***SIMILARITIES:***

- Both the DOH and the LTCOP are oversight entities for long term care facilities.
- Both have the ability to investigate complaints on behalf of complainants.

***DIFFERENCES:***

- However, the LTCOP investigates in a much different way than the DOH to identify the root causes of problems to assist in mediation with facility staff to resolve resident complaints BEFORE regulatory action becomes necessary.
- With the LTCOP, facilities have an opportunity for significant improvement before receiving a formal citation for a given problem.

# Nursing Home Reform Law (in brief)

- In order to participate in Medicare/Medicaid, nursing home agrees to meet the minimum standards set forth in federal law.
  - States may have additional protections; not less.
- Requires every resident is provided the care and quality of life services sufficient to attain and maintain their highest practicable physical, emotional, and psycho-social well-being.
- Lays out specific resident rights: care and monitoring to quality of life that maximizes choice, dignity and autonomy.
- Standards apply for all residents regardless whether care is paid for by Medicare, Medicaid, or private pay.

# Resident Rights

- Resident rights stem from “Person Centered Care”
- Residents have the right to participate in their plan of care and this includes discharge planning.
- Every resident has the right to exercise their rights as a citizen/resident of the U.S. and as a resident of the facility.
- Every resident has a right to a dignified existence, self-determination, and communication with and access to persons and services outside the facility.
- Every resident has the right to be free from abuse, neglect, exploitation, and misappropriation of property.

# Person Centered Care

- To focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. (42 CFR 483.5)
- Person Centered Care Planning: **Get a copy of the care plan!**
  - Based on resident's medical, nursing, mental, and psychosocial needs.
  - Based on resident's goals and desired outcomes.
  - Based on a comprehensive resident assessment that includes:
    - Customary routine, cognitive patterns, mood, ability to and methods of communication, and physical, dental, and nutritional status.
  - Services to be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being
  - Resident's goals and desired outcomes
  - Discharge Planning
  - Quarterly reviews and care plan meetings: care plan is fluid.

# Resident Right: Discharge Planning

- Discharge Planning: is part of the care plan!!!!
  - A process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge.
- Facilities must develop and implement an effective discharge planning process that focuses on:
  - The resident's discharge goals;
  - Prepares residents to be active partners in the process;
  - Post-discharge care; and
  - Reduction of factors leading to preventable readmissions.
- Resident (and representative if applicable) must be involved and asked about interest in returning to the community
  - 10 NYCRR 415.3(c)- information on HCBS
  - MDS Section Q

# 6 Allowable Reasons for Discharge

1) Necessary for the resident's welfare and the residents needs cannot be met at the facility;
2) Appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
3) Safety of individuals is endangered due to the clinical or behavioral status of the resident;
4) Health of individuals in the facility would otherwise be endangered;
5) Resident has failed, after reasonable and appropriate notice, to pay for (or to have paid) under Medicare or Medicaid at the facility; or
6) The facility ceases to operate.

***Every one of these allowable reasons can be involuntary!**

# Requirement: Written Notice

- Must be provided to the resident and resident's representative in a language and manner they understand;
- Reason for discharge/transfer;
- Effective date of discharge/transfer;
- Location to where the resident is being discharged/transfer;
- Statement of the resident's appeal rights, including contact information of the entity which receives appeals (i.e. NYSDOH), information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
- Name, address, and phone number of the State Long Term Care Ombudsman Program

# Written Notice : Timing Requirements

- General rule is written notice must be provided 30 days before discharge
- However, 30 day written notice is not required when:
  - Safety or health of other individuals in the NH would be endangered;
  - Resident's health has improved sufficiently;
  - Resident's urgent medical needs necessitate an immediate transfer/discharge
  - Resident has not resided in the NH for 30 days
- **In the above situations, written notice may be given as "soon as practicable" but no later than the day the facility made the decision to discharge**.
- It is inappropriate for the notice to be provided to the resident as they are being escorted out of the facility!
- NYS Public Health Law 2803-z: for facility-initiated transfer/discharge, at least 30 day written notice unless resident cannot be cared for safely, or is a danger to others.

# Requirement: Safe Discharge Location

**The discharge location must be safe!**

- To be determined "TBD" is never appropriate
- Questionable discharges: Hotel, Shelter, DSS
- Home of a relative or friend:
  - Does the relative/friend want the resident in their home?
  - Is the home safe?
- Is the discharge plan safe?

*New Public Health Law 2803-z*:

- No facility shall initiate a discharge of a resident to the home of another individual without the written consent of the resident and the other individual and the other individual has received and acknowledged the discharge plan to address the resident's needs.
- Prior to a facility initiating a discharge, it shall "use its best efforts" to secure appropriate placement or a residential arrangement for the resident, other than temporary housing assistance.

# Requirement: Documentation

- NH is required to properly document the discharge in the resident's record and ensure appropriate information is communicated to the receiving provider.
- The resident's physician must document the basis of the discharge.
- If the reason for discharge is the resident's needs cannot be met, the physician documentation must include:
  - The specific resident need(s) that cannot be met;
  - How the facility attempted to meet the resident needs(s); and
  - The receiving facility's service available to meet the need(s) that cannot be met at the current facility.

# Requirement: Sufficient Orientation

- Requirements of the NH:
  - Provide and document sufficient preparation and orientation to residents to ensure safe and orderly discharge/transfer.
  - Provide information to the resident (and representative) in a form and manner the resident can understand.
  - Provide the resident (and representative) with the opportunity in deciding where the resident will reside after discharge.
- These requirements are the same regardless whether the discharge/transfer is voluntary or involuntary

# Requirement: Discharge Plan Summary

- Summary of resident's stay: diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results;
- Final summary of resident's status;
- Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter); and
- Post-discharge plan of care that is developed with the participation of the resident, and with the resident representative (with resident consent).
  - Including where the individual will live, arrangements for follow-up care, and any post-discharge medical and non-medical services.

# Resident Right: Appealing the Discharge/Transfer

Step 1: Contact NYS DOH to file an appeal.

- Call: 1-888-201-4563 and clearly state you are appealing a discharge from the facility.
- Email: nhintake@health.ny.gov
- **The resident has the right to remain in the NH pending an appeal determination.** (Exception: endangerment→ hospital)

Step 2: NYS DOH will request a copy of the notice from the facility to review it for validity 'on its face.'

- If notice is invalid, facility will be informed it cannot discharge resident.
- If valid→ Step 3

Step 3: NYS DOH Bureau of Adjudication

- Sets the date/time/place of the hearing before an Administrative Law Judge (ALJ)
- Hearing will typically be where the resident is located
  - Currently hearings are being held virtually during COVID-19.

# Issue: Nursing Home to Nursing Home Transfer

- In general: transfer to another nursing home is inappropriate!
- Common legal reasons for discharge that are used to transfer resident to a different nursing home:
  - Resident's welfare and/or resident's needs cannot be met at the facility.*
  - Residents health has improved sufficiently so the resident no longer needs the services provided by the facility.
- Transfer for Long-Term Care ("LTC") or Long-Term Placement ("LTP") is not one of the 6 reasons to move a resident to another facility.
  - Every nursing home in NYS is dually Medicare & Medicaid certified.
  - If a resident exhausts Medicare coverage of the nursing home stay and is now classified as someone who needs "LTC" or "custodial" care, the facility cannot claim they do not have any beds available for "LTC" and transfer the resident.

# Issue: Medicare Coverage Ends

*When Medicare coverage of the nursing home stay is exhausted or terminated by Medicare, the Medicare Plan, or the facility.*

- If this occurs, the resident is responsible to ensure the NH is still paid, whether it is through private funds or Medicaid.
  - Non-payment is a reason for discharge!

- "Jimmo" standard: **there is no improvement standard for Medicare coverage**!
  - An **assessment** of the resident's clinical condition shows specialized judgment, knowledge, and skills of a qualified therapist are **necessary** for the performance of a **safe** and **effective** program.
  - This includes a maintenance program!
- Discharge planning can and should start on day 1

For more information visit the Center for Medicare Advocacy:
https://www.medicareadvocacy.org/medicare-info/improvement-standard

# Issue: "Patient Dumping" at Hospitals

*When nursing home transfers the resident to a hospital and refuses to readmit them to the first available bed.*

## Reasons why facility would do this?

- Resident (or family) is labeled as 'difficult'
- Resident has 'behaviors' that the facility chooses not to properly treat/provide care for

## Reason used by facility for discharge:

- Necessary for resident's welfare and resident's needs cannot be met
- Safety/Health of individuals in facility is endangered

## Things to remember:

- Discharge to hospital is never appropriate!
- Decision to discharge a resident should not be made based on the time of transfer to the hospital!
- Discharge notice must be issued to the resident (and designated representative)!

# Staffing Requirements

- No mandated staffing ratios in federal regulation:
  - 24 hour nursing care by licensed nurses and other personnel;
  - RN on staff at least 8 consecutive hours/7 days a week.
- *New *eff. Jan 1, 2022*: Maintain daily average staffing equal to 3.5 hours per resident per day (RN,CNA,LPN)- PHL 2895-b
  - 2.2 CNA/TNA
  - 1.1 RN and/or LPN care
- Enforcement of new law on hold (facilities must still meet “sufficient” standard).
- Know the nursing homes staffing information:
  - Required to be posted daily
  - CMS Payroll Based Journal (PBJ) Data: https://data.cms.gov
  - LTCCC: user-friendly PBJ data
  - https://nursinghome411.org/nursing-home-data-information/staffing/

# Ombudsman Advocacy-Summary

- Ombudsmen are not case managers
- Educate, inform, empower, advocate:
  - Resident rights
  - Care planning and discharge planning
  - How to appeal an involuntary discharge/transfer
  - Quality care and quality life
- Connect residents to resources:
  - Independent Living Centers/Open Doors
  - Legal Services
  - Local Resources (OFAs, NY Connects, County, etc.)

# Center for Elder Law & Justice

- Non-profit legal services agency, providing free full legal representation in ten WNY counties. (716) 853-3087 ; elderjusticeny.org

- Senior Legal Advice Helpline- NYS Residents
  - Free legal help for New Yorkers 55+
  - Answers to brief legal questions and referrals to legal resources across NYS; including nursing home residents rights questions and concerns.
  - Monday through Friday from 9:00am to 11:00am EST at 1-844-481-0973. You can also call and leave a message outside of those hours, and e-mail us at any time at helpline@elderjusticeny.org. A licensed attorney will respond to you within 2-3 business days.

- Contact:

Lindsay Heckler
(716) 853-3087 x212
lheckler@elderjusticeny.org

# Resources

- Center for Elder law & Justice
  - https://elderjusticeny.org/resources/long-term-care-resources/
  - https://elderjusticeny.org/about/news/
- Long Term Care Community Coalition
  - https://nursinghome411.org/
  - https://nursinghome411.org/learn/
  - https://nursinghome411.org/data/
- National Consumer Voice
  - https://theconsumervoice.org/

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1-855-582-6769

https://ltcombudsman.ny.gov/

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# Questions