The New York State Long Term Care Ombudsman Program recently completed an extensive questionnaire for the National Senior Citizens' Law Center regarding the implementation status of certain requirements of the OBRA Nursing Home Reform.

We have taken the responses to that questionnaire and compiled the attached report.
A STATUS REPORT ON
NEW YORK STATE’S IMPLEMENTATION
OF FIVE KEY PROVISIONS IN THE
NURSING HOME REFORM LAW

1. Transfer and Discharge Notice Request and Hearing System

2. Resident Assessment/Care Planning

3. Access to Therapies to Obtain or Maintain Functioning

4. Protecting the Right to Give Informed Consent

5. Use of Intermediate Sanctions

New York State Office for the Aging
New York State Long Term Care Ombudsman Program
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1. Transfer and Discharge Notice Rights and Hearing System

Requirement: The State, for transfers and discharges from nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism, meeting the guidelines established under subsection (f) (3) of this section, for hearing appeals on transfers and discharges of residents of such facilities; but the failure of the Secretary to establish such guidelines under such subsection shall not relieve any State of its responsibility under this paragraph. 42 U.S. C. 1396r(e) (3)

Section 415.3(h) of the New York State nursing home code details specific procedures that facilities must adhere to when discharging a resident. Part of this process directs facilities to advise residents of their appeal rights and to give the name, address, and telephone number to the State Long Term Care Ombudsman when a discharge notice is to be given to a resident. This is to ensure that the resident rights associated with transfer or discharge are acknowledged and upheld by both the facility and the State Health Department.

If the resident and/or family appeals the discharge, the Department of Health conducts an informal “meeting” to help resolve the conflict. The Department imposes a determination only when the parties cannot agree. Ombudsmen have attended these meetings to assist and support residents and their families.

To date, there have been approximately 15 hearings. The residents remain in the facility until a determination is reached. The burden of proof in New York State rests with the facilities in all cases when residents oppose discharge.

It is important to note that while there is a system in place in New York State that affords the resident and family an opportunity to challenge a discharge notice, to date there does not exist a written policy and procedure. As a result, accountability and continuity in terms of implementation are potential threats to the integrity of this process. We continue to encourage the Department of Health to complete the written policy and procedures on this process quickly in order to ensure that residents’ rights in this area are protected.

2. Resident Assessment/Care Planning

Requirement: Facilities must conduct a comprehensive, accurate, standardized, reproducible assessment, based on a uniform minimum data set, of each resident’s functional capacity in at least 13 different areas. They must then, based on the assessment, prepare a care plan with participation by resident and family. 42 U.S.C. 1396r(b) (2) and (3); 42 CFR 483.20(b)

For some time, New York State has focused on well designed and meaningful resident assessment and care planning techniques. As a result, many facilities have involved residents and families successfully in identifying the problems and needs that require an inter-disciplinary approach that achieves the desired goal either of improving resident functioning or maintaining resident status at the highest possible level of functioning.
New York State has provided extensive training to facilities on the use of the federally mandated Minimum Date Set (MDS+) and Resident Assessment Protocols (RAPS) now in use in all facilities for resident assessment and care planning. While it appears that the large majority of facilities are doing meaningful assessments and care plans, there have been a significant number of facilities cited for deficiencies in this area.

For the most part, the problems that facilities are experiencing with resident assessment and care planning are in all likelihood a result of procedural errors in terms of learning and translating already sound practices to the MDS+/RAP process.

3. Access to Therapies to Obtain or Maintain Functioning

Requirement: Facilities must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 42 U.S.C. 1396r(b) (2)

As with many aspects of the new nursing home code, the Bureau of Long Term Care Services has provided training to providers in the area of access to therapy.

Resident needs and specific goals are documented through the MDS+/RAP process of assessment and care planning. Surveyors are instructed to identify negative outcomes if residents are not attaining the highest practicable level of functioning. Surveyors make these determinations based on care plans, observations of care, and interviews with residents and families.

Therapy is available to all residents who require these services through an all inclusive reimbursement rate provided under RUG-11. (According to the Health Department, New York State's rehab rates are among the highest reimbursable rates in the Nation.) As a result, basic maintenance therapy often is shifted out of the "formal" provision of service to a more "informal" mode of treatment where therapy recommendations are implemented by nursing personnel, i.e., ambulation, range of motion exercise, etc. While this system is appropriate in some cases, concern exists for residents who might not receive the recommended services because of the staffing or time constraints often experienced by the nursing department.

4. Protecting the Right to Give Informed Consent

Requirement: Each resident has the right to be fully informed in advance about care and treatment, to participate in planning care and treatment, and to make choices about significant aspects of her/his life. 42 U.S.C. 1396r(c) (1) (A) (i); 42 CFR 483.15(b) (3) In addition, under the Patient Self-Determination Act, facilities must give residents information about state law on advance directives and may not condition the receipt of care on executing an advance directive. 42 U.S.C. 1396a(a) (57)
State regulations and health facilities memoranda from the Department of Health have provided facilities with instructions on these issues. However, while surveillance and enforcement procedures are used to ensure compliance in this important area, there are potential problems. We believe that some residents are being denied access to the full range of information necessary to make an informed decision regarding treatment and other health care issues. Facilities often will provide only enough information to the resident so that a decision is of more benefit to the facility rather than the resident. After admission, some facilities begin to manipulate changes in the resident's initial decision, although they said they agreed with the resident and family before admission.

5. Use of Intermediate Sanctions

Requirement: States must have the following remedies for violations of federal law: denial of payment, imposition of civil money penalties, appointment of temporary management, appointment of monitors and authority to close facilities (or alternative remedies approved by HCFA). 42 U.S.C. 1396r(h) (2), 1396(g) (4) In addition, federal law requires that each state "specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies." 42U.S. C. 1396r(h) (2) (A)

Since the implementation of OBRA, the following remedies have been imposed on New York State facilities:

A. Denial of payment imposed on 3 facilities.
B. Civil money penalties imposed on 85 facilities.
C. Temporary management (receivers) placed in 4 facilities.
D. Monitors placed in 3 facilities.
E. No closures.

Fine actions are taken routinely as both a punitive and a preventive measure for serious and/or recurring violations.

Up until recently, receivership actions generally have resulted in voluntary receiverships, in which there is a voluntary surrender of the certificate to operate a nursing home in New York State and an agreed upon receiver takes over operation the facility. (If a voluntary receivership is not possible, then the State will take action to seek both revocation and an involuntary receiver.)
Ombudsman programs have been involved in interviewing proposed receivers and providing the Department of Health with recommendations based on this and resident and substate program input.

However, Federal law now requires that if a sanction other than termination is to be taken, the State must stipulate to repay Medicaid money to HCFA if the facility fails to correct the citations warranting sanction within a 6 month period. New York State has declined to stipulate, because a facility having citations meriting termination is not a facility that the State is willing to bank on to correct those citations.

This decision is unfortunate. Receiverships are far less traumatic to residents, families, and staff. In addition, Ombudsman Program input into this process often resulted in modifications to the proposed receivership agreement and positive facility change which ultimately gave residents the opportunity to receive a better quality of care.

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