Involuntary Nursing Home Discharges: A Fast Track from Nursing Homes to Homeless Shelters

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Introduction

- Background on Mobilization for Justice, Disability and Aging Rights Project
- White Paper: Involuntary Nursing Home Discharges: A Fast Track from Nursing Homes to Homeless Shelters
  - Based on MFJ's experience representing residents, together with review of the 73 decisions rendered by the NYS Department Health in 2018

https://mobilizationforjustice.org/wp-content/uploads/Involuntary-Nursing-Home-Discharges.pdf

Presentation outline

- Discharge planning and community integration
- Legal Background
- Findings
  - Substantive Problems
  - Procedural Problems
- Recommendations

Grounding principles

Protecting the rights of people with disabilities to:

- Autonomy
- Self-determination
- Community integration
  - Olmstead: Interpreting the Americans with Disabilities Act to require that services be provided to people with disabilities in the most integrated setting possible

Olmstead v. L.C., 527 U.S. 581 (1999)

Overview of Laws and Regulations

- Nursing Home Reform Act of 1987

Person-centered care means "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 Requirements Apply to Discharge Planning

- The facility must **involve the resident** and resident representative in the development of the discharge plan AND inform the resident and resident representative of the final plan.
- The discharge plan must address the **resident's goals** of care and treatment preferences.

42 CFR § 483.21(c).

Preparation

"A facility must provide and document sufficient orientation and preparation to residents to ensure safe and orderly discharge from the facility. This orientation must be provided in a form and manner that the resident can understand."

42 CFR § 483.15(c)(7).

Focus of Discharge Planning

The facility must develop and implement an effective discharge planning process that focuses on:

- the resident's discharge goals;
- the preparation of residents to be **active partners** and effectively transition them to post-discharge care; and
- the reduction of factors leading to **preventable readmissions**.

42 CFR § 483.21(c).

Comprehensive assessment and care planning obligations

- Required from the inception of nursing home stay
- Minimum Data Set ("MDS") assessment
  - at least quarterly
  - Section Q: designed to give "residents a direct voice in expressing preference" and "the facility a means to assist residents in locating and transitioning to the most integrated setting."

https://www.hhs.gov/sites/default/files/mds-guidance-2016.pdf

Section Q of the MDS

- If the resident expresses interest in returning to the community, the facility **must refer** them to a Local Contact Agency, an organization that helps residents of nursing homes access community-based housing and services.

Preadmission Screen Resident Review (PASRR)

- Assessments required for residents with known or suspected mental health or developmental disabilities
- Purpose: to ensure that they are not unnecessarily institutionalized in long-term care settings in violation of the Americans with Disabilities Act.
- Required prior to admission, at least annually, and upon a significant change in condition. CFR § 483.106(a).

Six Allowable Bases for Involuntary Discharge/Transfer

1. necessary for the resident's welfare and the resident's needs cannot be met in the facility;
2. resident's health has improved sufficiently → no longer needs the services provided by the facility;
3. safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
4. health of individuals in the facility would otherwise be endangered;

Six Allowable Bases for Involuntary Discharge/Transfer, cont.

5. failure to pay, after reasonable and appropriate notice, (or to have paid under Medicare or Medicaid); or

6. the facility ceases to operate.

42 CFR § 483.15(c)(1)(i).

Notice to Transfer/Discharge

Residents are entitled to 30 days Notice, but with exceptions, including:

1. the safety or health of others in the facility would be endangered;
2. the resident's health has improved sufficiently to allow for a more immediate discharge or transfer;
3. discharge is due to the resident's urgent medical needs; OR
4. the resident has not resided in the facility for 30 days.

If one of the exceptions apply, the facility must still give notice as "soon as practicable." 42 CFR § 483.15(c)(4).

Requirements of the Notice

- Must be provided to the resident and representative in a language and manner they understand 42 CFR § 483.15(c)(3)(i).
  - i.e. understandable to residents with limited English proficiency, visual impairments

Requirements of the Notice, cont.

- Must include:
  - Reason(s) for the discharge
  - Effective date of the discharge
  - Location to which the resident is being discharged
  - Regulations that support the discharge
  - Right to appeal and how to file an appeal
  - Contact information for the Long Term Care Ombudsman Program (LTCOP)
  - For residents with developmental or mental health disabilities, contact information for the state's designated Protection and Advocacy Program

42 CFR § 483.15(c)(5).

Right to Appeal

- The resident may appeal the decision to discharge within 60 days of receiving the notice.
- If the appeal is filed before discharge, the discharge is stayed until a hearing and appeal decision
  - EXCEPTION: endangerment to the resident or others in the facility.
  - If the facility alleges imminent danger, it "must document the danger that failure to transfer or discharge would pose."

Required Documentation

- Basis for discharge – must be documented in the resident's nursing home record
- Resident's doctor must complete the documentation if:
  - Basis is improved health OR
  - Resident's needs cannot be met at the facility
- A doctor (but not necessarily the treating doctor) must complete the documentation if basis is a danger to the safety or health of individuals in the facility

42 CFR § 483.15(c)(2).

The Appeal Hearing

- Nursing home bears the burden of proving:
  - (1) the discharge is necessary; and
  - (2) the discharge is appropriate.
- Residents have a right to represent themselves, be represented by counsel, "or use a relative, a friend or other spokesman." 42 CFR § 431.206(b)(3).
- Access to records: opportunity to examine the file and any documents the nursing home will use at a reasonable time before the date of the hearing

42 CFR § 431.242(a).

Conduct of the Hearing

- The resident may bring witnesses, question or refute testimony, including by cross-examination
- In New York State, judges have the power to obtain "medical assessments and psychosocials" and issue subpoenas. If the ALJ determines that an impartial medical assessment is necessary, it must be obtained at the expense of the State Medicaid agency
- Decisions are issued in writing and inform the parties of the process for appeal of the decision

42 CFR § 431.242(a); 42 CFR 431.240(b).

Other Rules

- New York State:
  - Manual for Administrative Law Judges
  - Regulations regarding shelter admissions
- New York City
  - Department of Homeless Services policy on shelter admissions
- Federal rules on publication of decisions
  - Once rendered, involuntary discharge decisions must be made available to the public

Findings: Discharge Planning Failures

Nursing homes fail to conduct discharge planning as part of comprehensive person-centered care planning

- Three of the most common problems:
  - Failure to obtain needed benefits, services, and housing
  - Failure to comply with shelter referral requirements
  - Failure to ensure that residents move to the least restrictive setting appropriate to their needs

Discharge Planning Failures: Context

- NY State Department of Health fails to enforce discharge planning standards
- Longstanding problem and not just NY: HHS OIG report from 2013

  OFFICE OF THE INSPECTOR GENERAL, U.S. DEP'T OF HEALTH & HUMAN SERVS., SKILLED NURSING FACILITIES OFTEN FAIL TO MEET CARE PLANNING AND DISCHARGE PLANNING REQUIREMENTS, February 2013, OEI-02-09-00201, available at: https://oig.hhs.gov/oei/reports/oei-02-09-00201.pdf
- Forthcoming HHS OIG report on problems with discharges in 2022

Failure to apply for or obtain needed services prior to discharge

- Trying to discharge a resident to her home after she suffered numerous falls. The facility did not ascertain whether home care was available or what devices were needed to maintain her safely at home.
- Proposing to discharge a resident who uses a wheelchair to an assisted living facility that does not accept residents who use wheelchairs (itself a violation of the law).
- MFJ client was discharged to an apartment through a waiver program without durable medical equipment, prescriptions, or home care services in place. The referral she received for a PCP was to a provider who did not accept her insurance.

Failure to Comply with Shelter Referral Requirements

NYC shelter referral requirements set forth eligibility criteria, exclusionary criteria, and procedures to request reasonable accommodations

https://www1.nyc.gov/assets/dhs/downloads/pdf/DHS-%20Institutional_referral_procedure_7182018.pdf

- Yet NYC nursing homes routinely discharge to shelters, even when residents have service needs that the shelters cannot meet
- ALJs uphold decisions to discharge to homeless shelters, even when there's no evidence that any attempt was made to find housing

Shelter Discharges

- In 2018 1,294 nursing home residents were discharged to homeless shelters*
- Only 31 residents who faced discharge to a shelter had a discharge hearing
- The nursing home prevailed in 81% of the cases in which a shelter was the proposed discharge location

*Source: LOCAL LAW 114 OF 2017 REPORT ON MEDICAL HEALTH SERVICES IN SHELTERS, 2018 REPORT

Failure to Seek the Least Restrictive Setting

- Failure to use the PASRR process to enable residents with mental health disabilities to access community housing
- Failure to refer to or follow up on referrals to local agencies for housing through waiver programs
- Referring to homeless shelters residents in the process of obtaining community housing, putting housing applications in jeopardy

Misunderstanding of Eligibility for Nursing Home Care

- Nursing homes contend that discharge is appropriate because the resident no longer needs **skilled services**
- But in New York State, all nursing home beds are dual certified. Nursing homes cannot discharge residents on the basis that they need custodial services and not skilled services.

CMS Infograph: Custodial Care vs. Skilled Services

- This is a misunderstanding of the range of services that nursing homes provide
- CMS Infographic: Custodial Care vs. Skilled Care

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/infograph-CustodialCarevsSkilledCare-%5BMarch-2016%5D.pdf

Discharge Appeal Decisions Misapply the Standard for Discharge

- Judges adopt the "skilled services" reasoning
  - "resident has reached maximum rehabilitation potential"
  - "Appellant no longer needs skilled care in a nursing home…"
  - "If the Appellant is well enough to live in an apartment in the community, the Appellant does not need to be in a nursing home."

Procedural Problems in the Discharge Process

- Failure to serve Notice as required
- Notices must be furnished to the LTCOP, but may be sent late. The LTCOP is underfunded, so their capacity to follow up with residents for whom they receive notices is limited.

Procedural Problems – Effectiveness of the Notice

- Notices to Discharge/Transfer are difficult to understand
  - No standardized format
  - The basis is often a box that's checked, with no underlying facts provided
  - Frequently only in English, even when resident or representative has limited English proficiency

Notice problems, continued

- Often small type, hard to read
- Seldom in an accessible format, even when resident has a known visual impairment
- Confusing layout can make it difficult to tell who to contact to request an appeal

Confusing Notice Example

Excerpt from discharge notice issued by a New York City nursing home:

If you wish to appeal this transfer or discharge decision, you can do so in writing or by calling:

- New York State Department of Health
  875 Central Avenue
  Albany, New York 12206 — 888-201-4563

- Disability Rights New York:
  725 Broadway #450
  Albany, NY 12207 — (800) 993-8982

- New York State Department of Health
  Long Term Care Ombudsman Program
  11 Park Place, Suite 1110
  New York, New York 10007 — 212-812-2901

Challenges Filing an Appeal

Even assuming the resident timely received the Notice and it was intelligible, requesting an appeal can be difficult.

- In New York State, appeal requests go to the nursing home complaint hotline.
- Isolation and lack of phones→ hard for residents to confirm their appeal request was received.

Legal Representation in the Discharge Hearing Process

- Nursing homes were twice as likely as residents to have legal counsel
  - Nursing homes had counsel in 19 cases
  - Residents (or their guardians) had counsel in 7 cases
  - Residents with counsel won their case every time
  - Compare: overall residents won their case 42% of the time

Challenges for Residents Without Legal Representation

- Refuting medical records and testimony by nursing home staff
  - Appearance of expertise and professionalism
- Obtaining conflict-free medical records and assessments
  - Unused power by judges to request assessments and require Medicaid to pay for them
  - Unused power by judges to issue subpoenas

Challenges for Residents Without Legal Representation, cont.

- Challenges with using nursing home records
  - Often provided shortly before the hearing
  - Medical terminology
  - Voluminous – difficult to find information unless records are text searchable and reviewed on a computer
  - Knowing what documents to ask for to refute testimony

- Need for knowledge of the intricacies of the regulations – i.e. requirement of documentation by treating physician

Challenges During the COVID-19 Pandemic

- Moratoria on evictions not applied to involuntary discharge hearings
- Lack of access to nursing homes by advocates and family members
- Difficulties with video hearings plus lack of guidance
- Facilities improperly using limited exceptions to transfer procedures for COVID cohorting
- Discharges to homeless shelters and other unsafe settings during COVID

Jessica Silver-Greenberg and Amy Julia Harris, *'They Just Dumped Him Like Trash': Nursing Homes Evict Vulnerable Residents*, N.Y. TIMES, June 21, 2020.

Recommendations

- Right to counsel in nursing home discharge hearings
- Enforce existing regulations
- Strengthen existing regulations
- Standardize the Notice to Discharge for readability
- Simplify process to request an appeal
- Increase funding to the Long-Term Care Ombudsman Program
- Prohibit discharges to homeless shelters

Recommendations, cont.

- Train administrative law judges on:
  - Federal and state requirements on comprehensive care planning, discharge planning, and the PASRR process;
  - Skilled services versus custodial care;
  - Standards for admission to assisted living programs;
  - Standards for admission to shelters;
  - Seeking assessments paid for by Medicaid;
  - Issuing subpoenas;
  - Medicaid waiver and other programs designed to assist nursing home residents transition to community settings

Questions and Answers

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