Activities of the
Virginia Department of Health and
Long Term Care Stakeholders Workgroup
Regarding Nursing Facility Resident Readmission and Discharge

House Bill 1274 (2012)[1] requires the Commissioner of Health to convene a workgroup[2] to clarify state and federal requirements and develop guidelines applicable to nursing facility resident transfers and discharges, including but not limited to related notice requirements and transfer procedures for inpatient medical care. HB1274 also requires the Commissioner to report on the Secretary of Health and Human Resources, and the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions concerning the progress of the workgroup. In actuality, HB1274 formalized a workgroup convened by the Virginia Department of Health (VDH) in 2011 that had been meeting on the same issues covered by the legislation, i.e., nursing facility discharge practices and whether facilities were improperly discharging residents. Because the elder rights advocates sought the introduction of legislation in 2012 that "any written notice of involuntary transfer or discharge be sent to the State Long-Term Care Ombudsman at the same time such notice is sent to the [resident]," a compromise was reached that resulted in HB1274.

DISCUSSION

According to leaders of the elder rights advocacy sector: (i) nursing facility residents have a right to return to the same facility once hospitalization is no longer needed; (ii) residents and their families are confused about their rights of readmission to the facility, and (iii) nursing facilities routinely use emergency transfer to the hospital to discharge unwanted residents, which violates state and federal law. The nursing facility industry counters that federal and state law prohibit facilities from retaining residents when a facility can no longer meet the medical needs of a resident or when a resident is a danger to themselves, other residents, staff or visitors. Facilities also claim that current state and federal laws and regulations are confusing, so any missteps by nursing facilities are not intentional.

In order to address these issues, VDH convened a stakeholder workgroup to: (i) investigate the causes under which a nursing facility initiates a transfer or discharge of a resident, (ii) determine if facility-initiated transfers or discharges (commonly referred to as involuntary) are allowed under state and federal laws and regulations, (iii) identify possible gaps in service delivery leading to the need for a facility to involuntarily transfer or discharge a resident, (iv) develop proactive recommendations and strategies for handling residents with behavior problems (thought to be the major cause of involuntary transfer and discharge), and v) determine the validity of the allegations that residents are being discharged unfairly.

Over the course of the workgroup's discussions, various issues concerning interpretation of federal and state laws and regulations could not be resolved. One example is the use of the

[1] See Appendix A
[2] See Appendix B

term "voluntary" or "involuntary" when describing the transfer or discharge of a resident, especially in cases of transfer to a hospital. While common understanding would suggest that transfer to a hospital was conducted in response to an emergency medical situation, some workgroup members strongly disagreed citing it as an involuntary movement of the resident. Furthermore, federal and state laws and regulations do not categorize or define the transfer or discharge process as either voluntary or involuntary; but they do list the circumstances in which a facility can remove a resident from the premises. The circumstances under which a transfer or discharge can occur are deliberately limited in scope. However, frequently a resident is transferred based on more than one of the allowable circumstances thereby adding to the inability to cite clear cut stipulations. In addition, anecdotal information shared during workgroup meetings describe a disconnect between hospital-based medical practice and communication and practices in nursing facilities. One example is the use of observations beds for longer than 48 hours, rather than admitting the resident to the hospital. This practice negatively affects the resident's ability to return to the same nursing facility bed, disrupts the resident's Medicare reimbursement, and violates state and federal regulations. Additionally, nursing facilities rely on hospitals as a chief source of resident referral; therefore, nursing facilities claim reluctance to call attention to questionable practices over concern of losing a vital referral source. Over the course of 2012, various hospital practices have gained national attention and are being further scrutinized by the Centers for Medicare and Medicaid Services (CMS).

WORK GROUP ACTIONS

The elder rights advocates sought the development of a bed-hold notice that would be given to each resident upon transfer to the hospital. The nursing facility industry, on the other hand, requested guidance clarifying current law and regulation regarding the circumstances under which a nursing facility may transfer or discharge a resident. Using the language of the bed hold notice adopted by the Department of Medical Assistance Services (DMAS), the workgroup agreed to the language of the bed-hold notice[3]. That notice was distributed to all nursing facilities December 2011 by VDH. The workgroup agreed that federal databases would be used to track the incidences of involuntary discharge beginning January 2012. The workgroup also agreed to reconvene after the 2012 legislative session regarding the guideline requested by nursing facilities.

During the summer of 2012, VDH developed and circulated to work group members the requested guideline clarifying state and federal requirements regarding transfer and discharges. Unfortunately, the various viewpoints on the meaning and intent of the laws and regulations did not coalesce; and the parties were unable to agree concerning a guideline. Both sides did agree the State Ombudsman should receive a copy of the facility-issued notice of discharge at the same time the notice is issued to the resident. Having heard the concerns of each side, VDH determined to exercise its oversight authority regarding the development and issuance of a guideline utilizing, where appropriate, the input received from the work group.

[3] See Appendix C

DATA

Rather than rely on anecdotal information, VDH searched available state and federal regulatory databases and complaint registries to determine the extent of the problem pertaining to transfer and discharge. The empirical data that could be extracted from available systems, while not specific, suggested such problems were isolated and rare rather than common or widespread as alleged.

Recently, VDH became aware of the National Ombudsman Reporting System (NORS).[4] According to NORS, the number of "discharge/eviction - planning notice, procedures, and implementation" complaints in Virginia increased from 96 in 2007 to 155 in 2010. The proportion of these complaints as a total of all complaints received by the Virginia Long- Term Care Ombudsman program increased by only 1.1 % from 2007 to 2010, the last year for which the data is available. Comparing the NORS data to the number of live discharges collected annually by Virginia Health Information (VHI)[5] from nursing facilities confirms that such problems are isolated and rare. Nevertheless, VDH intends to continue monitoring the data to assure remedial action is taken when necessary.

TRAINING RESOURCES

Since the beginning of this project, the workgroup heard of third party organizations providing training initiatives designed to assist nursing facilities in handling residents with behavioral problems, which are thought to be the causality of involuntary discharge. These programs were widely advertised in hopes that facilities would take full advantage of the expertise and knowledge available. Such programs include, but are not limited to:

- A three part webinar series "addressing behavioral health needs of the growing aging population." The series was developed by the Virginia Geriatric Partnership and funded by a grant from the Virginia Center on Aging's Geriatric Training Education Initiative. The webinars are archived at: http://worldeventsforum.blogspot.com/p/community-partnerships-ethical-and.html. According to the report issued by the Partnership, 600 senior service providers and long term care staff participated in and directly benefitted from this series.

- The National Partnership to Improve Dementia Care and Reduce Unnecessary Antipsychotic Medication Use in Nursing Facilities, a new initiative from CMS. Launched in March 2012, "the goal of the partnership is to optimize the quality of life and function of [nursing facility residents] by improving the approach to meeting the behavioral health needs of all residents, especially those with dementia. More information on the program can be found at: http://www.leadingage.org/phillips_antipsychotic_checklist.aspx.

[4] The NORS database can be found at: www.agidnet.org

[5] VHI is the health care data reporting organization under contract with VDH to annually collect data from designated medical care facilities and services.

- The Community Services Boards in Tidewater offer a variety of training on care of persons with mental health and behavioral health problems.

RECOMMENDATIONS

In addition to the development of the VDH OLC guidance document, VDH offers the following recommendations for consideration. These recommendations are meant to address a number of the concerns identified from the stakeholder workgroup members. The recommendations can be categorized into three major areas; review of resident rights, medical care communication and behavioral health resources.

- Review of resident rights
    - Local ombudsmen should partner with facilities to reiterate basic resident rights, including rights surrounding bed hold and discharge, within 30 days of a new resident being admitted to a facility;
        - The purpose of this review is twofold, it gives new residents a second review of their rights post the anxiety of the admission process and provides the Ombudsman an opportunity to meet new residents before any problems arise.
    - The annual resident rights review required by the Regulations for the Licensure of Nursing Facilities 12VAC5-371-150 E should include a review of the facility's bed hold and discharge policies and procedures;
- Medical care communication
    - Nursing facilities and hospitals should improve sharing of resident medical information and status to assure complete care, especially when a resident is transferred to a hospital for emergency medical care.
    - Nursing facilities and hospitals should use the model transfer form;
    - Residents should not be placed in hospital observation beds for longer than 48 hours;
    - Hospitals should fully stabilize residents with behavior problems prior to approving their return to the nursing facility;
    - Better collaboration between nursing facilities and hospitals pertaining to psychotropic medication prescribing and use is needed to assure a resident's smooth return from the hospital to the facility.

- Behavioral health resources
    - Crisis stabilization programs and mobile mental health units, such as the successful RAFT[6] program in Northern Virginia, should be supported and funded.
        - Nursing facilities should work with DMAS to utilize some of the federal Civil Money Penalty funds in support and expansion of mobile mental health units, such as RAFT;
        - Nursing facilities should work collaboratively with state and local government entities, such as the Community Services Boards, in support

[6] RAFT is the Regional Older Adult Facilities Mental Health Support Team managed by the Arlington County Senior Adult Mental Health Services office. The RAFT web site is: https://www.arlingtonva.us/departments/HumanServices/AgingDisability/raft/page65159.aspx

of residents with behavior problems. Use of available programs should be expanded and encouraged by the industry associations;

- Nursing facilities should use telemedicine for delivery of behavioral health services, which has been proven to be highly successful;
  - The industry associations should partner with the Virginia Telemedicine Network to expand and encouraged to assure those resources are available to all facilities;
- Nursing facilities should become more proactive in providing staff development and orientation opportunities regarding the care needs of residents with mental health and behavioral health problems.

APPENDIX A

CHAPTER 730

An Act to develop guidelines addressing nursing facility transfer and discharge procedures.
[H 1274]
Approved April 9, 2012

Be it enacted by the General Assembly of Virginia:

1. *§ 1. The Commissioner of Health shall convene a work group, utilizing to the extent practicable any ongoing work group, to clarify state and federal requirements and develop guidelines applicable to nursing facility resident transfers and discharges, including but not limited to related notice requirements and transfer procedures for inpatient medical care. The work group shall consist of five representatives of the Virginia Elder Rights Coalition; a total of five representatives of providers designated jointly by the Virginia Hospital & Healthcare Association, the Virginia Health Care Association and the Virginia Association of Nonprofit Homes for the Aging; two representatives of the Department of Behavioral Health and Developmental Services; one representative of community services boards; one representative of the Department of Medical Assistance Services; one representative of the Virginia Academy of Emergency Physicians; and a representative of the Virginia Bar Association. The Commissioner will report the work group's progress to the Secretary of Health and Human Resources and the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by December 1, 2012.*

Appendix B

Work Group Members

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APPENDIX C

Bed-Hold Notice for Resident[7]

<Printed on Facility Letterhead or Memo paper>

Notice of Bed Hold Policy

_____

Date

You are being sent to the hospital today. If you are a Medicaid resident and you are admitted to the hospital, Virginia Medicaid does not pay to hold your bed. Whatever your payment source, unless the nursing home is paid to reserve the bed while you are in the hospital, the nursing home may move someone else into your room. However, even if the nursing home is not paid to hold your bed, you *may* have the right to return as soon as a bed is available in a semi-private room in this nursing home as long as you still need the services provided by this nursing home (and, if you are on Medicaid, you are eligible for Medicaid nursing home services).

If the nursing home does not readmit you to the first available bed in a semi-private room when you are ready to leave the hospital—

- You have the right to appeal the nursing home's decision to the Department of Medical Assistance Services, Appeals Division, 600 East Broad Street, Suite 1300, Richmond, VA 23219 (fax number: 804-371-8491).

- You may also file a complaint with the Office of Licensure and Certification, 9960 Mayland Drive, Richmond, VA 23233 (Toll Free: 1-800-955-1819 or in the metropolitan Richmond area: 804-367-2106).

- For help in filing an appeal or a complaint, contact the Office of the State Long Term Care Ombudsman at (804) 565-1600 or toll-free 1-800-552-3402.

[7] The complete Bed-Hold Guideline can be found at: www.vdh.virginia.gov/OLC, under Laws, Regulations and Guidelines.