NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 4, 2018

DAL: NH 18-05
SUBJECT: Nursing Home Discharge Requirements

Dear Nursing Home Administrator:

The purpose of this letter is to remind nursing facilities of their obligation to uphold the *Olmstead* decision by ensuring that all residents who express a desire to return to the community are provided the opportunity and assistance by the facility to allow the resident to live in the most integrated and least restrictive setting possible.

Section 504 of the Federal Rehabilitation Act of 1973 prohibits programs receiving federal funds from discriminating against a qualified individual based on their disability, including individuals with disabilities living in nursing facilities. Facilities must make reasonable accommodations to assist residents in discharging to the community. Additionally, facilities are required to adhere to 42 CFR 483.15 and 10 NYCRR 415.3(h) which details facilities' roles and responsibilities in their admission, transfer, and discharge practices. Section 415.3(h) states that facilities must "provide sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility, in the form of a discharge plan which addresses the medical needs of the resident and how these will be met after discharge, and provide a discharge summary pursuant to section 415.11(d); and permit the resident, their legal representative or health care agent the opportunity to participate in deciding where the resident will live after discharge from the facility."

10 NYCRR 415.11(d) further requires a discharge summary to include:

- A recapitulation of the resident's stay;
- A final summary of the resident's status to include information set forth in paragraph (a)(2) of section 415.11(d) at the time of the discharge that shall be available for release to authorized persons and agencies, with the consent of the resident or legal representative; and
- A post-discharge plan of care that shall be developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment and assure that needed medical and supportive services have been arranged and are available to meet the identified needs of the resident.

The Department will be reviewing the discharge practices of the facilities as part of our surveillance protocols.

As you know, Section Q, question Q0500 of the Minimum Data Set (MDS), is used to identify those nursing facility residents who wish to return the community. Federal guidelines require that all Medicare and Medicaid certified nursing homes ask its residents on a quarterly basis, unless otherwise noted, if they wish to receive information about returning to the community. Question Q0550 allows the resident, or if the resident is unable to understand or respond, the legal representative to elect to only be asked about returning to the community on annual comprehensive assessments. If a resident has an active discharge plan in place, the facility ***does not*** need to complete question Q0500. All reasonable attempts should be made to ask the resident directly about their desire to return to the community. All questions on the MDS must be asked as they are written. Question Q0500 must be answered based on the resident's wishes and not the facility's determination or opinion on whether the resident is capable of returning to the community.

To assist facilities in the accurate completion of Section Q, the U.S. Department of Health and Human Services' Office for Civil Rights released *Guidance and Resources for Long Term Care Facilities: Using the Minimum Data Set to Facilitate Opportunities to Live in the Most Integrated Setting* and further specifies facilities' obligation to accurately complete question Q0500 in Section Q of the MDS. We encourage all facilities to review this document carefully.

Any resident who answers affirmatively to question Q0500 must be referred to the New York Association on Independent Living's (NYAIL) **Open Doors** program for more information. Failure to refer a resident in a timely manner may result in a statement of deficiency.

Residents who are referred to **Open Doors** will be met by a Transition Specialist who will provide information to the resident and/or their designated representative on available home and community services that may be available to support them in the community. If the resident and/or their designated representative decide to pursue community discharge, the Open Doors Transition Specialist will work with the resident and/or their designated representative, other support persons of their choosing, and facility staff to assist in coordinating the resident's discharge from the facility.

Additional information requiring the facilities' obligations in completion of the MDS can be found at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.

Nursing Homes wishing to send Section Q referrals to Open Doors should use the referral form at https://ilny.us/programs/mfp/section-q. This form can be emailed or faxed to the Regional Lead Independent Living Center listed in the Section Q contact list at the same website. Referrals may also be sent to NYAIL via e-mail to secq@ilny.org or via fax to 518-465-4625.

We encourage all facilities to review their current practices and training materials to ensure compliance with the *Olmstead* decision.

Should you have any questions, please contact your local DOH office or the nursing home surveillance program at (518) 408-1267.

Sincerely,

Daniel B. Sheppard
Deputy Commissioner
Office of Primary Care and Health Systems Management

cc: Mark Kissinger
Mark Hennessey
Shelly Glock