

**Spring/Summer
Issue
June 2010**

Page 1

From the Commissioner

Pages 2-3

From the Director:

Exciting Period Ahead for
Adult Services Following
Enactment of Elder Justice
Act

Update on the Online PSA
New Worker Orientation
Manual

By Michael Cahill

Pages 4-6

Focus on Family-type-
homes for Adults: An Issue
of Safety!

By: Rich Piche and Deb-
bie Greenfield

Page 7

Save the Date for
AATI !

Pages 8-11

The Family Health Care
Decisions Act A Major
Step Forward

By Alan Lawitz

Pages 12-14

Protective Services for
Adults:

Everyone deserves to be
safe



FROM THE COMMISSIONER

Gladys Carrión, Esq.

This issue of our newsletter reflects the fact that there is quite a lot going on in the field of Adult Services: new legislation, new initiatives, and a greater public recognition of the important work done by local district Protective Services for Adults staff.

Inside these pages you will find, among other things, articles on the new federal Elder Justice Act and the New York State Family Health Care Decisions Act, laws that have the potential to provide significant benefits for PSA workers and their clients. There's also an article describing very positively how the Orange County DSS PSA unit delivers services to protect adults with impairments who have no one else willing and able to assist them.

In addition, I want you to know that in April I sent letters to local commissioners inviting their participation in our new round of Certificates of Recognition. This round will seek to honor exemplary programs or practices that successfully promote the protection of vulnerable adults. These may be operated entirely by a local district or may be a partnership involving other public or private entities working together on behalf of our clients.

With the recent enactment of the Elder Justice Act, which provides for authorization for future additional federal funding for PSA, both for demonstration project grants and a range of other programs, it is more important than ever for us to seek out and publicize promising programs and practices serving our clients. I look forward to receiving nominations from local commissioners.



From the Director:

Exciting Period Ahead for Adult Services Following Enactment of Elder Justice Act

Well, they actually did it! This past March the Congress passed, and President Obama signed into law, the Elder Justice Act as part of the Health Care Reform legislation.

The Elder Justice Act (EJA) will provide for the first time a coordinated federal response to elder abuse, neglect and exploitation issues. It also has the potential to provide some significant federal funding in New York State and across the country for Protective Services for Adults and other programs serving vulnerable elders.

Among other things, the Act would provide for:

- Establishment of an Elder Justice Coordinating Council, to foster coordination throughout the federal government (HHS, Justice, other agencies) on elder abuse issues, and an Advisory Board of national experts in the field to make recommendations to the Council;
- An Adult Protective Services Grants Program to state and local programs under which the state would receive funds annually based on a formula for the purpose of enhancing APS programs. The formula is based on the percentage of the State's total population that is 65 or older. According to Census Bureau projections for 2010, New York's percentage of population age 65 or older is 6.59%, the third highest percentage in the nation.
- Demonstration grants to States testing various approaches to preventing, detecting or combating elder abuse.
- Grant program to establish and operate Elder Abuse, Neglect and Exploitation Forensic Centers.

In addition, there are several provisions related to improving patient care in certain long-term care (LTC) facilities such as nursing homes and others receiving Medicare or Medicaid funding. These include:

- support for activities to enhance training, recruitment and retention of staff of long term care facilities;
- grants and training for long term care ombudsmen programs;
- funding of grants to LTC facilities for technology intended to improve patient safety and reduce medication errors;
- establishment of a National Training Institute for certain LTC Surveyors;
- requirements for reporting to law enforcement and to HHS crimes committed against persons who are residents, or receiving care from, LTC facilities;
- penalties for retaliation against staff of LTC facilities who make complaints about patient care;
- funding a study on establishment of a national nurse aide registry.

What is important to understand is that, while the EJA contains numerous authorizations of funding the provisions noted above, the Congress will still have to take further action to make appropriations of funding available.

The EJA has been pending in Congress for many years, and OCFS has been among the many state and local agencies, public and private, supporting this bill.

We look forward to working with HHS, in conjunction with the local social services districts and our state partners, to implement this new law.

Alan Lawitz



Update on the Online PSA New Worker Orientation Manual

By Michael Cahill

The feedback on the new online version of the self-study manual, which debuted in January, has generally been positive. A new caseworker in Schenectady said that reading the guide helped prepare him for the April New Worker Institute (NWI), which we were happy to hear, and that he actually enjoyed doing the quizzes at the end of the modules. That really made our day.

As with any distance learning tool involving the internet, however, there is always the possibility of glitches and a few problems have been reported. Several upstate districts tried to sign on to the manual to no avail. It turned out the caseworkers were unable to access the OCFS intranet, which is where the manual and a number of other online tools are located, including the links to the OCFS Bureau of Training, the back issues of the OCFS Adult Services Newsletter, and the Adult Services Automation Project (ASAP) Help Files.

The districts notified the Brookdale trainers and Brookdale reported the problems to us. With the help of the OCFS webmaster, the NYS Office for Technology, and the local district LAN administrators, links were opened and the caseworkers were able to register and begin their work. If you're struggling with access, please contact Brookdale or your OCFS representative. We may have a solution.

One district out west and another downstate asked how long it would take to complete the manual. A rough estimate to read through a module is around 30 minutes to an hour. There are seven modules altogether. The manual is organized in bite-sized chunks so that caseworkers can devote as much or as little time as they have available on a given day. We do ask districts to support new hires in their efforts to complete the manual before attending NWI, but not completing the manual is not a bar to attending NWI. At this point, trainees should be encouraged to do what they can to prepare for the institute.

We continue to look for feedback on the manual.

Please let us know by using the email addresses in the manual or by giving our office a call at (518) 473-6446.



Focus on Family-type-homes for Adults: An Issue of Safety!

By: Rich Piche and Debbie Greenfield

We all remember the tragic fire that destroyed an OMRDD-licensed group home in March of 2009 resulting in 4 resident deaths. This particular disaster occurred despite the fact the building was recently constructed, equipped with a sprinkler system and had staff available to escort residents from the premises; a building with much greater fire safety protections than required in Family-Type Homes for Adults (FTHAs) and staffing levels that also surpass our level-of-care requirements.

This incident brings to the forefront the important role played by both operators and Family-Type Home coordinators in protecting the vulnerable residents in our FTHAs. It is with this tragedy in mind that we call to attention the need for our operators to adhere to the admission and retention standards outlined in regulations, as well as the recent requirements of Amanda's Law. Amanda's Law, which took effect on February 22, 2010, mandates, among other things, installation of carbon monoxide detectors on the lowest story having a sleeping area in an effort to safeguard our vulnerable residents. OCFS recently sent out a letter to local commissioners, a fact sheet and a new administrative directive (10 OCFS ADM 02) which detail the requirements for compliance, and which expressly state that this new law applies to FTHAs, among other licensed settings. Please review compliance with this new requirement by your operators, especially in the course of your annual unannounced inspection.

In recent years we have observed in many cases a more physically frail, cognitively impaired FTHA resident. Both of these factors strongly affect a resident's ability to evacuate a building in an emergency. We have found that some operators, convinced of their ability to provide good care, have accepted residents with rehabilitation needs back into the facility. Although the care may in fact be exemplary, it is inappropriate in a FTHA without sufficient fire safety protection for this type of population, and is also a violation of admission/retention standards. These standards are covered in the FTHA Operator's Manual, as well as the regulations, and should be reviewed when you inspect/visit your FTHAs. Even if residents meet admission/retention standards, operators should consider both a resident's physical capabilities and cognitive issues in combination when incorporating them into the facilities' evacuation plan.

Key fire /safety regulations include the following:

Supervision:

- Supervision services include conducting and supervising evacuations and fire evacuation drills.
- All residents and other occupants of the home shall be trained in the means of rapidly evacuating the building.
- The operator shall conduct semi-annual evacuation drills at various times of the day and night for all occupants of the home, including participation by the designated substitute(s).

- The operator shall record the date and time of each drill and how long it took to evacuate the home.
- The operator, together with the FTHA coordinator, shall develop a plan to protect residents in a fire or other emergency. The plan shall include procedures for:
 - evacuation of the home
 - temporary provision of essential services
 - relocation of residents
 - coordination with community resources/local emergency planning organizations posting emergency telephone numbers by the telephone.

18 NYCRR 489.10 (b)

Locks:

“Chainlocks, hasps, bars, padlocks and similar devices shall not be used in a way which would inhibit access to an exit or the free movement of residents.” 18 NYCRR 489.12(m)(3). As operators care for an increasing number of residents with dementia, we have seen a number of instances of locks being used to prevent wandering. This is very hazardous in unprotected (wood frame) buildings and not allowed in any FTHA. Residents who exhibit wandering behavior are not appropriate for Family-Type-Home level of care and any locks observed must be removed immediately. Door alarm (vs. locking) systems may be utilized to alert operators/staff of comings and goings. If that is not sufficient to address the wandering problem, additional staffing must be provided for supervision purposes until the resident is transferred to an appropriate level of care.

Smoke Detectors:

Acceptable testing laboratory listed smoke detectors shall be installed in the following locations:

- in a multi-level home, at the top of all stairways and in a bedroom area no more that 20 feet from the top of the stairs.
- in an FTHA which is on a single floor, in corridor(s) leading to bedrooms or where recommended by the local fire department.

An ABC-rated fire extinguisher which meets National Fire Protection Association standards shall be properly installed in the kitchen and charged.

18 NYCRR 489.12(n)

Avoid Fire Hazards:

Building exits shall be free of obstructions at all times.

The following are considered fire hazards and are prohibited:

- smoking in bed
- nonmetal containers for wood or coal ashes
- unsafe accumulation of combustibile material
- unsafe storage of flammable material
- overloaded electrical circuits
- hot plates in residents’ rooms

- ◆ the use of self-contained fuel burning space heaters or stoves unless installation was approved by local building or fire department and approved in writing by your local department of social services.

18 NYCRR 489.12(n)(4)

Emergency Procedures:

It is also important to remind operators that by regulation they must orient and train employees and volunteers in the emergency procedures that govern the home and whom to contact in the event of an emergency.

The OMRDD effort to explore means for preventing such disasters in the future also cited the advantage of having local fire personnel be familiar with facility layout and the evacuation characteristics of residents. Although not required by current regulations, we encourage you to strongly suggest that operators involve their local fire departments with the completion of fire inspections, the layout of their homes and when possible, monitoring fire evacuation drills and provide feedback.

Adherence to the rules and regulations that govern the FTHA program along with your oversight, go a long way in averting disaster and helping to provide a healthy and safe environment for our residents.



We are pleased to announce that the Bureau of Adult Services is in the process of developing training on the Family-Type-Home for Adults Program. We plan to kick off this training event in the Fall of 2010. Initial plans are to hold these meetings as part of the regularly scheduled PSA Regional Supervisors Meetings. Details to follow!



THE 17TH ANNUAL NEW YORK STATE
ADULT ABUSE TRAINING INSTITUTE
"BREAKTHROUGH: ADULT ABUSE AND THE ELDER JUSTICE ACT"



SAVE THE DATE
SEPTEMBER 15-16, 2010
ALBANY MARRIOTT HOTEL AND CONFERENCE CENTER

The Family Health Care Decisions Act: A Major Step Forward

By Alan Lawitz

On March 16, 2010, Governor Paterson signed into law the Family Health Care Decisions Act. The Act allows families and close friends to act as surrogates and make medical decisions on behalf of incapacitated patients in general hospitals and nursing homes. This includes decisions to withhold or withdraw life-sustaining treatment, in accordance with the standards and procedures set out in the Act. In addition, the Act has procedures to allow for consent to treatment decisions for those incapacitated patients who have no family or friends available to serve as surrogates.

Prior to the enactment of this law, New York was one of only two states that had no law recognizing a general right of family members to make surrogate health care decisions for their loved ones where no health care proxy or living will was in place. Despite efforts in recent years to encourage the use of advance directives, most people do not enter into health care proxies or living wills. In addition, there are others born with disabilities that never have the decision-making capacity to express their wishes. Many patients at or near the end of their lives, with terminal illnesses and lack of capacity in hospitals or nursing homes, have had to continue to receive aggressive treatment (feeding tubes, CPR, ventilators, dialysis, surgery, antibiotics, etc.) to try to save or prolong their lives, because there was no one legally authorized to say otherwise on their behalf.

Key components of the Act include the following:

Determination of Incapacity. An attending physician must make an initial determination that a patient lacks decision-making capacity, to a reasonable degree of medical certainty. This determination is subject to a concurring determination. Once such determination is made, notice of the determination is given to the patient (where there is any indication the patient can comprehend this information), and to at least one person on the list of potential surrogates who is highest in priority.

Selection of Surrogate. The selection of a surrogate is made from a list of individuals ranked in order of priority, including: any guardian authorized to decide about health care in accordance with Mental Hygiene Law Article 81; the spouse or domestic partner; a son or daughter 18 years or older; a parent; a brother or sister 18 years or older; family members and close friends. The surrogate's authority commences upon the determination of the patient's incapacity and the identification of the surrogate.

Surrogate's Rights and Responsibilities. The surrogate has the right to make any health care decision the patient could have made, and has the right to medical information and records to make informed decisions about the patient's health care, as well as the responsibility to obtain such information. Health care providers must provide this information to the surrogate.

Patient's Right to Object. If the patient objects to the determination of incapacity, the choice of a surrogate or to a health care decision made by a surrogate, the patient's objection shall prevail, unless a court determines the patient lacks capacity or another legal basis exists for overriding the patient's decision.

Decision-Making Standard. The surrogate must make health care decisions in accordance with the patient's wishes, including religious or moral beliefs or, if the patient's wishes are not known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests.

Withholding/Withdrawal of Life-Sustaining Treatment. There are specific provisions about decisions to withhold or withdraw life sustaining treatment. Such decisions shall be authorized only if:

1. treatment would be an extraordinary burden to the patient and the physician determines, with independent concurrence of another physician, that the patient has an illness or injury which is expected to cause death within 6 months, whether or not treatment is provided, or patient is permanently unconscious; or
2. the provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances and the patient has an irreversible or incurable condition.

Where There Are No Family/Friends to Serve as Surrogate. Where there are no family or close friends available to serve as surrogates, the statute contains procedures by which surrogate consent may be provided by:

1. an attending physician, without the need for any additional consents, for routine medical treatment;
2. an attending physician, in consultation with hospital staff directly responsible for the patient's care, with an independent concurrence from at least one other physician, for major medical treatment;
3. for decisions to withhold or withdraw life sustaining treatment, such decisions may be made by: a court, if the court finds the decision accords with standards for decision-making within the Act; or by an attending physician, with independent concurrence of a second physician, if they determine, to a reasonable degree of medical certainty, that

- I. life-sustaining treatment offers the patient no medical benefit because the patient will die imminently, even if treatment is provided; and
- II. provision of life-sustaining treatment would violate accepted medical practices.

Conscience Objections. Private general hospitals and nursing homes and individual health care providers shall not be required to honor a health care decision made under this Act if: the decision is contrary to a formally declared policy of the hospital or an individual's sincerely held religious or moral conviction; and the patient, family or surrogate has been promptly told of such policy or belief prior to or upon admission, if reasonably possible; and the patient is promptly transferred to another hospital or provider that is reasonably accessible and willing to honor the decision of the patient, and pending the transfer honors the decisions or seeks judicial review.

Immunity. Ethics Review Committee members, health care providers and their employees, surrogates and guardians are given immunity from civil or criminal liability for health care decisions and other actions taken reasonably and in good faith pursuant to the Act.

Special Proceedings. Any person connected with the case and any member of a hospital Ethics Review Committee may commence a special proceeding in court with regard to any matter arising under the Act. A court can designate any person from the surrogate list to act as surrogate, regardless of their priority on the list, if the court determines such appointment would best accord with the patient's wishes or best interests.

Remedy. Any hospital or attending physician that refuses to honor a health care decision by a surrogate made in accordance with this Act shall not be entitled to compensation for treatment, services or procedures refused by the surrogate, with certain exceptions (such as when matters are pending in an Ethics Review Committee, or when the problem is due to a dispute between persons on the surrogates list).

Implementation By DOH. DOH is to issue regulations necessary to implement this Act. DOH is to prepare a statement of the rights, duties and requirements of this Act and shall require that a copy of such statement shall be furnished to patients, members on the surrogate list known to the hospital, at or prior to admission, or within a reasonable period of time thereafter, and to each member of the hospital's staff directly involved in such care.

Additional Provisions. There are numerous other amendments to existing law (relating to do not resuscitate laws, health care proxy law, adult guardianship law in article 81 of the Mental Hygiene Law (MHL) and article 17-A of the Surrogate Court's Procedure Act) to conform to the provisions of the Act. Of note is the fact that section 81.22(a)(8) of the MHL is revised to state that a court may grant an article 81 guardian the power to act as surrogate for decisions about life-sustaining treatment for patients in a general hospital or nursing home in accordance with the Act, and to consent to or refuse treatment for routine or major medical treatment, in accordance with the decision-making standards in the Act.

The New York State Task Force on Life and the Law is directed to form a special advisory committee to assist it in considering whether the Act should be amended to incorporate procedures, standards and practices for withholding or withdrawing of life-sustaining treatment for patients with mental illness or with MR/DD, and for patients residing in mental health facilities. The task force is also directed to consider whether the Act should be amended to apply in settings other than general hospitals or nursing homes.

Effective Date: June 1, 2010. However, hospitals (and health care providers in such hospitals) may adopt a policy to carry out health care decisions in accordance with the provisions of the Act immediately upon enactment of the legislation.

A Closing Thought:

It is truly of landmark significance that under this new law there will now be a legally authorized health care decision-maker established by law as a default where an individual in a hospital or nursing home has not completed a health care proxy or a living will. However, individuals with capacity will need to consider whether it would still be preferable for them to execute a health care proxy and select one's own health care agent, rather than rely on a surrogate selected by operation of the statute, an individual with whom one may have never discussed their wishes, values and preferences for health care, and the specific treatments you would or would not like to receive, under certain circumstances.

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Irene Kurlander



Anne Caldwell



Protective Services for Adults:

Everyone deserves to be safe

By Deborah J. Botti

Sometimes, the referral comes from a neighbor, the police or medical personnel. Other times, a financial institution might notice unusual withdrawals being made on an elderly person's account.

“We provide financial management, formally or informally,” says Irene E. Kurlander, senior case supervisor with the Human Services branch of the Orange County Department of Social Services. “It might be a matter of a caseworker informally helping someone to pay bills or in extreme cases, our being named representative payee to financially manage an individual's benefits.”

It could even be the utility company that flags a situation that warrants investigation. Electric service was to be cut off to a particular residence, and a call was made to Protective Services for Adults, more commonly known as Adult Protective Services or APS, which falls under the purview of Human Services.

“When utility companies have reason to suspect someone has a serious impairment, is in a neglectful situation in the home or other hardship, they are required to make a referral to DSS,” says Kurlander. “We'll follow up with a letter or phone call and then go out to the home, if necessary. We can help fill out an application for monetary assistance – or it might be a multigenerational household and more intervention will be required.”

In this case, it was learned that an elderly gentleman lived in the home with a relative and her new companion. “The caseworker had a gut feeling that something wasn't right,” says Kurlander.

The caseworker convinced the caregivers to agree to a medical evaluation for him, during which it was determined that the arm he had limited use of was not impacted by a stroke, as the caseworker was told.

Rather, his arm was broken – and never set. And during his hospitalization, where he was out of the home setting, a dramatic – and positive – change was noted in his demeanor. He inferred he did not feel safe at home – and because of the intervention by PSA, he did not return to that situation. PSA found a suitable Family-Type-Home, where he’s been thriving ever since.

“We receive about 45 calls a month of suspected adult abuse or neglect,” says Kurlander. But with an aging population and families buckling under all kinds of stress, more calls, not less, are anticipated in the future. “Every call is logged. Referrals are assigned to a caseworker within three business days – or within a day if there’s concern about imminent harm or abuse ... although there is no mandate in New York State to report adult abuse.”

While a handful of the referrals are withdrawn, the vast majority are accurate and go on to the assessment stage. All cases are entered into a database.

The overall goal is to help keep people safe within their communities by linking them with the services necessary to do so. Most referrals can be resolved within two months. Up until about two years ago, about 60 percent of all referrals involved people age 60 and older. Now, Kurlander says they’re starting to see younger people with mental illness, drug and alcohol addictions, self-neglect and behaviors that are putting them at risk.

There are four major segments of the program: assessment for and provision of ongoing protective services; family-type-homes; formal and informal financial management; and guardianship pursuant to Article 81 of the state Mental Hygiene Law.

“Every person has an individualized plan,” says Kurlander. “We listen to them and tailor services to those needs.”

Kurlander points to a call received from a landlord in the western part of the county. “His tenant was a woman in her late 70s. There were some developmental delays and vision problems. The home and person were not being kept up,” she says.

The caseworker tried to arrange for home-care services, but the woman refused. “Someone who has capacity has the right to refuse our help,” says Anne Caldwell, deputy commissioner of the Orange County Department of Social Services. “Adults have the right to make decisions – even if they’re poor ones. ... It’s a fine line.”

In this case, the landlord was able to apply a little pressure, acknowledging that she was certainly within her rights to refuse help; however, he would then be within his right to not renew her lease for improperly maintaining the premises. She decided to rethink the situation – and has had an aide for several years now.

“She now looks clean and well cared for,” says Kurlander. “However, every once in a while, she decides she doesn’t want the aide, and we have to let her know that the landlord called. This justifies the need to keep PSA involved.”

Caldwell and Kurlander are also aware of the stigma that they’re up against. “Our division is available without regard to income,” says Caldwell.

Yet, it's the arm of the Department of Social Services that assists during times of economic hardship that most are familiar with. "Many seniors are proud – and don't want to acknowledge that they're failing and need help," says Kurlander. "But we'd rather err on the side of caution – perhaps opening a case with another county or community-based agency without the stigma."

A woman in her 80s appeared at a shelter due to a power outage. Because of her respiratory difficulties and need for oxygen, the shelter referred her instead to a medical facility where she could be cared for properly. She said she lived with her son and that he would be coming to get her when the power returned. The medical facility made the referral to DSS and PSA followed up with the family. As soon as the son had the driveway shoveled, he came for his mother – declining any further help. He even refused her staying one more night at the medical facility, which would have allowed him the time to catch up with the extra work that the storm dumped on him.

In extreme cases, Kurlander's department can petition for guardianship. "This is the most intensive intervention," she says, "one with a legally high threshold. There is a huge burden to prove that someone has lost his or her capacity to make decisions."

Kurlander is following an elderly woman through PSA. Her husband, who was very competent, made all the decisions; however, he passed away. Her health is failing and her mental capacity is diminishing.

"She's not capable of understanding the magnitude of her health concerns," says Kurlander. "If a person is at risk, we can seek temporary guardianship to get them into a facility for evaluation."

Most people though, she says, are cooperative and realize that they need some level of help. "If they are resistant, we try to offer something they might agree to, just to get our foot in the door."

Kurlander credits the experience and stability of her staff of 15 caseworkers and two other supervisors with the ability to handle upward of 500 cases a year.

"They are the ones with the expertise to determine what someone really needs," she says. "They're governed by the goal of doing whatever it takes to keep someone in their home or in the community safely."

Can they help you?

To receive assistance through the Department of Social Services' Protective Services for Adults division:

- A person must be 18 or older
- Have some type of impairment, be it physical, emotional or mental
- The impairment must have an impact on daily functioning
- The person must be at increased risk for harm to themselves or another
- There is no one to act in a responsible manner on his or her behalf in the community.

To make referrals:

Protective Services for Adults is under the auspices of the state Office of Children & Family Services. It can be reached at 1-800-342-3009 or at www.ocfs.state.ny.us for more information or for the phone number of your local adult services office,

- ◆ In **Orange County**, call (845) 291-2800 9 a.m.-5 p.m. Monday-Friday.
- ◆ In **Dutchess County**, call (845) 486-3300.
According to Deputy Commissioner Debra Bonnerwith, along with assessment and follow-up when required, “Our staff can assist eligible clients with various services, including financial management and assistance with shopping or transportation.”
- ◆ In **Ulster County**: (845) 334- 5125
- ◆ In **Sullivan County**: Contact the Department of Family Services in Liberty at (845) 292-0100 Ext. 2429, 2443 or 2391.