Don't ask; don't tell: The short-sightedness of San Francisco Long Term Care Policy:

From: Benson Nadell; Program Direction
San Francisco Long Term Care Ombudsman Program
Felton
6221 Geary Blvd
San Francisco, Ca. 94121
415 751 9788

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- What follows are comments from the San Francisco LTC Ombudsman Program based on cases and referrals regarding the difficulty patients/residents are experiencing in decisions to discharge them from skilled nursing facilities after Medicare reimbursed rehabilitative services are no longer covered. Most are unaware of resident rights under Federal Nursing Home Law. Many are unclear or uninformed of post discharge plans, and insecure about the safety of where they are going to. Also what informs these comments is the closure of hospital based skilled nursing units , and the shift of those patients to the remaining free standing skilled nursing facilities , as summarized by the Post Acute Task Force and ensuing Post Acute Care Collaborative. And finally the closing of the last sub acute SNF in the City by Sutter –CMPC has been also informed these comments- a closure that has galvanized various collaborations of advocates in the SF.

From the perspective of the Ombudsman Program looking at present trends from cases and abuse/neglect reports sent to the Program, Long Term Care Policy, including the emphasis on long term services and supports for persons living in home, community and neighborhood are myopic. Those who need 24/7 care and living alone are particularly vulnerable to this lack of a future looking set of policies.

In the Ombudsman Federal Law for Ombudsmen nationwide there is an emphasis on whether Inactions, actions and decisions may adversely affect health safety

welfare and rights. What follows is a statement on how omissions in local policy may be adversely affecting those persons who do need 24/ 7 care.

Policy: San Francisco intentionally pre-selects data sets to create policy it desires and suits the need of year to year planning for long term care services and supports based on existing contracts to the myriad of non profits who barter for contracts every four or so year, through a narrows RFPProcess.

The Audit report of 2015 mentioned this limitation of data analysis in terms on the lack of interconnectivity of data sets and lack of analysis for true needs assessment.

Data collection is partially political. If you ask the right questions, data can be asked for, or if new, extrapolated. This would result from both the political will and the ability of Mayor and City and County BOS to create action items to ask for such data.

What sorts of questions are not asked?

1. **What happens when hospitals discharge persons as sub-acute level of care to other locations ? in terms of mortality, and ICU re-admissions.**
2. **What destinations do hospitals use for both sub acute and post acute discharges?**
3. **How many patients are discharged per month to home? To SNF – for post acute or long term care SNF; and to RCFE/assisted living/**
4. **How many persons from RCFE come to ED or ER per month without admission but observational status?**
5. **How many persons from RCFE/Assisted living are actually admitted? And how many are returned to RCFE- a count for each month?**
6. **How many patients are discharged to destinations out of county?**
7. **How many patients per month lack capacity and lack proxy or support systems(" Unrepresented")**

Data derive from such questions. Why would San Francisco want to know data from the above questions? The Formulation of long term care policy across the continuum cannot begin with funding unmet need or fill in the gaps until the data sets improve. We can have numbers of SNF facilities , number of beds;

and number of RCFE beds. But does the data contain a segmentation of those facilities by bed use, payment system, or for RCFE by size , by monthly cost, inclusive or ala carte. Matching the number of beds against any answers to the above questions will not create a sense of need. Need derives from complex factors , established at the time of hospitalization , with a calculus of acute and chronic conditions. Need is then mediated by cost and personal economy. Pricing in the market place will structure access for persons who may need 24/7 care. We could go to census data by District and then match supply of beds by pricing, but we would miss data in the middle.

- \Hospitals do not aggregate data or share data on monthly discharges of patients by destination or if they do , they are not shared with public policy makers in SF who may want to long at trajectories of placement. Much is made of " transitions" in an exuberant focus on community living, aging in place etc. but there is not evaluative process of such " transitions"- ; it is as if the goal of returning and living at home, a value statement , substitutes for measures of success in that discharge.
- Hospitals by a CMS rule are penalized if a discharged patient is re-admitted within 30 days with same diagnosis. For this reason and because hospitals have closed their in house SNF units for Rehab. The County based, free standing SNF have entered into a welcomed agreement to become Post Acute Partners. There is even a Post Acute Care Collaborative. Data from this Collaborative is bare bones and does not cover the variety of issues post Medicare, reflecting the co-morbidities of the discharged patients to these SNF. There is no tracking data in terms of trajectories of illnesses, once discharged. The reasons are with no tracking, no liability. Much is made of uninterrupted patient –flow with an archaic measure of LOS or length of stay.

a. These Post Acute SNF are variable in their quality of care, and attentiveness to a person centered care planning. Most do not have an interdisciplinary set of meetings at beginning middle and end of a patient's stay to measure goals and objectives. Each SNF in their own way keeps the patient in the dark in terms of person centered planning

unit the day of non-coverage. Then there is a meeting with a utilization person and SW.

b. These community SNF do not collect data on persons sent to various destinations.
c. . There is no data asked for and none collected.
d. There is only one sub-acute SNF unit within a hospital, with easy accesses to a hospitalist on a daily or weekly basis, and easy access to an in-house ICU unit. That unit at St Luke's is closing. Since Sutter-CPMC acquired this hospital, in addition to other services provided before by this important community hospital, open admissions to this sub-acute unit from other hospitals were closed. These other hospitals have sent persons needed round the clock suctioning and vent care to other destination, often at a distance from the City- making family visiting next to impossible. No one in the city has asked the Hospital Council to collect data on where these patients go, how long the live, and number of re-admissions to acute settings at some distance from these receiving SNF. In most cases the receiving SNF are also Post Acute SNF with an emphasis on short term rehab rather than quality long term care. By blocking admissions to the St Luke's Sub acute unit, Sutter CMPC is indirectly responsible for these other patients not thriving or even living long at other receiving SNF out of county. Again, the City does not ask for such data. No questions, no data.
e. The pending closure of Swindell Dementia Care RCFE has also raised questions. No one is asking: 1: how many RCFE have a dementia specialty; 2. what do they charge; Where are they located? 3: What is the required staffing in these dementia/memory units? 3: are there any funding streams to help pay such monthly rates?
f. Instead the SFDPH and DAAS provide numbers without drill down on consumer interested questions. The numbers rely on a count of Licenses to RCFE in SF. However, many on that list have already closed, and have not formally surrendered their licenses. So there is an inflated count. The Ombudsman Office which visits all RCFE at least quarterly, staffing and time permitting; has a more accurate count of facilities still open.(January 2018 that number would be 67-down from 70 due to closures.) But that Ombudsman count is not data but

anecdotal-compared to an inflated official number from State of California Department of Social Services, Community Care Licensing, which is less than diligent in terms of tracking closures.

g. So there is a facility and bed count, but where is the count of beds, stratified by sized of RCFE, allowable conditions, inclusive charges into monthly rate, vs. ala carte charges over and above the monthly rate.
h. Where is the data on ,not only quantity of bed and facilities, but data on access to admissions based on various disparities of access measures; and sometimes discriminatory admission criteria? Again no one is asking these questions, therefore no data.
i. Has the City asked to examine the various assessment instruments used by the larger assisted living RCFE to determine how each determines need as linked to monthly costs? Again, no questions, no data. Are these assessment instruments each with its own weighting system consistent with other assessment instruments? Is anyone asking?

Again, data can only flow from existing data. Until the right questions are asked by City and County leaders, Long term care policy will be skewed towards those questions that are asked. Data will always be missing in this context.