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Testimony
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I wish to enter the following into the Public Record.

I have been with the Ombudsman Program since 1986 and have seen unfolding trends as to availability of long term care facilities. Under Federal Law the Ombudsman , as Representative of the State Ombudsman , California Department of Aging, is to identify problems made by or on behalf of residents of facilities, resulting from actions, inaction, or decisions that may adversely affect their health. Safety, welfare or rights. In California Law the Ombudsman are also charged to respond to received reports of abuse and neglect. Ombudsmen are abuse/neglect investigators. This State Law widened to jurisdiction to include dependent adults either mentally ill or developmentally disabled, who reside in other types of licensed care facilities.

I have been a member of the following City Task Forces:

1. Discharge Planning Task Force
2. Dementia Expert Panel
3. Long Term Care Coordinating Council

Sub-acute is not post acute: The PACC Report re: St Luke's SNF closure misses the target, and contains a narrative about costs of hospital days and need to have a specialized assessment tool for psychiatric assessment, "Locus', used to facilitate discharges of persons with behaviors related to psychiatric/cognitive etiologies.

This Ombudsman recommends another assessment tool recommended by CMS which would better transition persons with not just an acute, Medicare reimbursed event, but the concomitant co-morbidities requiring care in these receiving SNF. For safe transition a patient discharged to a post acute SNF in the community must take an integrated approach. That is what this proposed CMS assessment tool

would provide. Called Care and B-Care (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html)

This model assessment, if in place, would mitigate many of the problems that persons experience in the Community SNFs in San Francisco. These problems become the substance of complaints and mandated reports of abuse and neglect sent to the Ombudsman Program: The Program receives a bulk of referrals from patients in the various receiving community SNFs.

Is policy in reaction to a problem or based on forecasting for the future?
Who is responsible for future long term policy for all those constituents in each Supervisorial District:? The hospitals and the hospital council?
: Should the Board of Supervisors and advocates for persons in each District allow the Hospitals to dictate local long term care policy, given their needs? Should their problem of getting stuck with difficult cognitively or psychiatrically impaired patients be a driving force in the shaping of larger public policy for others filing through hospitals to a next and uncertain destination?

Summary of Grievances Received by S.F. Ombudsman

Post Acute SNF Rehab in Community SNFs:

1. Not enough days of coverage and need to appeal based on person centered rates of progress through the rehabilitative plan.
2. When first arriving at SNF there is initial interdisclipinary meeting with patient and representative to set goals and objectives with the plan. But at a community SNF, the person waits for someone to come into a room and , it is difficult to sort out who is who and what their role is. Each staff person says something else.
3. There is the lack of follow up progress meetings using the CMS interdisciplinary approach.
4. Many patients have chronic diseases and need for help with activities of daily living(ADLs) which get less attention than the other therapies. The focus is kept on the number of days and coverage rather than a person centered approach-again , required by CMS in Regulation. Chronic

conditions slow down healing. Patients get complications of illness and infection, while the insurance clock is ticking.

5. Patients have told Ombudsmen that they had to wait a few days for medications to be filled due to a time lag from acute to post acute communication and transmission/ processing of that patient information by the receiving SNF. Many are in pain from surgeries and repairs. We have received complaints of patients receiving medications for another patient in the SNF.
6. Persons are admitted for rehabilitative services through therapy. But they are identified as fall risks and are unable to bear weight (or get rehab) until an Ortho doctor clears the person-all the time on the Medi-care ticking clock.
7. Many post –acute residents would have benefited from access to an integrated approach with access to an M.D. hospitalist or specialist. But in the world of community SNFs the staffing is unreliable. Nurse aides are assigned or float. Their jobs are difficult and there is no work load assessment for each newly admitted patient based on an initial care plan meeting with goals and objectives. Patients are adrift.
8. The real care meetings occur in the last few days of coverage. Social workers and the utilization case managers work on a discharge plan which is cursory. Many patients, in shock that they are going home, call the Ombudsman Program. They aren't ready; the therapists did not do a home evaluation for safety or accommodation to new disability. The Social workers and case managers in their roles confuse the departing patient and the conversation is about insurance co-pays. Many leave unsafely because of the cost of co-pays on a limited income. There is no support for these transitions for the scared and anxious patient. CMS requires a person centered approach; in practice the approach is insurance centered.
9. Those who need chronic disease management (ie longer term care in a SNF) are told that is not covered by Medicare. CMS requires notification to each about Medi-Cal. But these Post acute SNF want to preserve beds for the next influx of (more profitable then Medi-cal) Medicare short stay "rehab" beneficiaries. Even if the SNF is certified to bill Medi-Cal and has a percentage of long term residents under LTC(Long term care) Medi-Cal reimbursement, the case manager is told they will have go elsewhere, here is a list of SNF in a very impacted Bay Area. This violates Federal Nursing Home Rights.
10. A patient who is eligible for Medi-Cal should be given assistance to applying; this person has rights to not be moved or coerced to leave without consent. It is illegal to discharge a person without consent, and a full

discharge plan evaluation. This does not occur. Nor is the conversation about going home a supportive one.

11. Medicare is a fast track, allowing, in general, 100 days or less for rehab. By contrast Laguna Honda with mostly persons coming to rehab under Medi-Cal the approach is better and drawn out, ,with longer time lines. The process of discharge planning is professional by comparison. Ombudsmen have participated in advocating for residents on the discharge track at LHH, to get a resident voice heard and integrated into the plan. In addition LHH has resources for placement.
12. Persons discharged home from post acute community SNFs have called the Ombudsman Office complaining that they were waiting three days until a home health agency showed up. In a few cases the home health agency as ordered had a waiting list and there was no backup plan. Many persons discharged home live alone . There is no support for functional limitations: so a person sits unable to walk ; or lies in bed. This may seem anecdotal. But most agencies who serve these individuals or Adult Protective Services(APS) who gets the new referral can attest to the dismal experiences some have had in the transition home. There is no wait for needed care in good discharge planning.

In summary, the use of the community SNFs as "post acute partners" to the hospital is in disarray. Persons sent there are at risk of effects of disorganization, communication break downs, and poor care coordination, of consequences of post acute medical events and acquired disabilities with pre-existing chronic diseases.

RCFE /Assisted living are regulated by State of California Community Care Licensing; Federal Payment programs do not pay. RCFE are market place and each consumer pays the monthly rate. Most do not have any optional long term care insurance product. State Regulations do not require a uniform standardized assessment for all assisted living/ board and care. The regulations on provision of care do not focus on qualitative outcomes. The Licensing Agency staff do not review quality of care issues, only if needs are being met.
Persons with incidental medical needs are allowed to reside in these RCFE under certain conditions. The co-morbidities of residents have exceeded the skills of many staff: O2 is allowed, as are colostomy , catheters, stage 1 and2 pressure sores, diabetic management, along with persons with dementia. RCFE house persons where the care management is lacking and the staff are inadequate in number and in skills. CCL inspectors are not trained to review quality of care.

Summary of Complaint/Grievances Ombudsman RCFE

1. Small board and care home type
    a. Evictions for complaining
    b. Sub-standard food: slice of boloney and thin soup
    c. Medication mismanagement
    d. Diversion of personal monies for payback soda and cigarettes no receipt
    e. Accepting persons back from hospital without reviewing Discharge summaries and H&P. Man with Parkinson's treated for psychiatric illness and assumption he had parkinsonian side effects. No one reviewed paper work; not on sinimet, kept falling; died.
    f. Woman receiving psychiatric medications in board and care along with case management, dies suddenly , to everyone's dismay. In her late 70's – concern over death, lessened. Ombudsman discovered she had history of cardiac problems and this was not monitored by visiting doctor ; no follow up EKG. Smaller facilities lack skill base.
    g. During Ombudsman repeated visits, half residents always in bed, shrouded in blankets. No quality of life; on TV watching and smoking. No one wants to complain. They know nothing better.
    h. In a private pay smaller RCFE- a man develops Stage 1V Pressure sores. He has a hospital bed and own room. The staff are poorly supervised and he is not turned. He should have been hospitalized because stage 3 and 4 sores are beyond the scope per Title 22. Nor was he ever in a higher level of care. He dies.
    i. An agency calls Ombudsman: a client in RCFE misses appointments. She the falls, and breaks an arm. There is no notification to MSW with that agency.
2. Larger RCFE –Assisted Living
    a. A male resident calls the Ombudsman Program : He fell beyond the reach of the call system. He is afraid to notify management, because in this RCFE room check costs an extra $ 500 per month. When the morning staff found him, they put him in bed. Without assessing him, the pain worsened. His daughter upset, called 911. He had a fractured femur.
    b. In a large CCRC-(continuing retirement community) which includes RCFE, the condominium owners in this care facility are going to pay for a wall which damaged by wind and rain as an additional capital expense. The fine print is in then Contract. This is over and above the monthly costs. Yet the residents have no shares in the business of this State wide large Corporation.

c. At an RCFE with a memory care unit. Staffing has been reduced by the new management company after purchase of the building. One employee calls the Ombudsman Program that others still working have hit and pulled those elderly residents with memory disorders. A police report is also sent to the Ombudsman Program. Morale is low among caregivers.
d. An elderly man is running out of money to pay the $ 7000 per month rate. He has Alzheimers Dementia. His daughter calls the Ombudsman Office. His income is actually only $ 2900 per month. His disease has progressed. Because he refuses to pay the rate, he is facing eviction. The daughter calls for a nursing home alternative. All are focused in SF on post acute. The daughter calls other RCFE ; he is unable to pay their monthly rate as well.
e. An elderly woman with dementia returns from a hospital after a fall. New medications were order. The receiving RCFE never fills the order; nor did they review the paperwork. The RCFE blames the son, who happens to live out of state for not picking up the order at Walgreens. The Ombudsman reviews the med. Room and talks to the med-tech. That person was off for four days and missed the communication. She apologized.
f. A 87 year old man becomes septic from sores. He is diabetic with renal failure. The Dialysis clinic calls the Ombudsman Program with a follow up mandated abuse/neglect report. He missed the last appointment. The clinic notice pressure sores. Calls to the RCFE were met with voice messages. The RCFE calls 911 and he is taken to acute hospital. He stays in the ED for a day and half. The ED MSW calls the Ombudsman Program saying he has pressure sores and also fills out a neglect abuse mandated report. He is not admitted to acute but is sent back the following weekend, after a short IV anti-biotic course. RCFE are unable to provide IV interventions under Title 22.
g. An RCFE advertising Memory /Dementia Care has a secured section with delayed egress. It is not well staffed. In the evening at least 4 residents sun-down. The Wellness Director calls their respective MD and orders was given for Depakote and Seroquel- which are contra-indicated for elderly persons. No consent is obtained.

Solutions:

Bricks and Mortar:

It is impossible in this real estate market to build, or purchase and refurbish existing building for new SNF or RCFE which will be accessible to the many persons aging and acquiring disabilities through illnesses, accidents, and acute medical events. Many low income and moderate income are in rent control housing. Many apartments in the private market lack elevators. Pressures for housing for newer generations of tenants makes in difficult for those aging in place to who live alone, without access to family support systems, to continue, after a hospitalization. With the homeless housing initiative becoming dominant, often the housing for those aging who require 24/7 care receive less attention.

The following are solutions predicated on the following premise: where there is a will there is a way.

Solutions:

Homes of decedents without heirs – Land Trust with leasing:

Every year individuals who live alone without beneficiaries or clear estate planning die. Real estate investors plough through death notices to see if such a property could be purchased. These houses without heirs revert to the Public Administrator for sale through Probate. In SF this is very imperative. What steep climb would it take, for the City to create a Public Trust where some of these properties could held in a holding company, after maintenance and repair, as a long term investment in smaller versions of assisted living RCFE. Eminent domain could be used for those properties without claim on them. If there is data on the number of live alone homeowners who die intestate, I do not know where they would be. Something similar was done when Agnews Developmental Center was closed, under Court Order. Brilliant Corners became the holder of some homes in San Mateo, and nurses were hired to by management caregivers.

Re-zoning with Fire Safety up-grade of abandoned commercial properties and lofts : modification of work/living zone for assisted living as long term investment.

Another idea would be to look at abandoned commercial properties, like warehouses with open interiors. Gutted and sub-divided, they could be re-zoned for mixed work-living spaces. The acquisition would be similar, through eminent domain.

To solve the bricks and mortar part of long term care, there will be have to be creative solutions that by-pass the frenetic housing market. New construction for SNF or RCFE residents who have limited incomes seems to be impossible, unless there were some cost shifting quotas in loan and construction approvals by the City.

Again affordable long term care of the assisted living type, with care packages thrown in, is higher than for new supportive housing. The average monthly cost for assisted living in SF in the market ranges from $4500- $12,000 per months plus add-ons for more care. All the larger RCFE or CCRC which include Life care plans, are recent. Most more resemble hospitality construction. Capital investment and property determine monthly costs, so that there is no dollar to dollar equivalent for care for each costumer. Some have specialized memory care for persons with degrees of dementia; some have delayed egress to prevent escaping. Not all memory care products and services are equivalent. Neither are the monthly rates- none of which are posted on respective web-sites. So to think about brick and mortal part of RCFE is to consider value added calculations.

Solution 2. More supportive housing. Supportive housing provides support services for coordinating care by professionals either in the ground floor Housing has social workers. For those living alone, if low income, IHHS would be available but not 24/7. Most IHHS workers of the 30,000 or so recipients in SF are family caregivers who come from other locations, visit, to provide care. If no family then either IP or Homebridge.

Solution Rejected:: Protection and Advocacy which was monitoring the two Civil Rights Cases against City and County, Davis V. SF and Chambers V SF posted response to the Laguna Honda Feasiblity Study August 23, 207.This set policy for the duration of the two Settlement Agreements where an affordable low income RCFE Assisted Living would not be invested in as a resolution to housing for those discharged from LHH or any other SNF. The City missed the chance to solve this lack of RCFE. Instead the shift was to rental subsidies from the city.

http://www.disabilityrightsca.org/advocacy/LHH/PublicMemo-AssistedLiving.pdf

https://ia802309.us.archive.org/30/items/assistedlivingfa1200sanf/assistedlivingfa1200sanf.pdf

http://www.stoplhhdownsize.com/PublicCommentsOnDraftAssistedLivingProjectStudy.pdf