

Written Testimony from Evy Brescia, LMSW

March 3, 2016

Re bill SB 278 Act Concerning Nursing Home Facility Minimum Staffing Levels

To The Human Services Committee:

I was a Director of Social Work in Nursing Homes for 25 years. I left the Nursing home in the fall of 2014 to work as a Care Transition Liaison for a home care company in Connecticut. I now am paid much more, have 90% less stress, and have much better work hours! I was here 5 years ago advocating for this change in the Social Work ratio. Everyone agreed at that point that it was needed, however, did not pass the appropriations committee. I was the only Social Worker of all the nursing homes who testified, not because other Social Workers did not agree with me....they just could not afford to take the time out of their busy facilities to be here. IF they took time off, it was to spend time for themselves, families etc because that is also important. Most social workers said, "the state doesn't care...they won't do anything,...etc." I testified 5 years ago because I was frustrated and burnt out and I knew that unless the NASW knew what was going on....they would not advocate for the profession. Change cannot occur unless you know about the issues. Perhaps it is the fault of the profession that we advocate more for others than our profession.

I am taking today off from my job, not working in this field, and advocating for this change.....not for myself any longer, but for all the Social Workers who are still trying to perform the roles and duties of a nursing home social work in today's world with today's challenges....while still working under the Public Health Code's ARCHAIC social work ratio to nursing home residents! It is not only unrealistic to perform those duties, it is unrealistic to even expect it during state surveys!

I can't blame the state of CT for not making the change if you do not know what is going on in that setting. It may look fine on paper when the state surveyors look over notes, assessments etc of a Social Worker, but I will tell you that what is being written is what a Social Worker knows needs to be written for state surveyors. Most of the intensive documentation is done on the more difficult cases, the ones that take Social Workers away from the other residents and/or families that need the time of a Social Worker. Now 5 years later, the State of CT has no reason to be ignorant any longer to the needs in the nursing home, the roles of the Social Worker, the need to decrease the ratio, and the need to VALUE HUMAN BEINGS over BUDGET CUTS!! IF not now, when? There will always be budget cuts, there will always be someone advocating for their services or programs.....THIS HAS TO BE THE TIME!!

This is 5 year after I testified, the nursing home picture has again changed. With an increase in younger people, increase in depression, increase in residents with major mental illness, increase in homelessness, increase in alcohol and drug addiction....and yet, the same amount of Social Work hours of over 30 years ago when elderly residents were the majority of patients (the only younger were those with downs syndrome or mental retardation).

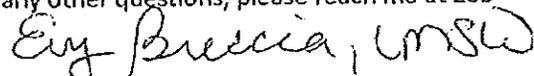
I am sickened that this is the year 2016 and this is still allowed. I am sickened to think that Social Workers are placed in the position to triage instead of truly giving desperately needed time to give to each resident and family in the nursing home setting! There are more recreation staff than Social Workers. Many times there are the same amount of Maintenance workers to Social Workers. With everything required of Social Workers, it is an injustice to human beings to allow this to continue.

I can only hope that the Human Services committee can value Human beings in this state, at the sacrifice that it may cost the state money at first, but will save money when they can give effective services. There has to be value given to people and the social work profession over a dollar bill! Social Workers go into this field to help people, not for the money. It is too bad that I didn't receive the money that I do now, for doing more, making more of a difference and working more hours.

If we want Social Workers to go into this field of Social work, we have to do the profession justice as well. Once they feel that they cannot give the attention to people more than the required meetings and paperwork, many will leave.

Please, this is the time to make this change. Knowing it is needed (as it was 5 years ago) and making a change to address those needs cannot wait any longer. Please value people and the profession.

Thank you for your time and consideration. If you have any other questions, please reach me at 203-482-1852.


Evelyn (Evy) Brescia, LMSW

Previously
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Social Work responsibilities at Danbury Health Care Center Nursing Home

Now called
Western Rehab.
Care Center

180 bed facility with long-term and short-term residents

Submitted by Evy Brescia, MSW

(25 years as a Nursing home Social Worker)

3/3/10

FYI: 2 full-time Social Workers (compared to 2 full time maintenance staff, and 4 full time recreation staff)

More people in housekeeping and laundry than in social services!

* Same amt of Maintenance Workers as Social Workers!

1. Most time consuming: Discharge planning which includes:

* Not even a concept when Public Health code ratios were set.

- Discharge meeting with resident and staff
- Initiating the d/c paperwork
- Coordinating all home care services (nursing, PT, OT, ST, Home health aides, homemakers etc)
- Referrals for homecare and homecare programs such as CCCI (Connecticut Community Care, Inc), outpatient rehab, and medical equipment
- Arrange for transportation (family, logisticare for t19 residents, sweetheart bus, wheelchair van, ect.)
- Order oxygen, blood sugar machines, insulin, etc
- Collect and all d/c summaries from all disciplines and compile a d/c packet
- Go over d/c summary with resident/family upon d/c
- Fax d/c summary to all involved with post-d/c care: homecare agencies, CCCI, PCP and specialists)
- Follow up calls with d/c client: day after, week after, and 1 month after
- Meals on Wheels referral
- Emergency response system

2. Also very time consuming: The new MDS 3.0 assessments (as of October 2010)

* Not developed when Public Health Code ratios were established.

An MDS is the Minimum Data Set which is a long interdisciplinary assessment which gives the resident more of a voice in their care plan. Each resident is now interviewed. If the resident is too confused or unable to answer, the nursing staff is interviewed instead. Every short term

rehab and Medicare paying resident has one done on admission and very often until d/c home. Long-term residents have one done for every Quarter and change of condition.

- *Social Workers have 4 sections to complete: the brief mental status test (testing for short-term memory impairments), Depression scale (PHQ9), problem behavior, and discharge planning.*

The MDS is then entered into the computer system (which DPH has access to) and a care plan is developed based on the problems identified. It also is the main tool to determine which reimbursement rate we will receive on each resident. The information is time sensitive and is a priority.

3. Review of the PASRR (Pre-admission Screening and Resident Review), which replaced the former MI/MR (Mental illness, mental retardation) *also not developed during initiation of Public Health Code ratio
We are responsible for tracking all short term residents that are approved for short term stays and anyone who triggers for a level 2 screen...having a major mental illness, developmental disability, or mental retardation. If the facility is looking for Medicaid reimbursement, the social workers are responsible for for level of care evaluations, and additional information which will determine if a person will have his/her stay paid for.....major priority and pressure!
4. An Initial social History is initiated within 5 days of admission, usually at the same time as the MDS. We identify prior functioning, support systems (or lack thereof), past issues with mental health issues, alcohol and/or drug dependence, a discharge plan, etc.
5. Quarterly and Annual assessments and notes A social work assessment that addresses what the needs are, our interventions, and any changes....as well as a summary of a resident's medical, spiritual, leisure, and emotional status.
6. Room change notes Done for every person who changes rooms and the roommate on the receiving end. Inform all departments of the room change.
7. Room change calls Asking the resident or responsible party if it is ok to move to another room, many times off the unit they became familiar with...while upholding the resident's right to refuse. Yet, most times, their bed is needed for a new admission!
8. Follow up on complaints and monitor grievance log
9. Assist with setting up irrevocable funeral contracts

10. Assisting with developing advanced directives (DNR, Power of Attorney, withholding treatment orders, and living wills.
11. Completing the Medicaid applications and copying necessary information needed. Follow up. MORE APPLICATIONS THAN IN PAST YEARS>
12. Referrals to Hospice or palliative care, offer support to dying resident and their loved one.
13. Apply for Veteran Benefits
14. Application for conservatorship and attending probate hearings
15. Refer to protective services for discharges against medical advice
16. Medicare part B and D enrollment
17. Dealing with social issues such as involuntary discharges, non-payment, homeless, poor home environment or lack of resources, family issues, substance/drug abuse, Medicaid penalties, etc (HAPPENING MORE AND MORE IN DANBURY AREA!
18. Giving facility tours when admissions dept. unavailable
19. Apply for senior housing, section 8, or other placement locations
20. Meet with agency marketing staff: homecare and medical equipment
21. Assist with tax returns of residents who qualify
22. Order clothing, footwear, and diabetic shoes, as well as obtaining tv, radios, shavers, favorite food snacks, soda, and cigarettes
23. Trying to spend resident trust accounts so that they stay within Medicaid eligibility and meet social security standards as rep payee
24. Send out letters to bill collectors for Medicaid recipients
25. Make sure that clothing is brought to laundry for labeling
26. Order newspapers for residents

27. Coordinate hairdresser list
28. Make a list for chaplain to visit ea. Week
29. Register for absentee ballots for local, state, and federal voting
30. Run the annual travelling clothing store event
31. File notes on chart
32. Update resident face sheet information with correct contact information and funeral home
33. Initiate transfer to geriatric psych hospitals for residents with unstable behavioral symptoms (Masonic home, Sharon hosp, etc)
34. Notarize documents
35. Send out sympathy cards to the families of deceased residents
36. Call family members to pick up personal effects of a deceased resident
37. Provide support to grieving families when they come back for personal items
38. Assist with financial needs ie, help with check book and/or bills
39. Contact insurance plans to discontinue plans, or change plans
40. Change of address forms for post office for long-term residents
41. Attending many meetings :
 - Medicare meetings(PPS) for all residents being covered by medicare (daily)
 - Weekly medicare meetings
 - Rehab meetings on all short-term residents (weekly)
 - Morning report (daily)
 - Care planning meetings (ave 3 times a week on at least 3 to 5 residents in ea. mtg)
 - CQI (quarterly)
 - Medical staff (quarterly)
 - Medicaid pending (periodically)

- Discharge meetings (throughout the week 2 to 3)
- Interim meetings, as needed with families, residents, staff
- Marketing (weekly)

42. Retrieve about 20 voice mails a day, on top of answered calls and try to return them

43. Constant interruptions from staff, residents, and families unplanned and throughout the day, every day!!

44. Address birthday cards for every resident in ea. Month

45. Attempt to have 1:1 visits with residents to meet their needs ie: (which is happening less and less, but most important and very time consuming! Quality of life issues! Impossible to meet with current ratio, given all the previous 44 items!!

- Depressed mood (common problem)!
- Adjustment issues
- Family guilt
- Anger
- Roommate issues
- Financial
- Discharge or long-term issues
- Spiritual
- End of life decisions
- Dying process
- Companionship
- Pet visits
- Personal needs (clothing, tv,
- Family conflicts
- Mental health issues
- Behavioral
- Social stimulation
- Reality orientation
- Assess for further needs

- Clothes to Goodwill
- Alz Support group (M)
- Form. Council Support Tu. (Q)