

Senate Budget Committee #3
The Honorable Mark DeSaulnier, Chair
Discussion and Oversight of
Administration's Transition Plan for Adult Day Health Care
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Testimony of Judy Canterbury, MSN, CNP, RN

Mr. Chair and Members of the Senate Budget Committee, I want to thank you for holding this oversight hearing on the ADHC Transition Plan that will eliminate this benefit for 37,000 Medi-Cal beneficiaries and will probably affect several thousand other patients who attend the ADHCs and whose care is paid for through other resources such as the Veterans' Administration or by family members.

My name is Judy Canterbury. I am by profession a geriatric nurse practitioner. I serve as the administrator for three ADHCs and have worked in adult day services for over 34 years. I started my career in ADHC working in one of the ADHC demonstration projects in San Diego. I have been actively involved in the development of Adult Day Health Care in California. I served on the Health Care Advisory Board of my local county, and the Alzheimer's Advisory Committee at the State level, where I chaired the task force on secured perimeter residential facilities for the elderly. I am a founding member and past president of our California Adult Day Services Association and spent 6 years on the board of the National Adult Day Services Association working on projects to educate providers throughout the country. As a family member, I also watched as my father-in-law died in a state run nursing home in 1976, two hours from family, because his ailing wife was no longer able to care for him. If she had had the opportunity of sending him to a program such as adult day health care provides, she would have chosen to keep him home. Therefore, I speak to you as a nurse, an administrator and someone who deeply cares about aging and long term policy.

One of the centers I currently manage is in the Sacramento area. About 3 months ago, Robertson ADHC, another Sacramento ADHC program, closed. The social worker at Robertson contacted other ADHC centers in the area in an attempt to transfer their patients to other service providers. The social worker at Robertson provided families with information on the ADHC centers that were remaining open, other potential services, such as the PACE program and IHSS. In spite of the efforts of other centers, at least two of the Robertson participants were hospitalized and one has been in a rehabilitation facility for over two months. He has been unable to return to any adult day health care center due to injuries he sustained when he fell at the board and care home where he lives.

Rancho Cordova ADHC admitted about 25 patients who had been attending the Robertson Center. Most of the families were desperate to admit their loved ones, as they had no other resources for care and there was a long waiting list for any other potential services. A number of family members had to take time off from their jobs during the transition period jeopardizing their livelihood.

Obtaining needed information to allow the patients to be admitted to a new ADHC took a great deal of time. The wait for information from some health care providers was as long as one month. This delay in services was very difficult for these families. Families did not get a break during this time and had to carefully plan essential out-of-home activities, such as grocery shopping, when other family could come in and care for the patient.

At the Rancho Cordova center, we take care of about 280 patients each week. On a daily basis, we serve about 140 patients. About 90% use a walker, wheel chair or cane. We have anywhere from 30-40 wheelchair patients a day. Almost 50% are dealing with moderate to severe cognitive impairments as a result of dementia, mental health issues or traumatic brain injury. Over 10% need feeding assistance daily. About 50% need assistance with finding or using the bathroom. Ninety percent have a high risk of falling. About 50% do not speak English or have difficulty understanding English. In fact, patients at Rancho Cordova speak 10 different languages and our staff is representative of the population served. Medi-Cal covers the cost of care for 90% of our patients. The other 10% are paid for by private pay, the Veteran's Administration or the Regional Center.

If this center were to close, we estimate that at least 20-30 patients would be referred immediately to skilled nursing facilities. More would follow in rapid succession as families burn out, falls occur, or medications are mismanaged. All may not go to skilled nursing facilities. EMS responders and emergency rooms are troubled by the increased volume they appropriately anticipate.

Families do not want to place their loved one in a skilled nursing facility, but they will be unable to keep them at home without a place that can give them the few hours of relief and support while providing a safe haven such as an adult day health center where the patient's health care needs can be dealt with in a timely manner. It makes no difference what you call it, but it is folly to expect In-Home Support Services or a case manager in a managed care organization to provide the expertise that comes with the bundle of services the patient has been receiving in adult day health care.

The leaders of the Department of Health Care Services need to visit local adult day health care programs and take a good look at the people being served. They need to talk to the families who are trying to maintain their loved one at home. How can they provide guidance on a transition to wherever for appropriate services if they know nothing about the people that will be affected and their needs? If this population were in any other category, the State would be required to hold stakeholders meetings that include family and caregiver input. They would also have meetings where they would bring together all the resources they say are available and allow them to document what they can and can't do. The two meetings held by the Department have been very one sided, with the Department telling the centers what the plan is, but making little effort to elicit ideas or information that could be used for this transition.

My recommendation is that this process be slowed down so the transition can be done in a thoughtful, orderly fashion after the Department has had the opportunity of discussing this process on an open forum that includes all the interested parties. This could be done through regional meetings, as the resources in various areas of the State differ. Meetings could be facilitated by a designated lead agency that would call the ADHCs, managed care providers, representatives of other potential services and include input from patients and their caregivers. This process would follow the model set forth through the closure of State developmental disabilities facilities and development of Long Term Care integration projects. We also need to study what has happened in communities where ADHCs have already closed. Where are these patients now? How many went into skilled nursing facilities or just died for lack of care.

I personally believe that some programs will survive but very few. Programs serving adults in a day program that provides health care combined with the opportunity for people to interact with each other is not a new concept. This type of service has been around far longer than the California model of adult day health care. In fact, within California there are a variety of adult day services that meet a wide range of client needs. However, ADHC is the only model that addresses medical needs before they become a medical crisis. While we can understand the State's financial difficulties, closing this Medi-Cal program in a hurried and irresponsible way will lead to human disasters and a financial debacle.

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