"How Do We Respond to That Level of Need?"

Supporting The Mental Health of Skilled Nursing Facility Residents in San Francisco

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Contents

Executive Summary

The COVID-19 pandemic has exacerbated existing mental health needs and gaps in access to supports for residents of long-term care (LTC) settings. Rates of mental health treatment for residents in LTC facilities tend to be low, and service delivery was made more complicated by the pandemic. This study examines the needs and gaps in access to services for LTC residents in Skilled Nursing Facilities (SNFs) and produces several recommendations for mental health service delivery in this setting. In the City & County of San Francisco there are approximately 2,500 SNF residents between 18 SNFs, 17 of which provide LTC.

Findings

Based on a literature review, best practice research, a survey of San Francisco SNFs, and stakeholder interviews, this report identifies the following findings:

- **The pandemic has impacted resident mental health and quality of life:** As a result of the risk posed by COVID-19, as well as associated infection control measures, residents of SNFs experience mental health distress (e.g., anxiety around contracting the virus, isolation) and impacts on quality of life (e.g., disruptions to dietary routines, decline in cognitive functioning). Even as COVID-19 related restrictions are alleviating and residents of SNFs are protected by high rates of vaccination, there is a reluctance (described as "fear of re-entry") among residents of SNFs to re-engage and resume pre-pandemic routines.
- **Resident needs exceed staff capacity**: Existing suboptimal caregiving ratios, high rates of staffing turnover, and the degree to which staff are spread thin in SNFs generally, is conducive to a situation in which staff do not have time to give adequate attention to the socioemotional needs of SNF residents. Stakeholders identified staff capacity as an obstacle to optimal care generally, and a missed opportunity for recognition of, and response to, residents' mental health needs specifically.
- **There are impacts on caregiving staff and opportunities for empowerment:** Stakeholders identified empowerment of caregiving staff (e.g., decreased caregiving ratios, increased training) as being especially worthy of consideration.
- **There are issues with access to formal mental health treatment:** Systemic barriers, such as prohibitively low Medi-Cal reimbursement rates for mental health providers, were cited by stakeholders as an obstacle to SNF residents receiving needed services. Stakeholders also voiced a concern around psychotropic medications being used to manage the symptoms of SNF residents' distress, without addressing underlying mental health needs.

- **There are limitations of Tele-connectivity:** Tele-connectivity (i.e. the use of internet enabled devices for virtual encounters, such as video-calls) has the potential to bridge gaps for SNF residents to their larger communities (e.g., social engagement with loved ones through video calls, telehealth access to mental health services). However, it is often not a solution for residents with cognitive impairment or dementia. Even for residents who can successfully engage with tele-connectivity, significant limitations must be addressed including:
    - Unreliability of internet connections
    - Lack of access to internet enabled devices (e.g., when asked in the survey what the City & County of San Francisco could do to support SNF residents' mental well-being, the most frequent response was a need for tablets or other devices to facilitate tele-connectivity)
    - Need for staff assistance in manipulating devices and engaging with platforms
- **The pandemic provides a unique opportunity for improvement:** Stakeholders identified the current sociopolitical moment of increased scrutiny of SNFs as an opportunity to address longstanding issues.

The COVID-19 pandemic has laid bare existing deficiencies in the care that SNF residents receive to support their mental health and socioemotional well-being. Prevalence of poor mental health symptoms among SNF residents is significantly higher than the prevalence of such symptoms in community dwelling older adults. Prevalence of the use of psychotropic medications is high and rates of access to therapy services are low, despite evidence that pairing medication with therapy is more effective than use of medication alone. Inadequate patient to staff ratios and very high staff turnover compromise provision of adequate care to support resident well-being and quality of life. These factors inhibit the ability of caregiving staff to build rapport with residents, to take the time to provide person-centered care, and to adequately perform essential care tasks (let alone more nuanced tasks relating to recognition of and response to socioemotional needs).

Recommendations

These findings, a review of the relevant clinical research, and insights collected from the array of stakeholders who provided input, inform the following recommendations:

1. **Sweeping Overhaul of the Status Quo:** The success of any intervention would undeniably be supported by addressing underlying systemic issues which currently impede adequate access to mental health supports and

services for SNF residents. Steps to be taken towards meaningfully improving upon the status quo include advocating for:

- Increased Medi-Cal and Medicare reimbursement rates for mental health practitioners in order to incentivize providers to accept public-paying patients
- Decreased reliance on psychotropic medications in favor of access to therapeutic interventions
- Improved caregiving staff ratios to reflect the Centers for Medicare and Medicaid Services' (CMS) recommended hours per day per resident of nursing for optimal care
    i. Lower patient to certified nursing assistant ratios (ideally 3:1)
    ii. Increased presence of registered nurses in SNFs
- Addressing the very high rates of caregiving staff turnover

2. **Standardize "Person-Centered" Care:** This approach to care is based in treating people served with empathy, sensitivity, and acceptance. It emphasizes that quality of life should be understood as specific to each person, and relies on strategies (e.g., active listening) to promote residents' autonomy. Research indicates that interventions as simple as providing residents with increased positive attention can be beneficial in terms of improving their mood and functioning. Person-centered care is associated with significant improvement in LTC residents' feelings of helplessness and boredom. It is also associated with increased job satisfaction for LTC staff and improved capacity to positively meet residents' needs. Person-centered care is expected to be the norm, but in practice finding the time necessary to provide needed attention, listen to residents' perspectives, and make adjustments to LTC environments accordingly, is not always feasible. For person-centered care to be effectively implemented, understandings of what constitutes person-centered care must be standardized and staff must have the capacity to provide care accordingly.

3. **Advocate for Safe Resumption & Enhancement of Social Engagement Activities:** Stakeholders repeatedly mentioned social engagement and activities for residents (e.g., basic human connection, opportunities to spend time outside, organization of special activities or events within SNFs) as potentially simple adjustments, which would have significant benefits for residents' socioemotional well-being. As a result of high vaccination rates among SNF residents and loosening public health restrictions, many SNFs are resuming communal meals and taking steps towards easing restrictions on visitation. It is crucial that SNFs and their residents are supported in efforts to resume, and develop, social engagement activities (e.g., communal meals, group exercise, creative expression programs,

gardening, and importantly, visitation) which are so integral to socioemotional well-being.

4. **Promote Evidence-Based On-Site Therapeutic Practices:** There are a variety of evidence-backed therapeutic interventions which could be delivered to SNF residents on-site, and which have the potential to significantly impact the mental health of LTC residents.

    *   *Telephonic Outreach*: An intervention in which older adults receive friendly check-in calls (and/or can place outgoing calls as needed) with the objective of forming social connections, facilitating warm referrals to needed resources, and improving mental health symptoms. In one longitudinal study of a telephonic outreach program, older adults (some of whom were referred by the LTC settings where they resided) were found to be able to form social connections and gain confidence through weekly check-in calls from trained volunteers. The Institute on Aging's Friendship Line would be an example of a telephonic outreach which could be utilized to support residents of San Francisco SNFs.
    *   *Life Review Groups*: A therapeutic intervention involving structured evaluation of one's life, aimed at coping with negative experiences and finding positive meaning. The findings of a meta-analysis of dozens of studies of life review indicated a clinically significant effect of such activities on mitigating symptoms of depression for older adults. Another study of the efficacy of life review looked specifically at the use of this intervention for people living in nursing homes, and found an association with improved quality of life and life satisfaction. As we enter the "new normal" after a year of the COVID-19 pandemic, it seems likely that residents of SNFs would benefit from the opportunity to come together to reflect in a structured way, and to process the trauma which they have lived through.
    *   *Group, Individual, Staff Therapy (GIST)*: A cognitive behavioral approach to treating depression, adapted specifically to the LTC context and with the goal of developing coping skills. In one study of this intervention, participants experienced a significant overall reduction in self-reported symptoms of depression, as well as increased life satisfaction. An additional benefit was that participation in group sessions was observed to foster rapport among residents, and provided organic opportunities for residents to emotionally support one another.
    *   *Behavioral Health Activities Intervention (BE-ACTIV)*: An individual therapy model, developed collaboratively with caregiving staff. Residents attend weekly individual therapy sessions and staff

receive training on depression and the benefit of pleasant events for residents' socioemotional wellness. In one randomized control trial of this intervention, 87% of participating nursing home residents reported improvements in their mood and 86% of staff reported improved relations with residents (despite not spending any additional time with residents compared to prior to the intervention).

5. **Train Caregiving Staff on Mental Health & Trauma Informed Care:** Research suggests that staff in LTC contexts who provide direct care to residents may generally be limited in terms of their ability to recognize symptoms of mental health distress in the people they care for, and may inadvertently perpetuate mental health distress for residents. The variety of staff members in SNFS who have intimate contact with residents provide an opportunity for recognition of, and response to, residents' mental health symptoms, if they have the right tools to do so. Programs that emphasize training for LTC staff around mental health issues have demonstrated significant improvement in detection and response to residents' symptoms of depression. Given the widespread trauma experienced by staff and residents alike, training around Trauma Informed Care would be particularly salient to supporting mental health needs.

6. **Ensure Tele-Connectivity for all Residents Who Are Able to Benefit:** Many residents of SNFs do not currently have consistent access to reliable internet, nor to adequate numbers of internet-enabled devices, nor to formal instruction to support their acquisition of skills around the use of technology. Utilization of technology can allow residents to connect with loved ones, communicate with healthcare providers, and to bridge the gap between themselves and their larger communities. A subset of residents could likely gain some degree of independence in their use of technology, with access to supported use and training. Others would likely continue to need extensive support in their utilization of technology and might need to rely on staff indefinitely. However, for some residents, particularly those with cognitive impairment, the use of technology may remain aversive, or even distressing, regardless of the degree of support they are able to receive. As such, it is likely that tele-connectivity cannot be successfully generalized to all residents of SNFs.

Given that San Francisco is a hub of the technology sector and that there are a variety of existing organizations working to bridge the digital divide, it is likely that partnerships could be formed to support tele-connectivity for SNF residents. Existing efforts are in place at the state level to provide

communications technology to older adults, including LTC residents, but such funding has been limited.

Taken together, these recommendations could have a significant positive impact on the mental health and well-being of SNF residents who have suffered through a year of isolation and fear. However, even the most well thought out improvement to care will not be successful if the status quo of staff not even having the time or resources to perform their most essential duties does not shift. It is crucial to consider the additional burden that any proposed intervention may pose on caregiving staff, who are already often overworked, underpaid, and spread very thin. The socioemotional well-being of SNF residents is very much interconnected with the extent to which the people who care for them have the resources they need to optimally do so. As we begin to regain a semblance of the "new normal", there is an opportunity, and arguably an imperative, to improve our support of residents of SNFs—as well as the people who care for them.

Introduction

Research Objective

This report seeks to identify mental health needs and gaps in mental health service access for people who live in SNFs. The research questions which are central to this inquiry are:

- What are the mental health needs of people living in SNFs?
- How has the pandemic impacted the mental health needs of people living in SNFs?
- What are the gaps in access to and provision of mental health services for people living in these settings?
- What are some promising practices in delivering mental health services to this population?
- Given the emphasis on tele-connectivity (i.e. internet enabled devices for virtual encounters, such as video-calls) in the context of the COVID-19 pandemic, are there best practices in increasing digital access to promote the delivery of mental health services?

To address these research questions this study includes: a literature review, research on best practices, a survey of San Francisco SNFs, and stakeholder interviews, including conversations with SNF residents. The findings have been applied to inform actionable policy recommendations. While LTC settings share commonalities in experiences and resident mental health needs, particularly during the COVID-19 pandemic, this report focuses on providing recommendations to support the mental health of residents of SNFs.

The report proceeds as follows: background on the impacts of the COVID-19 pandemic on SNFs and on the mental health of SNF residents generally; a review of the literature; an analysis of issues which arose in the survey responses and stakeholder interviews, and recommendations for policy alternatives.

Glossary

- _Long-Term Care (LTC):_ This term encompasses a variety of services intended to meet a person's care needs, and to help a person live as safely and independently as possible when they are not able to perform activities of daily living on their own.[i] Most LTC is provided at home by unpaid family members or friends, or by In Home Supportive Services if the person in need of care is eligible for Medicaid. LTC is also provided in residential contexts, such as

Assisted Living Facilities, Skilled Nursing Facilities, and Intermediate Care Facilities.[ii] [1]

- *Skilled Nursing Facility (SNF):* Colloquially known as "nursing homes." These settings serve people who require 24 skilled nursing care.[iii] Many SNFs operate as for-profit entities, while others are non-profit, and very few are publicly operated. In California in 2017, 84% of SNFs were operated for-profit, 12% were operated as non-profits, and 3% were publicly operated.[iv] San Francisco's only publicly operated SNF is Laguna Honda Hospital and Rehabilitation Center. SNFs in San Francisco range in size from dozens to hundreds of residents. There are approximately 2,500 SNF residents in San Francisco between 18 SNFs, 17 of which provide LTC.[xv] Attempts were made to incorporate data illuminating resident demographics in terms of: race, ethnicity, language, and LGBTQ+ identities. Despite these efforts, this data was not available which has necessitated the omission of data points regarding these crucial elements of residents' lived experience.

- *Long-Term Care Resident of Skilled Nursing Facility:* There are two types of residents of SNFs, those receiving rehabilitation (i.e. people living in a SNF for a brief period of time while they recover from surgery or an acute illness) and those receiving LTC. As of February 2021, 17 of the 18 SNFs in the City & County of San Francisco provide LTC.[v] [2] This report focuses specifically on LTC residents of SNFs. Hereafter, "SNF residents" and "people who live in SNFs" should be understood to be referring exclusively to LTC residents of SNFs. The vast majority of SNF residents are over the age of 65. Many residents (more than 50% at most surveyed San Francisco), but by no means all, experience cognitive impairments such as dementia and Alzheimer's.

- *Medi-Cal:* California's Medicaid program. A public health insurance program which provides healthcare services for low-income individuals, including seniors. As the primary payer source for most nursing home residents (62% in California, as well as nationwide, in 2017), Medi-Cal funds a significant proportion of LTC in SNFs.[iv]

- *Centers for Medicare and Medicaid Services (CMS):* The federal agency within the Department of Health and Human Services that administers the nation's major healthcare programs, and provides oversight to the nursing home industry.[3]

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[1] See Appendix A for Descriptive Matrix of Long Term Care Contexts
[2] See Appendix B for Detailed List of all San Francisco SNFs providing LTC
[3] CMS data will be referenced throughout this report. It is necessary to note that while CMS provides the most thorough, publicly available data on SNFs, the information is self-reported by nursing homes. Investigative efforts have found that the information provided sometimes misrepresents the situation in nursing homes as being safer for residents than it is in actuality, and thus CMS data may not be fully accurate (see Silver-Greenberg, J., & Gebeloff, R., 03/13/2021)

Background

The COVID-19 pandemic has highlighted, and exacerbated, existing mental health needs and gaps in access to mental health services. In March 2020, San Francisco introduced the first shelter-in-place measures in the United States in an effort to control the spread of the novel coronavirus (COVID-19).[vi] Since then, people in the San Francisco Bay Area (and around the world) have contended with the new reality of the COVID-19 pandemic.

In addition to people's concern about the possibility of contracting the virus, social distancing measures to control the spread have disrupted routines and social connections. These stressors have resulted in increase rates of distress during the pandemic, including increased rates depression and anxiety nationwide.[vii] The tradeoffs inherent in attempts to balance the physical health risks posed by COVID-19 and the mental health risks posed by isolation are particularly evident for people living in LTC settings. People living in LTC settings had especially high rates of depression and social isolation prior to the pandemic, and during the pandemic have faced a uniquely distressing situation due to disruptions resulting from infection mitigation measures and to their increased risk from COVID-19.[viii ix x]

> *One survey of family members of people living in LTC facilities found that **91%** of respondents had noted a decline in their loved one's demeanor during the pandemic.*

According to the Centers for Disease Control, "given their congregate nature and residents served…nursing home populations are at the highest risk of being affected by COVID-19." [xi] This has borne out during the pandemic.

Skilled Nursing Facility Residents:
Percent of Total Population vs. Percent of COVID-19 Deaths

	Total Population	COVID-19 Deaths
United States	0.4%	33%
California	0.3%	22%
San Francisco	0.3%	26%
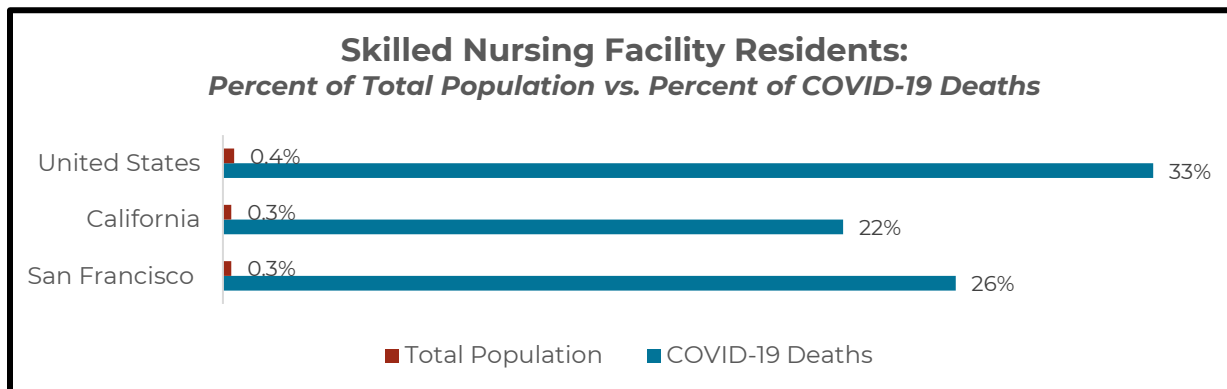
xii xiii xiv xv lx lxxxiv

The increased risk of serious illness or death resulting from COVID-19 to residents of LTC settings has led to especially stringent measures to control infection during the

course of the pandemic. Such measures have included restriction of visitation by friends and family, as well as cancellation of group social activities and congregate meals within the residential setting.[4] The increased risk to people living in these settings results from both health (e.g., suppressed immune systems, compromised physiological barriers) and institutional factors (e.g., staff shortage, lack of personal protective equipment, shared bathroom/dining/living facilities).[xvi]

It is notable that in San Francisco, where mitigation measures have been especially strict during the pandemic, the number of COVID-19 deaths among SNF residents during the pandemic was equivalent to 5% of the total number of SNF residents.[xv] [5] While this statistic speaks to the profound toll which COVID-19 exacted upon San Francisco's population of SNF residents, it is lower than corresponding rates elsewhere. In California, the number of COVID-19 deaths among SNF residents was equivalent to 9% of the total number of SNF residents.[lxxxiv xii] Nationwide, the number of COVID-19 deaths among SNF residents was equivalent to over 10% of the total number of SNF residents.[xii lx] [6] The comparison of these figures speaks to the efficacy of San Francisco's stringent public health mitigation measures in precluding additional loss of life in this vulnerable population.

In addition to the deaths among nursing home residents directly attributable to COVID-19, data indicates that deaths related to dementia and Alzheimer's increased during the pandemic. For example, during the summer of 2020 the number of such deaths was 20% higher than the number in prior years, with increased isolation and stress due to COVID-19 mitigation measures as likely contributing factors to the increase.[xvii]

COVID-19 has taken a profound toll on residents of SNFs, both in terms of loss of life and in terms of the trauma of over a year of isolation. One consequence of this ordeal is that public attention has been drawn to longstanding issues which impact the socioemotional wellness of people living In SNFs.

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[4] See Appendix C for Timeline of COVID-19 Public Health Regulations for Skilled Nursing Facilities in San Francisco

[5] Turnover of short term rehabilitation residents and vacant beds complicate the estimation of the exact number of SNF residents, and these figures are approximate

[6] Approximate Figures: San Francisco- 120 COVID-19 deaths among SNF residents/ 2,500 SNF residents total. California- 9,050 COVID-19 deaths among SNF residents/99,950 SNF residents total. United States- 132,000 deaths among SNF residents/1,246,000 residents total

Literature Review: Mental Health of Skilled Nursing Facility Residents

Older residents of LTC facilities are generally at increased risk of mental health distress. Transitioning into a LTC is a major lifestyle shift for most people. Loss of one's home, pets, belongings, autonomy, privacy and access to familiar routines can be demoralizing. Adapting to institutional furnishings, institutional odors, staff turnover and limited capacity, and facility scheduling of all aspects of life (e.g., bathing, meals, leisure) can be jarring. This adjustment may foster feelings of dependency or hopelessness, which can in turn detract from mental well-being.[xviii] There is a specifically increased risk of depression for people who have lost physical functioning (e.g., mobility, use of senses) and the ability to live independently, but who are cognitively unimpaired.[xix] Depression in residents of LTC is associated with loneliness, health-related problems, failure to thrive, and in some cases, suicidality.[viii]

Pre-pandemic estimates indicate that the prevalence of depressive symptoms was as high as 44% among older adults living in residential care settings (significantly higher than the rates among community-dwelling older people).[viii xviii] Despite the high prevalence of poor mental health symptoms in this population, rates of mental health treatment tend to be low. In one summary of existing research, 50-75% of residents with depression in LTC nationwide were receiving no treatment at all. [xix]

*In the fourth quarter of 2019, **2%** of California nursing home residents were reported to have received any form of psychological therapy in the prior week, while **34%** had received an antidepressant and over **20%** had received an antipsychotic.*

When residents do receive treatment, there tends to be a reliance on pharmacological intervention.[xx] Despite the fact that psychotherapy in conjunction with the use of psycho-pharmaceuticals has been found to be significantly more effective in treating mental health issues than the use of pharmaceuticals alone.[xxi]

In addition to considerations around most effectively meeting residents' mental health needs, the overreliance on psychotropic

medication can be accompanied by significant health risks. The Food and Drug Administration warns that people with dementia are at serious risk of medical complications, including death, as a result of taking antipsychotics. This entity has also clearly stated that antipsychotics are not approved for the treatment of symptoms of dementia related psychosis.[xxii] Yet, these powerful medications are prevalently administered to a population which is comprised of many people who are diagnosed with dementia.

In addition to the risks posed to residents' health, the use of these medications can compromise quality of life. Antipsychotics can be strong enough sedate residents to the extent that they are unresponsive and lethargic.[xxii] In effectively meeting mental health needs, it is crucial that the underlying distress (which leads to behavioral health symptoms) is targeted in interventions, rather than only managing the challenging symptoms themselves.

Obstacles to successful diagnosis and treatment of mental health issues include the fact that older people in general are less likely to report symptoms (perhaps due to stigma), and the fact that some behavioral health clinicians regard symptoms like depression as, "a normal part of the aging process."[xix] A crucial first step to meeting the mental health needs of this population is identifying symptoms of mental health distress and recognizing that those symptoms necessitate a response.

Person-Centered Approach to Long Term Care

Existing CMS policies explicitly require LTC facilities to ensure that residents' dignity is respected, that their individuality and preferences are acknowledged, and that the daily life involvement of residents is meaningful.[xxiii] [7] These regulations function to establish the expectation and the intention for SNFs to uphold LTC residents' humanity, autonomy, individuality, and their right to live their lives in the way they wish. This approach is in line with the "person-centered" care model, which aims to improve quality of life for residents of LTC by individualizing care.

The person-centered approach to care is based on empathy, sensitivity, acceptance, and active listening to promote optimal human growth. There is an emphasis on the notion that quality of life and well-being should be understood as specific to the being individual served.[xxiv] Person-centered approaches in LTC typically involve opportunities for social stimulation, continuity of resident care (e.g., consistent staffing), an emphasis on staff empowerment, and environmental enhancement.

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[7] See Appendix D for Descriptive Matrix of Regulations Relevant to Person-Centered Care

These approaches also include interventions focused on promoting residents' sense of personal control, independence, and autonomy. Evidence indicates that successful implementation of models of person-centered care require stable leadership, effective communication, and investment in staff training about the intended facility culture change.[xxiv]

Additional evidence suggests that incorporating residents' perspectives can provide invaluable feedback in ensuring that LTC settings provide high quality care which meets residents' desires and needs.[xxv]

By observing the interaction between environmental factors in LTC and the internal emotional experiences of residents, caregivers and psychological practitioners could collaboratively implement positive change in LTC settings.[xxvi] Components of quality of life which could be addressed include: lack of privacy, aversive sensory experiences (e.g., unpleasant smells or noises), decline in personal pleasures (as compared to life before living in LTC), and experience of stressful or otherwise unpleasant events.[xviii]

Providing residents with the opportunity to voice preferences and frustrations, and having those acknowledged to the extent possible, can promote a sense of agency and self-worth.[xxvi] Relatively small or simple adjustments to the environment can elicit improvements in resident well-being. For example, results of several small trials indicate that interventions as simple as providing residents with increased positive attention can be beneficial in terms of improving their mood and functioning.[xxvii]

Person-centered care is a means of ensuring that SNFs feel more like home, and less like institutional settings, for the people who live in them.

Example of a Person-Centered Approach to Care

Intervention	Logistical Details	Efficacy
Eden Alternative Model of Care[xxiv]	• Promotes resident mental health and well-being through person-centered adjustments to the environment • Seeks to make LTC settings warmer, more positive environments, more conducive to human growth and less conducive to distress • Opportunities for residents to feel self-efficacy and agency in their own lives, as well as to access pleasurable and generative activities[xxvi]	• Associated with significant improvements in feelings of helplessness and boredom for LTC residents • Associated with increased job satisfaction for LTC staff and improved capacity to meet residents' individual needs in a positive way[xxiv]

Promising Approaches to Mental Health Support in Long Term Care

In LTC settings, pharmacotherapy is, and has been, the response of choice to resident mental health needs. Unfortunately, research has found that efficacy rates of antidepressant use alone in LTC are low.[xxi] However, psychotherapy in conjunction with the use of psycho-pharmaceuticals is significantly more effective in treating mental health issues than the use of pharmaceuticals alone.[xxi]

One meta-analysis of 20 studies of depression among LTC residents found that both group and individual psychotherapies were promising in terms of addressing residents' symptoms. The same evaluation found that the majority of the psychosocial interventions reviewed had the potential to mitigate symptoms of depression for people living in LTC, including people with significant physical frailty and/or cognitive impairment.[xxi]

Small trials of psychosocial interventions in LTC, particularly those that rely on pleasant activities, indicate the potential of such practices to improve depression symptoms for residents of LTC settings.[xxvii] Useful behavioral health approaches to meet the mental health needs of LTC residents include: challenging distorted cognitions (cognitive therapies), increasing pleasant events (i.e. preferred activities,

positive social interactions), addressing relationship issues (interpersonal therapies), and life review activities.[xviii]

When pursing any intervention, it is critical to consider the logistics of mental health treatment in LTC settings:

- Avoid scheduling conflicts (e.g., therapy being aversively scheduled at the same time as preferred leisure activities)
- Ensure staff availability to provide needed assistance
- Address limitations to individuals' participation in therapy (e.g., chronic pain as a distraction, cognitive impairment as necessitating modifications to the therapeutic approach)
- Ensure privacy for confidential conversations (e.g., presence of roommates during phone or video calls).[xviii]

To engage optimally with mental health services, residents must be supported in feeling as secure and comfortable as possible while receiving their services.

Examples of Promising Therapeutic Practices

Intervention	Logistical Details	Efficacy
Behavioral Health Activities Intervention (BE-ACTIV)[xxvii]	• 10 weekly individual therapy sessions with a mental health professional (several of which staff are invited to join) • Opportunities for experience of pleasant events (i.e. crafts, music) facilitated by staff • Program developed collaboratively with staff to ensure feasibility • Staff participate in training on depression and the benefit of pleasant events for residents' socioemotional wellness • Staff receive training reference manuals and resources to facilitate requisite pleasant events	• Randomized control trial: nursing home residents (n = 42) who received the treatment were more likely than the control group to self-report improved mood and functioning • 90% reported that they would recommend BE-ACTIV to a friend, 87% reported improvements to their mood • Staff did not spend any more time with residents than they had before, but 86% reported improved relations with residents

Intervention	Logistical Details	Efficacy
Group, Individual, Staff Therapy (GIST) [xxi]	• Adaptation of a cognitive behavioral approach to treating depression, specifically oriented to the LTC context • Goal: implementing coping strategies and building a foundation for the use of these skills • 10 or more 75-90 minute group sessions • 3 individual therapy sessions (the first to set positive short term goals and the second to address barriers to participation) • 2 "coach" (a peer or staff member identified by the individual to be their support) sessions	• Program flexible enough to be applied in a range of LTC settings and was developed with consideration to cost effectiveness • One study of the program at a veteran's home: participants (n=13) universally rated GIST as "helpful" or "very helpful" • Participants experienced a significant reduction in self-reported symptoms of depression, and marked increased in reported life satisfaction • Additional benefit: participation in the groups fostered rapport among residents provided opportunities for residents to emotionally support one another
The Life Review Group Program[xxviii]	• 8 weekly group life review sessions • Participants reflect on aspects of their lives, interpret their past and create a new positive outlook on the future	• Analysis of program for residents of a senior housing facility: participants showed an increase in self-esteem and life satisfaction compared to a control group
The Stories We Live By[xxix]	• 8 small group (4-6 participants) weekly life review sessions • Participants process difficult past life events, develop agentic life stories to promote coping and goal development, and reflect on specific positive memories	• Randomized controlled trial: participants reported significantly decreased symptoms of depression and anxiety • Life review has the potential to improve symptoms of depression and anxiety and to improve emotional, psychological and social well-being

Intervention	Logistical Details	Efficacy
Telephonic Outreach[xxx]	- Weekly "check-in" phone calls to seniors from trained volunteers - Objective: form social connections, facilitate connection to resources as needed, and improve mental health symptoms - Relied on volunteers (social work, psychology, and nursing students) who committed to 3 months of calling 3-5 seniors - Some participants referred by the LTC facilities where they lived	- Mixed-methods longitudinal study to analyze a telephonic intervention program for older adults - Seniors were able to form satisfying relationships, gain confidence, and engage with their community via telephonic outreach initiatives - Such programs (for example, the Institute on Aging's Friendship Line) are scalable, cost-effective, and beneficial tools to promote social connectedness and mental health

Promising Approaches to Social Engagement in Long Term Care

Studies have found that people in LTC who have more social connection experience lessened symptoms of depression and anxiety, better mood and emotional outcomes, lessened boredom, and lessened cognitive decline.[xxxi] The experiences of social isolation and loneliness are associated with increased symptoms of depression and anxiety among older adults. In something of a vicious cycle, social disconnectedness and isolation predict higher rates of depression and anxiety, which in turn predict higher degrees of perceived isolation.[xxxii] As such, social disconnectedness can catalyze a negative downward spiral in mental health. Recognizing and addressing social disconnectedness has the potential to be a protective factor for the mental well-being of older adults.

Resident Activities

In the context of the COVID-19 pandemic many traditional means of ensuring social engagement for residents of LTC settings essentially became obsolete (e.g.,

communal meals, group exercise, group activities).[xxxii] This is significant, as best practices for supporting residents' social engagement (and thus their mental well-being) include offering of individual or group based activities.[xvi] A wide variety of activities have been found to have beneficial impacts on loneliness and social connectedness.

For example, interacting with pets has been found to have social benefits, and one study found that interaction with a robotic dog has similar benefits to interaction with a live dog for LTC residents.[xxxi] Communal meals, group exercise, creative expression programs (e.g., art, music, storytelling), and visitation have been found to foster interaction and to promote social engagement. Gardening activities have been associated with improved social relationships and lessened feelings of loneliness. Humor or laughter therapy has been associated with increased social participation and interaction, as well as a decrease in loneliness.[xxxi] Incorporating activities like these ones into the lives of LTC residents can promote social engagement and support socioemotional well-being.

Visitation

In addition to disruption of social connectedness within the LTC setting, visitation restrictions during the pandemic effectively cut residents off from the outside world. Isolation from friends and family, who often play an important role in supporting social well-being (as well as supporting facets of care such as grooming and meals), can exacerbate issues of loneliness which existed prior to the pandemic.[xxxiii] In the context of the COVID-19 pandemic and going forward, efforts must be made to ensure that the need for social distancing in LTC settings does not equate to social disengagement for LTC residents.[xi]

A study of the relationship between symptoms of depression, social isolation, and use of video calling (i.e. Skype, FaceTime) among (albeit community dwelling) in older adults, found that use of video calling had a longitudinal association with lower risk of depressive symptoms and social isolation. This was found to be true of video calling significantly more so than other modalities of electronic communication such as email, instant messaging, or social media.[xxxiv] These findings indicate the potential of video calling to mitigate feelings of isolation but the researchers did acknowledge that there were necessary considerations around access to, and ability to use, such technology.

A study conducted during the pandemic found that regular videoconferencing with family members was associated with beneficial impacts on social support and feelings of loneliness[xxxi] The results of a phone based survey of older adults in the San

Francisco Bay Area indicated that access to and familiarity with technology was associated with improved coping with disruptions and maintaining of social connections.[xxxv] Many SNF residents, however, would benefit from needed staff assistance to make video-calls to friends and family.[xvi] Even after the COVID-19 pandemic has resolved and a "new normal" is reached, these modes of communication have the potential to play an important role in fostering social connection between LTC residents and their social circles or larger communities.

The Potential for Telehealth & Tele-connectivity for Skilled Nursing Facility Residents
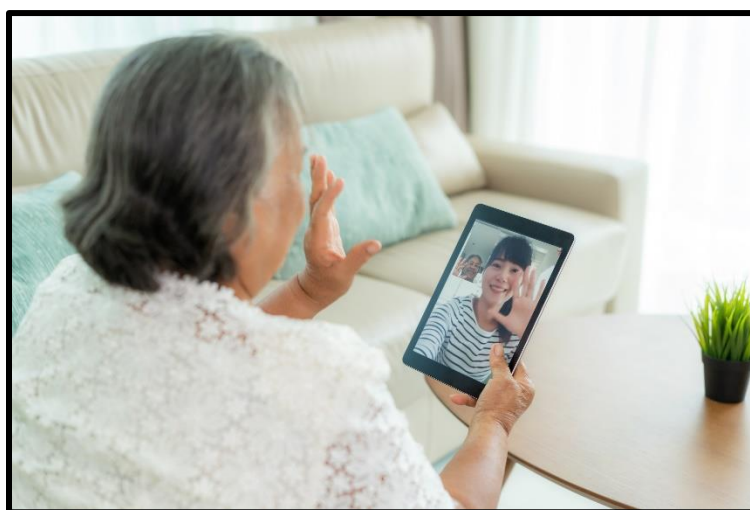
In addition to the potential for virtual social engagement, the COVID-19 pandemic has highlighted the fact that teleconferencing tools have the potential to play a crucial role in facilitating mental health services (i.e. telehealth). Studies have found that such services (e.g., telehealth therapy sessions) are comparable to in-person services in terms of effectiveness for conditions including depression, anxiety disorders, and post-traumatic stress disorders.[xxxvi] Benefits of telehealth in LTC can include easier access to services for residents with high cognitive needs, and coordination of complex care when multiple providers need to communicate about a residents' needs.[xxxvii]

There are several crucial factors to consider in promoting the tele-connectivity of SNF LTC residents. To successfully utilize telehealth, residents of LTC need access to internet and to internet enabled devices. A nationwide survey of nursing home residents found that only 40% of residents own a web-enabled device and that only 47% of residents indicated that their facility has web-enabled devices available for them to use.[xxxviii] Without devices, tele-connectivity is simply not feasible.

While tablets are commonly used, there is evidence that voice-first-technology (for example, Amazon's Echo Dot) is particularly accessible for older adults and people with disabilities as these devices do not require manual manipulation (such as engagement with touchscreens) for use.[xxxix] This is an important consideration,

because for optimal outcomes in SNFs, the technology being used must be accessible to people with cognitive and/or communication impairments.[xl] There are other important, and fairly simple, considerations to facilitate accommodation of impairments and successful resident use of tele-connectivity tools. For example, ensuring that patients who use hearing aids are wearing them during calls, and familiarizing residents with the technology they will use prior to the call, can ease the process.[xli]

Familiarity with technology is integral to successful engagement with tele-connectivity. To effectively make use of telehealth options, residents of LTC must have some baseline level of familiarity with technology.[xxxi] Individuals who do not have this must rely on their caregivers to have a workable level of digital literacy. Providing simple trainings for individuals with low-tech skills (e.g., both residents and staff of LTC settings) may facilitate the use of technology to optimize well-being outcomes. [xxxvi] Technology has the potential to serve as a bridge for SNF residents to the world outside of the facilities where they live, but only if they receive the supports that they need to optimally engage with these channels.

Role of Caregiving Staff in Supporting Resident Mental Health

CMS requires that SNFs "must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." [xiv] This delineates an expectation that SNF residents are cared for by adequate numbers of staff, who are equipped with the training and resources necessary to provide optimal care.

The variety of staff members who have frequent, intimate contact with residents in LTC has the potential to be advantageous in terms of recognizing when residents are experiencing symptoms of depression. This is particularly true when staff have the skills to identify and address socioemotional needs. Programs that emphasize staff training on mental health issues have demonstrated significant improvement in detecting and addressing LTC resident's depression.[xix]

For example, a study of the "BeyondBlue Depression Training Program for Aged Care Workers" found that improving caregiving staffs' knowledge about depression promoted their self-efficacy in identifying and responding to signs of depression in the people whom they cared for. Additionally, caregiving staff demonstrated improvements in their attitudes towards working with care recipients who had depression. [xlii] These findings indicate that training staff to recognize and respond to

depression can improve access to care for LTC residents who are depressed, and can improve resident quality of life.

However, existing research suggests that LTC staff generally may be limited in terms of their ability to recognize depression in the people whom they care for.[xviii] Staff with relatively little (if any) training in mental health issues, working with a diverse (i.e. cognitively, socio-culturally) array of residents, may struggle to parse out symptoms of depression in residents' behavior. This in turn can lead to symptoms of mental health issues being perceived as resident "stubbornness", "grumpiness", or "laziness." [xviii] The misidentification of symptoms of depression can lead to residents who would most benefit from social interaction and attention receiving the least due to the perception that they are just unpleasant or unfriendly. Staff who do not have sufficient training in responding to mental health needs can inadvertently perpetuate depression for residents of LTC.[xxi]

When proposing any intervention which relies on the involvement of caregiving staff in addressing residents' mental health, it is crucial to consider the degree to which staff in LTC settings are often spread very thin and experience significant stressors themselves. This was true even prior to the COVID-19 pandemic. In 2019, one survey found that 30% of nurses in nursing homes met the criteria for "burnout", and half of surveyed nurses reported that they had been unable to make the time to have a comforting conversation with a patient whom they knew would have benefited from such attention. [xliii]

*In a 2020 nationwide survey of nursing home RNs, **72%** reported missing at least one necessary care task in their most recent shift due to a lack of time and/ or resources.*

Additional stressors on nursing home caregiving workers include that they tend to be overworked and underpaid. In San Francisco as of December 2020, the median annual salary of a nursing home Certified Nursing Assistant (CAN) was $35,427; by comparison, the median income for a single person household in San Francisco the same year was $89,650.[xliv xlv] The rates of pay for this often very challenging work are not competitive, which complicates staff retention.

Two surveys of LTC staff conducted in 2020 found that the challenges of COVID-19 had exacerbated the already significant burdens experienced by a vulnerable workforce. The researchers postulated that this would contribute to increased rates of burnout, staff turnover, and ultimately to worsened staffing shortages in LTC settings.[xlvi xxxviii] This is particularly concerning given the high rates of burnout, turnover, and shortage before the pandemic.

A recent study which utilized CMS payroll daily staffing data found that prior to the pandemic, the average nursing home in the United States had a nearly 100% annual turnover rate for nursing staff.[xlvii] This has implications for the extent to which caregiving staff are able to build rapport with the people they care for and to become familiar with residents' preferences. In addition to these underlying issues around staff retention and capacity which must be considered, there are systemic inadequacies in how caregiving staffing is structured in SNFs.

While CMS does provide recommendations around levels of nursing staffing to ensure optimal care, there are no federally mandated staffing levels for nursing homes.[xlviii] In California, nursing homes with less than 100 beds must have at least one registered nurse (RN) on duty during the day, every day, and one licensed vocational nurse (LVN) on duty at night. Facilities with 100 or more beds must have an RN on duty 24 hours per day. In the context of the COVID-19 pandemic, California has allowed for workforce shortages that can permit levels of staffing to fall well below evidence-based standards for care.[xiv]

Comparison of Staffing Ratios

	Nursing Assistant Care	Licensed Nursing Care	Total Care
Care Provided by	Certified Nursing Assistants (CNA)	Licensed Vocational Nurse (LVN) and/or Registered Nurse (RN)	CNAs, LVNs, & RNs
CMS Recommendation for Optimal Care [xlix l]	2.8 Hours per Resident per Day (HPRD)	1.3 HPRD (of which at least 0.75 should come from an RN)	4.1 HPRD
California Law [xiv]	2.4 HPRD	1.1 HPRD	3.5 HPRD
Median for San Francisco SNFs [li] (3rd quarter of 2020)	2.4 HPRD	1.7 HPRD	4.5 HPRD
Lowest in San Francisco [li] (3rd quarter of 2020)	1.8 HPRD	1.2 HPRD	3.2 HPRD

While many San Francisco SNFs exceeded the required ratios, during the 3rd quarter of 2020, 8 of the 17 which provide LTC were below the recommended staffing level for RN staffing hours per day or for total nurse staffing hours per day. Of the 17, 6 were below the recommended level for both RN staffing hours and total nurse

staffing.[li] Lower staffing levels have been linked with adverse overall outcomes for residents (including diminished ability for staff to provide person-centered care).[xlix]

During the COVID-19 pandemic, California nursing homes with total RN staffing levels less than the recommended 0.75 hours per resident per day had a significantly greater probability of resident COVID-19 infections.[xlix] This is just one example of the extent to which SNF caregiving staff do not currently have the capacity to adequately meet residents' basic care needs, let alone their socioemotional needs.

Status Quo: Mental Health Needs & Gaps in Access to Services for Skilled Nursing Facility Residents in San Francisco

Participants & Measures

The following research methods were conducted to gather insights about the mental health needs and service delivery gaps in San Francisco SNFs: [8]
- Interviews with: [9]
    - 4 SNF directors of social services (DSS) and/or directors of nursing services (DNS)
    - 9 additional long term care and telemedicine stakeholders and advocates
- Survey of San Francisco SNFs that provide long term care (responses received from 8 of 17 SNFs)[10]
- Brief conversations with several residents of one SNF
- Focus group of 10 ombudsmen who work specifically with SNF residents
- Analysis of the results of a survey of quality of life completed by dozens of residents of one SNF in November and December 2020 (hereafter referred to as "the site-specific survey") [lii]

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[8] See Appendix E for Stakeholder Outreach Methodology
[9] See Appendix F for Stakeholder Interview Instrument
[10] See Appendix G for Survey Instrument

Impacts of the Pandemic on Residents' Mental Health & Quality of Life

> *"One resident, I think she died of a broken heart, it [the isolation] killed her. Another resident told me, 'I feel so alone...am I going to go crazy?'"*
> -Ombudsman

In the course of information gathering, the impression that the pandemic had fostered mental health challenges, and exacerbated existing mental health needs, came up repeatedly.

This is indicative of the extent to which the COVID-19 pandemic has been an immensely traumatic event for a population who were already prone to high rates of isolation and depression.

A similar theme arose around the pandemic creating new challenges, and worsening existing challenges, for the functioning of SNFs generally.

Existing problems with issues around inadequate rates of staffing, resident isolation, and obstacles to the provision of person-centered care were exacerbated by the realities of the COVID-19 pandemic. The systemic stressors that accompanied the public health crisis put pressure on an already strained modality of providing care, creating new and worsening issues to contend with.

> *"SNFs are a bit of a broken system, they're not functioning the way we expect them to, even before the pandemic. People can't just get lost in there, they can't get locked up in there."*
> -Stakeholder

Specific themes are described below.

Fear of contracting COVID-19:

One specific source of distress for residents was the fear of contracting COVID-19. According to stakeholders, during the pandemic many SNF residents have spent their days watching TV, and the constant (sometimes sensationalist) coverage of the pandemic and death tolls was a source of anxiety for many. One ombudsmen observed that the anxiety level among SNF residents was elevated due to the media being consumed so frequently and the lack of alternative social programming. Outbreaks within facilities were also noted as a source of acute distress.

> *"We had ten [COVID-19] deaths. They were wheeled out and no one saw them again. Before, we would have had a memorial service and a time for closure."*
> -SNF Director of Social Services

Many residents of SNFs have struggled with an awareness of the risks that they face from COVID-19, and that the virus has intruded upon the places where they live. The presence of COVID-19, both in the media being consumed and within the facilities themselves, has been a source of profound distress.

Loneliness due to visitation restrictions:

The loneliness resulting from residents not being allowed to have visitors was the most commonly identified concern for stakeholders.

When asked about the duration of a complete lack of visitation, the DSS at one SNF responded that residents had

> *"One man told me that he might as well not live because he hasn't seen his family in so long. Depression and despair seem to be increasing significantly."*
> -Nursing Home Care Reform Advocate

experienced over 5 months (March to September 2020) with no visits at all. One resident expressed that for her, the hardest part of the past year was missing her family. The abrupt loss of regular contact with loved ones and important people has been destabilizing, isolating, and distressing for a population who already struggled with prevalent loneliness.

Isolation:

The isolation experienced by residents who were restricted to their rooms for months was also a recurring theme. Stakeholders acknowledged the extreme loneliness and boredom of being in a room, generally entirely by oneself, for so long.

> *"We just need a connection to the outside world, that's all."*
> -SNF Resident

Stakeholders observed that for residents who were accustomed to being able to access communal areas, confinement to their rooms was very difficult. Additionally, the unique challenges of being highly dependent on other people to have needs met while being sequestered alone was identified as a stressor experienced by many residents. Spending months alone in a room, and hoping that someone would respond if assistance was needed, has been harrowing for many residents of SNFs.

Boredom due to routine and activity disruptions:

Boredom stemming from disruption to activities and routines was another commonly referenced source of distress for SNF residents. One ombudsmen stated that early in the pandemic residents had absolutely no contact with their families, not even virtual visits (i.e. FaceTime or Zoom).

The DSS of one SNF acknowledged that group activities were cancelled entirely for months, and that for most of that time residents were alone in their rooms watching TV. An ombudsman expressed that he had observed a "universal lack of engagement" and "forced passivity" while conducting virtual visits with residents. He observed that people would generally still be in bed in pajamas in the middle of afternoon.

> *"They want us to stay in our rooms. It drives me nuts, it's just the same old stuff every day."*
> -SNF Resident

In the site-specific resident survey, less than half of respondents expressed agreement with the statement "I participated in meaningful activities in the past week." The DSS of one SNF identified the absence of restorative activities (i.e. walking outside, swimming in the pool) as "another level of loss for people." The absence of stimulation, opportunities to engage in preferred activities, and pleasant events have had profound implications on quality of life for residents of SNFs.

Loss of dietary and dining routines:

Meal times are often an important source of socialization at SNFs, but communal dining was suspended for over a year in SNFs due to social distancing imperatives.

> *"Socialization at meal times is important. With the cues of everyone being around, eating together and talking, people eat better."*
> -SNF Director of Nursing Services

The DNS of one SNF shared that, prior to the pandemic, most residents (even those who required feeding assistance) would eat in the dining room. She described mealtimes as social and expressed that because the food was on warmers everyone was able to get a hot meal and choose what they wanted to eat. She contrasted this with mealtimes during the pandemic, when residents received tray-service in their rooms eating whatever they were served, alone. In the site-specific survey responses (for 2019 as well as 2020, this is not a pandemic specific issue), less than a quarter of residents expressed agreement with the statement, "I get my favorite foods here." This rate is strikingly low, and speaks to the limitations which exist around meal times even prior to the

pandemic's restrictions on dining. Eating with other people and eating foods that one prefers are important factors in day to day quality of life.

Prior to the pandemic, many residents of SNFS also had familial involvement in support at meal times, with family members providing company or providing culturally appropriate food. One ombudsmen shared that before the pandemic, the children of many residents would take turns to visit their parents each day at lunch and dinner. This stakeholder observed that in recent months, even when children would drop off food for their parents, staff did not have the capacity to sit with residents while they ate and encourage them like their family would. For some residents, even having culturally appropriate food dropped off was not possible. The DSS of one SNF acknowledged that during the pandemic family members were not able to bring home-cooked meals, and identified this as a significant loss for residents who were accustomed to having access to home cooked food from their families.

There were also trends in resident weight loss and diminished appetite reported by SNF staff during the pandemic. The DSS of one SNF observed trends in weight loss for residents and noticed that when asked the questions of the Patient Health Questionnaire (PHQ-9) there was an increase in residents answering affirmatively when asked if they had experienced poor appetite. She speculated that eating in their rooms in isolation, without social interaction, may have affected residents' appetites negatively.

Loss of control over personal space:

Disruptions to other facets of life were also identified as sources of distress for residents. One ombudsmen shared that during the pandemic some residents had to move rooms as frequently as three or four times in the course of the year and that many had expressed being very upset by these moves. For residents who had essentially spent months on end alone in a given room, subsequently being moved out of that room was a very disorienting transition. Another ombudsmen gave the example of a specific individual who found it "devastating" being moved to another room during this already traumatic experience.

While some SNF residents in their own rooms struggled with the isolation of almost always being alone, other residents sharing a room struggled with the constant presence of a roommate. The inability to leave their rooms to get some space from a roommate when they needed it caused additional distress and tension for many residents.

Resident cognitive decline and loss of functioning:

For many residents, access to therapies and services was impeded (or entirely precluded) by visitation restrictions. Lack of opportunity to exercise or to benefit from rehabilitative and mobility therapies led to decline in physical abilities. Lack of stimulation and social engagement led to cognitive decline for many people. An ombudsmen described seeing widespread decline in terms of mobility, general health, and the ability to communicate or process simple questions. Another ombudsmen relayed a conversation with the Speech Language Pathologist at one SNF who, while conducting assessments, was dismayed by the decline in cognitive abilities for residents who had been ill with COVID-19.

> *"I don't think anybody is the same. Residents are experiencing functional decline based on being in their rooms for so much time. They have a new normal now."*
> -SNF Director of Social Services

The DNS of one SNF described the unique stress experienced by residents who had to spend time in the COVID-positive "red zone." She shared that residents spent weeks without seeing any person outside of full protective equipment, which could be frightening, especially for those with cognitive impairment who did not fully understand what was happening.

In the survey of San Francisco SNFs, the vast majority of respondents indicated that over 50% of their residents had cognitive impairment, Alzheimer's or dementia.

Stakeholders observed an acceleration of cognitive decline for many patients with these conditions in the past year. The DNS of one SNF observed that due to a lack of visitation and stimulation, the dementia of some residents "increased exponentially" which she believed resulted in a more rapid death than they would otherwise have experienced.

> *"Three people on my unit have died because of lack of visitors, a screen isn't the same. They couldn't see their important people and they died earlier than they had to."*
> -SNF Director of Nursing Services

The disruption of needed supports, as well as opportunities to exercise and engage in stimulating activities, has contributed to regression in functioning for many residents of SNFs.

Residents Exhibit "Fear of Re-entry":

Numerous stakeholders identified that SNF residents' have a "fear of re-entry" as restrictions to daily life have started to lift. The DSS of one SNF observed that it seemed to her like residents had become so accustomed to living with restrictions that they were afraid to resume past routines. She specifically cited that for many residents it seemed that the idea of resuming regular interaction with other people felt uncomfortable or daunting.

"People don't get over this, a year of isolation, just like that."
-Nursing Home Care Reform Advocate

The DNS of another SNF gave the specific example that even after the dining room reopened, residents were reluctant to resume eating meals there and that a single resident was eating in the dining room alone. She also mentioned that pre-pandemic residents had gathered to socialize by a bird cage which was maintained at the facility's front desk, but that they were unwilling to resume doing so now that they safely could, even with staff encouragement.

The observation that residents were struggling to set aside fears which they had spent a year cultivating was echoed by many stakeholders. Despite the fact that many people have spent months on end awaiting the day when things could return to normal, resuming old routines appears to be complicated for many residents of SNFs.

Residents Needs Exceed Caregiving Staff Capacity

Staff capacity is a significant obstacle to meeting residents' mental health needs. The administrator of one SNF pointed out that this was not a new issue, and that for years staffing had been a challenge for San Francisco SNFs. This was echoed by an advocate for nursing home reform who stated that even prior to the pandemic, staffing in SNFs was, "totally insufficient."

Inadequate staffing ratios:

The inadequacy of existing patient to staff ratios was commonly cited as an obstacle to providing adequate support to residents. One ombudsmen expressed that this situation was not specific to the pandemic, citing that even before the public health crisis and even when staffing levels were at the current ratio, residents were being told, "we're short staffed, you'll have to wait". This stakeholder expressed that this state of affairs was indicative that staffing ratios were insufficient to adequately meet residents' needs.

Several ombudsmen relayed that some residents had described needing help but having to wait for hours before someone responded to their call bell. In the site-specific survey only approximately half of resident respondents expressed agreement with the statements, "I am able to get help right away if needed" and "staff respond quickly when I ask for assistance." Less than one third of respondents expressed agreement with the statement, "I can have a bath or shower as often as I wish."

> *"The whole ratio of staff to residents in nursing homes is woefully inadequate… 5 or 6 residents to 1 CNA per shift. They don't have a lot of time to chat, they never did. With COVID it became even more challenging."*
> **-SNF Director of Social Services**

One stakeholder voiced that it would make a difference if staff were able to give residents fifteen minutes of attention to talk about whatever they wanted to talk about, but acknowledged that given existing limitations on capacity, staff do not currently have the time to do so. In the survey, respondents universally answered "yes" when asked if their facility provides person-centered care, with the exception of one respondent who answered "not sure." However, stakeholder interviews indicated variability in the degree to which resident care could be qualified as person-centered given the existing limits to staff capacity.

High staff turnover:

High rates of staff turnover were also cited as an obstacle to recognizing and responding to residents' mental health needs. One advocate for nursing home care reform expressed the concern that facilities are not providing person-centered care because they do not have enough staff to do so.

This stakeholder also identified that due to the low rate of pay, caregiving staff do not stay in their positions and that this was detrimental to the quality of care received by residents. Similar sentiments in regards to the impacts of high rates of turnover on the care being received by residents were echoed by several ombudsmen.

Limited ability of caregiving staff to identify/respond to mental health needs:

In discussing the mechanisms through which resident mental health needs are addressed by staff, the DSS of one SNF described a system conducive to residents' needs potentially going unnoticed or unmet. She explained that CNAs spend significantly more time with residents than RNs, but that the CNAs tend to only have a "rudimentary" understanding of mental health needs. She also noted that RNs

receive formal training and are better equipped to catch signs of residents' mental health needs, but that their time with residents is often limited to medication administration.

> *"I am not sure if staff are accurately recognizing verbalizations of suicidality. They are more responsive to behaviors which are giving them a hard time than the actual suffering which is internalized, withdrawal and changes in mood, things like that. Nursing homes tend to focus on behavioral health issues that are negative and obvious, not so good at focusing on more subtle cues."*
> **-Ombudsman**

This essentially means that CNAs are tasked with recognizing and flagging mental health needs for interdisciplinary care teams. This is complicated by the limits of their formal training and general capacity to provide adequate attention to residents.

The gaps in caregiving staff's capacity to recognize and respond to resident mental health symptoms are likely conducive to a missed opportunity for meeting mental health needs.

Need for technological staffing support:

In the context of the pandemic, residents' need for technological support has arisen as an additional burden for staff who are already spread thin. When asked in the survey whether there was a staff tasked with supporting residents' video calls, SNFs universally replied "yes", and nearly half of respondents stated that doing so took up more than half of that staff's time at work.

The DSS of one SNF shared that only about 12% of residents are able to access video call on their own and that even those fairly independent residents do need staff support sometimes. She said that of hundreds of residents, only about a dozen actually do their own video calls. One ombudsmen mentioned that residents were set up for one short video call per week, because staff did not have time to set up more than that.

> *"It is a huge effort, between scheduling [FaceTime calls] and someone in the room holding the iPad, then disinfecting equipment...a lot of staff support is needed."*
> **-SNF Director of Social Services**

Staff mental well-being & burnout:

The "trickle down" of staff mental well-being to residents' mental well-being was also something that came up in multiple stakeholder interviews.

> *"Caregivers are given these jobs without a lot of supervision or direction. [They] don't have a lot of information about the particularity of each resident, staff have to figure it out. They might get yelled at by an angry resident for not knowing something. Staff are working so hard in an unstable environment, working with a vulnerable population and they are vulnerable themselves. The whole thing becomes this codependent trauma where the mental health of the [caregiving] workers is mirroring the mental health of the people expecting care from them."*
> -Ombudsman

The DNS of one SNF identified a need for additional resources for caregiving staff, acknowledging that they are doing a very hard job which is conducive to burnout.

When asked about needed resources, the DSS of another SNF expressed that she wished she could provide additional resources for staff. She observed that when staff feel as though they are being taken care of, they are better able to perform care for residents. Ensuring that caregiving staff have the resources and tools they need to adequately perform their work would have very clear benefits for residents in terms of the quality of care received.

Opportunities to Optimize Support for & Capacity of Caregiving Staff

Many stakeholders acknowledged the extent to which SNF caregiving staff perform difficult work, despite not receiving adequate resources nor sufficient appreciation. Improving supports and resources for caregiving staff was an area for improvement that repeatedly arose in stakeholder interviews

Pay and Benefits:

Caregiving staff assist residents with all aspects of life, including bathing, using the toilet, eating, dressing, and accessing opportunities to connect with their loved ones. Their work can be physically and emotionally demanding. A recurring theme was that this is challenging, necessary work, which is not currently valued to the extent that it should be.

The DSS of one SNF expressed a desire to provide staff with additional paid time off, and a comfortable break space to offset the high stress nature of their work. Several ombudsmen broached the issue of increasing pay to foster staff retention, and to adequately remunerate caregiving staff for the important work that they do. Adequately compensating the people who do this work was identified as a crucial

step towards maintaining them in their roles and ensuring continuity of care for residents.

Staffing ratios:

As has been mentioned under previously discussed themes, existing ratios of patients to caregiving staff compromise adequate care. One ombudsmen specified that the current ratios of approximately five patients to one staff should be replaced with significantly smaller ratios. This stakeholder suggested ratios of three patients to one staff per shift, as a more appropriate and effective caregiving dynamic. Reducing the number of people whom each CNA is tasked with attending to would undoubtedly have positive implications for the amount of time and attention provided to each person being cared for.

Mental health training and support for staff:

Providing staff with increased training also came up repeatedly. The DSS of one SNF acknowledged that the pandemic has been traumatic and that her facility could use specific resources or materials to support staff understanding of trauma informed care. An ombudsmen identified a need for increased training so that staff would be better equipped to recognize and respond to subtle mental health issues that might presently be going unaddressed. When asked in the survey about training for caregiving staff, 75% of SNFs responded that "all" caregiving staff received training about recognizing/responding to residents mental health needs. When asked specifically whether caregiving staff receive training in trauma informed care, the rate dropped to 50%. These findings indicate the presence of existing staff training protocols within SNFs, which have the potential to be augmented or built upon.

Issues with Access to Formal Mental Health Treatment

Prohibitively low reimbursement rates

Many stakeholders identified the low reimbursement rates for Medi-Cal and/or Medicare psychological providers as an obstacle to meeting residents' mental health needs. Of the respondents to the survey, half of SNFs in San Francisco indicated that over 75% of their LTC residents were supported through Medi-Cal.

The DSS of one SNF acknowledged a consistent, years-long, difficulty with access to psychiatrists who accept Medi-Cal. She expressed that because most residents cannot afford private pay, and most psychiatrists do not accept Medi-Cal, it is very

difficult to find providers to provide mental health services to SNF residents. This same sentiment was echoed by respondents from other SNFs as well.

> "Mental health services, that is probably the greatest need, it is a glaring deficit. People with mental health needs are rejected because of Medi-Cal, they can't afford the private providers, and you see them and they are miserable and their behavior makes those around them miserable too."
> -SNF Director of Social Services

In an open-ended question on the survey asking what the City and County of San Francisco could do to support SNF residents' well-being, several respondents indicated a need for access to affordable, consistent psychological/ psychiatric providers.

The dearth of providers who are willing or able to provide psychological and psychiatric care to residents of SNFs is a significant obstacle to the access of needed mental health services.

Possible overreliance on psychotropic medication

Some stakeholders were concerned about an over-reliance on pharmaceuticals to manage residents' mental health, and inadequacies in oversight of psychotropic medication.

One ombudsmen voiced concerns that residents who exhibit behaviors that are challenging or inconvenient for staff, are medicated to the point of sedation without addressing the underlying distress that led to their challenging behaviors in the first place. These concerns dovetail with the previously cited CMS data delineating high rates of psychotropic medications being administered to SNF residents.

Other stakeholders spoke to the limitations of psychiatrist involvement in oversight of residents' medications.

> "Anyone on a psychotropic drug would usually review with a psychiatrist, but that's not the case here, the primary care physician does it. We had two residents seen at UCSF, they take Medi-Cal, but the waitlists are forever. Working as a team with those psychiatrists was really helpful, especially when psychotropic medications need adjusting... that should be the norm."
> -SNF Director of Social Services

Limitations of Tele-connectivity

Lack of devices and hardware:

Many SNF residents lack consistent access to internet enabled devices. The DSS of one SNF shared that even after ordering extra tablets they only have two or three per unit and use of the tablets by residents had to be scheduled. The DSS at another SNF stated that after pursuing California Department of Public Health funding, her facility was able to obtain two tablets. She acknowledged that with the exception of a few residents who have their own devices, those two tablets were shared between dozens of residents. Notably, when asked in the survey what the City & County of San Francisco could do to support SNF residents' mental well-being, the most frequent response was a need for tablets or other devices to facilitate tele-connectivity.

Lack of reliable internet:

Concerns about reliability of internet in SNFs also arose in stakeholder interviews.

> *"It [video calling] doesn't work, it's not working right now. I can't see you, I can't hear you very well."*
> -SNF Resident
> (being interviewed via video-call)

An ombudsmen observed that in the course of conducting virtual visits with residents, at least at some SNFs, the wireless internet connection could be poor and residents became frustrated or discouraged. Another stakeholder expressed concerns about the unreliability of internet connection in SNFs.

Lack of accessibility for many SNF residents:

Many residents are limited in the extent to which they can participate in technological platforms for health care or social engagement. In the survey, respondents from SNFs universally answered that less than 50% of residents could access video calls independently, and nearly two thirds of respondents answered that less than 25% of residents could do so.

This is especially true for residents with cognitive impairment or dementia. The DSS of one SNF stated that for residents with dementia, it was confusing (and even distessing) to talk to someone through a screen. This was echoed by many other stakeholders.

Limitations were acknowledged in use of technology for both social engagement and telehealth purposes.

The DNS of one SNF stated that virtual group activities were challenging and quickly discontinued due to challenges around having sufficient devices, sufficient staff support, and the extent to which many residents did not understand what was happening on the screen.

> *"We tried [tele-mental health] but Zoom was just not effective. It's hard enough to approach mental health with these folks in person, but on Zoom, it's hard to focus. Residents didn't want staff there but we didn't have a choice for supporting them with the manipulation of the iPad for their call."*
> -SNF Director of Nursing Services

> *"Do some of our patients have trouble engaging with the communication modality? Yes. But between a video encounter and a phone call, the video encounter has more potential for a fruitful and engaged encounter. Video health has become a necessity rather than a luxury. The challenge is mitigating gaps that exist because of technology. The best that we can do so far is a more thoroughly prepared support [staff/caregiver] for patient."*
> -Doctor at University of California San Francisco
> (expertise in telemedicine)

Promoting the successful technological engagement of SNF residents is nuanced and requires consideration of issues around access, limitations, and support needs.

Basic Things Make a Big Difference

A recurring theme around supporting SNF resident mental well-being was that basic things, such as human connections and getting to go outside, can make a very big difference.

Human connection:

The importance of human connection was repeatedly emphasized by stakeholders. The DSS of one SNF identified having people to spend time with and talk to, as the single thing that residents need the most. In the site-specific survey, less than a third of residents expressed agreement with the statement, "there are people for me to do things with here."

> *"I think we underestimate how hard it is to meet new caregivers and have them involved in the intimate details of your existence if you don't know them. We underestimate the importance of having someone who knows you, having at least one person who knows you."*
> **-Ombudsman**

In the site specific survey, less than one third of residents expressed agreement with the statement, "some of the staff know the story of my life." This rate seems particularly low in consideration of the fact that approximately half of the respondents have lived in this SNF for more than two years. High staff turnover and limited staff capacity impact the extent to which residents feel like they know, and are known by, the people who care for them.

Time outside:

The opportunity to spend time outdoors also came up repeatedly as an important, and seemingly basic, factor in supporting residents' mental well-being. Despite the well-documented benefits of time spent outside, residents do not always have access to the outdoors. In the site-specific survey only about one third of residents expressed agreement with the statement "I can easily go outdoors if I want." An ombudsmen observed that at one SNF residents evidently benefited from the option to go outdoors every day rather than staying indoors, or in their rooms constantly. The DSS of one SNF shared that a favorite past time for many residents was spending time out in the yard or walking in the garden. Numerous stakeholders observed that daily time outdoors, even if it was brief or limited to a small area, was a highlight of many residents' days.

Special activities:

Some stakeholders provided specific examples of positive experiences or activities which they had observed to benefit residents' mental well-being. The DSS of one SNF shared that early in the pandemic, their

> *"It's the little things that make us happy, having those...the feelings go with that."*
> **-SNF Rsevesident**

facility's activity therapists provided individualized kits for residents. These kits were observed to be special for residents, and provided opportunities for diversion and stimulation. One SNF resident expressed a desire for digital books (i.e. Audible, Kindle) to keep herself busy. She shared that isolation was more bearable if she had opportunities to continue learning and growing.

The DSS of one SNF shared that residents appreciated that every Sunday and every holiday, staff would circulate with an iPad playing music from the 1950's and 1960's,

distributing treats. She emphasized the importance of differentiating special days as from other days, to foster excitement and disrupt monotony.

An ombudsmen shared that at one SNF the director clearly made an effort to be involved and festive. This stakeholder provided the example of the director putting up lanterns and distributing tea with cakes for the Mooncake festival. She observed that it seemed to make residents feel like there were still things happening and that there was some community camaraderie, even though they were isolated.

Another ombudsmen recounted that one SNF decorated for Valentine's Day and gave residents chocolate covered strawberries but expressed, "Things like that are few and far between unfortunately, that's why it really stands out when we see it." Special events and special activities, even relatively small things, while not a substitute for formal mental health supports, have the potential to be very meaningful and uplifting for residents of SNFs.

Policy Recommendations

The preceding findings underline the extent to which the status quo of support for the mental health of SNF residents is inadequate. Residents of SNFs are prone to depression, isolation, loneliness, and boredom. The existing structures of support are not adequately addressing these needs. The COVID-19 pandemic has laid bare existing deficiencies in the care that SNF residents receive to support their socioemotional well-being.

In weighing various approaches to improving supports for the mental health of SNF residents, there are factors which must be taken into account. The feasibility of any intervention's success would be contingent on:
- Ease of implementation
- Associated costs
- Degree of political support
- Generalizability to the needs of a neuro-diverse population
- Effectiveness in meeting mental health needs of SNF residents

It is necessary to note that the following recommendations are not specific to the diversity of racial, ethnic, cultural, linguistic, and LGBTQ+ identities present among San Francisco SNF residents, given the dearth of available demographic data in this regard. The issues and recommendations discussed in this report are generally applicable to issues which impact residents of SNFs, but do not delve into the undeniable nuances of these impacts for people with multiple identities. For

example, residents who do not share a language with the staff who provide care for them may experience compounding of feelings of isolation.

This report proposes six policy recommendations for consideration.
1. Sweeping Overhaul of the Status Quo
2. Standardize "Person-Centered" Care
3. Advocate for Safe Resumption & Enhancement of Social Engagement Activities
4. Promote Evidence-Based On-Site Therapeutic Practices
   a. Telephonic Outreach Interventions
   b. Life Review Groups
   c. Group, Individual, and Staff Therapy (GIST)
   d. Behavioral Health Activities Intervention (BE-ACTIV)
5. Train Caregiving Staff on Mental Health & Trauma Informed Care
6. Ensure Tele-Connectivity for All Residents Who Are Able to Benefit

Sweeping Overhaul of the Status Quo

In considering how best to improve upon approaches to supporting the mental health of LTC residents of SNFs, there are several areas for improvement which are not immediately actionable at the county level. For example, recommendations for caregiving staffing ratios come from the Federal level (CMS), and establishment of Medi-Cal reimbursement rates for mental health practitioners are established at the state level. Despite these limits to implementation feasibility at the local level, these areas of need must be considered in advocating for optimal support of the mental health of SNF residents.

The success of any intervention would undeniably be supported by addressing underlying systemic issues which currently impede adequate access to mental health supports and services for SNF residents. For example, the effectiveness of high quality training on mental health and trauma informed care for caregiving staff will be diminished if those staff do not have time to act upon their training or if those staff are not retained in their roles. Another example would be that even the most eloquently crafted regulations stipulating person-centered care will fall short if caregiving staff do not have adequate time to provide minimally necessary care.

Too Much Staff Turnover & Too Few Staff

High turnover rates of caregiving staff pose a serious obstacle to the socioemotional support of residents of SNFs. An absence of continuity in staffing compromises the

establishment of rapport between residents and the people who care for them. Lack of staff retention is also a complication to the provision of thorough training given that training is an investment which facilities may be hesitant to make if they do not expect the staff being trained to be working for very long. If caregiving staff were paid more and felt more empowered, it is likely that they would be more effective and more inclined to stay in their position, providing needed continuity of care to the residents they serve.

The existing caregiving ratio of patients to staff is starkly inadequate, which poses a substantial obstacle to optimal socioemotional care (let alone general care) for SNF residents.

During the pandemic, the average San Francisco SNF's staffing levels were approximately in line with, or even exceeded, those stipulated by California law and CMS recommendations. Despite this, stakeholders observed a widespread lack of capacity for caregiving staff to provide adequate socioemotional care. This suggests that the existing ratios are insufficient to support optimal resident care.

> *"Even before COVID, residents were hearing, 'we're short-staffed, you'll have to wait', even if they were at ratio. The ratio is not enough"*
> **-Ombudsman**

CMS recommends optimal staffing levels of 2.8 hours of CNA care per resident per day.[l] In an 8 hour shift, this means that one CNA would be able to provide the optimal level of care to fewer than three residents. Stakeholders indicated that actual ratios of CNAs to residents in San Francisco SNFs are approximately 5 to 6 residents per CNA per shift. This indicates that ratios of residents to CNAs are approximately double what would be optimal.

In terms of RN care, CMS recommends 0.75 hours per resident per day. In California, only facilities with over 100 beds are required to have an RN on-site 24 hours per day. Given this, 24 hours of RN care would provide only 32 of the 100 or more residents with the recommended 0.75 hours per day of care. For facilities with fewer than 100 beds, an RN is only required to be on-site during the day, and the discrepancy between levels of licensed nursing care provided and the level of care recommended at smaller facilities would be even starker.

Insufficient staffing levels are linked with adverse overall outcomes for residents (including diminished ability for staff to provide person-centered care). [xlix] The pandemic has highlighted and intensified the existing pressures on SNF staff, which limit their provision of adequate care. If staff do not currently have the time or the capacity to perform even their essential care duties, it is unrealistic and

unreasonable to expect them to assume additional responsibilities without increasing the support available to them.

Acknowledgement of the existing systemic problems is in no way intended to find fault with caregiving staff or in SNFs. This is very challenging work and the people who do it generally do it because they are caring and passionate about serving a population that is vulnerable. They deserve supports, resources, and a functional system in which to optimally perform the important work that they do.

To lower staffing ratios, SNFs would need increased funding, either through increasing resident rates or receiving increased government reimbursement.

Too Many Psychotropic Medications & Too Few Mental Health Practitioners

Another important issue in meeting the mental health needs of LTC residents of SNFs is the reliance on psycho-pharmaceutical interventions to manage difficult behaviors.

> *"Residents whose behaviors give staff a hard time, they get medication… but the underlying distress which leads to the challenging behaviors, is that addressed?"*
> -Ombudsman

Despite evidence that psychotherapy and psycho-pharmaceuticals are most effective when used in tandem, rates of psychotropic medication use for SNF residents are high and rates of access to therapy services are low.

As was previously mentioned, in the fourth quarter of 2019, California nursing home residents were seventeen times more likely to have received an antidepressant in the prior week, and ten times more likely to have received an antipsychotic in the prior week, than to have accessed therapy services.

Additional causes for concern around the use of antipsychotics for SNF residents are the associated significant health risks for patients with dementia, and the sedating effects of these medications which can compromise patient quality of life. A status quo in which residents who are exhibiting mental health distress are sedated to the point of manageability and are exposed to health risks in the process, rather than having their needs met, is unacceptable and must be improved upon.

Another significant barrier to the access of needed mental health services for residents of SNFs is the lack of psychologists and psychiatrists who accept Medi-Cal. Stakeholders repeatedly identified low reimbursement rates as an obstacle to the availability of adequate mental health providers to meet the needs of SNF residents. The need to increase reimbursement rates to incentivize provision of psychological and psychiatric care to LTC residents of SNFs was a recurring theme in conversations with stakeholders.

> *"One of the biggest problems for psychological care for nursing home residents is that Medicare and Medi-Cal don't pay for it, and unless there is a reimbursement for it, it won't happen. We need to increase the reimbursement rates for psychiatrists and psychologists working in nursing homes, but it is not a priority [for policymakers]."*
> -Nursing Home Care Reform Advocate

Channels for Advocacy

The issues identified in this report are longstanding, systemic problems with a nationwide, multi-billion dollar industry. Addressing all factors which compromise the optimal care of SNF residents is not necessarily a task that can be meaningfully accomplished at the local level. Nonetheless, these salient factors must be considered in advocacy efforts, and in any approach to addressing this problem.[11]

> *"All of a sudden they [SNF residents] became a huge focus because so many of them were dying [from COVID-19], they weren't a focus before, and I am hoping that they stay in the limelight a while longer. We need to continue to focus on areas that affect the elderly."*
> -SNF Director of Social Services

There are steps being taken towards significant reform of this nursing home industry at the state level. At present, there are an array of Assembly and Senate bills intended to address some of the issues and inadequacies highlighted during the COVID-19 pandemic.[12] Many of these bills are in line with the approach to reforming the status quo which has been called for in this report, and are worthy of support. For example, California lawmakers have proposed legislation to address issues of financial transparency and government oversight. The proposed policies would strengthen penalties for issues like over-medication of residents and chronic understaffing.[liii]

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[11] Action Item (Letter) under consideration
[12] See Appendix H: Current Relevant Legislation

The practices by which the mental health (and general well-being) of residents of SNFs is supported is in dire need of reform. The current moment of sociopolitical scrutiny of the care provided in these settings and the momentum behind improving upon the situation pose an opportunity for changes to be made. While the City & County of San Francisco may not necessarily be able to reform overarching issues such as adequate pay for caregiving staff to promote retention and continuity of care, adequate Medi-Cal reimbursement for mental health practitioners to incentivize the provision of sufficient care to meet the needs of SNF residents, or appropriate staffing ratios to ensure optimal care for residents, these issues must be considered in any approach to systemic improvement and included an advocacy agenda.

Standardize Person-Centered Care

As has been discussed, the person-centered approach to care is based in treating people served with empathy, sensitivity, and acceptance. This model of care emphasizes that quality of life should be understood as specific to each person, and promotes active listening strategies to understand people's preferences. Another characteristic of person-centered care is the objective of making LTC settings warmer, more positive environments, where residents can feel like they are at home.

In interviews, stakeholders repeatedly expressed the value of residents being known and seen as individuals by the people who care for them. Residents of SNFs rely on their caregivers for assistance with the most intimate intricacies of their daily lives, which is a tremendously vulnerable position to be in. All residents would benefit from recognition of their individuality and preferences by the people who care for them.

While existing CMS policies explicitly require that care for SNF residents should demonstrate respect for their dignity, meaningful involvement in their daily lives, and acknowledgement of individuality, the realities of care do not always reflect these expectations.[xxiii] Stakeholders repeatedly raised the point that if staff do not have time to perform essential care tasks, nor to get to know residents, the provision of person-centered care will not be a feasible priority.

> *"They [SNFs] are not doing it [person-centered care] at all, they don't have enough staff. When you have that level of turnover it is very destructive to the care, older people need to develop relationships with caregivers but they're constantly changing. The pay is low, they [staff] are not paid enough to compete with other jobs."*
> -Nursing Home Care Reform Advocate

Given that factors such as staffing limitations often impede person-centered, simply stipulating a (fairly subjective) expectation of person-centered care may be insufficient to ensure the consistent application of such a standard.

Strengthening monitoring of the extent to which care is person-centered, or attaching more specific expectations of what constitutes person-centered care, would likely increase the extent to which this model of care is ascribed to.

Person-centered care is expected to be the norm, and SNF residents deserve effective care that approaches each person as an individual. For this to happen effectively, understandings of what constitutes person-centered care must be standardized and staff must have the capacity to provide care accordingly.

Advocate for Safe Resumption & Enhancement of Social Engagement Activities

SNFs are now in a position to take the steps necessary to safely re-open following a year of restrictions. As a result of high vaccination rates among SNF residents and loosening public health restrictions, many SNFs are resuming communal meals and taking steps towards easing restrictions on visitation. These are promising signs that a semblance of normalcy for SNF residents is on the horizon. This moment of transition is an opportunity to gather residents' perspectives, to ensure that the programming and connections which are beginning to be offered, are in line with their wants and needs.

This transition, between over a year of significant restrictions and a "new normal", is a daunting endeavor and will undoubtedly be a gradual process. There will likely be some degree of trial and error as best practices are developed to balance residents' safety with the need to re-engage. The decisions which are made now, about which activities or opportunities are available to residents and how they will be facilitated, will have implications for how social engagement for SNF residents evolves from this point forwards. It is imperative that such decisions are informed by the needs and wants of residents who will be affected.

In interviews, stakeholders repeatedly mentioned social engagement and activities for residents (e.g., basic human connection, opportunities to spend time outside, organization of special activities or events within SNFs) as potentially simple adjustments, which would have significant benefits for residents' socioemotional well-being. Concerns about the socioemotional impacts of over a year of "lockdown" for residents, and an eagerness to start opening up opportunities for engagement, were also mentioned.

In line with this, stakeholders emphasized the importance of being able to safely (i.e. with social distancing and personal protective equipment) resume small group activities and visitation by loved ones to maintain the psychosocial well-being of residents. As activities and visits begin again, there are opportunities to improve upon what was available to residents prior to the pandemic.

It is important that SNFs and their residents are supported in efforts to resume, and to continue to enhance, social engagement activities (e.g., communal meals, group exercise, creative expression programs, special events, and visitation) which are so integral to socioemotional well-being. To be successful in transitioning into the "new normal", as well as ensuring that the "new normal" of social engagement is reflective of residents' preferences and needs, SNFs will need resources and clear guidance around how to safely proceed with re-opening.

Promote Evidence-Based On-Site Therapeutic Practices

There are a variety of evidence-based therapeutic interventions which could be delivered to SNF residents on-site, and which have the potential to significantly impact the mental health of LTC residents.[13]

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[13] See Table: Examples of Promising Therapeutic Practices (p. 17-19)

Telephonic Outreach Interventions

In this form of intervention, older adults receive friendly check-in calls (and/or can place outgoing calls as needed) with the objective of forming social connections, facilitating connection to needed resources, and improving mental health symptoms. In one longitudinal study of a telephonic outreach program, older adults were found to be able to form social connections and gain confidence through weekly check-in calls from trained volunteers (social work, psychology, and nursing students who received supervision and had access to a support call-line)[xxx] Notably, some of the participants in this study had been referred to the outreach intervention by the LTC facilities where they lived.

The Institute on Aging's Friendship Line is a 24–hour-toll-free hot and warm-line staffed by trained volunteers, which serves older adults in California who may be at risk of social isolation or loneliness. The Institute on Aging is based in San Francisco. While not a substitute for formal therapeutic mental health services, this existing free resource supports seniors who may be struggling with isolation or loneliness.[liv] According to Friendship Line staff, at present there is fairly limited engagement between SNF residents in San Francisco and this resource. In an interview, the director of The Friendship Line stated that the Friendship Line is available to provide informational in-services for residents and staff. She cited that this is a resource which they provide as part of their Department of Disability and Aging Services contract, which includes education and community outreach.

> *"It's a free service and we can reach thousands of people, we're just on the phone, the barrier of effort and time is low... what if everyone coming into a SNF got a daily check-in from the Friendship Line?"*
> **-Senior Director of Integrated Behavioral Health Services for the Friendship Line**

To increase utilization of the Friendship Line by SNF residents, it would be necessary is to ensure that residents are aware of the resource, and that they have access it (i.e. that the phone number is available to them and that they have the means of utilizing a phone to make/receive calls). These are fairly simple considerations towards facilitating a connection between residents and a beneficial resource.

 The Friendship Line should be promoted to residents of SNFs in San Francisco as a resource for supporting their socioemotional well-being. While some residents with more severe cognitive impairment and/or dementia might not be able to benefit from such an intervention, many residents would likely benefit tremendously from something as simple as an empathetic listening ear. The resource exists, it is

effective, and it would fill a need for social connection that is not adequately being met.[14]

Life Review Groups

Life review involves a structured evaluation of one's life, aimed at coping with negative experiences and finding positive meaning. It is an evidence-based treatment of depression for people in later life.[xxix] As has been mentioned, a study of the efficacy of life review for people living in nursing homes found an association with improved quality of life and life satisfaction.[lv]

Life review interventions can be beneficial to people with and without symptoms of depression, and to those with a range of cognitive abilities, including those with cognitive impairment such as dementia.[lvi] Although, people with more advanced dementia may not be successful in participation. Another possible limit to generalizability is that people who have experienced significant trauma may be better served through other therapy approaches, as recalling trauma in a group setting may not be optimal for themselves nor for other participants.[lvi]

One possible limitation to the feasibility of implementing life review groups would be logistical considerations around identifying qualified individuals to facilitate these groups on an ongoing basis, without overloading existing staff capacity. There are examples of students in nursing and mental health practitioner programs successfully facilitating therapy groups.[xxviii] There are also many universities in proximity to San Francisco with students who are required to complete practicum hours towards their degrees (for example, as nurses or mental health clinicians) and who have supervision through their programs. Given this, identifying students who would be willing to facilitate such groups seems feasible. An important logistical consideration would be the extent to which supervision of a student practitioner within the SNF would be necessary, and whether an existing staff person had the capacity to assume this role.

Life review group interventions are effective in terms of supporting the mental health and socioemotional well-being of LTC residents. An additional advantage of these groups is that hearing the stories of residents provided the people who care for them with an opportunity to get to know them better.[xxviii] Another benefit of is that recalling and reflecting on the past is a naturally occurring process which older adults tend to do anyway, and which is not typically stigmatized (i.e. many older

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[14] An additional avenue for telephonic (and eventually in-person) social support to consider would be the Little Brothers of San Francisco (littlebrotherssf.org). While this is not a mental health Intervention, it is an avenue for fostering consistent social connections for older adults.

people tend to enjoy telling others about their lives). For example, in one recent phone-based survey of older adults living in the San Francisco Bay Area, researchers found that the people they reached were eager to discuss their lives and that this in and of itself appeared to be therapeutic for them.[xxxv] As such, participation in life review groups might be less daunting than groups labeled as "therapy" for older adults who experience stigma around accessing mental health services.

As has been discussed, stakeholders in the SNF context have indicated the enthusiasm of residents to participate in social activities, particularly given the past year of limited opportunities to do so. Life review activities would provide an opportunity for social engagement and continued personal growth. Additionally, a life review group can foster rapport among residents by providing opportunities to get to know and emotionally support one another.[xxi]

As we enter the "new normal" after a year of the COVID-19 pandemic, it seems likely that residents of SNFs would benefit from the opportunity to come together to reflect in a structured way, and to process the traumatic experience which they have lived through.

Group, Individual, Staff Therapy (GIST)

GIST is a cognitive behavioral approach to treating depression, adapted specifically to the LTC context.[xxi] The objective of this program is to activate coping behaviors, increase positive mood, focus on pleasant activities, and work towards easy to attain "simple, doable, positive and meaningful" goals (e.g., "this week I will call my son"). The program is based on the idea that the regular practice of a handful of basic coping skills across a range of stressful or distressing situations can alleviate symptoms of depression.

GIST is flexible enough to take place in a range of LTC contexts and was developed with specific consideration to cost effectiveness. Group sessions are repeated to cover the same skills from week to week, which flexibly allows new members to join at any point as each session is the same. An additional benefit to this format is that repetition of simplified skills promotes retention of content for both residents and the staff supporting them. Involvement of, and collaboration with, caregiving staff has benefits for staff as well as for residents. Staff familiarity with target skills can empower them to better understand residents' socioemotional needs and to support residents' use of coping skills in their day to day lives. Many staff would likely benefit from the opportunity to hone their own positive coping skills as well.

In one study of this intervention, participants experienced a significant overall reduction in self-reported symptoms of depression, as well as increased life satisfaction. An additional benefit was that participation in group sessions was observed to foster rapport among residents, and provided organic opportunities for residents to emotionally support one another.

This intervention would entail similar considerations to the life review group therapy proposal, in terms of identifying practitioners to facilitate the therapeutic intervention protocol on an ongoing basis.

Behavioral Health Activities Intervention (BE-ACTIV)

BE-ACTIV is an individual therapy model, developed collaboratively with LTC caregiving staff.[xxvii] This intervention emphasizes opportunities for residents to experience pleasant events (e.g., crafts, music) facilitated by staff. Residents attend weekly individual therapy sessions (several of which staff are invited to join) for at least 10 weeks. Staff receive a 2 hour training on depression and the benefit of pleasant events for residents' socioemotional wellness.

In one randomized control trial of this intervention, 87% of participating nursing home residents reported improvements in their mood and 86% of staff reported improved relations with residents (despite not spending any additional time with residents compared to prior to the intervention). Involving caregiving staff in the therapeutic dynamic was identified as being especially beneficial to residents' psychosocial outcomes, both for ensuring feasibility of the intervention and for supporting continuity of therapeutic approaches in residents' day to day lives.

This intervention would entail similar considerations to the life review group therapy and GIST proposals, in terms of identifying practitioners to facilitate the intervention protocol on an ongoing basis.

Train Caregiving Staff on Mental Health & Trauma Informed Care

The COVID-19 pandemic has been a traumatic event, for SNF staff as well as for residents. As these facilities begin to resume some semblance of pre-pandemic "normalcy", there is an opportunity to empower caregiving staff with the resources necessary to support recovery. Providing training for caregiving staff around meeting mental health needs and responding to trauma would be beneficial to residents of SNFs, but also to staff themselves as they process what they have been through this past year.

The variety of staff members who have intimate contact with residents of SNFs provide an opportunity for recognition and response to residents' mental health symptoms, if they have the right tools to do so. The Director of Social Services at one SNF described the capacity of caregiving staff (specifically CNAs) to recognize and respond to residents' mental health symptoms to be generally "rudimentary". Caregiving staff have limited time to attend to any given resident, little formal training in mental health issues, and work with a culturally and cognitively diverse array of residents. As such, they may struggle to recognize symptoms of conditions such as depression and anxiety.

> *"This [pandemic] has been a trauma, it has been traumatic. Resources to train staff about the whole perception of what they've gone through as traumatic [would be helpful]."*
> -SNF Director of Social Services

Some stakeholders expressed a specific interest in resources around trauma-informed care to utilize in training caregiving staff. Programs that emphasize training for LTC staff around mental health issues have demonstrated significant improvement in detection and response to residents' symptoms of depression.[xix] Such staff training programs have also led to improvements in staff attitudes towards working with care recipients who had depression.

SNFs already have protocols for training staff and the addition of training material on these topics, or expansion of existing trainings on these topics, would not be prohibitive. Existing organizations are also available to facilitate trainings if further support or guidance is needed. For example, in an interview with the director of The Friendship Line, she mentioned that their organization facilitates trainings on topics such as social isolation, suicidal ideation, and loneliness. Building on established trainings and pursuing existing avenues for training would be conducive to high implementation feasibility of this intervention.

While not all residents of SNFs experience mental health symptoms, most (if not all) have experienced the pandemic as a traumatic event. Even residents who are not experiencing mental health symptoms would likely benefit from being cared for by people with an enhanced understanding of socioemotional well-being and meeting mental health needs. However, a limit to the generalizability of this intervention is that the needs of residents with very complex mental health profiles would likely be outside of the scope of these trainings for caregiving staff.
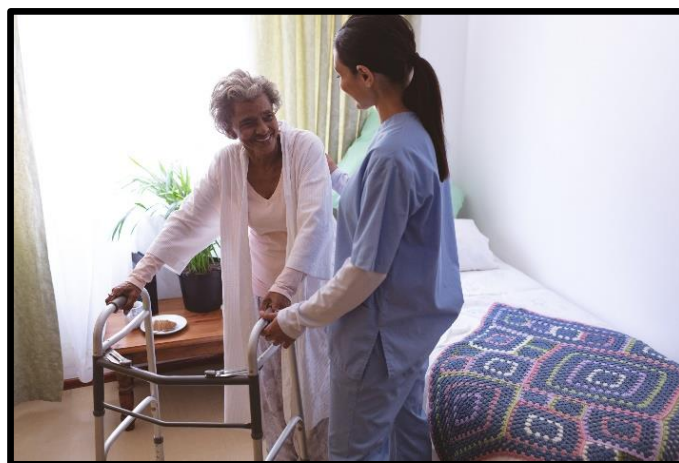
A component of properly supporting staff capacity to meet residents' mental health needs would be outlining clear protocols for properly identifying needs, and connecting people to appropriate treatment resources. In approaching such an intervention, it is crucial to bear in mind that providing training around mental health issues and trauma informed care to caregiving staff is effective, but only if they have the capacity to effectively apply the training to their work.

Ensuring Tele-Connectivity for all Residents Who Are Able to Benefit

As has been discussed, video-calling platforms can support regular communication with friends and family, to foster social engagement and mitigate isolation. These platforms can also provide opportunities for telehealth, including tele-mental health. Utilization of technology can allow residents of SNFs to connect with loved ones, communicate with healthcare providers, and to bridge the gap between themselves and their larger communities. However, findings have brought to light the basic obstacles to tele-connectivity (i.e. the use of internet enabled devices for virtual encounters, such as video-calls) in SNFs.

For example, many residents of SNFs do not currently have consistent access to reliable internet, nor to adequate numbers of internet-enabled devices, nor to formal instruction to support their acquisition of skills around the use of technology.

> *"We have a very short supply of iPads. We have two. Two total."*
> **-SNF Director of Social Services**

> *"For those suffering from dementia it [video-calling] was hard, they would look everywhere but the screen. They could hear their family but couldn't figure it out, for some it was quite distressing."*
> -SNF Director of Social Services

There are also limitations to the generalizability of tele-connectivity in this context. For many residents of SNFs, particularly those with cognitive impairments like dementia, engagement with technologies like video-calling can be very challenging. A subset of residents could likely gain some degree of independence in their use of technology, with access to supported use and training. Others would likely continue to need extensive support in their utilization of technology and might need to rely on staff indefinitely. For some residents, particularly those with cognitive impairment, the use of technology may remain aversive, or even distressing, regardless of the degree of support they are able to receive. As such, it is likely that tele-connectivity cannot be successfully generalized to all residents of SNFs.

To optimize this avenue of connection for those who are able to benefit, residents of SNFs need consistent and adequate access to reliable internet connection, to internet enabled devices, and to needed supports for their use of technology (e.g., trainings for residents and/or support staff). As is the case with training around mental health, training around tele-connectivity is only effective if staff have the capacity to effectively apply the training and the time to support residents as needed.

In the information gathering process, stakeholders repeatedly raised concerns about the lack of devices for residents to use, the inadequacy of the internet connections in place, and the demand for staff assistance in supporting tele-connectivity. This last factor was especially salient given existing limits to staff capacity.
In working to ensure tele-connectivity for SNF residents who are able to benefit, avenues of accessing devices and trainings must be identified. Given that San Francisco is a hub of the technology sector and that there are a variety of existing organizations working to bridge the digital divide, it is likely that partnerships could be formed to support tele-connectivity for SNF residents. For example, some organizations provide technology training for older adults, and partnerships with SNFs could be possible.

Existing efforts are in place at the state level to provide communications technology to older adults, including LTC residents. For example, stakeholders mentioned initiatives wherein the California Department of Aging distributed hundreds of voice-first technologies and tablets to Area Agencies on Aging. Also, CMS and the California Department of Public Health gave facilities the option to apply for funding

of communication technologies through the Civil Money Penalty Reinvestment Fund.[lvii]

A significant obstacle to efforts to support tele-connectivity of SNF residents would be procuring sufficient funding to purchase the quantity of devices necessary to ensure that all residents have consistent access to a device when they want one. Per the DSS of one SNF, the funds provided through their application to CDPH were only sufficient to obtain two iPads, which was not adequate to ensure that the facility's dozens of residents could access a device as needed.

For many residents of SNFs, tele-connectivity has the potential to serve as a bridge to the outside world. For this to be possible they need access to devices, reliable training, and staff who are equipped to meet their tele-connectivity support needs

Conclusion

There are a range of promising approaches and interventions which have the potential to be beneficial in addressing the mental health needs of people living in SNFs.

- Person-centered approaches to care have been found to significantly improve residents' quality of life.
- The Friendship Line supports the social engagement and mental well-being of older adults in San Francisco, and representatives of this resource are eager to foster engagement with SNF residents.
- Therapeutic interventions (e.g., Life review, GIST, Be-ACTIV) have promising implications for supporting the mental well-being of LTC residents.
- Training on mental health issues for LTC caregiving staff has been associated with significant improvement in detection and response to residents' mental health needs. Training on trauma informed care would be especially timely given the trauma which SNF residents and staff have lived through in the past year.
- Tele-connectivity has the potential to facilitate access to mental health services and socialization for some (but not all) people living in SNFs, so long as issues around access and digital literacy are considered in implementation.

In considering the implementation of any new intervention or approach to care, it is crucial to consider the additional burden it may pose on caregiving staff who are already overworked, underpaid, and spread very thin. Even the most well thought out improvement to care will not be successful if the staffing status quo does not shift to ensure adequate staffing levels, continuity of care, and the empowerment of staff with the skills necessary to provide optimal care.

COVID-19 has profoundly impacted residents of SNFs, both in terms of the lives lost to the virus and the consequences of over a year of isolation and disconnection from the outside world. The silver lining to the tragedies of the past year is that societal attention has been turned towards long standing problems with the way that SNF residents, and their mental health, are cared for.

As we begin to regain a semblance of the "new normal", there is an opportunity, and arguably an imperative, to improve our support of LTC residents of SNFs. Now is the time to act.

Appendices

Appendix A: Descriptive Matrix of Long Term Care Contexts

	Facility Type	Target Population	Capacity	Level of Care	Licensed By	Notes	Number in SF
Assisted Living Facility (ALF) Includes; Facilities for the Elderly (RCFE)[15][16] & Adult Residential Facilities (ARFs)[17][18]	Range: large facilities to small homes with admin/ owner onsite	Individuals with higher levels of functional impairment who require higher level of care (those with dementia, intellectual disabilities, etc.) RCFE; seniors (age 60+) ARF; adults (age 18-59)	Range 100+ beds to 6> beds In San Francisco (as of 2018) the majority of ALFs in both categories are in the <15 bed range	Supportive care/ assistance with daily living tasks, at least 2 meals/day, 24-hour supervision but not daily nursing care Limited medical services (e.g., gastrostomy, catheter, colostomy, ileostomy care)	Licensed by California Dept. of Social Services' Community Licensing Division.	Majority in SF are licensed as RCFEs Medicare does not pay for Assisted Living, the majority of services in California are paid for with private funds. ~15% of ALF beds in SF are supported by a city funded subsidy ~42% of ARF beds in SF are DPH placement	105 [lviii] [ARF: 38 ARFPSHN: 0 RCFE: 58 RCFECI: 6 RCFECC: 3]

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[15] RCFEs include RCFECIs which specifically house people with chronic illness (e.g., HIV/AIDS)

[16] RCFEs-Continuing Contracts have overlap with SNFs

[17] ARFs include Community Care Facilities (CCFs). CCFs are residential/group homes for children and adults with developmental disabilities vendored by the Regional Center which provide 24 hour non-medical residential care; personal services, supervision and facilities reflect 4 levels of care ranging from 1 (lowest need) to 4 (highest need)

[18] ARFs can also include ARFPSHNs (Adult Residential Facilities for Persons with Special Health Care Needs, designed specifically to serve the most medically fragile persons previously residing in a Developmental Center

	Facility Type	Target Population	Capacity	Level of Care	Licensed By	Notes	Number in SF
Skilled Nursing Facility (SNF) (aka convalescent hospitals, nursing homes, rehabilitation centers)[19]	In-patient medical facility	People with chronic illness and/or people who are recuperating from surgery/ illness who have a primary need of skilled nursing care on an extended basis	Range: [20] dozens to hundreds of beds	24 hour on-site skilled nursing and supportive care.

Services can also include; audiology, dietary, occupational therapy, speech pathology, outpatient services, social services, pharmacy, recreation therapy, rehabilitation, injectable or intravenous medications | Licensed by the California Dept. of Public Health, Licensing and Certification Division | Often funded by Medi-Cal and/or Medicare[21] | 19 [lix] |

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[19] SNFs include D/P SNFs which are often housed within a hospital and provide treatment for acute illness/injury and intensive rehabilitation services, residents typically stay less than 3 weeks before being discharged to a traditional SNF or to their homes
[20] In San Francisco there are 18 SNFs (as of 2019), 10 have <55 beds and 2 have >300 beds

	Facility Type	Target Population	Capacity	Level of Care	Licensed By	Notes	Number in SF
Intermediate Care Facility (ICF) *Includes;* *Intermediate Care Facility- for the Development-ally Disabled Habilitative (ICF/DD-H)* *&* *Intermediate Care Facility for the Development-ally Disabled-Nursing (ICF/DD-N)* *&* *Intermediate Care Facility for the Development-ally Disabled (ICF/DD)*	Group Homes- ICF/DD-H & ICF/DD-N Or Facility Setting- ICF/DD	Ambulatory or non-ambulatory individuals who are developmentally disabled and have intermittent recurring need for skilled nursing services but have been certified by a physician as not requiring continuous skilled nursing care	Range; 4-15 beds- ICF/DD-H & ICF/DD-N 16+ beds- ICF/DD	24 hour personal care, supportive care and recurring skilled nursing supervision but not continuous skilled nursing care (8 hours per day of nursing care)	Licensed by the California Department of Public Health Licensing and Certification Division	Can receive no reimbursement under Medicare and generally receives the bulk of financing under Medi-Cal	0 [lix]

Facility	Capacity/ Occupancy[lx 22]	Notes [lix]	Address	Phone	COVID-19 in Residents [lx] (Confirmed Cases/ Deaths)	Survey/ Interview Response
California Pacific Medical Center- Davies Campus D/P SNF	38 beds/ 21 beds	Accepts Medicare & Medi-Cal	601 Duboce Ave, 94117	415-600-6000	1/0	No
Central Gardens Post Acute	92 beds/ 84 beds	Accepts Medicare & Medi-Cal	1355 Ellis St, 94115	415-567-2967	41/17	Yes
City View Post Acute *(formerly Tunnell Skilled Nursing & Rehab)*	180 beds/ 77 beds	Accepts Medicare & Medi-Cal	1359 Pine St, 94109	415-673-8405	63/45	No
Hayes Convalescent Hospital	34 beds/ 31 beds	Accepts Medi-Cal	1250 Hayes St, 94117	415-931-8806	0/0	Yes
Heritage on the Marina	32 beds/ 18 beds	Accepts Medicare	3400 Laguna St, 94123	415-202-0300	1/0	Yes
Jewish Home & Rehab Center D/P[23] SNF	378 beds/ 254 beds	Accepts Medicare & Medi-Cal	302 Silver Ave, 94112	415-334-2500	98/5	Yes
Laguna Honda Hospital & Rehabilitation Center D/P SNF	769 beds/ 702 beds	Accepts Medicare & Medi-Cal	375 Laguna Honda Blvd, 94116	415-759-2300	62/6	Yes
Laurel Heights Community Care	32 beds/ 31 beds	Accepts Medicare	2740 California St, 94115	415-567-3133	7/7	Yes
Lawton Skilled Nursing & Rehabilitation Center	68 beds/ 43 beds	Accepts Medicare & Medi-Cal	1575 7th Ave, 94122	415-566-1200	20/0	No

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[22] Occupancy figures and COVID-19 case figures from the week of 02/07/2021

[23] Distinct Part (D/P) facilities are often housed within a hospital or on a hospital site and hospital residents may be transferred to the D/P SNF when they transition from needing primarily acute to post-acute care, most residents stay for less than 3 weeks before being transferred to a SNF or their home. D/P SNFs provide the same services as SNFs, treatment for acute illness/injury and rehabilitative services

Facility	Capacity/ Occupancy	Notes	Address	Phone	COVID-19 in Residents (Confirmed Cases/ Deaths)	Survey/ Interview Response
Pacific Heights Transitional Care Center	120 beds/ 93 beds	Accepts Medicare & Medi-Cal	2707 Pine St, 94115	415-563-7600	50/2	No
San Francisco Health Care	168 beds/ 102 beds	Accepts Medicare & Medi-Cal	1477 Grove St, 94117	415-563-0565	8/0	Yes
San Francisco Post Acute	53 beds/ 51 beds	Accepts Medicare & Medi-Cal	5767 Mission St, 94112	415-584-3294	6/1	No
San Francisco Towers	55 beds/ 15 beds	Accepts Medicare	1661 Pine St, 94109	415-447-5505	10/2	No
Sequoias San Francisco Convalescent Hospital	50 beds/ 32 beds	Accepts Medicare	1400 Geary Blvd, 94109	415-922-9700	5/2	Yes
St. Anne's Home	46 beds/ 40 beds	Accepts Medi-Cal	300 Lake St, 94118	415-751-6510	7/3	Yes
The Avenues Transitional Care Center	140 beds/ 83 beds	Accepts Medicare & Medi-Cal	2043 19th Ave, 94116	415-661-8787	97/5	No
Victorian Post-Acute	90 beds/ 54 beds	Accepts Medicare & Medi-Cal	2121 Pine St, 94115	415-922-5085	63/13	No

Appendix C: Timeline of COVID-19 Public Health Regulations for Skilled Nursing Facilities in San Francisco		
Order Number	**Date**	**Regulation/Event**
------	02/25/2020	Mayor Breed Declares a State of Emergency to prepare for COVID-19[vi]
------	03/05/2020	First reported cases of COVID-19 in San Francisco at local hospitals, likely resulting from community exposure[lxi]
C19-01	03/07/2020	Visitors and non-essential personnel restricted from Laguna Honda
C19-03	03/10/2020	Visitors and non-essential personnel restrictions and other safety measures extended to other SNFs in San Francisco[lxii]
C-19-01 (expanded)	03/11/2020	Visitors and non-essential personnel restricted from Zuckerburg SF General, additional safety requirements added to C19-01[lxiii]
C19-07	03/16/2020	City and County of San Francisco (and five other Bay Area Counties, as well as the city of Berkeley) implemented Shelter-in-Place orders to reduce the impact of COVID-19[lxiv]
C19-11	03/24/2020	Residents of Laguna Honda restricted from leaving the facilities except under limited exceptions[lxv]
C19-07c	04/29/2020	Shelter-in-Place orders extended for all residents of San Francisco[lxvi]
C19-13	05/07/2020	Congregate Living Facilities required to follow the Testing, Collaboration, Reporting, and Guidance Requirements of the San Francisco Department of Public Health[lxvii]
C19-07d	05/17/2020	Shelter-in-Place orders extended for all residents of San Francisco [lxviii]

Order Number	Date	Regulation/Event
C19-03b **&** **C19-01c**	09/04/2020	Expanded visitation at residential facilities to allow the flexibility to allow three new kinds of visitation; outdoor (i.e. both resident and visitor are outside), vehicle-based (i.e. where visitor remains in a vehicle), and window visits (i.e. where the resident remains in the building behind a door with a window or a window. Facilities have the flexibility to determine what kinds of visits to offer and how to do so safely. Required mandatory screening of visitors on day of visit, physical distancing, use of face covering, prohibition of exchange of gifts or any items between residents and visitors, advanced scheduling of visits, restriction on length of visits, restrictions on number of visitors, and other protections. "Necessary Visitation" (i.e. necessary for urgent health, legal, or other time sensitive issues) may justify visitation in a manner other than the allowed kinds of visits.[lxix]
C19-03c	03/10/2021	Expanded visitation to allow for indoor visits, while still encouraging other types of visits (i.e. outdoors, vehicle based) and mandating that facilities must follow screening procedures for visitors[lxx]

Appendix D: Descriptive Matrix of Centers for Medicare & Medicaid Services Regulations Relevant to Person-Centered Care

CMS Regulation [xxiii]	Regulation	Intent
F222- Restraints	Residents have "the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the residents' medical symptoms"	"For each person to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience"
F241- Dignity	Facilities "must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality."	"That in their interaction with residents, staff carries out activities that assist the resident to maintain and enhance his/her self-esteem and self worth"
F242- Self- Determination and Participation	Residents have "the right to choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care, to interact with members of the community both inside and outside of the facility, and to make choices about aspects of his or her life in the facility that are significant to the resident."	"That the facility must create an environment that is respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life"
F246- Accommodation Of Needs	Residents have "the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered."	"That the facility is responsible for evaluating each residents' unique needs and preferences and ensuring that the environment accommodates the resident to the extent reasonable"

CMS Regulation	Regulation	Intent
F248- Activities	Facilities "must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident"	"That the facility must identify each residents' interests and needs and involve the resident in an ongoing program of activities that is designed to appeal to his or her interests and to enhance the residents' highest practicable level of physical, mental, and psychosocial well-being.
F250- Social Services	Facilities "must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident"	"To assure that sufficient and appropriate social service are provided to meet the residents' needs"

Appendix E: Stakeholder Outreach Methodology

Several channels of outreach were pursued in the effort to obtain input from the Directors of Social Services and/or Nursing at the 17 SNFs which provide LTC in the City & County of San Francisco. A total of 11 individuals from 8 SNFs completed the survey (two SNFs had more than one survey response, for example from both the Director of Nursing and the Executive Director). A total of 4 individuals working for SNFs participated in interviews (3 of these also completed the survey). The 40 question survey was facilitated through Microsoft Forms, and included multiple choice and open-ended questions. It was active for most of the month of March 2021 and interviews were conducted from mid-February to mid-April 2021.

Emails were sent with a brief introduction about the Long Term Care Coordinating Council and the specific project regarding supporting the mental well-being of SNF LTC residents. The text of the email included reassurance that the project was not for oversight or regulatory purposes but to inform recommendations to be made to the Long Term Care Coordinating Council. Emails also included the link to the Microsoft Forms survey and a request to complete the survey and/or respond expressing amenability to being interviewed. In some cases one email was sufficient to procure survey and/or interview participation while for some SNFs as many as 4 emails were sent over a 4 week period without response.

Calls were made to most of the SNFs directly (except for those where an email address was already accessible) with a request to be transferred to the relevant individual and/or their voicemail and/or to leave a message for that person with the receptionist. In some cases one call was sufficient to obtain participation, in some cases as many as three calls were made over the course of approximately 4 weeks without successful procurement of participation. Additionally, a presentation introducing the project and requesting participation in a survey and/or interview was made during the San Francisco Department of Public Health's (SF DPH) COVID Command Center SNF Coordinating call on March 9th 2021, and follow up emails were sent by the person with SF DPH who coordinates the SNFs.

In addition to outreach to the staff of SNFs, outreach to pursue interviews with various additional stakeholders (e.g., SNF residents, SNF Ombudsmen, UCSF doctors with relevant expertise, the Executive Director of California Advocates for Nursing Home Reform (CANHR), the Senior Director of Integrated Behavioral Health Services with the Friendship Line, the co-directors of the San Francisco Tech Council, the Executive Director of Televisit) was conducted. Connections to other stakeholders were facilitated by members of the Long Term Care Coordinating Council with pre-existing professional relationships to these individuals and/or by asking the interviewees themselves if they could facilitate connections to additional relevant stakeholders.

Appendix F: Stakeholder Interview Instrument

Framing Notes:
- Interview should take approximately 30-45 minutes
- Interview is being conducted by a UC Berkeley Public Policy graduate student, in partnership with the Long Term Care Coordinating Council
- Emphasize that we are specifically interested in SNF residents of long term care, not rehab
- Reassure that the purpose of this outreach is to identify gaps/needs to be met and hopefully to match with opportunities/resources NOT for monitoring]

Open Ended Questions for Focus Groups/Interviews[24]
1. I know the pandemic has been a particularly traumatic experience for staff of SNFs. How are you doing?
    a. How are SNF caregiving staff being impacted?
2. Tell me how you feel the residents of SNFs seem to be doing overall during COVID-19?
    a. What have been the biggest challenges for residents during COVID-19?
    b. Are there specific changes that you have observed in terms of residents' well-being compared to before the pandemic?
3. What does social engagement for SNF residents look like currently?
    a. What does visitation look like?
    b. What do group activities look like?
    c. How do you feel that virtual group activities compare to in-person group activities?
4. Are there themes or trends in unmet needs for SNF residents (specifically around mental health, isolation, and/or loneliness) that you have observed during the COVID-19 pandemic?
    a. How about changes in terms of unmet needs since before the pandemic?
5. Have any residents received telehealth mental health services since COVID-19? How has that been working out?
    a. Would you recommend continuing with telehealth options for residents in a post-pandemic "new normal" world?
6. Does your SNF utilize the PHQ9 [questions to assess residents' symptoms of depression and anxiety]?
    a. If so, how often?
    b. Do you find this tool to be useful/accurate?
    c. Have you had a chance to compare results pre-pandemic to now? If so, do your PHQ9 surveys reveal differences in the mental health and well-being of residents in your facility since the onset of COVID-19? Please explain.
    d. Are the results publicly available?
7. Have you interviewed or surveyed residents to assess their well-being during COVID-19 beyond the PHQ9?
    a. What did you find? Would you be willing to share aggregate results?

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[24] Note: the questions on the interview instrument were adjusted as needed for interviews with stakeholders who were not staff of SNFs

8. Have you observed any particularly innovative/creative/successful methods of supporting residents' emotional well-being during COVID-19 at your facility or others?
   a. How about pre-pandemic?
9. In an "ideal world" what resources, programming, or services would be available to SNFs/ SNF residents to support resident mental health/well-being?
10. How about "ideal world" resources to support SNF caregiving staff?
11. How can the City help to support residents and staff of SNFs at this time?
12. Have you started planning for the "new normal" (i.e. post-COVID-19)?
    a. What do you anticipate changing or staying the same in terms of support for resident mental health/well-being?
13. Is there anything specific that you feel is important to consider when approaching identifying/meeting the mental health needs of SNF residents?
14. Are there existing outlets that you are aware of which we could utilize to conduct a focus group of residents' families/residents? (ex; advocacy org, support group)

Consent

0. "This survey is being conducted by a graduate student in public policy attending UC Berkeley. The survey results will be incorporated into a report for the Long Term Care Coordinating Council, and will inform recommendations about meeting the mental health needs of long term care residents. Participation is voluntary and any responses that you provide will be anonymized to ensure confidentiality."

Background Information

1. Which Skilled Nursing Facility do you work for/are you affiliated with? *[optional]*
   _____

2. What is your role/title?_____

3. How many long-term care residents reside in your facility?

4. What percentage of your long-term care residents are over the age of 65?
   [76-100%, 51-75%, 26-50%, 0-25%, Not sure]

5. What percentage of your long-term care residents have cognitive impairment, dementia, and/or Alzheimer's?
   [76-100%, 51-75%, 26-50%, 0-25%, Not sure]

6. What percentage of your long-term care residents are supported through Medi-Cal?
   [76-100%, 51-75%, 26-50%, 0-25%, Not sure]

7. Does your facility practice a "person-centered" approach to care?
   [Yes, No, Not sure]

Mental Health Needs & Services

8. How do residents seem to be doing, generally, in the context of COVID-19?
   [Most residents coping well, Some residents coping well/some not coping well, Most residents not coping well, Not sure]

9. Do caregiving staff (e.g., CNAs) at your facility receive training about recognizing/responding to residents' mental health needs (e.g., recognizing symptoms of depression)?
   [Yes all staff do, Some staff do, No we do not require/offer training like that, Not Sure]

10. Do caregiving staff at your facility receive training in trauma informed care?
    [Yes all staff do, Some staff do, No we do not require/offer training like that, Not Sure]

11. Have many/any residents pursued mental health services (or had mental health services pursued on their behalf) during COVID-19? *[None, A Few, Many, Not Sure]*

12. Did many/any residents pursued mental health services (or have mental health services pursued on their behalf) before COVID-19?
    [None, A Few, Many, Not Sure]

13. Have efforts to connect residents to mental health services during COVID-19 been successful?
    [Not Applicable, All have been successful, Most have been successful, Some have been successful, None have been successful, Not sure]

14. If so, what kind of mental health services? _____

15. Have many/any residents received telehealth mental health services (e.g., a video or phone call with a therapist) during COVID-19?
    [None, A Few, Many, Not Sure]

Access to Technology and Social Engagement
16. Do residents have access to internet/WiFi?
    [Not at all, Sometimes, Always, Not sure]

17. Do residents have access to internet enabled devices (e.g., iPads)?*[None do, Less than half do, About half do, More than half do, All/Almost all do, Not sure]*

18. Do you have staff or volunteers that help connect residents to video calls?
    [Yes, No, Not sure]

19. Approximately what percentage of residents are able to access video calls on their own?
    [76-100%, 51-75%, 26-50%, 0-25%, Not sure]

20. Approximately what percentage of residents are able to access video calls successfully with in-person support?
    [76-100%, 51-75%, 26-50%, 0-25%, Not sure]

21. For the majority of those residents who need support with video calls, does someone need to be present at all times during the call?
    [Yes, No, Not sure]

22. Do you have staff whose job it is to support residents in video calls?
    [Yes, No, Not sure]

23. If so, what percentage of their time is spent supporting residents' video calls?
    [76-100%, 51-75%, 26-50%, 0-25%, Not sure]

24. Does your facility currently have any in-person social engagement activities?
    [Yes, No, Not sure]

25. If yes, how frequently do residents typically have access to in-person social engagement activities?
    [Daily, Several days per week, Once per week, Several times per month, Monthly, Every Few Months, Not at all, Not sure]

26. Do you find virtual social engagement activities to be;
    [Effective, Not effective, Better than nothing, Not sure, NA (Don't organize virtual social engagement activities)]

27. Does your facility have communal dining at this time?
    [Yes daily, Yes sometimes, No, Not sure]

28. Is visitation by family/friends possible at this time?
    [Yes normal in-person visitation has resumed, Yes modified (e.g., through a window or distanced outdoor) visitation has resumed, No visitation is not currently taking place, Not sure]

29. Do you feel like the City's health orders restricting access and activities at SNFs have been:
    [too strict; not strict enough; or just right]

30. Please explain your thoughts on the restrictiveness of the City's health orders:
    _____

COVID-19

31. How do caregiving staff seem to be doing during COVID-19?
    [Most coping well, Some not doing well at all/Some coping well, Most not coping well, Not sure]

32. How has staff turnover been during COVID-19 (e.g., staff quitting/leaving) compared to before the pandemic?
    [Fewer staff leaving than before COVID-19, Turnover has been about the same, More staff leaving than before COVID-19, Not sure]

33. Have there been any non-COVID-19 deaths which might be attributed to the stress, isolation, and/or other mental health aspects of the pandemic?
    [Yes, No, Not sure]

34. If there have been non-COVID deaths which might be attributed to mental health aspects of the pandemic, please explain:_____

Conclusion/Next Steps
35. Have you done any interviews or surveys of residents' well-being during the COVID-19 pandemic?
    [Yes, No, Not sure]

36. Are there existing outlets that you know of which we could utilize to conduct a focus group of families/residents? (ex; advocacy org, support group) _____

37. In an "ideal world" what would you need to better support residents' mental health/well-being? Please list anything that the City& County could do to help. _____

38. Is there anything else that is important for us to know?_____

39. Would you, or someone else from your facility, be open to being interviewed to further inform the work being done on meeting mental health needs of residents in Long-Term Care (the interview would be 30-45 minutes and your insight would be invaluable and would be much appreciated!)?
    [Yes, No]

40. If so, please provide the best contact information to reach you or that person (email and/or telephone number) _____

Appendix H: Relevant Current Legislation		
Legislation Title	**Intent**	**CANHR's Position**
AB 665: RCFE Basic Services Internet Access[lxxi]	To require that residential care facilities for the elderly (RCFEs) provide at least one internet access tool with microphone and camera function to residents as a basic service	Watch
AB 470: Medi-Cal Eligibility[lxxii]	To prohibit the use of resources, including property and other assets, to determine eligibility under the Medi-Cal program.	Support
AB 1502: SNF Ownership & Management Reform [lxxiii]	To reform ownership and management of SNFs by setting "suitability standards" for individuals and entities seeking to operate SNFs in California. This bill would also direct the California Department of Public Health to thoroughly screen applicants before approving operation/management of SNFs.	Sponsor
SB 650: SNF Transparency & Accountability [lxxiv]	To require SNFs to file annual consolidated financial statements, to provide for more transparency in nursing home payments. To require SNFs to submit audited financial reports. To protect public funds from being misallocated by corporate SNF operators.	Sponsor
AB 849: Restoring the Enforcement of Nursing Home Resident Rights[lxxv]	To restore SNF liability to up to $500 per residents' rights violation (currently SNFs may only be held liable for $500 maximum regardless of how may rights are infringed upon).	Support
AB 323: Long-Term Health Facilities [lxxvi]	To enhance the SNF enforcement system by increasing penalties for state citations issued against SNFs (to keep up with inflation). To update the criteria for citations which cause the death of a resident to a more clear standard.	Support
AB 6: Health Facilities- Pandemics & Emergencies[lxxvii]	To require the Departments of Public Health and Social Services to set guidelines around health and safety for use by SNFs, ICFs, and congregate living health facilities during pandemics, other public health crises, and/or emergencies.	Support

Legislation Title	Intent	CANHR's Position
AB 749: SNF: Medical Director Certification[lxxviii]	To prohibit SNFs from contracting with medical directors who are not (or who will not be within five year) certified by the American Board of Post-Acute and Long-Term Care Medicine as a Certified Medical Director.	Support
SB 460: Office of Patient Representative[lxxix]	To create the Office of the Patient Representative. To train and provide oversight representatives to protect the rights of SNF residents who allegedly lack the capacity to make decisions and who do not have a surrogate decision-maker available to them.	Support
AB 1054: SNF Feeding Assistants[lxxx]	This bill would establish a SNF feeding assistant program	Oppose
AB 1313: COVID-19-Immunity from Civil Liability[lxxxi]	To exempt businesses from liability for any injury or illness that a person incurs due to COVID-19 based on the claim that the person contracted COVID-19 at or because of that business, if the business has complied with all health regulations.	Oppose
AB 636: Financial Abuse of Elder or Dependent Adults[lxxxii]	To authorize information relevant to incidences of elder or dependent adult abuse to be given to a federal law enforcement agency.	Watch
SB 769: Housing Rental Vouchers- SNF patients[lxxxiii]	To create a pilot program (2023-2026) which would provide housing rental subsidies to SNF patients who could be discharged from their facility if their lack of housing was addressed.	Watch

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