Public Counsel

The nation's largest pro bono law firm

January 31, 2014

VIA ELECTRONIC AND U.S. MAIL

United States Commission on Civil Rights
1331 Pennsylvania Ave., NW, Suite 1150
Washington, DC 20425

Re: Patient Dumping Hearing, February 14, 2014

Dear Commissioners:

Thank you for the invitation to testify at the Commission's February 14, 2014 hearing on homeless patient dumping, and for your interest in and attention to this critically important issue affecting the civil rights of our nation's most vulnerable residents. I look forward very much to our discussion.

My written testimony is composed of three sections: (1) a description of the social and legal problems involved in homeless patient dumping, (2) a discussion of steps taken by advocates and government officials to begin addressing the problem, and (3) a series of policy recommendations for future analysis and action.

But let me begin by providing some brief background on how Public Counsel became involved on this issue.

On March 20, 2006, Kaiser Permanente Bellflower Medical Center placed a disoriented, 63-year-old homeless patient in a taxi, drove her 15 miles away, and dropped her off in Skid Row in the heart of downtown Los Angeles—wearing nothing but a hospital gown, a diaper, and socks. Several days later, Southern California residents were horrified to turn on the evening news and see video footage of this dangerous situation unfold. A video camera placed outside the shelter that took her in captured Carol Ann Reyes being dropped off by the taxi and wandering in a daze on the sidewalk where she had been left. The incident immediately gathered nationwide attention and became the symbol for the ongoing phenomenon of "homeless patient dumping." Public Counsel and the ACLU of Southern California represented Ms. Reyes, and, together with the Los Angeles City Attorney's Office, filed a lawsuit seeking injunctive relief and damages. A copy of the Complaint in *Carol Ann Reyes v. Kaiser*, BC362075 (Los Angeles Superior Court) is attached as Exhibit A.

Less than a year later, on February 8, 2007, Hollywood Presbyterian Hospital discharged a paraplegic homeless patient, placed him in a van, and deposited him without his wheelchair on the side of a street near Skid Row. Onlookers quickly called the police after observing the

individual, Gabino Olvera, dragging himself down the street still wearing a hospital gown and a Foley catheter, with his belongings in a bag clenched between his teeth. Public Counsel, the ACLU of Southern California, and the law firm of Robins Kaplan Miller & Ciresi brought suit, and the Los Angeles City Attorney's Office filed a separate action. A copy of the Complaint in *Olvera v. Hollywood Presbyterian*, BC383940 (Los Angeles Superior Court) is attached as Exhibit B.

In the intervening years, Public Counsel has represented more than a half-dozen additional homeless patients in litigation against various hospitals aimed at addressing this practice. *See, e.g.*, Exhibits C. All these cases have since settled (the majority without the necessity of a complaint being filed), and many have resulted in the adoption of "best practices" protocols that have profoundly changed the operational discharge practices of these (and other) hospitals. *See, e.g.*, Exhibits D, E. The attention that this issue has received over this time period also has led to a series of legislative and policy efforts (discussed in Section II), which we believe have started to change the landscape.

In short, we have worked on the front lines of this issue since it hit the national consciousness eight years ago. As the nation's largest *pro bono* law firm, Public Counsel and its staff attorneys, social workers, paralegals and network of thousands of volunteers are all committed to making access to justice a reality and to defending the civil and economic rights of all Americans. I have been personally involved in representing Carol Reyes and Gabino Olvera, and am committed to Public Counsel's continued work in this area.

Our legal efforts on behalf of homeless Americans have helped expose the problem of patient dumping and promote solutions. But the problem is obviously ongoing. We welcome the opportunity to engage in broader discussions about how national laws and initiatives can make a difference.

I. Defining the Problem

Homeless patient dumping is a national problem that exists at the intersection of the homelessness epidemic, our affordable housing crisis, and the challenges of health-care delivery. It results in part from our society's tragically insufficient response to the combination of structural factors—including deep poverty, lack of social supports, and homeless individuals' own health-care needs—that keep people on the streets, and is exacerbated by the lack of housing options and respite care facilities for homeless patients who predominantly utilize our nation's emergency rooms.

Many of the underlying statistics are known to all.

According to a recent HUD report, on any given night in America more than 407,000 homeless individuals were in shelters, transitional housing programs, or on the streets. *See* HUD's June

2010 Annual Homeless Assessment Report to Congress (2010 AHAR). Of these individuals, 26.2% had a severe mental illness, and 109,000 were chronically homeless. *Id*.

The effect of homelessness on a person's health is staggering. The homeless are three to six times more likely to become ill than people who are housed (National Health Care for the Homeless Council, 2008) and three to four times more likely to die prematurely than the general population. See O'Connell, J.J., "Premature Mortality in Homeless Populations: A Review of the Literature," Nashville (National Health Care for the Homeless Council, 2005). Although studies vary, the average life expectancy for a person living on the streets is between 42 and 52 years of age.

Homeless individuals also utilize emergency rooms at an alarming rate. Emergency room care should not be a substitute for quality primary care, but it is for too many people who are homeless. According to the Centers for Disease Control and Prevention, the homeless accounted for more than 680,000 emergency visits nationwide in 2010. See 2010 National Hospital Ambulatory Medical Care Survey, Table 2 (http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2010_ed_web_tables.pdf). Their ER utilization rate was calculated as being more than 2½ times greater than for those who are housed. *Id.* Another recent study conducted in Texas determined that the average homeless individual in the area utilized the emergency room five times per year—for a total cost per patient of more than $18,000 annually. See The Lewin Group, "Frequent Users of Health Services Initiative," prepared for the California Endowment and the California HealthCare Foundation (August 2008).

To our knowledge, academic studies measuring the prevalence of homeless patient dumping have not been conducted. But anecdotally, our office has heard from advocates from San Francisco, Chicago, New York and Boston that the practice is frequent and persistent. In Los Angeles, during the period immediately after the 2006 Carol Ann Reyes matter, the City of Los Angeles received calls or communications about more than 55 incidents of patient dumping. *See* "Dumping of Homeless by Hospitals Stirs Debate," *New York Times* (February 23, 2007).

Federal laws do not go far enough to address patient dumping. Some people have argued that the practice of homeless patient dumping is completely addressed by provisions of federal Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA imposes various requirements on Medicare-participating hospitals, mandating that they: (1) conduct medical screening examinations, (2) provide necessary stabilizing treatment to any patient seeking emergency medical care, and (3) if unable to comply with requirements (1) and (2), transfer the patient to a facility that can provide those services. *See* Pub L 99-272, Title IX, 9121(b), 100 Stat 164 (1986). Thus, a participating hospital violates EMTALA if it refuses to provide services or discharges a patient improperly before stabilizing the emergency medical condition.

But what if the patient is arguably already stabilized, but vulnerable because of his/her age, mental condition or disability? What if the patient requires additional respite care to take care of

a wound, infection, or other medical condition? What laws govern the unwilling transport of these patients to distant parts of town with dangerous conditions?

In our opinion, these questions lie at the crux of the homeless patient dumping conundrum. The major violations of patients' civil rights center around the following:

- Lack of proper psychiatric assessments to determine capacity;
- Lack of informed consent to be transported;
- Unlawful hospital discharge with inadequate follow-up instructions;
- Unlawful transport to unknown parts of town that pose significant health risks;
- Callous and/or reckless disregard for the safety of the patient upon discharge to "skid row" areas; and
- Failure to ensure a "warm handoff" to the shelter or other provider.

EMTALA, by itself, is not enough. More needs to be done.

II. Steps Taken to Address the Problem

Since Public Counsel and the ACLU filed the Kaiser action in 2006, advocates have adopted a multi-pronged approach to addressing the homeless patient dumping problem. We discuss each prong in turn.

A. Litigation

As discussed above, Public Counsel and other local city attorney's offices have filed suit to stop the practice. These suits have alleged claims under state elder abuse and neglect statutes, state common law negligence, medical malpractice theories, and false imprisonment theories. The most encouraging effect of these cases is that numerous hospitals have called our office and asked for the "model discharge protocols" implemented in other cases. Nothing makes us prouder.

The lawsuits, however, continue. In 2013, the Los Angeles City Attorney filed and settled a case against Beverly Hospital in Montebello, California, for homeless patient dumping. "L.A. City Atty. Mike Feuer vows to crack down on 'patient dumping,'" *Los Angeles Times* (January 3, 2014). Our office is currently investigating other recent complaints of patient dumping.

B. Legislation

In 2007, in response to the attention that the Kaiser case and others had gathered in the media, California State Senator Gil Cedillo introduced SB 275, a bill that would have made it a misdemeanor (punishable by a fine up to $10,000) for a hospital to cause a patient to be transported to a location other than the patient's residence without the patient's clearly and explicitly manifested consent to the transfer. See Exhibit F (SB 275 Bill Analysis). The Senate and Assembly passed the bill, but Governor Arnold Schwarzenegger vetoed it on October 14, 2007.

The City of Los Angeles, however, was not deterred by the Governor's veto. On May 16, 2008, the Los Angeles City Council passed Ordinance No. 179913, which states that "[a] health facility may not transport or cause a patient to be transported to a location other than the patient's residence without written consent, except when the patient is transferred to another health facility following bona fide procedures…." Los Angeles Municipal Code Section 41.60 (b).

The City of Sacramento introduced a similar ordinance in 2010, but it failed to be enacted into law. *See* "McCarty's proposal for homeless patients fails to advance," *Sacramento Bee* (January 7, 2010).

C. Hospital Symposium and Regional Planning

In Southern California, another way that we have attempted to craft a larger solution to the homeless patient dumping issue is to bring together hospital discharge planners, affordable housing providers, government officials, and advocates for the homeless to begin creating a regional plan for improving health-care delivery to the homeless, and to plan how hospitals should discharge their homeless patients.

On June 10, 2013, Public Counsel sponsored a Los Angeles Regional Hospital Symposium entitled "Medicare Reimbursements and the Affordable Care Act: Planning for the Chronically Ill Homeless." Representatives from more than 50 hospitals attended, along with numerous homeless services providers, elected officials, and housing advocates. *See* "Experts seek better health outcomes for homeless," *Los Angeles Times* (June 11, 2013). Symposium panels discussed the issue of homeless patient dumping from the perspective of litigation, policy, prevention, and county-wide resources. In addition, various presenters discussed how the Affordable Care Act mandates penalties for hospitals with high readmission dates, and therefore creates incentives for more effective delivery of services to the homeless.

The full Hospital Symposium packet, complete with full presentations and policy briefs, is attached as Exhibit G.

D. Multi-Agency Task Force

In connection with these efforts, Public Counsel and the City Attorney's Office participate in a newly created, multi-agency task force—the Task Force for the Chronically Homeless & Ill Patients—which consists of public health experts, hospital management, city prosecutors, nonprofit advocates, and housing experts. One of the principal goals of this task force is to continue to refine the "best practices" for discharge planning, to begin to coordinate the various services in the community so that discharge planners have the most accurate information about where to refer or send homeless patients who need follow-up care, and to work to develop more recuperative care facilities for homeless patients discharged from area hospitals. The task force would like to develop a website that compiles information about available beds and follow-up services that are immediately available to discharged homeless patients. This information would be available to hospitals, government agencies, and nonprofit social service agencies. We are very encouraged that this task force could serve as a model for other jurisdictions in terms of how to coordinate services.

III. Recommendations

Based on our experience with issues of homeless patient dumping over the past nearly ten years, we see the following three policy recommendations as critically important in addressing this problem:

(1) Strengthening EMTALA to prohibit unlawful transportation of the homeless.

Hospital administrators, patient coordinators, discharge planners, and other health professionals are familiar with EMTALA and work hard to comply with its terms. As discussed above, EMTALA requires hospitals to treat the homeless, and the corresponding implementation regulations (Code of Federal Regulations, title 42, section 482.43) require hospitals to develop appropriate discharge policies.

But additional provisions are needed—in both EMTALA and its regulations—specifically prohibiting transport of homeless patients without informed consent and requiring adoption of specific protocols dealing with discharge of the homeless. And specific financial penalties are needed to increase the desired deterrence effect. The Cedillo Bill (SB 275) attempted to do exactly that. From the perspective of organizations like Public Counsel, which represent the homeless on a day-to-day basis, this additional regulatory framework is desperately needed in order to achieve broader compliance.

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(2) Dissemination of "best practices" discharge protocols.

Hospitals have made huge strides in identifying the need for training of social workers and discharge planners, as well as in approving and implementing specific discharge policies that focus on the homeless. Hospital associations have assisted in this process by disseminating these best practices. Two of these sample protocols are attached as Exhibits D and E.

But currently the adoption of these protocols is somewhat haphazard. In our opinion, various federal agencies with jurisdiction over hospital regulation can play a greater role in encouraging (and perhaps requiring) stakeholder meetings to discuss discharge protocols. The aim of these meetings should be to assemble and refine discharge protocols that are specific to the particular needs of the community, and to connect with other service providers so that discharge planners will have the most up-to-date information on available community resources. For example, Public Counsel is beginning to work with Los Angeles advocates, hospitals, and city staff to consider creating a website that can track real-time data on housing and health-care resources for use by discharge planners.

(3) Encouraging the increased production of recuperative beds.

Finally, we believe that a key component of a broader, nationwide solution is the availability of recuperative beds. Many homeless patients need low-level or intermediate-level follow-up care that they cannot receive in a shelter or on the streets. Without this additional care, their medical conditions often will deteriorate, requiring further emergency room treatment and/or readmission. For example, a 2011 study by the Los Angeles County Department of Health Services found that homeless patients who had immediate access to recuperative beds after their initial discharge had the following outcomes 12 months later:

- 62% reduction in the number of inpatient admissions;
- 68% reduction in the number of inpatient hospital days; and
- 20% reduction in the number of ER visits.

See Exhibit H, Presentation by Senior Deputy for Health and Advocacy Yolanda Vera, Slide 27. Simply put, recuperative beds make a huge difference.

But publicly funded beds are in desperately short supply. Los Angeles County, for example, has only 48 such publicly funded beds (San Francisco has 65, and Boston has 104) but is nearing completion of a project that will add an additional 120 beds. *Id*., Slides 26, 29.

Obviously, much more is needed. We believe that the federal government can and should encourage and facilitate financing of such local projects. We believe that, with a larger inventory of such beds, the prevalence of homeless patient dumping would decrease substantially.

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Thank you again for the opportunity to present our viewpoint on this incredibly important topic. I look forward to meeting with you on February 14. If you would like any further information or data to supplement this testimony, please call me directly at (213) 385-2977 x104.

Very truly yours,

Hernán D. Vera
President & CEO