County of Sacramento
Elder Death Review Team
2012 Report

Acknowledgements

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Executive Summary

The Sacramento County Elder Death Review Team (EDRT) was formed in 1999. It was one of the first such efforts in the nation. It created a multi-disciplinary committee focused on reviewing questionable deaths of elder and dependent adults in Sacramento County. This was a collaborative effort launched by Sacramento County District Attorney Jan Scully, and the Director of Health and Human Services, Jim Hunt, in collaboration with other concerned community leaders.

EDRT examines the responses of Adult Protective Services, law enforcement officers, prosecutors, victim services, health care providers, and others involved with victims of elder and dependent abuse or neglect.

Since the inception of EDRT, significant progress has been made. Communication and cooperation among agencies has been enhanced and a clear focus on the victims of elder abuse has been fostered. EDRT continues to focus attention of the systems and agencies responsible for assisting and protecting the elderly. EDRT advocates for system changes to improve the response to victims and prevent reoccurrence in the future.

For this report, we reviewed multiple elder deaths in Sacramento County. These cases generally come to us through referrals by our member agencies. We often request follow-up information from various sources as we carefully conduct our review of the circumstances surrounding the death.

A recurring theme that we have encountered in these cases can best be described as follows: A family has an elder adult whose condition has steadily declined to the point where he or she can no longer be left alone. A family member decides to move in with the elder to assist them with their care. This family member is quickly overwhelmed with the task they have assumed, and the situation begins to deteriorate. As time passes, the problems multiply, often involving serious health conditions, financial constraints on the family, an elder who refuses to be taken to the doctor, and so forth. Suddenly, the situation becomes critical as multiple problems cascade rapidly, 911 is called, and medical intervention is too late.

As we begin to review the situation, we find a family that was ill-equipped to handle the situation they found themselves in. The multitude of problems associated with the care of the elderly overwhelmed them quickly, and they did not grasp the rapidity with which these conditions can worsen.

For these reasons, we have this year updated our *Independent Living: Resource Guide*. We believe this to be an outstanding resource for those who find themselves thrust into the position of caregiver for an elder. Elder caregivers will find in this pamphlet some wonderful agencies that can help them with financial issues, transportation, conservatorship, home repair, medical issues, mental health issues and other important needs.

The Elder Death Review Team requests the assistance of the Board of Supervisor in publicizing the availability of this pamphlet. It can be obtained by contacting the District Attorney or the Department of Health and Human Services. It is available in English, Spanish, Russian and Hmong. It is also available at the District Attorney website and at EDRTCoordinator@saccounty.net.

Additionally, the EDRT believes that public service announcements should be sought to encourage caregivers to utilize the resources that are available to them. Elder and dependent care is difficult, no one disputes that. There are a myriad of problems that can quickly arise, and generally, the person thrust into the position of caregiver has no experience in dealing with situations like these.

I am grateful to the many members of our Elder Death Review Team for their energetic efforts on behalf of elder and dependent persons in this county. Our efforts have also led to the creation of similar teams in other jurisdictions, and this once neglected area of law and care is receiving increasing attention nationwide.

I also appreciated the continuing support of the District Attorney and the Sacramento County Board of Supervisors. We will continue our efforts to improve the lives of all elders and dependent adults, and welcome any feedback that the Board will choose to provide.

Respectfully,

JAN SCULLY
DISTRICT ATTORNEY

Marv Stern
Assistant Chief Deputy District Attorney
Chair, Elder Death Review Team

10 Years Later: A History of the Sacramento County Elder Death Review Team

2001-2011

In August 1999, the Sacramento County District Attorney's Office and the Department of Health and Human Services partnered with law enforcement, local senior service agencies and advocates to create the "Focus on Elder and Dependent Adult Abuse Campaign," a unique regional partnership to highlight elder abuse and find solutions to the problem. Nine multi-disciplinary working groups formed and met regularly with members from various public and private programs and agencies, including hospitals, community based organizations, and the faith community. This interaction and teamwork laid the groundwork to develop a system of protection utilizing cross-agency and community collaboration. The "Focus on Elder and Dependent Adult Abuse Campaign," was the logical forum for community advocates to pose their questions and concerns regarding elder and dependent adult abuse. The concept of a multi-disciplinary elder death review team grew out of this process; however, at the time there was no enabling legislation that allowed the exchange of privileged elder death information. Led by the Sacramento County District Attorney's Office, Sacramento County sponsored and wrote legislation to authorize the establishment of elder death review teams in the State of California and allow third-party exchange of vital information. On September 19, 2001, the Governor signed into law SB 333, authorizing the establishment of Elder Death Review Teams. Armed with this empowering legislation, the Sacramento County Elder Death Review Team (EDRT) was officially and jointly formed by the District Attorney's Office and the Department of Health and Human Services, with representatives from the Adult and Aging Commission, the Sheriff and Police Departments, the Coroner's Office, the State Department of Health Services, Licensing and Certification Division, the Long-Term Care Ombudsman, experts in the field of forensic pathology, medical personnel with expertise in elder abuse, and representatives of local and state agencies that are involved with elder abuse reporting. As the first Elder Death Review team in the state, and one of the first in the nation, Sacramento County became a national model for other municipalities seeking to establish their own elder death team.

The mission statement for the Sacramento Elder Death Review Team, to examine deaths associated with suspected elder abuse and/or neglect, also recognized that "responding to, and preventing, elder abuse and neglect fatalities lies within the community, and not with any single agency or entity…" Further… "A careful examination of (elder) fatalities provides the opportunity to develop education, prevention and, if necessary, prosecution strategies that will lead to improved coordination of services for families and our elder population."

The goals of the Sacramento EDRT, to prevent elder abuse fatalities, examine deaths of elders with suspected elder abuse and/or neglect, improve system response by identification of service delivery gaps, and develop intervention strategies to reduce fatalities and eliminate ongoing abuse and/or neglect mirror those of elder death review teams from across the nation and were captured in a 2005 American Bar Association report. "The goal of a (death review team) is to foster examination of and improvement in the responses of adult protective services, law enforcement officers,

prosecutors, victim assistance providers, health care providers, and others to the growing numbers of victims of elder abuse…"

The report from the American Bar Association (ABA) also cited other benefits of elder death review teams: "One of the primary advantages is that elder death review teams raise the awareness of agency administrators and, ultimately, the community about the seriousness and potential lethality of elder abuse…The existence of an elder death review team sends a message that the premature and/or unexplained death of an older person will be taken just as seriously as that of a younger adult or a child. Another benefit of participation is that many of the EDRT members bring high levels of knowledge and expertise to the discussions. Thus, team members have an opportunity to educate each other on a number of complex issues... Data generated by the teams may also prove invaluable in several ways. First, it can be used to educate the public about the potential deadly outcome of elder abuse. Second, it can help to identify patterns—known as lethality factors—of both perpetrator behavior and victims' situations that contribute to untimely deaths. This knowledge may eventually be used to more accurately predict risk, resulting in earlier intervention and, in some cases, preventing death."

The Sacramento Elder Death Review Team staffed its first cases in December 2001. In the ten plus years that it has been in existence, the Sacramento County Elder Death Review Team can count among its accomplishments:

- Recommended and advocated for internal agency and program change that subsequently prompted revised standards, practices, policies and procedures, and enhanced training and outreach
- Highlighted gaps in service at the micro and macro levels
- Kept the community eye on the elder protective system by:
  - providing report backs to the County Board of Supervisors
  - publication of a resource guide for overwhelmed caregivers
  - publication of an annual (now semi-annual) Elder Death Review Team report;
  - provision of a speakers bureau
- Been instrumental in bringing to light cases that were later prosecuted by County and State prosecutors

In addition the EDRT has compiled a number of findings and recommendations:

- A higher level of scrutiny is needed in cases involving elders with disabilities who may have communication problems and therefore are less able to protect themselves
- Protective services agencies should have a means to regularly consult physicians familiar with geriatrics
- A recommendation that the County engage in an educational out-reach program to educate not only the elderly, but additionally their care providers, family and other potential gate keepers, about the risks of common everyday medications that are not taken as prescribed
- Community education should also include information on commonly observed conditions within the elderly community that are indicative of serious health risks, or can lead to more serious conditions if not treated appropriately.
- Frail, elderly, isolated seniors may often benefit from increased frequency of visits during the course of an APS investigation.

- More frequent use of the County Elder and Dependent Adult Multi-Disciplinary Team to obtain comprehensive input on cases involving elders with terminal conditions and less than satisfactory family support or service options.
- Mandatory training for In Home Supportive Services Providers that includes basic medical care, CPR, health and safety training, community resources, etc.
- Mandatory background checks for In Home Supportive Services providers.
- Increase communication opportunities between hospitals, the coroner, Adult Protective Services staff, and the Long Term Care Ombudsman.
- Encourage hospitals and skilled nursing facilities to develop and distribute information at time of discharge on the identification and treatment of pressure ulcers to assist caregivers when caring for non-ambulatory elders.

The EDRT findings and recommendations are a call to action for enhanced and continuing prevention, intervention, and protective strategies for seniors who are unable to advocate for themselves. Aging is the great equalizer. If we live long enough we each face vulnerability and an increased need for assistance. The Elder Death Review team serves as a voice for our most vulnerable seniors, highlighting the need to continue to work together to prevent untimely and tragic deaths.

BUT IS IT NEGLECT….

Although there is uncertainty regarding caregivers that are uninformed and often overwhelmed, cases have come forward that appear clearly to be neglect. Neglect is defined as failure by a person in a position of trust to provide care that a prudent person would typically perform. Hallmarks implicating the possibility of neglect include the following:

MALNUTRITION

Elders and disabled persons who are found to suffer from frank malnutrition suggest that they are the victims of abuse and neglect. Malnutrition is identified as not only weight loss but also abnormalities of the body's proteins, as measured by blood tests. Although certain medical conditions can cause malnutrition, the victims of this type of abuse and neglect exhibit severe calorie inadequacy. This may occur because victims are unable to obtain food, prepare meals, or feed themselves.

DEHYDRATION

The victim suffering from dehydration has easily observable findings. The mouth and lips are dry, and the skin has what is termed "poor turgor." This simply means that if the skin on the arm is elevated, it should quickly resume its usual shape when released. If it remains elevated and folded, skin turgor is poor and suggests severe dehydration. Medical involvement is helpful in that blood tests of basic body chemistry may be diagnostic of dehydration. Victims who suffer from advanced dementia may lose their thirst drive, and caregivers are expected to provide adequate fluids nonetheless.

FAILURE TO SEEK MEDICAL CARE IN A TIMELY FASHION

When elderly or disabled people require medical attention, the trusted care provider needs to obtain this help. Some conditions require urgent care, such as falls with injuries or severe infections. Failure to get care may lead to serious complications or even death. In neglect cases, not only is there resistance to obtaining care but several days may pass before the victim is brought to medical attention.

MEDICATION DISARRAY

Older victims with multiple medical problems often have numerous prescriptions. The care provider must make certain that medicines are obtained as needed from the pharmacy. Medications need to be given as prescribed. Multiple hazards may make it difficult to properly take prescriptions, known as the
FIVE CAN'Ts:

- Can't read the label

    - Print too small
    - Language not understood
    - Can’t read
- Can’t open the prescription bottle
- Can’t swallow large tablets
- Can’t “stomach” the medicine
- Can’t afford it

Although these issues make medication compliance difficult, many sources are available to help care providers provide proper medication assistance.

PRESSURE ULCERS

When a person is unable to walk or change position without help, they are at risk for pressure ulcers or as they are commonly known, as bed sores. Other risk factors are moisture on the skin, malnutrition, and impaired sensation. Initially the skin is simply red in areas where there is pressure. As pressure ulcers become more severe the skin opens and may become so deep that underlying muscle and bone are exposed. Infection may occur throughout the body from the site of the pressure ulcer; this severe infection known as sepsis may be fatal.

Elder Death Review Team
Case Reviews

The following cases were chosen to illustrate the type of information reviewed by EDRT. A common element observed by the Committee in its review of elder death cases for this reporting period is the continuing theme of disconnect between family caregivers and the training required to give proper care to their loved one. (Names and other specific details have been deleted or generalized for confidentiality.)

Case Review #1

Case Summary:	This case involves a 91 year old female living at home under the care of family members. The client was an IHSS recipient and a Medi-Cal patient. She was frail and bed-bound. The client required assistance with all ADL care. A public health nurse made numerous requests to the client's primary physician for a referral for hospice. There was no response from the physician. The client died at home surrounded by family, without hospice care.
Care Provider Relationship:	Various family members acted as care providers.
Why Was Case Referred To EDRT:	The client died at home without hospice care despite numerous requests by the public health nurse and family to the doctor.
Concerns Addressed:	Is there any underlying problem related to the way Medi-Cal reimburses for the physician's time? If so, did this influence the physician's attitude about the level of care he gives his Medi-Cal patients.
Findings:	Public health nurses had experienced a recurrent lack of communication from this physician and his clinic in this and other instances. The committee also found there to be continued problems with this physician providing substandard care to his clientele.
Recommendations:	EDRT sent a letter to the physician attempting to contact him for feedback. The EDRT chair sent a letter to the Medical Board and the Department of Health Care Services Medical Review to express the committee's concern about the lack of proper treatment provided to the client with the expectation that this situation will be reviewed by them.

Case Review # 2

Case Summary:	The client was a 75 year old female who was discharged from the hospital, possibly too soon, with poor discharge instructions and another patient's discharge papers. There were no home care or medication instructions. The client's primary care physician gave verbal notice that he would no longer see the client upon her discharge from the hospital. The family of the client claimed that the client was able to walk into the hospital upon her arrival, but left the hospital too weak to walk. The family was unable to carry or get the client out of the home to be seen by another physician. Upon a follow up visit with the client, the Public Health Nurse called for an ambulance to bring the client back to the hospital. The client died ten days later. The cause of death was reported to be due to renal failure and heart failure.
Care Provider Relationship:	Various family members acted as care providers.
Why Was Case Referred To EDRT:	The public health nurse brought this case to EDRT on concern that the client may have been released too early with another patient's discharge papers and lack of medical instruction or supervision by a physician.
Concerns Addressed:	There were concerns that no one at the hospital reviewed medication or necessary home care with the client's family. Can a primary care physician refuse to see a client upon discharge from the hospital, leaving the client without a physician or medical guidance? Would the outcome been different had the client had adequate home care with medical supervision?
Findings:	The hospital reported that the client had been in months of decline. The incorrect paperwork that was sent home was for valuables and not for health care. The family had been encouraged by the hospital to place the client in a care facility, but they preferred to care for the client at home. The primary care physician had referred the client to a nephrologist, but an appointment was never made. The hospital was unaware that transportation of the client was an issue. It was also reported that upon the client's return the hospital, family members had requested that the client not be resuscitated.
Recommendations:	To seek clarification from the California Medical Board and the California Department of Licensing on guidelines for terminating the doctor patient relationship.

Case Review #3

Case Summary:	The client was a 92 year old male. He resided with his son and had a paid private care provider to care for him. The son found the client lying flat and gurgly and he called 911. The client arrived at the emergency room with deep tissue injuries, multiple open wounds and a blister on his heels. The client had lost approximately 40 pounds in the five months between his last doctor's appointment and his arrival at the ER. He was transferred from one hospital to another. The client died five days after his arrival at the first hospital. APS did not receive a report from neither the second hospital nor the paramedics. The first hospital failed to get a report to APS until after the client's death.
Care Provider Relationship:	The client was cared for by his son and a paid private care provider.
Why Was Case Referred To EDRT:	APS did not receive a report on this case until 13 days after the client's death. The client was in deplorable condition upon his arrival at the hospital.
Concerns Addressed:	There was a lack of timely and legible reporting to APS or law enforcement by either hospital or paramedic team. Neither the client's son nor the paid care provider had taken him to see a doctor in five months prior to his death. By the time he arrived in the hospital the client was in deplorable condition. How does law enforcement investigate this case without timely reporting?
Findings:	It was found that the client had died of pneumonia and not as a result of the sores on his body. The hospital focused their care on the patient's respiratory failure. The EDRT committee made an effort to get in touch with the son, but was unsuccessful. It was determined that the care provider was supposed to report any issues to his/her staff coordinator. While the care provider is bonded, they are not required to participate in any organized training. The health system delayed reporting suspicion of neglect to APS. Law enforcement was never notified and the coroner had no knowledge of this case.
Recommendations:	Hospital staffs needs to be educated on the procedures for reporting suspected abuse or neglect. APS will provide refresher training upon the request of the hospital or agency.

Case Review #4

Case Summary:	The client was a 58 year old female who arrived at the hospital with wounds to her thigh, stomach, back, buttocks and chest. She also had marks around her ankles. The client was unresponsive at the hospital. The client was an IHSS recipient being cared for by various family members. The client died five days after her arrival at the hospital. The client had been hospitalized for four months three years prior. At that time, the client's daughter was living with her in the hospital. In 2009 the client had been removed from a skilled nursing facility and went to live with her daughter. It was reported that Home Health Care finally refused to care for the client if she continued to live with her daughter. Various allegations of neglect and abuse had been made to APS previously.
Care Provider Relationship:	The client qualified for IHSS hours and was cared for by her daughter, granddaughter and great-granddaughter.
Why Was Case Referred To EDRT:	APS was concerned that the client was not receiving adequate care at home and as a result, developed multiple pressure wounds leading to her death.
Concerns Addressed:	The granddaughter was receiving IHSS pay and was the person providing care for the client, but was not adequately trained to care for the client. It is believed that the daughter received the training, but did not provide the care. Home Health Care had refused to care for the client as long as she remained in the care of her daughter.
Findings:	The committee found that the granddaughter was trying to care for the client, but lacked the proper training.
Recommendations:	Ongoing medical and social care management could have assisted in monitoring the care provided. This included attendance of medical appointments, evaluation of medical needs and proper education of the care provider, such as treatment of decubitus ulcers.

Case Review #5

Case Summary:	The client was a developmentally delayed 62 year old female who was bed-ridden and lived at home with her husband who cared for her. The husband is suspected to be developmentally delayed or

	mentally ill himself. He had a distrust of doctors, APS and law enforcement. The client had not seen her family in many years. She had not been to see a doctor in the four years prior to her death and had stopped eating about a year and a half prior to her death, according to her husband. He claimed he fed her through a straw. When the client arrived at the hospital, she was unresponsive, emaciated, dehydrated, and malnourished and had multiple decubitus ulcers. While the client was in the hospital, the husband was found crying under the client's bed in the fetal position and had to be coaxed out. An autopsy later revealed that the client had sepsis, an incarcerated hiatal hernia and metastatic cervical cancer.
Care Provider Relationship:	Husband acted as the care provider.
Why Was Case Referred To EDRT:	APS had concerns of possible neglect by the care provider, husband.
Concerns Addressed:	The client had not seen her family in over thirty years. She had not been to see a doctor in four years. The husband, who was caring for the client, had disabilities and or mental illnesses which may have limited his ability to provide adequate care for the client.
Findings:	The client and her husband had a history of refusing services from community agencies. The client was developmentally delayed and the husband was possible mentally ill himself. It is likely that the husband kept his wife isolated as a result of such mental illness.
Recommendations:	The EDRT noted that family members should have contacted APS with their concerns. The EDRT recommends that greater publicity of elder care resources would help prevent circumstances like these.

Case Review #6

Case Summary:	The client was a 77 year old male who lived at home under the care of his daughters. There was some discrepancy as to exactly where the client resided between his discharge from the hospital in March of 2010 and his admittance to the hospital in September of 2010. The daughters claimed he was a resident of a skilled nursing facility. According to an APS social worker, the client was not transferred to the skilled nursing facility, but was instead

	being cared for at home by his daughters. The client suffered from dementia. Multiple APS social workers attempted to make various home visits with the client and his daughters, but every attempt was unsuccessful. The client arrived at the hospital in September of 2010 and was placed in the ICU. He was suffering from Terminal Multiple Myeloma, Kidney Disease, Sepsis and Level 4 Decubitus Ulcers on the Sacral Area. The hospital wanted to place the client on comfort care, but the daughters were uncooperative. The daughters demanded the client be transferred to another hospital, but wanted him wheeled over on a gurney to the bank first. The daughters claimed to have a durable power of attorney for the client and were upset that he signed a do not resuscitate document out of their presence.
Care Provider Relationship:	The client's daughters were the primary care providers.
Why Was Case Referred To EDRT:	APS suspected neglect and possible financial abuse by the care provider.
Concerns Addressed:	APS concern that various attempted home visits with client and care provider were unsuccessful and the care provider was uncooperative with APS. There was a discrepancy as to where the client was when he was released from hospital the first time and when he was readmitted shortly before his death. Was the client a resident of a skilled nursing facility or was he at home under the care of his daughters. Were the daughters keeping the client alive for their financial benefit?
Findings:	It was determined; the client went back and forth between the hospital and a skilled nursing facility between February of 2010 and August of 2010. The hospital also had difficulties communicating with the client's daughters. The client requested comfort care after talking to the doctors about his options. The hospital's policy was to go with the client's preference. The DPOA that the daughters had was not for health care. Law enforcement reviewed the case and could not determine that a crime had been committed by the daughters.
Recommendations:	APS to request the care provider to provide an accounting of the client's finances.

Case Review #7

Case Summary: The client was a 59 year old female who lived at home and was

cared for by a paid IHSS care provider. The client suffered from MS for approximately ten years and had limited mobility. She attended an adult day care center for therapy and wound care twice a week. In the six months leading up to her death, the client had not been regularly attending her therapy session. She had not shown up to her previous four medical appointments. The care provider claimed that the doctor prescribed three weeks of bed rest for the client. The doctor claimed this was not true. The care provider also stated that she cared for the client's decubitus ulcers with hydrogen peroxide and topical ointment. On an APS home visit in January of 2010, the social worker was advised to bring the client in for a medical appointment that day. The client became weaker on the drive to the appointment and had to be resuscitated by the time she reached her appointment. She died later that evening.

Care Provider Relationship: The client qualified for 127 IHSS hours and had a paid IHSS care provider.

Why Was Case Referred To EDRT: APS suspected criminal neglect by the care provider.

Concerns Addressed: The client's doctor had made four appointments, all of which the client failed to show up for. Additionally, the client had stopped attending her adult day care program. There were discrepancies in the care provider report of prescribed care and that of the physician. The care provider was treating the decubitus ulcers with hydrogen peroxide and a topical ointment.

Findings: It was found that the client missed her appointments due to a lack of transportation. Preliminary autopsy results indicated that death was due to blood clots in the lungs, most likely related to a large uterus with big fibroids and limited mobility. Law enforcement investigated the case, but since the autopsy revealed that the client did not die as a result of the decubitus ulcers, the investigation was closed.

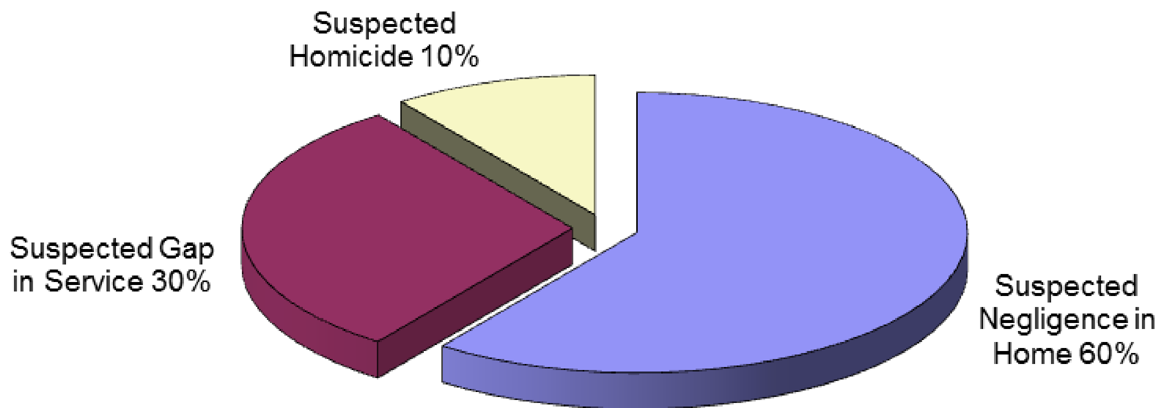
Recommendations: The EDRT noted that information is readily available to care providers regarding transportation services that will help elders, and perhaps better education regarding available resources could have assisted this IHSS worker.

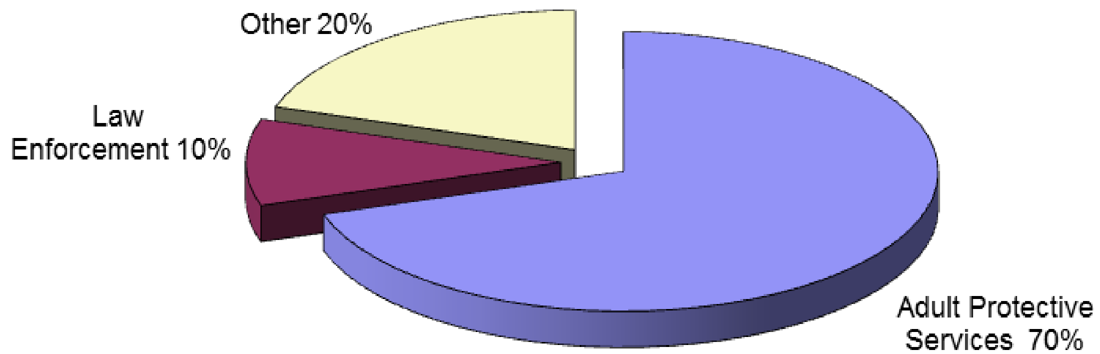
Case Review #8

Case Summary:	The client was a 57 year old female who lived at home under the care of her boyfriend. She was bed bound and morbidly obese. She arrived at the hospital pasted to a mattress as a result of dry feces. The client was admitted into the ICU due to large abscesses on her body and arms that oozed with puss. While in the ICU the client was disoriented and confused. She died four days later. An external exam by the coroner's office determined the death was a result of sepsis due to infected decubitus ulcers. Contributing factors included diabetes mellitus, hypertension and obesity. She had been admitted to the hospital twice before during the same year. An APS social worker along with law enforcement visited the home and found the home to be cluttered and malodorous. The client's caregiver stated that he tried to convince the client to see a doctor, but the client was combative and continually refused to do so. She had not seen a doctor in ten years.
Care Provider Relationship:	The client's boyfriend was the primary care provider.
Why Was Case Referred To EDRT:	APS social worker concern of criminal neglect by the care provider.
Concerns Addressed:	The client was discharged into the care of her boyfriend and not to a care facility.
Findings:	The primary care provider was ill-equipped to provide care for a patient with difficult behaviors resulting in no medical monitoring and insufficient care. The hospital encouraged the client to go to a care facility upon being discharged, but the client had mental capacity and the right to refuse treatment.
Recommendations:	The EDRT noted that there is little that the community can do when there is a competent elder in need of care who refuses it. The EDRT felt that this case underscored the need for a resource guide of the type attached to this report when family members become overwhelmed by the difficulties in caring for a difficult elder.

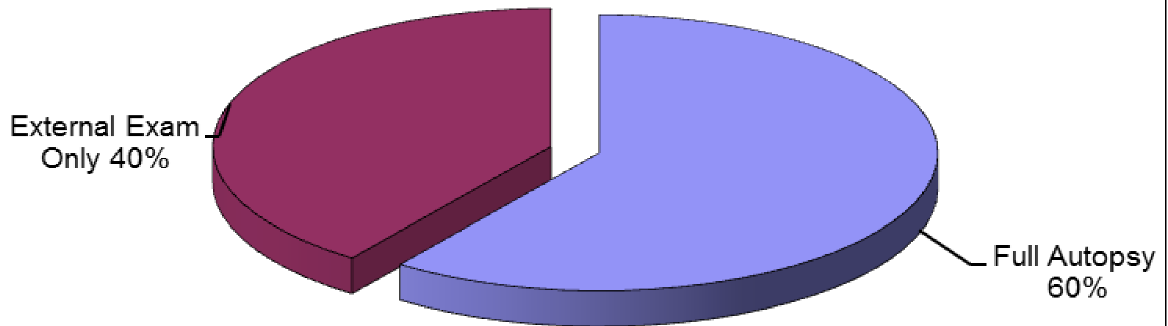
EDRT 2010/2011 Statistics

In 2010 and 2011 EDRT reviewed elder and dependent adult cases and collected statistical data. Following is a breakdown of information regarding the data elements collected on the cases reviewed:

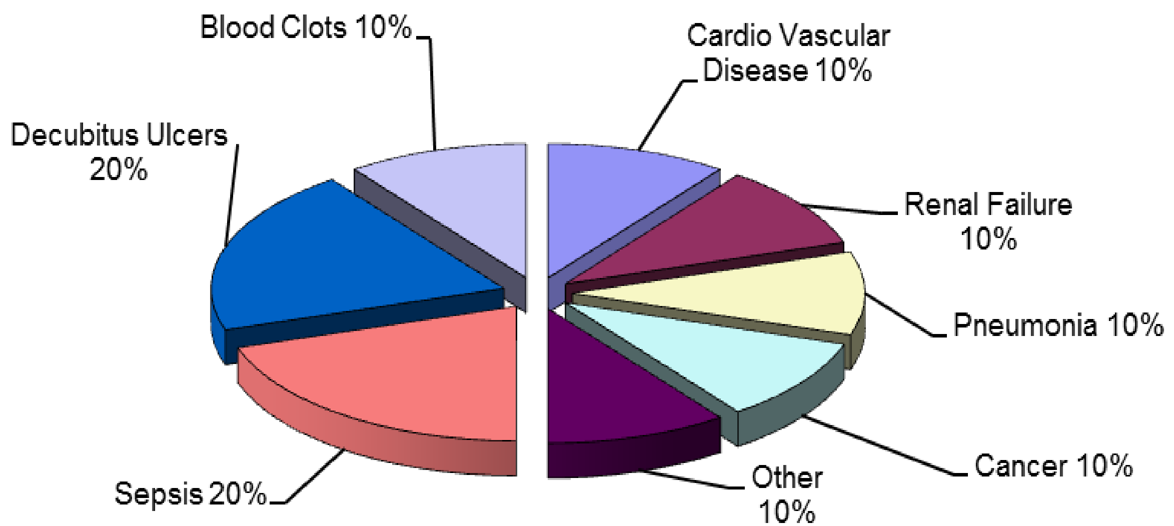

Reasons for Review at EDRT
Suspected Homicide 10%
Suspected Gap in Service 30%
Suspected Negligence in Home 60%

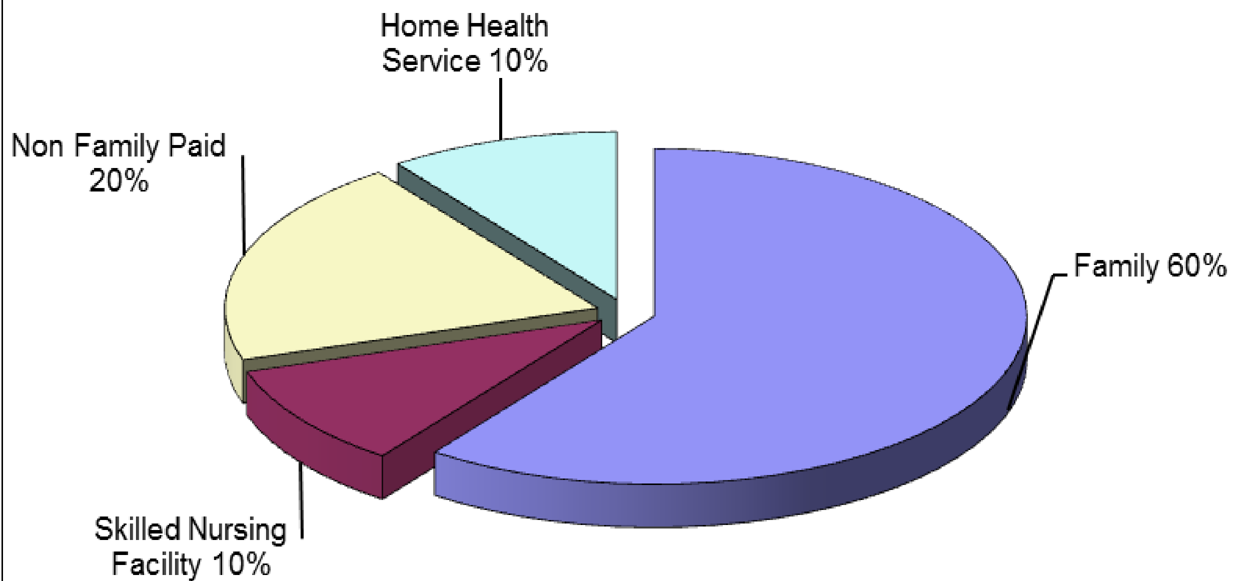

Reporting Party to EDRT
Other 20%
Law Enforcement 10%
Adult Protective Services 70%

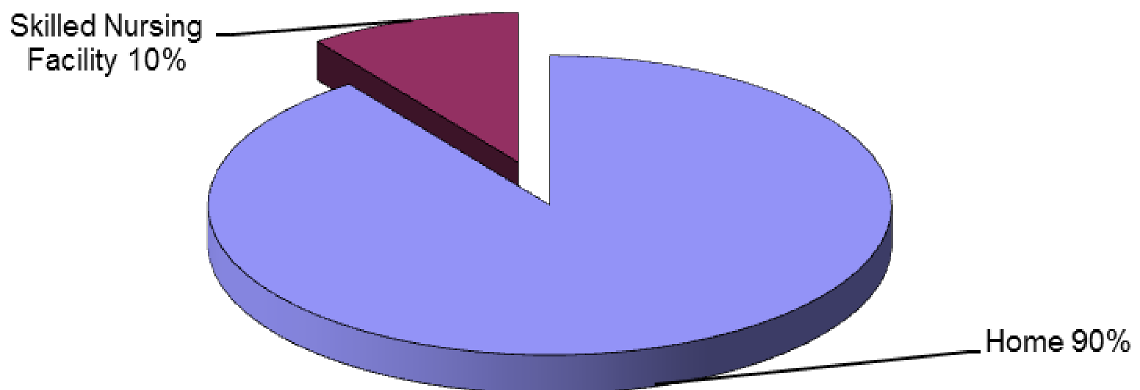
Forensic Examination



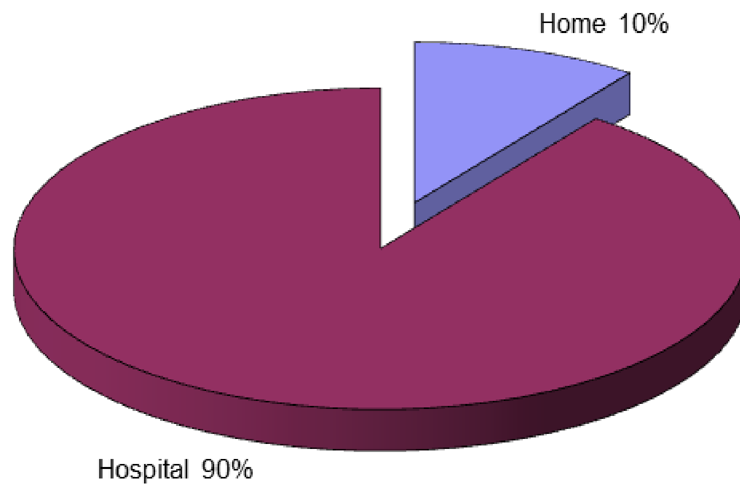
Cause of Death



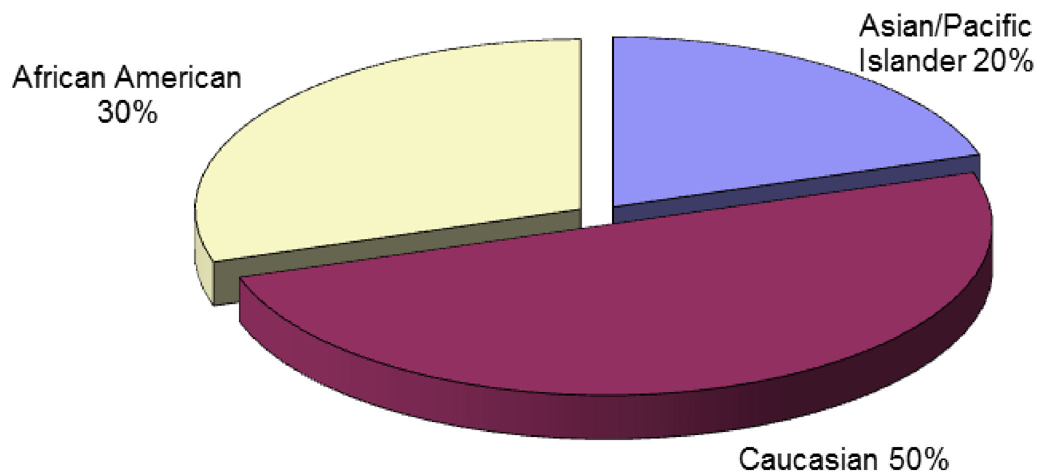

Care Provider Relationship
Home Health
Service 10%
Non Family Paid
20%
Family 60%
Skilled Nursing
Facility 10%


Place of Residence
(Place of residence prior to terminal event)
Skilled Nursing
Facility 10%
Home 90%

Place of Death



Ethnicity



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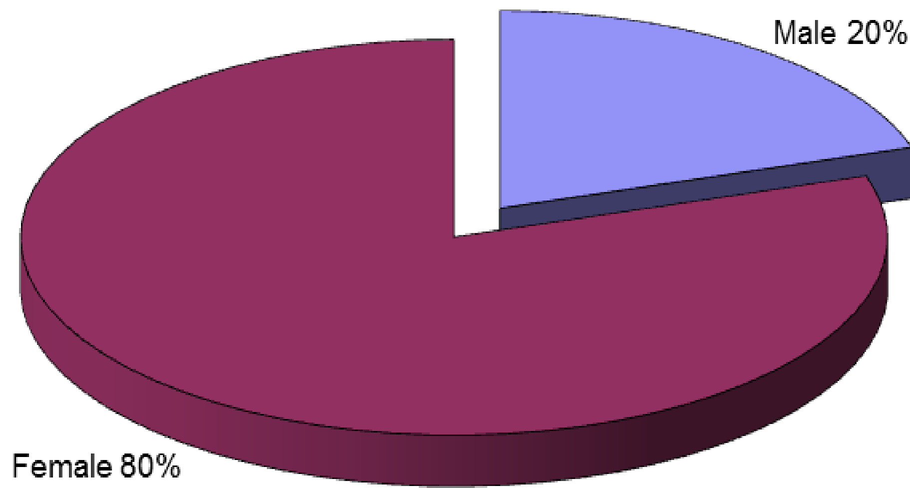

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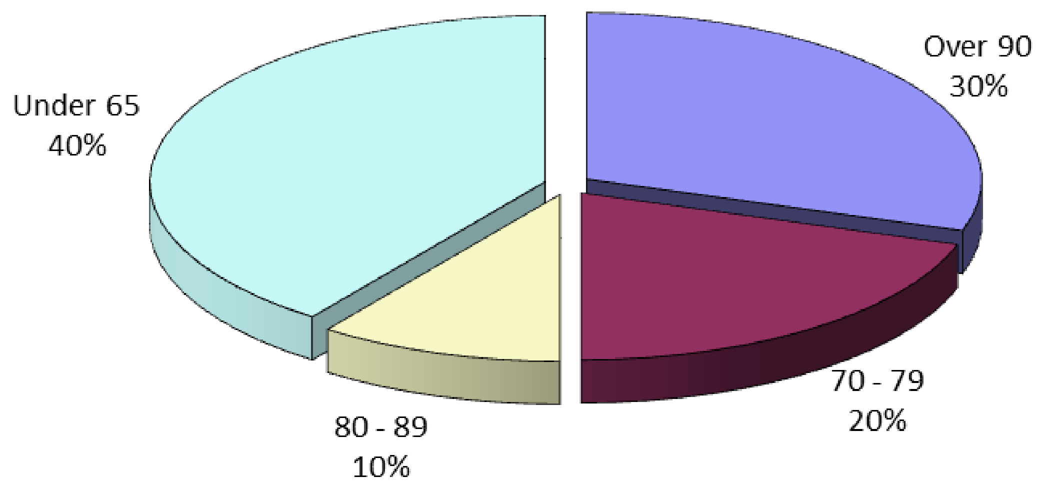

EDRT BROCHURE

Independent Living: Resource Guide

IN-HOME SERVICES

- 211 Sacramento
  211; 916-498-1000 or 800-500-4931
- The Senior Connection - Eskaton
  916-334-1072
- www.Healthfinder.gov

For domestic and/or personal care for elder or dependent adults in their home:

- Area 4 Agency on Aging
  916-486-1876
  www.a4aa.com
- In-Home Supportive Svcs., IHSS
  916-874-9471
- Sutter SeniorCare PACE
  916-424-8412

HOME REPAIR

Home repair assistance for seniors and the disabled:

- Contractors State Licensing Board (license verification/problems with contractors) 1-800-321-2752
- Home Assistance/Repair for Seniors (and disabled) 916-264-1506 or tsater@shra.org
- Rebuilding Together
  916-455-1880
- Sacramento Housing & Redevelopment Agency
  916-264-1500

For heating or cooling problems:

- Sacramento Municipal Utility District, SMUD
  1-888-742-7683
- SMUD Energy Assistance Team
  916-874-0979 or seat@saccounty.net
- Pacific Gas & Electric, PG&E
  1-800-743-5002

OTHER AVAILABLE RESOURCES...

For help finding a residential or long term care facility:

- Community Care Licensing
  916-263-4700

For seniors over 59 who need food delivered:

- Senior Nutrition Services
  916-444-9533

For free specialized telephone equipment for disabled consumers of any age:

- California Phones
  1-800-806-1191 - Call Center
  1-800-806-4474 – TTY
  www.ddtp.org

To report suspected abuse of an elder or dependent adult:

- Adult Protective Services
  916-874-9377
- Sacramento County Sheriff's Dept.
  916-874-5306
- Sacramento Police Department
  916-808-0650

If you suspect abuse or neglect at a long term care facility:

- Ombudsman Services of Northern CA
  916-376-8910 OR 1-800-231-4024
  www.osnc.net

Questions on conservatorships:

- Court Investigators Office
  916-875-3400

For transportation assistance:

- Regional Transit
  916-321-2877 OR 916-483-4327 TDD
- Paratransit
  916-429-2744
- South County Transit
  1-800-338-8676
- California Dept. of Developmental Svcs. (for eligible consumers)
  916-654-2054 TTY or 916-654-1690

For employment assistance:

- Sacramento Employment and Training Agency (SETA)
  916-263-3700 OR 1-800-735-2929 TTY
  www.seta.net

Low cost auto insurance for low income good drivers:

- 1-866-602-8861

To find out if a charity is legitimate:

- California Attorney General's Office
  (916) 322-3360
  www.ag.ca.gov/charities/

Find out if a sales person/company is legitimate before investing:

- Department of Corporations
  1-866-275-2677
  www.corp.ca.gov

Sacramento County
District Attorney's Office &
Department of Health & Human Services

Independent Living: Resource Guide

Service Categories:

- Medical
- Mental Health
- Financial
- Respite
- Legal
- In-Home Svcs
- Home Repair
- Other

IF THERE IS AN EMERGENCY CALL: 911

Provided by:
The Sacramento County
Elder Death Review Team
EDRTCoordinator@SacCounty.net

MEDICAL

For people without insurance:
- County Medically Indigent Services
  9616 Micron Ave, Suite 64
  Sacramento, CA 95827
  916-875-9843
  www.sacdhhs.com
- Mercy Clinic Folsom
  105 Dean Way
  Folsom, CA 95630
  916-983-3658
  www.mercyfolsom.org
- Mercy Clinic White Rock
  10487 White Rock Road
  Rancho Cordova, CA 95670
  916-364-0724
  www.mercyfolsom.org
- Sutter SeniorCare PACE
  (comprehensive medical care program)
  916-424-8412
- Health Insurance Counseling and Advocacy Program
  1-800-434-0222
  www.cahealthadvocates.org/HICAP
- Department of Health Care Licensing
  http://www.dhcs.ca.gov/services/medi-cal
- Medicare Assistance
  1-800-MEDICARE
  www.medicare.gov

Questions about end of life documents:
- California Medical Association
  916-444-5532
  www.cmanet.org

Questions about potential interactions with medications:
- www.drugdigest.org/DD/Home OR
- www.drugs.com/drug_interactions.html
- http://networkofcare.org/home.cfm

For help with buying prescriptions:
- 1-877-777-7815
  www.rxhelpforca.org

Grieving? Who to talk to when you have lost a loved one:
- Bereavement Network Resources of Sacramento, Inc.
  916-557-5882

MENTAL HEALTH

For elderly persons showing signs of dementia or mental health issues:
- UCDMC – Geriatric Clinic
  916-734-3574 Appointments
  www.ucdmc.ucdavis.edu
- Kaiser Alzheimer / Dementia Program
  916-973-6165
- DHHS Division of Mental Health Adult Access Team
  875-1055 or
  875-1000 (for an emergency)

Older Adult Prevention and Early Intervention Programs funded by Sacramento Mental Health Services Act:
- Mental Health America Northern California
  916-855-5444
- El Hogar Community Services Inc.: Senior Link
  916-369-7872

FINANCIAL

For help with Medicare:
- Medicare
  1-800-MEDICARE
  www.medicare.gov
- Health Insurance Counseling Advocacy Program (HICAP)
  1-800-434-0222
  www.hicapservices.net
- CalMedicare.org
  916-376-8915
  www.calmedicare.org

Apply for MediCal:
- Department of Human Assistance
  916-874-2215
  www.dhaweb.saccounty.net

Apply for social security/disability:
- U.S. Social Security
  916-381-9410 **OR** 1-800-772-1213
  www.ssa.gov

For tax advice and basic tax preparation for seniors:
- Tax Counseling for the Elderly (TCE)
  916-974-5303
  www.irs.gov

Questions about reverse mortgages:
- U.S. HUD Sacramento Office
  916-498-5220 Ext. 221

To report reverse mortgage fraud:
- 1-888-827-5605
  www.hud.gov

CARE GIVING

- IHSS Public Authority
  916-874-4411

For respite assistance:
- Cordova Senior Center
  916-366-3133
- Hart Senior Center
  916-808-5462
- Del Oro
  916-971-0893 or
  http://www.deloro.org

LEGAL

For legal help:
- Legal Services of Northern California
  916-551-2150
  www.lsnc.net
- Superior California Legal Clinics, Inc.
  916-972-1188
- Voluntary Legal Services Program
  916-551-2102
  www.vlsp.org
- Superior Court Self Help Center
  916-875-3400
- McGeorge Community Legal Clinic
  916-340-6080

SERVICIOS A DOMICILIO

- 211 Sacramento
  211; 916-498-1000 or 800-500-4931
- The Senior Connection - Eskaton
  916-334-1072
- www.Healthfinder.gov

Para cuidado a domicilio y/o cuidado personal, o cuidado de adultos incapacitados a domicilio:

- Area 4 Agency on Aging
  916-486-1876
  www.a4aa.com
- In-Home Supportive Svcs., IHSS
  916-874-9471
- Sutter SeniorCare PACE
  916-424-8412

REPARACIONES EN CASA

Ayuda con reparaciones en casa para personas de la tercera edad y aquellos con incapacidades:

- Contractors State Licensing Board
  (license verification/problems with contractors) 1-800-321-2752
- Home Assistance/Repair for Seniors
  (and disabled) 916-264-1506 or tsater@shra.org
- Rebuilding Together
  916-455-1880
- Sacramento Housing & Redevelopment Agency
  916-264-1500

Para problemas con el sistema de calefaccion o aire acondicionado:

- Sacramento Municipal Utility District, SMUD
  1-888-742-7683
- SMUD Energy Assistance Team
  916-874-0979 or seat@saccounty.net
- Pacific Gas & Electric, PG&E
  1-800-743-5002

OTROS RECURSOS DISPONIBLES...

Para ayuda encontrando una casa de ancianos o instalacion de cuidado a largo plazo:

- Community Care Licensing
  916-263-4700

Para mayores de los 59 anos que necesitan entrega de alimentos a domicilio:

- Senior Nutrition Services
  916-444-9533

Para equipo telefonico especializado, gratis, para consumidores descapacitados de cualquier edad:

- California Phones
  1-800-806-1191 - Call Center
  1-800-806-4474 – TTY
  www.ddtp.org

Para informar el abuso sospechado de una persona de la tercera edad o de una persona incapacitada:

- Adult Protective Services
  916-874-9377
- Sacramento County Sheriff's Dept.
  916-874-5306
- Sacramento Police Department
  916-808-0650

Si usted sospecha el abuso o la negligencia en una instalacion de cuidado a largo plazo:

- Ombudsman Services of Northern CA
  916-376-8910 **OR** 1-800-231-4024
  www.osnc.net

Preguntas respecto al protectorado:

- Court Investigators Office
  916-875-3400

Para ayuda con traslados:

- Regional Transit
  916-321-2877 O 916-483-4327 TDD
- Paratransit
  916-429-2744
- South County Transit
  1-800-338-8676
- California Dept. of Developmental Svcs. (for eligible consumers)
  916-654-2054 TTY or 916-654-1690

Para ayuda con empleo:

- Sacramento Employment and Training Agency (SETA)
  916-263-3700 O 1-800-735-2929 TTY
  www.seta.net

Seguro automovilistico de bajo costo para buenos conductores de escasos recursos:

- 1-866-602-8861

Para averiguar si una organizacion caritativa es legitima:

- California Attorney General's Office
  (916) 322-3360
  www.ag.ca.gov/charities/

Para averiguar si una persona/empresa es legitima antes de invertir:

- Department of Corporations
  1-866-275-2677
  www.corp.ca.gov

Sacramento County
District Attorney's Office &
Department of Health & Human Services

Viviendo Independientemente: Guia de Recursos

Categorias de Servicio:

- Medico
- Legal
- Salud Mental
- Servicios a Domicilio
- Financiero
- Reparaciones en Casa
- Asilo
- Otros

EN CASO DE EMERGENCIA MARQUE: 911

Ofrecido por:
The Sacramento County
Elder Death Review Team
EDRTCoordinator@SacCounty.net

MEDICOS

Para aquellos sin seguro:

- County Medically Indigent Services
  9616 Micron Ave, Suite 64
  Sacramento, CA 95827
  916-875-9843
  www.sacdhhs.com
- Mercy Clinic Folsom
  105 Dean Way
  Folsom, CA 95630
  916-983-3658
  www.mercyfolsom.org
- Mercy Clinic White Rock
  10487 White Rock Road
  Rancho Cordova, CA 95670
  916-364-0724
  www.mercyfolsom.org
- Sutter SeniorCare PACE (comprehensive medical care program)
  916-424-8412
- Health Insurance Counseling and Advocacy Program
  1-800-434-0222
  www.cahealthadvocates.org/HICAP
- Department of Health Care Licensing
  http://www.dhcs.ca.gov/services/medi-cal
- Medicare Assistance
  1-800-MEDICARE
  www.medicare.gov

Preguntas acerca de la documentacion despues de un fallecimiento:

- California Medical Association
  916-444-5532
  www.cmanet.org

Preguntas acerca de posibles interacciones entre medicamentos:

- www.drugdigest.org/DD/Home O
- www.drugs.com/drug_interactions.html
- http://networkofcare.org/home.cfm

Para asistencia economica para la compra de medicamentos:

- 1-877-777-7815
  www.rxhelpforca.org

De Luto? Con quien puede hablar en caso del fallecimiento de un ser querido:

- Bereavement Network Resources of Sacramento, Inc.
  916-557-5882

SALUD MENTAL

Para personas de la tercera edad mostrando senas de demencia o problemas de salud mental:

- UCDMC – Geriatric Clinic
  916-734-3574 Appointments
  www.ucdmc.ucdavis.edu
- Kaiser Alzheimer / Dementia Program
  916-973-6165
- DHHS Division of Mental Health Adult Access Team
  875-1055 or
  875-1000 (for an emergency)

Programas de Prevencion e Intervencion Temprana para personas de la tercera edad financiados por el "Sacramento Mental Health Services Act":

- Mental Health America Northern California
  916-855-5444
- El Hogar Community Services Inc.: Senior Link
  916-369-7872

FINANZAS

Para ayuda con Medicare:

- Medicare
  1-800-MEDICARE
  www.medicare.gov
- Health Insurance Counseling Advocacy Program (HICAP)
  1-800-434-0222
  www.hicapservices.net
- CalMedicare.org
  916-376-8915
  www.calmedicare.org

Solicitar Medi Cal:

- Department of Human Assistance
  916-874-2215
  www.dhaweb.saccounty.net

Solicitar ayuda del seguro social/deshabilidad:

- U.S. Social Security
  916-381-9410 **OR** 1-800-772-1213
  www.ssa.gov

Para asesoria de impuestos o para la preparacion de declaracion de impuestos para personas de la tercera edad:

- Tax Counseling for the Elderly (TCE)
  916-974-5303
  www.irs.gov

Preguntas acerca de las hipotecas revertidas:

- U.S. HUD Sacramento Office
  916-498-5220 Ext. 221

Para informar fraude en hipotecas revertidas:

- 1-888-827-5605
  www.hud.gov

PROVISION DE CUIDADO

- IHSS Public Authority
  916-874-4411

Para asilo:

- Cordova Senior Center
  916-366-3133
- Hart Senior Center
  916-808-5462
- Del Oro
  916-971-0893 or
  http://www.deloro.org

LEGAL

Para Asistencia Legal:

- Legal Services of Northern California
  916-551-2150
  www.lsnc.net
- Superior California Legal Clinics, Inc.
  916-972-1188
- Voluntary Legal Services Program
  916-551-2102
  www.vlsp.org
- Superior Court Self Help Center
  916-875-3400
- McGeorge Community Legal Clinic
  916-340-6080