File No. 170773 **Committee Item No.** 1
Board Item No.

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Comm: Public Safety & Neighborhood Services **Date:** April 11, 2018
Board of Supervisors Meeting: **Date:**

Cmte Board

☒	☐	**Introduction Form**
☒	☐	**Public Correspondence**

OTHER:

☒	☐	DPH Presentation Slides - November 29, 2017
☒	☐	DPH Presentation Slides - September 5, 2017
☒	☐	DPH Presentation Slides - July 26, 2017
☒	☐	Family Council Letter - March 20, 2018
☒	☐	CPMC Letter - February 20, 2018
☒	☐	SFHHJJ Proposals Letter - February 7, 2018
☒	☐	SFHHJJ Report - February 7, 2017
☒	☐	Family Council Letter - February 6, 2018
☒	☐	Comment Letters - November 28, 2017
☒	☐	Long-Term Care Ombudsman Letter - November 28, 2017
☒	☐	SFHHJJ Report and Proposals - November 28, 2017
☒	☐	Comment Letter - November 22, 2017
☒	☐	Family Council Letter - September 19, 2017
☒	☐	Comment Letters - September 12, 2017
☒	☐	SFHHJJ Proposals and Report - September 12, 2017
☒	☐	Family Council Letter - September 5, 2017
☒	☐	Long-Term Care Ombudsman Letter - September 5, 2017
☒	☐	Comment Letters - September 4 and 5, 2017
☒	☐	Hospital Council Letter - September 1, 2017
☒	☐	Comment Letter - August 18, 2017
☒	☐	SFHHJJ Proposals and Report - August 15, 2017
☒	☐	Comment Letter - August 12, 2017
☒	☐	Comment Letters - July 26, 23, and 21, 2017
☒	☐	Hospital Council Update - June 2017
☒	☐	Referral FYI - June 26, 2017

Prepared by: John Carroll **Date:** April 6, 2018

Supporting San Francisco's Vulnerable Post-Acute Care Patients

San Francisco Department of Public Health
Office of Policy & Planning

November 29 , 2017

Overview

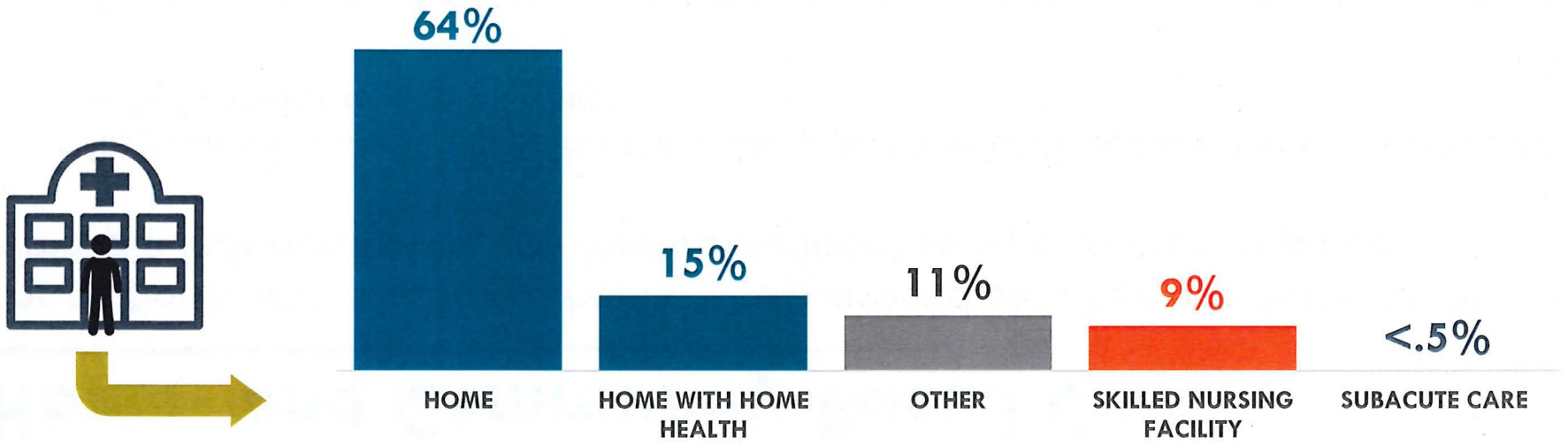
- Optimally, post-acute care is provided in home- and community-based settings whenever possible.
  - National, state, and local policies recognize the importance of aging in place to maximize independence and provide care in the least restrictive setting.
  - The vast majority of patients are discharged home after a hospital stay.

- Some patients who cannot be safely discharged home rely on skilled nursing facilities to receive post-acute care.

- As the city's population ages, San Francisco will need to rely on a multi-pronged and multi-partner approach to address the need for post-acute care that both:
  - prioritizes home- and community-based care, and
  - supports access to skilled nursing beds.

Some Patients Discharged from a Hospital Need Continued Care

Hospital discharge patterns are consistent on the national and local level



Home- and Community-Based Care

For patients who discharge home, wrap around services are essential to maintain independence, prevent institutional care, and age in place.

- Residential Care Facilities for the Elderly provide 24/7 supervision and assistance with Activities of Daily Living

- The Department of Aging and Adult Services supports programs that bridge the gap between acute and community-based care settings through programs that include:
  - In-Home Supportive Services
  - Community Living Fund
  - Case Management
  - Home Delivered Meals or Groceries
  - Transportation
  - Caregiver Support

Post-Acute Care Overview

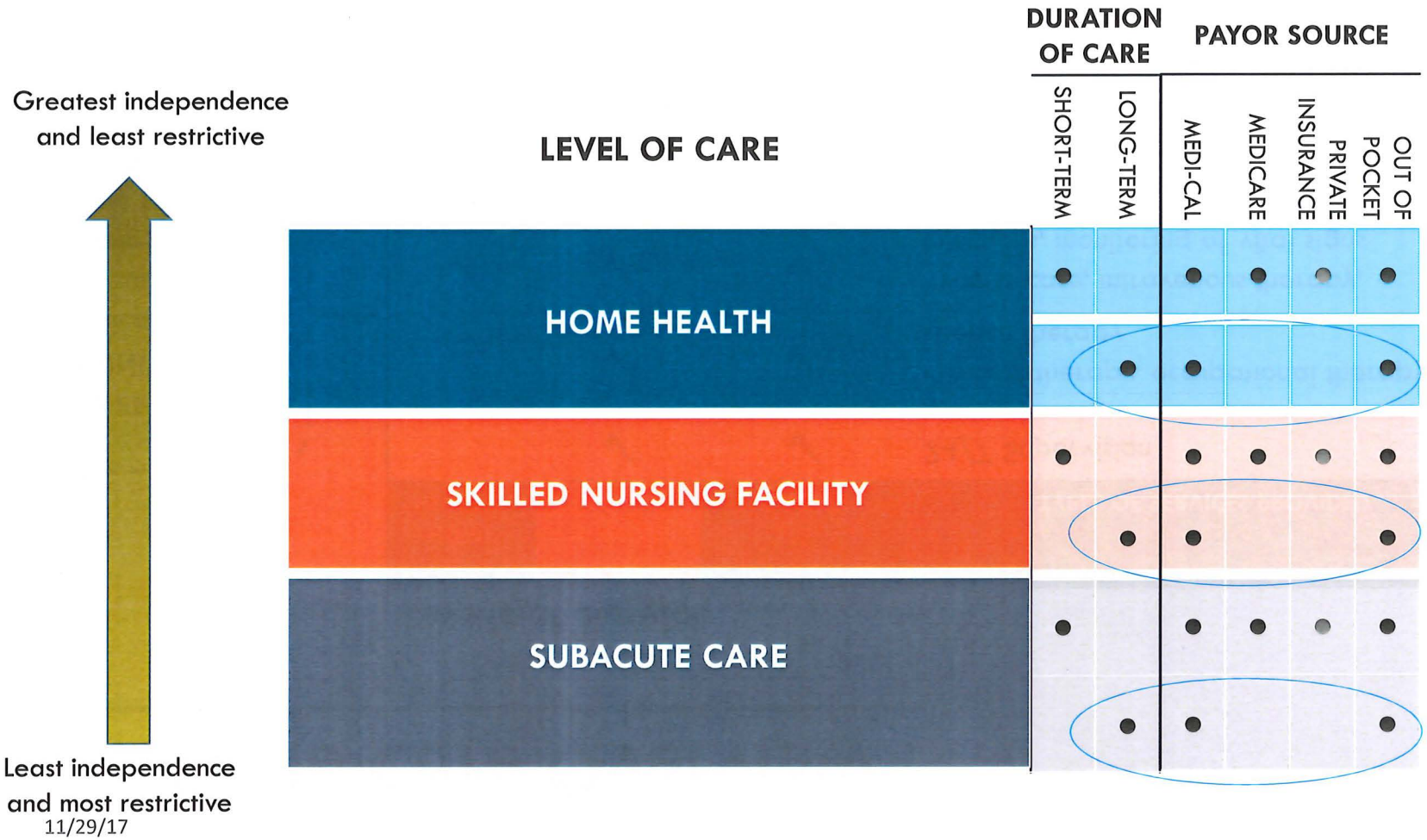
GENERAL DEFINITION
medical services that support recovery from illness following a hospitalization

Levels of Service

HOME HEALTH*	SKILLED NURSING FACILITY	SUBACUTE**	TYPES OF SERVICES PROVIDED
	✓	✓	24/7 Supervision
✓	✓	✓	Physical therapy, occupational therapy, speech therapy
✓	✓	✓	Wound care, intravenous therapy, injections, monitoring of vital signs
	✓	✓	Assistance with bathing, eating, dressing, feeding, transferring, toilet hygiene
		✓	Ventilator care, complex wound management, intravenous tube feeding

**Home Health Care is provided on a part-time basis*
***Subacute patients are medically fragile and require more intensive care*

Several Factors Impact Post-Acute Care



Access Challenges for Vulnerable Populations

- Low-income populations are challenged when accessing SNF and subacute care largely due to insurance reimbursement policies.
  - Medi-Cal reimbursement is low.
  - Medicare and private health insurance reimburse at higher rates, but only for short-term stays.
  - As a result, facilities are incentivized to serve more short-term patients vs. fewer long-term patients.

- Patients with behavioral needs or without a discharge destination are harder to place

Declining Skilled Nursing Bed Capacity

- Nationally, the number of hospital-based skilled nursing facilities has fallen (63 percent from 1999 to 2013)

- San Francisco has seen a similar decline
  - 30 percent decline in skilled nursing beds since 2003 (from 3,500 licensed beds to 2,439 licensed beds)
  - Largely due to a 43 percent reduction in hospital-based skilled nursing beds

Subacute Care Capacity

- Subacute care can be provided in two types of facilities
  - Short-term Stay: Long-Term Acute Care Hospitals
  - Long-term Stay: Medi-Cal designated Skilled Nursing Facilities

- San Francisco has two facilities that provide subacute care:
  - Kentfield Long-Term Acute Care Hospital - 40-bed facility located at St. Mary's Hospital.
  - CPMC St. Luke's - 40 bed Medi-Cal designated subacute Skilled Nursing Facility

Developing a Post-Acute Care Strategic Plan

- **Objective 1** – Prioritize Aging in Place to Maximize Independence and Support Care in the Least Restrictive Setting

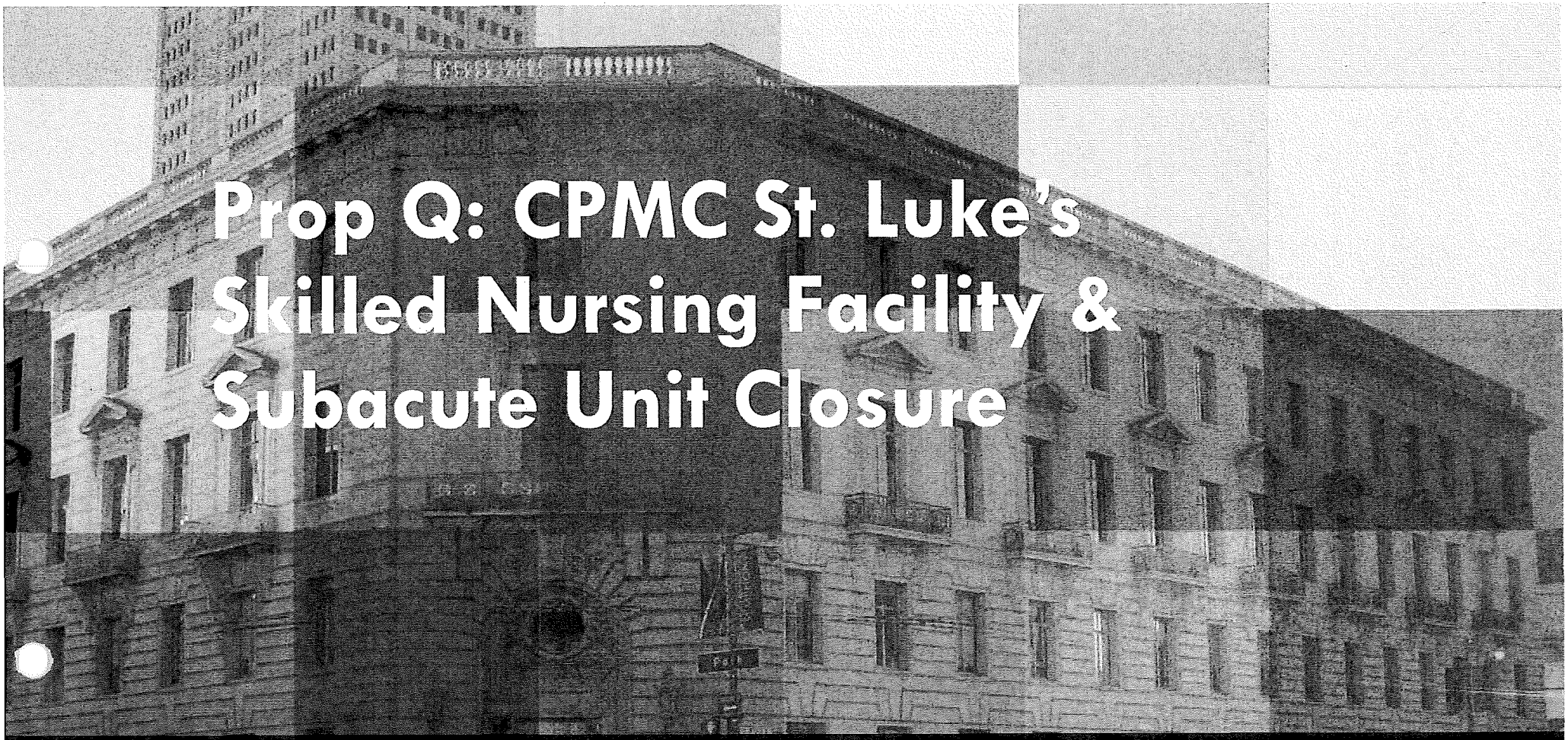
- **Objective 2** – Incentivize Residential Care Facilities for the Elderly and Skilled Nursing Facility Providers to Preserve and Create Beds

- **Objective 3** – Explore Unused Health Care Facility Space that May Provide Opportunities for New Residential Care Facilities and Skilled Nursing Facilities

Developing a Post-Acute Care Strategic Plan (cont.)

- **Incorporating Additional Stakeholder Feedback**
  - Patient and Family Meetings– (December 2017/January 2018)
  - Labor Meeting– (December2017/January 2018)
- **Aligning Several Related Efforts**
  - Post-Acute Care Collaborative (December 2017)
  - Health Care Services Master Plan (Spring 2018)
  - Regional efforts with San Mateo County (ongoing)
  - Local implementation of Medi-Cal Home and Community Based Waivers (ongoing)
- **Collaborating with Multiple Partners**
  - Collaborating with the Department of Aging & Adult Services
  - Coordinating with healthcare partners
- **Finalizing a Post-Acute Care Strategic Plan** (Spring 2018)

Thank You



Prop Q: CPMC St. Luke's Skilled Nursing Facility & Subacute Unit Closure

San Francisco Department of Public Health
Office of Policy & Planning

September 5, 2017

Presentation Outline

1) Skilled Nursing Bed Rates

2) Skilled Nursing Facility Reimbursement

3) Kindred Facilities in San Francisco

4) Discharges to Skilled Nursing Facilities Out-of-County

San Francisco's Skilled Nursing Bed Rate

$$\text{SNF Bed Rate} = \frac{\text{Number of skilled nursing beds}}{\text{Number of adults 65 and older per 1,000}}$$

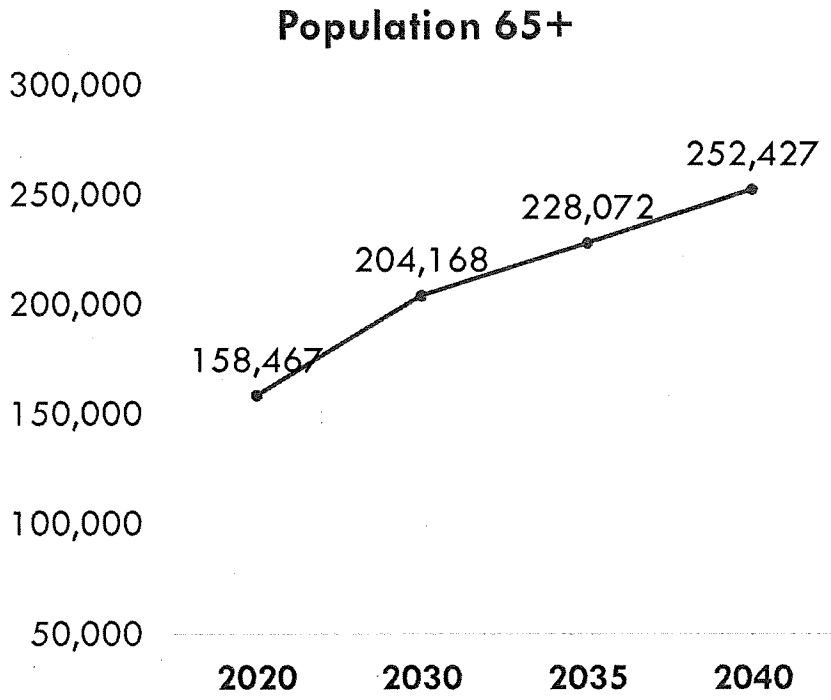
- **Currently,** San Francisco has 20 skilled nursing beds for every 1,000 adults 65 and older
- **If number of SNF beds remains constant, in 2030** San Francisco's bed rate will decrease to 12 beds per 1,000 adults 65 and older

- If San Francisco were **to maintain its current bed rate** as the population ages, the city would need 4,083 licensed SNF beds by 2030—an **increase of 1,644 beds over the current supply**

Skilled Nursing Bed Rates (Continued)

Projections are based on three assumptions:

1) San Francisco ages as projected
2) The number of skilled nursing beds remains constant
3) The city wants to keep the same bed rate



Source: California Department of Finance, 2016

Skilled Nursing Facility Reimbursement Rates

Type of Skilled Nursing Care	Skilled Nursing Setting	Medi-Cal	Medicare
General Skilled Nursing	Hospital-Based	~$300-$500/day	~$500-$900/day
	Freestanding	~$200-$300/day	
Subacute Care	Hospital-Based	~$890-$933/day	>$900/day
	Freestanding	~$400-$600/day	

Source: California Department of Health Care Services, 2016

Kindred Facilities in San Francisco

- **Kindred provides 25% of all SNF beds in San Francisco**
- **Three new operators will run Kindred's five facilities in San Francisco**

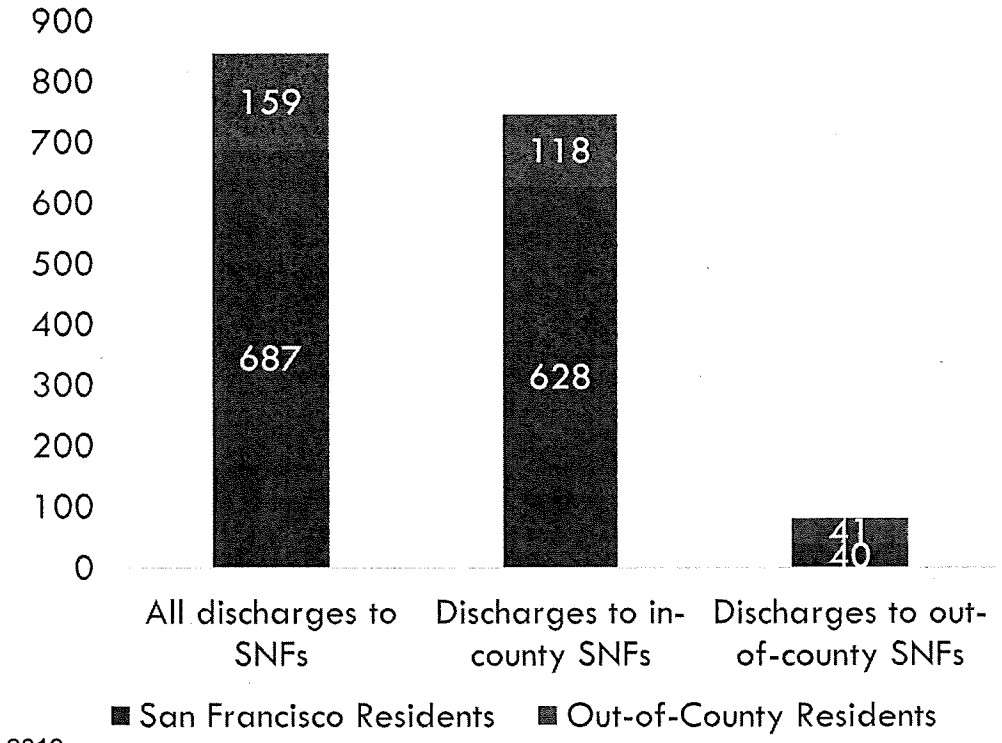
Facility	Beds	Patient Payer Source on December 31, 2015	New Operator
Kindred Victorian	90	• 80 Medi-Cal • 8 Medicare	Providence Group
Kindred 19th Avenue	140	• 120 Medi-Cal • 9 Medicare • 1 Managed Care • 1 Self-Pay • 5 Other	Aspen
Kindred Golden Gate	120	• 106 Medi-Cal • 8 Medicare • 1 Managed Care • 3 Self-Pay	
Kindred Tunnell	180	• 88 Medi-Cal • 30 Medicare • 14 Managed Care • 15 Private Insurance • 4 self-pay • 4 Other	Generations
Kindred Lawton	68	• 34 Medicare • 16 Managed Care • 5 self-pay	

Source: California Office of Statewide Health Planning and Health Development, 2015

Discharges to SNFs Out-of-County

- SFDPH is requesting data from San Francisco hospitals
- **In FY 2016/2017, ZSFG made 827 discharges to SNFs**
  - 746 (90%) of discharges were made to in-county SNFs
  - 81 (10%) of discharges were made to out-of-county SNFs
  - Of the 81 discharges to out-of-county SNFs, 40 were San Francisco residents. This represents 6% of all discharges to SNFs.

Zuckerberg San Francisco General Hospital SNF Discharges, FY 2016/2017



Thank You

Skilled Nursing Facilities

San Francisco Overview

San Francisco Department of Public Health
Office of Policy & Planning

July 26th, 2017

CPMC St. Luke's Skilled Nursing Unit

- CPMC St. Luke's Skilled Nursing Unit is expected to close in October 2017. This closure will:
  1) Decrease the total number of skilled nursing beds in San Francisco by 79 (39 skilled nursing and 40 subacute skilled nursing)
  2) Eliminate all subacute beds in San Francisco

- This reduction of hospital-based skilled nursing beds is likely to create a capacity challenge in San Francisco and is reflective of an industry-wide trend

- The Health Commission will hold two Proposition Q hearings in August and September to determine the impact of closure

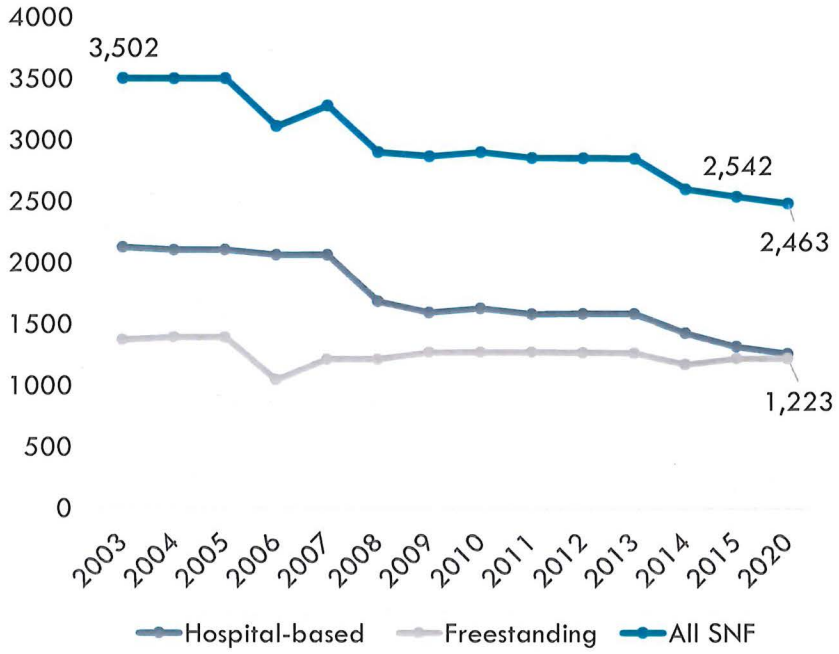
Skilled Nursing Facility Services

CATEGORY	CHARACTERISTIC	TYPE OF SKILLED NURSING CARE	
		GENERAL	SUBACUTE*
CAPACITY	Licensed beds in San Francisco	2,502	40
SUPERVISION	24/7	√	√
SERVICES	Physical therapy, occupational therapy, speech therapy	√	√
	Wound care, intravenous therapy, injections, monitoring of vital signs	√	√
	Assistance with bathing, eating, dressing, feeding, transferring, toilet hygiene	√	√
	Ventilator care, complex wound management, intravenous tube feeding		√

**Subacute patients are medically fragile and require more intensive care*

Declining Skilled Nursing Bed Capacity

Licensed Skilled Nursing Beds in San Francisco, 2003-2020



- *Nationally, the number of **hospital-based skilled nursing beds has fallen by 63%** from 1999 to 2013*
- *With a static bed supply, San Francisco's total skilled nursing bed rate would **decrease from 21 to 12 beds per 1,000 adults 65+ by 2030***

Skilled Nursing Beds at CPMC

With this closure, skilled nursing beds across all CPMC hospitals have declined by 83% since 2013

Campus	Licensed Skilled Nursing Beds		
	2013	2014	2017
California	101	0	0
Davies	38	38	38
Pacific	0	0	0
St. Luke's	79 (40 subacute)	79 (40 subacute)	0
TOTAL	**218**	**117**	**38**

Subacute Care Facilities in California

Across the state:

- *11% of subacute beds (523) are located in the Bay Area*
- *36% of subacute beds are in hospitals*

County	Number of Beds	Number of Facilities
Los Angeles	2,193	56
Orange	532	16
San Diego	423	11
San Bernardino	384	8
Santa Clara	**223**	**5**
Alameda	**149**	**5**
Riverside	139	4
Ventura	114	3
Fresno	83	2
San Joaquin	72	2
Tulare	67	2
Contra Costa	**58**	**2**
Sacramento	**52**	**2**
Kern	51	1
San Mateo	**44**	**1**
Yolo	44	1
San Francisco*	40	1
Monterey	**32**	**1**
Sonoma	**17**	**1**
Glenn	10	1
TOTAL	**4,727**	**125**

**** Estimated closure date October 2017***

CPMC Development Agreement

- The Development Agreement:
  - is **silent on the provision of skilled nursing beds** by CPMC
  - required CPMC to work with DPH and other hospitals to **develop proposals for providing subacute services**

- In 2016, DPH, hospitals, and community providers completed the Post-Acute Care Project Report putting forth short- and long-term recommendations, including:
  - Create a citywide **Post-Acute Care Collaborative**
  - Explore new incentives and funding options to **address current gaps** in facility-based care and **bring new** skilled nursing facility and subacute **providers into the market**
  - Explore **public-private partnerships** to support alternative post-acute care settings
  - Identify a process for delivering **real-time post-acute care information**

Citywide Post-Acute Care Collaborative

- As recommended in the Post-Acute Care Project Report, the San Francisco Section of the Hospital Council of Northern and Central California **launched the Post-Acute Care Collaborative (PACC)** in March of 2017

- The Collaborative includes key leaders from private non-profit hospitals, DPH, Department of Aging and Adult Services, the Jewish Home, and others

- The mission of the Collaborative is to develop solutions that **improve the accessibility and availability of post-acute care for low-income and vulnerable populations**

- The Collaborative is meeting through the end of the year and will release a report later this fall

Summary

- A reduction in hospital-based skilled nursing beds **strains the remaining supply of beds** in San Francisco, but is reflective of a nationwide trend
- San Franciscans needing **subacute care** will need to be placed **out of county**
- Access to skilled nursing care, including subacute care, is a **citywide and regional challenge**
- DPH has initiated **regional discussions** and the Post-Acute Care Collaborative will work on **citywide recommendations**
- The Health Commission's **Proposition Q hearings** will be on **8/15 and 9/5**

FAMILY COUNCIL
St. Luke's Sub-Acute & Skilled Nursing Facility

March 20, 2018

Via Email

Scott Ciesielski
ciesies@sutterhealth.org
Chief Nurse Executive
Sutter Health CPMC

RE: St. Luke's Sub-Acute and Skilled Nursing Unit

Dear Mr. Ciesielski:

We received your letter dated February 20, and we are disappointed that our thoughtful questions went unanswered. As family members of the sub-acute care residents, our goal is to build a trusting relationship with your organization. However, your reply to our letter of February 6 fails to provide adequate transparency about the process of closure and transfer and makes us feel disregarded. It is frustrating that you invite us to ask questions about the transfer process in your letter, but do not answer the ones we have sent you.

Our family members are unique individuals who have developed bonds with their caregivers over extended periods of time. Their caregivers are trained and experienced in sub-acute care and have a familiarity with the needs of each of our loved ones that has developed through long-term continuity of care. We demand that patients are cared for by Registered Nurses who are both trained AND experienced in the care of sub-acute patients, with current sub-acute experience and current, validated competencies in providing sub-acute care.

Although your letter of February 20 mentions regular, quarterly family meetings with individual residents and their families, it does not appear to include any strategy to communicate with the Family Council. We would therefore like to extend an invitation for you to attend our next Family Council Meeting on **Thursday, March 29, 2018 at 6:00 pm**. Attending this meeting will give you the opportunity to build trust, answer

general questions about the unit closure, transfer and new location, and show compassion for families and residents who are undergoing this extraordinarily stressful life event. Attached is a copy of our letter dated February 6, 2018.

Sincerely,

Raquel Rivera
Family Council Coordinator
(415) 273-9883
patientsarefirst@gmail.com

cc: Sarah Krevans, CEO, Sutter Health
Dr. Warren Browner, CEO California Pacific Medical Center
Mayor Mark Farrell
SF Board of Supervisors
SF Health Commission
Director Barbara Garcia, Department of Public Health
Benson Nadell, Ombudsman
Liz Cong
Jim Macksood
Melissa White
Susan Bumatay
Joshua Anderson
Austin Ord

Sutter Health
CPMC

February 20, 2018

Dear St. Luke's Subacute Families and Family Council,

I am replying to your Feb. 6, 2018 letter to Sarah Krevans and Dr. Warren Browner.

CPMC is committed to the safe and orderly relocation of residents in the St. Luke's Skilled Nursing Facility to CPMC's Davies Campus. We are preparing a detailed plan that cares for the individual needs of each resident during the move and continues delivering the exceptional, quality care your loved one has always received at CPMC.

As we continue planning for this transition, CPMC is fully aware of all regulatory requirements necessary to transfer residents to the Davies Campus Skilled Nursing Facility. Details of this complex planning process require sign-off by OSHPD as well as approval by regulatory agencies including DHCS. The transfer plan, as well as our staffing plan, are on track for their review and approval and we expect to move the residents in late June.

As we've expressed in previous public hearings, family meetings and letters, any time you have questions about this process you are welcome to contact Susan Bumatay, Liz Cong and Josh Anderson, whose contact information is below. In addition to our regular, quarterly family meetings, we will schedule open office hours in late March at the St. Luke's Skilled Nursing Facility so that you can meet with us and ask questions. We will send you more information once this is scheduled.

For now, the previous Relocation Plan you received answers many of your questions, and identifies the process for the orderly and safe relocation of all subacute residents.

- CPMC has assembled an interdisciplinary team of experienced professionals to facilitate a smooth transition. This team will take specific measures to minimize any transfer trauma a resident may experience as a result of relocation.
- This Resident Relocation Team is responsible for establishing and managing a highly detailed plan to relocate every resident. This team will assess each resident's needs before, during and after the move, and ensure that all necessary services and care are provided. This includes medications, services, supplies and treatments, as ordered by each resident's physician/practitioner.
- Residents will be safely moved via critical care ambulance. A Respiratory Therapist from the St. Luke's Campus will assist residents on ventilators prior to relocation into ambulances. Residents on ventilators will have a ventilator at the Davies Campus
- Skilled Nursing Facility set to the parameters per their respective transfer order, prepared by their physician.

In closing, please know that CPMC is committed to the clinical and psychological preparation of each resident for a successful transfer. As we have done in the past, we will continue to communicate with residents and their family designee as move day approaches, so that details are understood and questions can be answered well in advance.

Sincerely,
Scott Ciesielski, MS, R.N.
Chief Nurse Executive

Sutter Health
CPMC

Susan Bumatay, Executive Director, Case Management
925-584-4121

Liz Cong, Inpatient Case Manager, Care Coordination
415-641-6933

Joshua Anderson, Director, Acute Care/Nursing, Nursing Administration
415-600-0223

San Franciscans for Healthcare, Housing, Jobs and Justice (SFHHJJ)
c/o Jobs with Justice, 209 Golden Gate Avenue, San Francisco, CA 94102
Contact: Gordon Mar, gordon@jwjsf.org, (415) 840-7420

February 7. 2018

Proposals for Action by the S.F. Board of Supervisors

1. Issue a resolution that Sutter/CPMC:

   a. Accept new San Francisco-resident patients, both from within the CPMC system and from other San Francisco hospitals, into the SNF and SNF Sub-Acute Care Units at St. Luke's Hospital;

   b. Maintain the number of medical personnel and other resources needed to operate at the highest quality level a 40-bed SNF Sub-Acute Care Unit at the old St. Luke's hospital site until its closure and then at an appropriate interim site on a CPMC campus;

   c. Commit to the development and permanent operation of a successor hospital-based 39-bed post-acute SNF and 40-bed SNF sub-acute care facility as part of the construction of the planned new Medical Office Building on the St. Luke's site (CPMC's renamed Mission/Bernal Campus); and

   d. Commit that the total currently open CPMC post-acute SNF beds will not be decreased to accommodate St. Luke's SNF or SNF sub-acute patients, i.e., the 79 SNF and SNF sub-acute beds previously licensed at St. Luke's will be re-opened and maintained in addition to the current 38 Davies Campus post-acute SNF beds. This should occur both during the interim period following the closure of St. Luke's Hospital and after the opening of a new SNF and sub-acute SNF facility on the Mission/Bernal Campus.

2. Issue a resolution that Sutter/CPMC live up to its representation that after the closure of the California Campus, the Swindells Alzheimer's Residential Care Program will be maintained in its entirety and relocated without any interruption in service to a suitable location on another CPMC campus.

3. Issue a resolution that there now is a crisis, which will worsen in the next several years, in the availability of hospital-based SNF, including sub-acute care beds, and affordable RCFEs, including those with memory care units, within the City and County of San Francisco and the San Francisco Bay Area.

4. Direct the Department of Public Health to prepare by April 30, 2018, a report identifying all space in San Francisco hospitals that are licensed or could be re-licensed for use as SNF beds, including for sub-acute care patients.

5. Direct the Department of Public Health to prepare by April 30, 2018, a report identifying the number of beds occupied and the number of beds unoccupied in RCFEs, including memory care units within San Francisco. This report should also clarify the current and review future uses of Medi-Cal waivers and patch funding to subsidize low- and moderate-income residents requiring RCFE services.

6. Direct the Department of Public Health to prepare by April 30, 2018, a report presenting discharge data for the past ten years obtained from each public and private sector hospital in San Francisco on the number of out-of-county discharges, and submit the report to the Board of Supervisors. In addition, DPH should continue to collect out-of-county discharges annually on an on-going basis and provide annual reports to the Board of Supervisors. Both the initial 10-year summary, and the on-going annual reports, should specifically include the number of discharges to each type of out-of-county placement facility.

7. Direct the Department of Public Health, in consultation with labor and grassroots community groups as well as healthcare providers and associations, to take actions to develop both short-term and long-term solutions for insuring a sufficient number and range of post-acute care beds and facilities within the City and County of San Francisco for San Francisco residents discharged from San Francisco hospitals.

8. Along with other potential approaches to the insufficient number and range of post-acute beds in San Francisco, direct the Department of Public Health specifically to analyze and prepare reports on the following policy proposals:

    a. Cooperation agreements among private and public hospitals to operate and fund jointly hospital-based SNFs, including SNF sub-acute care units, within the City and County of San Francisco;

    b. The enactment of local legislation requiring the imposition of fines whenever a private hospital or healthcare facility removes a SNF bed from service without guaranteeing beforehand the availability of a similarly staffed bed elsewhere within the City and County of San Francisco so that there is not a decrease in such beds in San Francisco; and

    c. The enactment of local legislation that mandates a minimum number and range of hospital-based post-acute care beds that public and private hospitals within the City and County of San Francisco must create and maintain.

San Franciscans for Healthcare, Housing, Jobs and Justice (SFHHJJ)
c/o Jobs with Justice, 209 Golden Gate Avenue, San Francisco, CA 94102
Contact: Gordon Mar, gordon@jwjsf.org, (415) 840-7420

February 7, 2018

The Widening San Francisco Crisis in the Availability of Long-Term and Post-Acute Healthcare Services

The Problem and the Need:

Low-income and moderate-income San Francisco residents with disabilities or who are elderly cannot access adequate residential or institutional long-term care to live safely in San Francisco as their frailty and need for help increases. The continuum of needed care ranges from in-home supportive services, to Residential Care Facilities for the Elderly (RCFE), including facilities with memory care units, to community-based and hospital-based Skilled Nursing Facilities (SNF), including hospital-based SNF sub-acute care units for those who choose to live long-term on life-support.

Except for individuals eligible for Veteran Benefits, Medi-Cal is the only government program that covers long-term institutional care at a SNF. Medi-Cal support is only for income-qualifying individuals, and its reimbursement rates are low. It does not cover RCFE costs except with a specialized waiver. RCFEs are considered "non-medical" placements, and licensed nurses may not be on site.

A shortage at any level of care in this continuum hampers other levels of care. San Francisco in recent years has seen a dramatic decline in hospital-based SNF beds and community-based long-term SNF beds. A major factor is the refusal of acute care hospitals to provide short-term post-acute SNF care. Hospitals prefer instead to make referrals for short-term care to community-based SNFs, a discharge practice that then leads to a shortage in long-term care beds in community-based SNFs. Unlike long-term care, short-term care is covered by private insurance and Medicare at significantly higher reimbursement rates than Medi-Cal. For community-based SNFs, short-term care is far more profitable than long-term care.

Further adding to the San Francisco crisis in long-term care, affordable RCFEs, including those specialized for individuals with memory problems, are in very short supply. One reason for this decline is that many small RCFEs have closed or are in the process of closing because there is more money to be gained from selling the property than in the income to be earned from those in need of care.

The San Francisco Department of Public Health projects that there is a need citywide for 70 SNF sub-acute beds to provide long-term life-support services, such as ventilators, for San Francisco residents. At this time, there are in San Francisco no SNF sub-acute units, hospital-based or community-based, accepting new patients. There is also a dire lack of hospital-based SNF beds generally. Since the first years of this century, San Francisco hospitals have closed SNF units totaling hundreds of beds.

One consequence of not having sufficient spaces at all levels of needs is placing and maintaining sicker people in a lower level of care than is best for them. Such

misplacements aggravate the health decline of seriously sick individuals and reduce available non-medical beds for people well enough to benefit from them.

The reasons are largely systemic. For example, hospital-based SNFs are most suited to the elderly and those with complex illness after hospitalization. Because there are so few of these now even outside San Francisco, almost everyone who needs post-acute SNF level care gets discharged to a community-based SNF. In community facilities, the staffing mix, especially with respect to the availability of RNs and MDs, is poorer than in hospital SNFs.

Other systemic factors adversely affecting discharge practices are patient financial constraints and intense pressures on hospitals to free up acute care beds. The consequence of these practices is the over-discharging of still quite ill individuals to non-medical placements, such as RCFEs or even single residency hotel rooms. As a result, too many individuals end up back in an emergency room, sometimes multiple times. Because a brief hospital stay is considered an "observation" and not an "admission," or because more than one hospital ER may receive a particular patient, many "failed discharges" do not show up in current tracking algorithms.

Additionally, a number of important underlying societal conditions need to be taken into account to resolve this public health crisis. They include increases in the elderly San Francisco population as the large baby boomer generation ages; the high cost of land in the Bay Area leading to the displacement or consolidation of healthcare facilities and hospitals; the lack of enforceable citywide healthcare planning; and, at its core, a "free market" healthcare delivery system that favors providing services that generate the most revenue, such as short stay hospital acute care, and discourages the provision of services that need to be subsidized with revenue from other sources.

The Present Context:

Recent decisions made by Sutter Health's California Pacific Medical Center (CPMC) are central to the widening crisis in healthcare services for elderly and disabled San Francisco residents. CPMC already has taken steps to shut down both its 39-bed post-acute SNF and its 40-bed SNF Sub-Acute Care Unit at its St. Luke's Campus and also plans to close the Swindells Alzheimer's Residential Care Program on its California Campus (an RCFE with enhanced "memory care").

Nothing in the 2013 Development Agreement between CPMC and the City and County of San Francisco, which concerns the development of a new hospital on the St. Luke's site and a new hospital campus at Van Ness Avenue and Geary Street, addresses the continuation or termination of the St. Luke's SNF and SNF Sub-Acute Care Unit. With respect to the Swindells Program, the Agreement has language indicating that Swindells will be transferred to another site, but the language is conditional and not likely legally binding. In short, though invoked by CPMC to justify its actions, the Agreement neither mandates nor constrains what CPMC can do regarding these matters. Indeed as to Swindells, the Agreement holds out the promise of maintaining this program in its entirety.

Following S.F. Board of Supervisors committee hearings last summer and fall, CPMC proposed to transfer remaining patients in the St. Luke's SNF Sub-Acute unit to a newly created sub-acute care unit on its Davies Campus. There are currently 19 patients cared for at the St. Luke's unit. The proposed transfer, which would use some of the existing 38 post-acute SNF beds at Davies, is scheduled for June 2018 in preparation for the opening of the new replacement hospital at St. Luke's. The new hospital has already been erected elsewhere on the St. Luke's site (now termed by CPMC the Mission/Bernal Campus) and has no SNF beds. CPMC has indicated that it will maintain new SNF sub-acute beds at the Davies Campus only until the last of the 19 St. Luke's SNF sub-acute patients have died or otherwise are discharged from the unit.

CPMC has not accepted new patients for admission to the St. Luke's sub-acute unit since 2016, and since 2012 has allowed only patients from CPMC campuses to be admitted. CPMC sought on an ongoing basis to transfer sub-acute care patients out-of-county until families and patients organized and successfully stopped this attempt in 2017. Since 2012, an unknown number of patients needing SNF sub-acute care have been transferred out-of-county due to CPMC not making available all 40 sub-acute beds at St. Luke's.

In 2019 or 2020, CPMC says it will cease providing residential dementia care services when it closes the California Campus and moves hospital and related services to the new Van Ness/Geary Campus. The California Campus site has been sold to a private developer. The Swindells Program currently houses 18 patients, and is the only service center among several at the California campus that will be discontinued after the move. Swindells, which was originally funded by private donors for individuals with memory problems, has had no new recent admissions, and the population receiving care has been allowed to dwindle.

CPMC's decisions to close Swindells and to end St. Luke's post-acute SNF services as well as the only SNF sub-acute care service unit in San Francisco fly in the face of its public obligation to appropriately use the enormous tax savings it garners as a tax-exempt non-profit entity for charitable purposes. Instead, CPMC acts as though it were a for-profit entity and wants to provide only healthcare services that produce surplus revenue. The proposed termination of services by CPMC exacerbates an already severe crisis in the availability of services along a continuum of long-term and post-acute care that the people of San Francisco require.

Solution Overview:

To meet the needs of seniors, people with disabilities, and other San Francisco residents, the San Francisco Department of Public Health must promote and have the legal tools to ensure the availability of a full continuum of care within the City and County of San Francisco. This should be care that is affordable and high quality, and includes long-term and post-acute healthcare services and residential care. Such options are essential to the well-being of San Francisco residents. As we age, the timely availability of appropriate care and supervision not only prevents sickness and shortens or avoids hospitalization, it allows us to age in our beloved City instead of having to leave it merely to survive.

San Francisco has to act pro-actively now to stop the loss of beds, units, and facilities along the entire continuum of long-term and post-acute care and residential placements. In joint participation with private and public hospitals and other healthcare and residential facilities, an expanded network of affordable options should be established for elderly and disabled San Francisco residents. At the same time, comprehensive support for in-home and community-based services for those not in dire health circumstances must continue. One type of care cannot be provided at the expense of another.

The first step towards a solution is to stop and reverse the progressive loss of St. Luke's hospital-based SNF beds, including SNF sub-acute beds, and to stop the closure of Swindells. CPMC's decisions have major public health consequences. They should not be left unchecked by the public and public officials.

The essential follow-up step is to initiate a public-private partnership to maintain, expand, and partially fund a full continuum of long-term and post-acute healthcare services within San Francisco. This next step requires the service and financial participation of CPMC and other San Francisco hospitals and healthcare facilities along with targeted supplemental public funding.

Sutter Health's CPMC not only has to reverse its decisions regarding the closings of the St. Luke's SNF and SNF sub-acute care units and the Swindells Alzheimer center, it also has to participate affirmatively in the future provision and funding of long-term and post-acute services. And so, too, do Dignity Health's St. Mary's and St. Francis Hospitals, Chinese Hospital, Kaiser Permanente, UCSF, and Zuckerberg San Francisco General Hospital.

Acute care hospitals can expect substantial savings in resources and costs if they can shorten delays in transferring dischargeable patients to appropriate post-acute placements including re-opened hospital-based SNF and SNF sub-acute care units.

There is also need for the participation of major long-term care facilities, such as Laguna Honda and large privately operated, community-based SNFs and RCFEs. A sufficient supply of beds at all levels in the continuum of services will allow San Franciscans to age in their City with safety and dignity.

Contributing to the resolution of the San Francisco crisis in long-term, post-acute care and RCFEs is in everyone's interest. An effective resolution requires comprehensive planning and coordination, with joint and shared provision of resources and funding from all San Francisco hospitals and large institutional healthcare and residential facilities.

FAMILY COUNCIL
St. Luke's Sub-Acute & Skilled Nursing Facility

February 6, 2018

Via Email and U.S. Mail

Sarah Krevans
krevans@sutterhealth.org
Sutter Health
2200 River Plaza Drive
Sacramento, CA 95833

Dr. Warren Browner, CEO
brownew@sutterhealth.org
California Pacific Medical Center
2351 Clay Street, 7th floor
San Francisco, CA 94115

RE: St. Luke's Sub-Acute and Skilled Nursing Unit

Dear Ms. Krevans and Dr. Browner:

The residents and families at St. Luke's Subacute Unit now have five months before the proposed move to the Davies Campus in June 2018. Communication regarding these plans has been non-existent. This inadequate communication is the cause of stress and trauma to those involved, and erodes trust in CPMC's proposal to relocate residents. In this letter, we ask specific questions relating to CPMC's plans to ensure:

- The safety of residents (especially during relocation)
- The minimization of transfer trauma
- Continuance of care to meet the resident's needs

1. What is the plan to make the existing skilled nursing facility at Davies subacute ready by the June 30th deadline?

Regarding licensing and compliance:

We are aware that California State Law and Title 22 require that these beds must be contiguous within a wing that is clearly defined as a subacute unit, and be cared for by trained nursing staff assigned to subacute residents alone. Please supply in writing the following:

- Copies of any correspondence with the licensing authorities and forms regarding licensing application
- Clarification as to whether you intend to accommodate both subacute and SNF residents within the Davies unit and how this will be managed given licensing requirements

Regarding availability of beds:

Given that all the beds at Davies SNF are currently occupied, we need to understand what the plan is to accommodate 19 subacute residents by June 30th. Please supply, in writing, details of:

- How and when these 19 beds will be emptied
- Whether subacute residents will be moved as beds become available between now and June, or all at one time
- Whether the deadline of June 30th is a real goal for transfer or a soft date

Regarding the plan for environmental modifications

We are aware that significant modifications will have to be made to the rooms to install treatment and monitoring equipment needed for the subacute residents. This will require re-engineering of the post-acute SNF unit at the Davies campus. We are aware that for approval of a subacute unit, certain OSHPD criteria also must be met. Please supply, in writing, details of:

- The modifications that will be required for this subacute population
- What the timeline for these environmental modifications are

2. What is the plan for transferring residents?

Given the complex needs of this fragile population, our expectation is that a patient-centered detailed plan for transfer will be written at least one month in advance. Please supply in writing, a copy of this plan. We expect such a plan to include details of:

- Transport to be used
- Who will travel with residents:

  - Staffing: critical care nurse/staff known to resident
  - Family member – with the provision of adequate notice (5 working days) of time/date of transfer
- Translators to be supplied as necessary
- How many residents will be transferred at a time and over what duration
- Staffing at each facility during transfer including how many, what level, staff familiar to residents wherever possible, and nurse-to-nurse handovers
- A written plan of care for each resident for use during transfer, available to resident, family and healthcare providers involved in transfer

3. What is the plan for minimizing transfer trauma, preparing residents for the transition, and welcoming them at Davies?

As frail and vulnerable people, the forthcoming transfer of these subacute residents is a potentially traumatic experience. We require that everything will be done to minimize trauma. This we believe can be achieved by excellent communication and preparation including many of the points already made in this letter. In addition however, we need information regarding details of how plans will be communicated to include:

- Individual multi-disciplinary family conferences for each resident to discuss plans and potential risks of transfer
- Weekly bulletins provided to residents and families summarizing developments. All communications should meet literacy levels of 8th grade and below, be made available in English and the recipients' first language, and conveyed by hand, mail or email as preferred
- Preparation, orientation, familiarization and welcoming residents and families to the new environment. This should include information about location, transport routes, tours of the facility and introductions to new staff
- Maintenance of current roommate relationships as requested

4. How will CPMC assure continuity of care for subacute residents?

We ask that the standard of care provided to our residents will not suffer, and that it will include familiar, consistent, trained and oriented caregivers. We ask that you supply in writing details of:

- How you will incentivize current staff familiar with these residents to transfer

- Plans for staff recruitment, orientation and training
- A guarantee that CPMC's own subacute staffing guidelines will continue to be met

We hope that you will work with us to alleviate the stress and anxiety that this anticipated move has caused residents and families by addressing all of the concerns mentioned above. Please provide a written response to this letter within 10 working days (Health & Safety Code Section 1418.4).

Sincerely,

Raquel Rivera
Family Council Coordinator
(415) 273-9883
patientsarefirst@gmail.com

cc: Mayor Mark Farrell
SF Board of Supervisors
SF Health Commission
Director Barbara Garcia, Department of Public Health
Benson Nadell, Ombudsman
Scott Ciesielski
Liz Cong
Jim Macksood
Melissa White
Susan Bumatay
Josh Anderson
Austin Ord

References:

1. See following citations regarding transportation of ventilator patients:
http://journal.chestnet.org/article/S0012-3692(15)46080-5/pdf
http://accessmedicine.mhmedical.com/content.aspx?bookid=520&sectionid=41692269

2. Citations of title 22 and related codes:
Subacute Care Unit, Title 22 § 51215.5

3. See following citations regarding transportation of ventilator patients:
http://journal.chestnet.org/article/S0012-3692(15)46080-5/pdf
http://accessmedicine.mhmedical.com/content.aspx?bookid=520&sectionid=41692269

Carroll, John (BOS)

From: Carroll, John (BOS)
Sent: Wednesday, November 29, 2017 11:21 AM
To: 'pmonette-shaw@earthlink.net'
Subject: RE: Public Safety and Neighborhood Services Committee November 29 Testimony — 1,381 San Franciscans Discharged Out of County; Need "Certificates of Preference" Return Program

Categories: 2017.11.29 - PSNS, 170773

Thanks for your comment letter. I have added your message to the official file for the hearing.

I invite you to review the entire matter on our Legislative Research Center by following the links below:

Board of Supervisors File No. 170773

John Carroll
Assistant Clerk
Board of Supervisors
San Francisco City Hall, Room 244
San Francisco, CA 94102
(415)554-4445 - Direct | (415)554-5163 - Fax
john.carroll@sfgov.org | bos.legislation@sfgov.org

Click here to complete a Board of Supervisors Customer Service Satisfaction form.

The Legislative Research Center provides 24-hour access to Board of Supervisors legislation and archived matters since August 1998.

From: pmonette-shaw [mailto:pmonette-shaw@earthlink.net]
Sent: Tuesday, November 28, 2017 6:59 PM
To: Ronen, Hillary <hillary.ronen@sfgov.org>; Sheehy, Jeff (BOS) <jeff.sheehy@sfgov.org>; Fewer, Sandra (BOS) <sandra.fewer@sfgov.org>
Cc: Safai, Ahsha (BOS) <ahsha.safai@sfgov.org>; Peskin, Aaron (BOS) <aaron.peskin@sfgov.org>; Carroll, John (BOS) <john.carroll@sfgov.org>; Goossen, Carolyn (BOS) <carolyn.goossen@sfgov.org>; Hepner, Lee (BOS) <lee.hepner@sfgov.org>; Yee, Norman (BOS) <norman.yee@sfgov.org>; Sandoval, Suhagey (BOS) <suhagey.sandoval@sfgov.org>; Choy, Jarlene (BOS) <jarlene.choy@sfgov.org>
Subject: Public Safety and Neighborhood Services Committee November 29 Testimony — 1,381 San Franciscans Discharged Out of County; Need "Certificates of Preference" Return Program

Please see the attached printer-friendly version of this testimony.

November 28, 2017

Public Safety and Neighborhood Services Committee, Board of Supervisors
The Honorable Hillary Ronen, Chair

The Honorable Jeff Sheehy, Member
The Honorable Sandra Lee Fewer, Member
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

Re: **St. Luke's Hospital SNF and Sub-Acute Units**

Dear Chair Ronen and Members of the Public Safety and Neighborhood Services Committee,

Attached is my testimony for the Public Safety Committee's November 29 hearing.

My written testimony addresses:

1. A Plan Be Developed to Rapidly Identify and Build Additional In-County SNF Facilities
2. "Regional Solutions" for SNF and Sub-Acute Care Facilities Are Inappropriate
3. Developing Additional Sub-Acute Units Should Not Focus Only on Mental Health Patients
4. A "Certificates of Preference" Program Must Be Established
5. A GAP Analysis Must Be Conducted Rapidly
6. The LOCUS Assessment Tool Should Not Be Used
7. ADHC Units in Hospital-Based Facilities Be Opened

The "Certificates of Return" issue was not addressed in the PACCs draft final report, but it is a crucial element that the Board of Supervisors must require.

Respectfully submitted,

Patrick Monette-Shaw
Columnist
Westside Observer Newspaper

Patrick Monette-Shaw

975 Sutter Street, Apt. 6
San Francisco, CA 94109
Phone: (415) 292-6969 • e-mail: pmonette-shaw@eartlink.net

November 28, 2017

Public Safety and Neighborhood Services Committee, Board of Supervisors
The Honorable Hillary Ronen, Chair
The Honorable Jeff Sheehy, Member
The Honorable Sandra Lee Fewer, Member
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

"At least 1,381 San Franciscans have been discharged out-of-county."

Re: **St. Luke's Hospital SNF and Sub-Acute Units**

Dear Chair Ronen and Members of the Public Safety and Neighborhood Services Committee,

Draft preliminary data from DPH finally reporting private-sector hospital data shows there have been at least 1,381 San Franciscans have faced out-of-county placement, as Table 1 below shows. The data remains subject to change. That figure is likely far higher, because St. Mary's, St. Francis, and Kaiser didn't respond to DPHs survey of private hospitals, and Chinese Hospital claims it doesn't know how many of its patients it discharged out-of-county.

The agenda for your November 29 hearing currently posted on the Board of Supervisors web site clearly indicates the hearing is to be about the proposed closure of St. Luke's **SNF unit and** its sub-acute (SNF) unit. This hearing should be about the severe shortage of SNF facilities in San Francisco, and this hearing should **NOT** focus ***only*** on the sub-acute care facility shortage in San Francisco.

It's my understanding that the severe loss of SNF units in the City may be being moved to the Public Safety Committee's scheduled December 7 hearing, which was supposed to be a hearing ***only*** on residential care facilities of concern to Supervisor Norman Yee. Indeed, the hearing request Supervisor Yee introduced last June specifically stated it was to be a:

> *"Hearing to consider the state of, and understand the efforts of City departments regarding, institutional housing, particularly assisted living, residential care facilities, and small beds for seniors in San Francisco; and requesting the Department of Aging and Adult Services, and Department of Public Health to report."*

To move at the last minute the focus of the severe shortage of SNF units citywide to Yee's December 7 hearing — which is a completely separate, albeit inter-related issue — is a major violation of "process." The "medical-based" SNF shortage shouldn't be combined with non-medical residential facilities.

The primary focus of your November 29 hearing should also be on out-of-county patient dumping and the massive loss of in-county skilled nursing facility capacity, not only on sub-acute beds and Supervisor Yee's legitimate concern about the lack of Residential Care Facilities (RCFE) and ***non-medial*** residential care that, though closely intertwined.

Since I presented written testimony to the Neighborhood Services and Public Safety Committee last July 23, the Department of Public Health provided me on November 27 updated data on the number of San Franciscans discharged to out-of-county facilities.

That number has climbed from 291 discharges just from LHH and SFGH last July, to now 1,381 out-of-county discharges from only two of our six private-sector hospitals in just the past five years, without providing data for private-sector out-of-county data for previous years.

It's entirely possible many more thousands of San Franciscans have already been dumped out of county by private-sector hospitals and our two public hospitals. They deserve a return-trip ticket to San Francisco!

Table 1: Updated Hospital Out-of-County Discharges, FY 2012–2013 — FY 2016–2017

	Fiscal Year	Laguna Honda Hospital	SFGH[1]	Private-Sector Hospitals[2]	Total
1	FY 06–07	35	?	?	35
2	FY 07–08	36	?	?	36
3	FY 08–09	14	?	?	14
4	FY 09–10	18	27	?	45
5	FY 10–11	6	54	?	60
6	FY 11–12	19	41	?	60
7	FY 12–13	26	30	39	95
8	FY 13–14	28	42	2	72
9	FY 14–15	25	68	25	118
10	FY 15–16	20	56	261	337
11	FY 16–17	20	40	449	509
	Total[3]	**247**	**358**	**776**	**1,381**

[1] San Francisco residents discharged from SFGH but not admitted to LHH. Data prior to FY 09-10 for SFGH unavailable; not tracked electronically.

[2] DPH only asked six private-sector hospitals to provide data: Chinese Hospital, University of California San Francisco, St. Mary's, St. Francis, CPMC, and Kaiser. Chinese Hospital reported an unknown number of San Franciscans discharged out-of-county, and St. Mary's, St. Luke's and Kaiser have not provided data to DPH. The data shown here are only from CPMC (312) and UCSF (137) for calendar year 2016 and FY 2016–2017, respectively.

[3] Data excludes out-of-county patient diversions prior to hospitalization via the Diversion and Community Integration Program (DCIP), and "Transitions" and successor programs, and excludes out-of-county placements chosen by families due to a lack of appropriate level of care beds in San Francisco.

Note: Data is preliminary and subject to change by SF DPH.

Source: San Francisco Department of Public Health responses to records requests.
Updated: November 27, 2017

This Public Safety Committee ***must*** ascertain just how many out-of-*county discharges of San Franciscans there have been from all* private-sector and public-sector hospitals in San Francisco, dating back to July 1, 2006. As previous Civil Grand Juries have noted — and I reminded this Committee last July — "You can't fix what you don't measure."

The 1,381 out-of-county discharges of San Franciscans noted in Table 1 above are more than likely just the tip of a very large iceberg, and are preliminary data subject to updates!

"The 1,381 out-of-county discharges of San Franciscans noted in Table 1 above are more than likely just the tip of a very large iceberg, and are preliminary data!"

Major Concerns

The Board of Supervisors and your subcommittee should follow up and require — for reasons below — that:

1. **A Plan Be Developed to Rapidly Identify and Build Additional In-County SNF Facilities:** The Department of Public Health and Health Commission created the PACC two-and-a-half years ago. The PACC's draft final report fails to address building out additional in-county SNF facilities as rapidly as possible. Clearly, while sub-acute in-county facilities are critically needed, so too are in-county SNF facilities, which must be expanded quickly.

2. **"Regional Solutions" for SNF and Sub-Acute Care Facilities Are Inappropriate:** We've heard too much about trying to find "regional solutions" to solve the lack of a sufficient number of SNF units in San Francisco. DPH Director Garcia regurgitated at the Board of Supervisors Committee of the Whole hearing on September 12 the PACC's, the Health Commission's, and Supervisor Yee's assertion that a "***regional*** solution" for SNF level-of-care should be pursued. ***That just portends even more out-of-county discharges.***

3. **Developing Additional Sub-Acute Units Should Not Focus Only on Mental Health Patients:** Director of Public Health Barbara Garcia testified September 12 in her remarks to the Board of Supervisors (presumably under oath) that DPH is working with Dignity Health on trying to develop a sub-acute unit, ***but only for mental health patients***. DPH and the PACC do not appear to be looking for solutions for sub-acute patients who do **not** have a mental health diagnosis. This Committee needs to ascertain from Garcia whether DPH is working on establishing any public/private partnership to open additional sub-acute facilities (should St. Luke's/CPMC succeed in closing St. Luke's sub-acute unit) for **all** San Franciscans, not just those who have mental health diagnoses.

4. **A "Certificates of Preference" Program Must Be Established:** To its credit, the PACCs draft final report does recommend that if patients are dumped into out-of-county facilities, patients in "*regional SNF facilities should, however, be transferred back to a corresponding facility in San Francisco as space becomes available*.

   To transfer them back to San Francisco, a tracking system needs to be developed quickly. Dr. Palmer has noted:

   > *"To facilitate return of San Franciscans as space becomes available, a formal 'Certificate of Preference' system must be developed to give patients placed out of county preference for return to San Francisco-based facilities. Such a preference program should be prioritized for rapid development and implementation.*
   >
   > *Importantly, since DAAS and DPH have jointly funded development of the* SF *GetCare database developed by RTZ Associates at a cost of millions of dollars, RTZ should be awarded a contract to enhance the* SF GetCare *database to track the Certificates of Preference, and each private-sector hospital in San Francisco should be given access to the database and be required to use it to track 'regional' placements.*
   >
   > *DPH should be assigned as the lead agency to oversee governance of placement practices and protocols.*
   >
   > *Consideration should be given to retroactively issuing 'Certificates of Preference' to people previously discharged out-of-county from both our public hospitals, and private-sector hospitals, as an issue of equity."*

   The 1,381 San Franciscans already placed out-of-county must be included in any *Certificates of Preference* return program.

   As noted last July, DPH and DAAS have paid at least $7.8 million between July 1, 2002 and April 10, 2017 to RTZ Associates to develop over a dozen different components of the SF*GetCare* database. The Neighborhood Services and Public Safety Committee should direct the two departments fund a certificates of preference tracking system as a high priority.

"The 1,381 San Franciscans already placed out-of-county must be included in a Certificate of Preference program."

5. **A GAP Analysis Must Be Conducted Rapidly:** The Budget and Legislative Analyst issued its report "*Performance Audit of Senior Services in San Francisco*" on July 13, 2016, which noted that no gap analysis — including a gap analysis similar to the one Rapid City, SD performed to assess expressed preferences for assisted living and skilled nursing facility level of care — has been performed, completed, or submitted to the Board of Supervisors.

   The PACCs draft final report noted that in a second point-in-time survey conducted on October 5, 2017, 85 patients were waiting for post-acute care placement. Of those 85, 26 (30%) of the patients expressed that their primary desired post-acute care placement setting was to a long-term SNF. Another 20 (23%) expressed a preference for placement in a short-term SNF, and 13 (15%) expressed preference for discharge to a board and care facility. Of the 85 patients, 31 (37%) were waiting for custodial level of care placement. The draft report doesn't stratify whether the 85 people waiting for discharge had expressly refused out-of-county placement.

   "Of those 85, 26 (30%) of the patients expressed that their primary desired post-acute care placement setting was to a long-term SNF. The draft report doesn't stratify whether the 85 people waiting for discharge had expressly refused out-of-county placement."

   We've heard anecdotally for years that "most" patients do not want to be placed in an "institutional" SNF facility, but if 30% of patients in the PACCs second point-in-time survey expressed preference for long-term care SNF placement, the "mostly" claim appears to have possibly been untrue. DAAS and DPH should be required to immediately conduct a gap analysis, as the BLA recommended, including a gap analysis of those who prefer long-term care SNF placement in-county in San Francisco.

   If Rapid City, SD can conduct a gap analysis of expressed preferences for SNF-level placement, this Public Safety Committee should require that DPH and DAAS conduct such a gap analysis in San Francisco, immediately.

6. **The LOCUS Assessment Tool Should Not Be Used:** An alternative assessment tool other than the LOCUS tool must be required.

   LOCUS — *Level of Care Utilization System for Psychiatric and Addictions Services* — is an assessment tool widely used by behavioral health managers and clinicians throughout the country to support recommendations for psychiatric and mental health patients with behavioral issues affecting their discharge placement in appropriate level of care settings.

   LOCUS is intended primarily to evaluate addicts with psychiatric illness, but can be used for those with primary psychiatric illness. It is ***not*** a tool intended for use with the elderly medically ill or for folks with a primary diagnosis of dementia-related illness/cognitive impairment from non-psychiatric causes.

   The PACCs draft final report notes that of 117 patients awaiting post-acute care placement in April 2017, 81 (69%) did ***not*** have behavioral health challenges, and 91 (78%) were ***not*** substance abusers facing admission restrictions, suggesting using the LOCUS tool would be inappropriate

7. **ADHC Units in Hospital-Based Facilities Be Opened:** While ADHC level of care may be an issue more appropriate for Supervisor Yee's December 7 hearing, there is no reason why adult-day health care units in hospital-based facilities should not be opened, or re-opened. Take Laguna Honda Hospital, which shuttered its ADHC in November 2009 that had primarily served patients with various forms of dementia. To the extent ADHC facilities are not held to the same seismic-retrofit standards as acute-care hospitals there are, more than likely, several "finger wings" in LHH's old buildings to re-open an ADHC, at least as an interim measure until seismically-safe units can be identified and opened.

Following today's hearing on St. Luke's two units — SNF and sub-acute units — and following your December 7 hearing on Supervisor Yee's concerns about the lack of RCFE facilities in the City, this Committee should broaden your scope and dedicate a subsequent hearing to closely examine the overall loss of SNF facilities in the City (not just sub-acute SNF beds). Because it is the massive loss of overall SNF beds that has exacerbated both the sub-acute bed shortage, and the RCFE shortage. They're all intertwined, and this Committee would be derelict in your ministerial duties if you don't hold a hearing on the broader crisis in the inadequate amount of SNF beds in the City overall.

Respectfully submitted,

Patrick Monette-Shaw
Columnist, Westside Observer Newspaper

cc: The Honorable Asha Safai, Supervisor, District 11
The Honorable Aaron Peskin, Supervisor, District 3
The Honorable Norman Yee, Supervisor, District 7
John Carroll, Clerk of the Public Safety and Neighborhood Services Committee
Carolyn Goossen, Legislative Aide to Supervisor Hillary Ronen
Lee Hepner, Legislative Aide to Supervisor Aaron Peskin
Jarlene Choy, Legislative Aide to Supervisor Norman Yee
Suha Sandoval, Legislative Aide to Supervisor Ahsha Safai

Carroll, John (BOS)

From: Carroll, John (BOS)
Sent: Wednesday, November 29, 2017 11:18 AM
To: 'Benson Nadell'; marc.morewitz@sfdph.org
Subject: RE: BOS St Luke's Sub-Acute Closure Testimony-Benson Nadell-SFLTCOmbudsman11/2917

Categories: 2017.11.29 - PSNS, 170773

Thanks for your comment letter. I have added your message to the official file for each hearing. Please bring at least seven copies of the correspondence for the members of the committee.

I invite you to review the entire matter on our Legislative Research Center by following the links below:

Board of Supervisors File No. 170773

John Carroll
Assistant Clerk
Board of Supervisors
San Francisco City Hall, Room 244
San Francisco, CA 94102
(415)554-4445 - Direct | (415)554-5163 - Fax
john.carroll@sfgov.org | bos.legislation@sfgov.org

Click here to complete a Board of Supervisors Customer Service Satisfaction form.

The Legislative Research Center provides 24-hour access to Board of Supervisors legislation and archived matters since August 1998.

From: Benson Nadell [mailto:nadellbl@aol.com]
Sent: Tuesday, November 28, 2017 4:45 PM
To: Carroll, John (BOS) <john.carroll@sfgov.org>; marc.morewitz@sfdph.org
Subject: BOS St Luke's Sub-Acute Closure Testimony-Benson Nadell-SFLTCOmbudsman11/2917

Dear Mr. Carroll,

I am testifying , in my capacity of over three decades in the San Francisco Long Term Care Ombudsman Program regarding the agenda item
for the BOS Committee meeting a 1:00PM November 29, 2017

I am also copying Marc Morewitz, Secretary to the SF Department of Public of Health, Health Commission.

My request is to make the enclosed written Testimony part of the Public Record.Please see attached enclosure.

Thanks you very much

Sincerely

Benson Nadell
Program Director
San Francisco Long Term Care Ombudsman Program
Felton
6221 Geary Blvd.
San Francisco, Ca.
94121
415 751 9788

From: Benson Nadell; Program Director
San Francisco Long Term Care Ombudsman
Felton Institute
6221 Geary
415 751 9788

Testimony : Re: St. Luke's Sub Acute Unit.

Board of Supervisors
November 29, 2017

I wish to enter the following comments into the Public Record regarding the eventual disappearance of a sub acute unit at St Luke's Hospital (the only subacute unit in SF) which used to have open admissions before Sutter took over that community hospital.

Introduction

The Ombudsman Program was created by Federal Law to identify, investigate and resolve complaints and grievances resulting from actions, inactions and decisions, which may adversely affect the residents' health, safety and welfare and rights. The California mandate included advocacy and protection of vulnerable and dependent institutionalized elderly and disabled, and to investigate reports of abuse and neglect.. The San Francisco Program staff are neither Federal or State Employees:local Ombudsmen are considered Representatives of the State Ombudsman within the California Department of Aging.

I have been with the Program since 1987 and have we have observed and monitored multiple closures of Skilled Nursing Facilities (SNFs) and Residential Care Facilities for the Elderly (RCFES-mostly "board and care" homes of the mom and pop variety).

Sub-acute Care and the History of CPMC-Sutter Ownership:

Sub acute SNF is a rare skilled nursing designation under California Department of Health Care Services. A long term care sub acute unit is best found in hospitals which have an ICU. All patients are ventilator and tracheotomy dependent and need 24/7 suctioning. These most vulnerable and dependent patients need the shortest distance to the ICU by medical transport. Most are hooked to multiple monitors connected to computers. It is not post-acute care, which is a Medicare

reimbursed benefit. Sub-acute is not post-acute: Post acute SNF care is driven by Medicare coverage. Sub—acute is a long term specialized benefit with a high daily rate under M-Cal. The Medicare population of beneficiaries mostly consists of an aging or geriatric population. Some are disabled.(Ombudsmen under Probate Code have to witness Advanced Health Directives, to determine volition and willingness(not sound mind) when a SNF resident signs such a Directive.. By and large, many who sign reject life supporting interventions if their mind is not functioning; or the possibility of recovery is not possible. That is a conversation with provider and patient. But there is still the choice. Sub-acute care grew out of pediatric cases where life supports were necessary. It was extended to adults with multiple needs for life supports particularly those with disability and chronic illnesses. This Ombudsman would estimate that the number of Medicare beneficiaries choosing sub-acute long term vent/trach/ suctioning dependency would be a small number).

Sutter CPMC took over St Luke's and initially wanted to close this community hospital serving the SF neighborhoods of Bayview, Ingleside, Excelsior, Crocker Amazon and the Mission. With intervention of Board of Supervisors , advocates and citizens that corporate plan was reversed. A smaller hospital would be built.

At the same time, Sutter CPMC entered into an agreement with City and County Planning Commission and Department of Public Health with compliance reports to serve the poor and to donate millions to community organizations, from 2013 to 2016. The yearly Compliance Report was just released.

Community Organizations serving those who were aging in place received grants as administered by SF Foundation. It was a negotiated form of generosity in exchange for approvals to build a new acute care hospital at Cathedral Hill on Van Ness. This was the bright side of the "Development Agreement" with Sutter-CPMC.

The Dark Side: Sutter, when it gained control of St Lukes, intentionally attempted to starve the hospital by demanding that Brown and Toland send all Medicare patients to the acute campus at Webster Buchanan. A law suit was filed and Supervisor Ammiano at the time brought this starvation practice to light .

Some Court History: with eventual vacating of anti-trust complaint.

https://www.bizjournals.com/sacramento/stories/1999/02/22/story1.html
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20A/PDF%20AntitrustPrinciplesWhitePaper.pdf
https://www.sfdph.org/dph/files/hc/HCMins/HCMin2001/HCMin020601.htm
https://cdn.ca9.uscourts.gov/datastore/memoranda/2016/07/15/14-16234.pdf
file:///C:/Users/fsa/Downloads/gov.uscourts.cand.259136.64.0.pdf
https://www.courtlistener.com/docket/4179606/sidibe-v-sutter-health/
https://antitrusttoday.com/2016/07/18/health-plan-members-convince-ninth-circuit-revive-antitrust-class-action-dominant-northern-california-healthcare-provider-sutter-health/

Also in 2012, CPMC/Sutter forced the sub-acute unit at St Luke's to change its admission policy from open to closed admission (only CPMC-Sutter patients). No longer would other hospitals be able to admit those suction , trach and vent dependent patients to the unit. Prior to this restrictive admission policy, the Sub acute unit had 40 patients.under the Medi-Cal daily rate ($800 -$1200 per day). The unit was financially sustainable when balanced with other hospital payment streams.

CPMC Sutter has just informed the families of St. Luke's Sub-Acute SNF that their solution is to move the St Luke's unit to the Davies SNF and to wait for attrition (death) of the remaining resident/patients while closing the door to any future candidates for this level of Medi-Cal reimbursed long term sub acute care.

Other hospitals do not keep data on similar (intensively ill) patients discharged into regular community SNF with parameters of mortality, trips to remote ICU via trips to an ER at another location. Simple! Since no data is collected, there is no documented need.

Where is the accountability for less than successful trajectories for those who are trach/vent dependent? 24 nursing care under M.D. supervision with monitoring machinery is not option for a person living by him/herself.

Concerns and Requests About CPMC Subacute SNF Care

1. When the St Luke's sub acute is moved to the Davies Campus and merged with the existing post acute SNF, assurances must be made that the level of care, with all the required monitoring devices and staffing coverage, are made.

2. This Ombudsman requests that all the applications for sub acute care filed with Department of Health Care Services, all the OSHPD paper work be submitted to BOS and SFDPH and advocates for public review and comment. These applications must be filed prior to June 2018.
3. The Sub-Acute Patient Family Council must be allowed to review the re-tooling of the unit and receive copies of State approval. If Sutter CPMC fails to do this, the Ombudsman Program will recommend that the families remain at the present St Luke's. Again, patients cannot be moved without consent.
4. The Davies Distinct Part SNF on One South is a post acute rehab SNF. Does this proposed move suggest a case mix approach?
Note that sub acute needs cannot be met by a Medicare driven rehabilitative model.

Shutting Down Hospital Based Skilled Nursing Facilities

Sutter CPMC starved the revenue from Medicare at its California Campus SNF. The SNF was hospital based, and patients benefited from hospital based doctors and nurses who provided daily attention to patients requiring rehabilitative and restorative services after an acute medical event. The elderly on Medicare benefitted from attention to chronic disease management, and their complex medical profiles. They were able to receive integrated care monitoring from a skilled hospital team

Sutter CPMC, in order to empty its SNF beds - shifted patients to new "post acute partners," (community based SNFs). Then Sutter turned around, and convinced the Health Commission at the Proposition Q Hearing for the California Campus SNF closures, that the beds were not filled, and there was less demand.

This also occurred with St. Mary's SNF in 2015, and with St. Luke's SNF in 2016-17.

Patients were discharged to remaining SNF beds in San Francisco .These SNFs clamored for the higher Medicare daily post acute rehab payment rate (which Medicare will generally only allow for 100 days or less). The community SNFs' mission to provide long term care under Medi-cal was less profitable, and so long term beds were lost to their "new mission."

This "Post Acute Policy" was created by the Hospital Council It has created a crisis in long term SNF care for those on Medi-cal...

Critique of "Solutions" by the Hospital Council

SFDPH Health Commission asked the Post Acute Collaborative(PACC) (formed by the Hospital Council of Northern and Central California) to come up with a solution to the crisis in long term care, including SNF and Sub-Acute SNF Care, in San Francisco. Per the PACC December 2017 draft report, there is an ongoing emphasis on acute hospital "length of stay" (LOS) problems and "patient flow."

The overarching question is: Should the Board of Supervisors and advocates for persons in each District allow the Hospitals to dictate local long term care policy, given their needs? Should their problem of getting stuck with difficult cognitively or psychiatrically impaired patients be a driving force in the shaping of larger public policy for others filing through hospitals to a next and uncertain destination?

Sub-acute is not post acute: The PACC Report re: St Luke's SNF closure misses the target, and contains a narrative about costs of hospital days and need to have a specialized assessment tool for psychiatric assessment, "Locus', used to facilitate discharges of persons with behaviors related to psychiatric/cognitive etiologies.

Psychiatric and cognitive issues may be an important impediment to discharges to the community based SNF, (reframed as " Post Acute Partners') as well as safe discharges back to a pre-existing community setting or a new one. However the report fails to mention that this problem is caused by acute hospitals shutdowns of their own SNFs and Acute Psychiatric units (which is another way they have increased revenue, since psychiatric care is not a profitable as regular acute hospital care). And it does not mention the numbers of Medi-cal patients that these hospitals HAVE successfully sent out of county due to lack of long term beds caused by the shift of hospital SNF rehab to community SNFs.

Hospitals, if we take the PACC Report at face value, are concerned about patient flow and emptying out beds for those waiting in ER. The Ombudsmen job does not include advocating for acutely hospitalized patients. The closing of hospital based SNF has implications which remain unexamined. For all I know there is no post discharge data collected by acute hospitals as to metrics of success of their discharges. The metrics used now focus on returns to ER and re-hospitalizations (within 30 days-a supposed CMS <Center for Medicare and Medicaid Services> penalty).

In a Post Acute SNF, either hospital or community based, the Ombudsman has and can advocate for rights of the resident and to slow down the process of discharge.

This Ombudsman recommends another assessment tool recommended by CMS which would better transition persons with not just an acute, Medicare reimbursed event, but the concomitant co-morbidities requiring care in these receiving SNF. For safe transition a patient discharged to a post acute SNF in the community must take an integrated approach. That is what this proposed CMS assessment tool would provide. Called Care and B-Care (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html)

This model assessment, if in place, would mitigate many of the problems that persons experience in the Community SNFs in San Francisco. These problems become the substance of complaints and mandated reports of abuse and neglect sent to the Ombudsman Program: The Program receives a bulk of referrals from patients in the various receiving community SNFs.

Summary of Grievances Received by S.F. Ombudsman

Post Acute SNF Rehab in Community SNFs:

1. Not enough days of coverage and need to appeal based on person centered rates of progress through the rehabilitative plan.
2. When first arriving at SNF there is initial interdisclipinary meeting with patient and representative to set goals and objectives with the plan. But at a community SNF, the person waits for someone to come into a room and , it is difficult to sort out who is who and what their role is. Each staff person says something else.
3. There is the lack of follow up progress meetings using the CMS interdisciplinary approach.
4. Many patients have chronic diseases and need for help with activities of daily living(ADLs) which get less attention than the other therapies. The focus is kept on the number of days and coverage rather than a person centered approach-again , required by CMS in Regulation. Chronic conditions slow down healing. Patients get complications of illness and infection, while the insurance clock is ticking.

5. Patients have told Ombudsmen that they had to wait a few days for medications to be filled due to a time lag from acute to post acute communication and transmission/ processing of that patient information by the receiving SNF. Many are in pain from surgeries and repairs. We have received complaints of patients receiving medications for another patient in the SNF.
6. Persons are admitted for rehabilitative services through therapy. But they are identified as fall risks and are unable to bear weight (or get rehab) until an Ortho doctor clears the person-all the time on the Medi-care ticking clock.
7. Many post –acute residents would have benefited from access to an integrated approach with access to an M.D. hospitalist or specialist. But in the world of community SNFs the staffing is unreliable. Nurse aides are assigned or float. Their jobs are difficult and there is no work load assessment for each newly admitted patient based on an initial care plan meeting with goals and objectives. Patients are adrift.
8. The real care meetings occur in the last few days of coverage. Social workers and the utilization case managers work on a discharge plan which is cursory. Many patients, in shock that they are going home, call the Ombudsman Program. They aren't ready; the therapists did not do a home evaluation for safety or accommodation to new disability. The Social workers and case managers in their roles confuse the departing patient and the conversation is about insurance co-pays. Many leave unsafely because of the cost of co-pays on a limited income. There is no support for these transitions for the scared and anxious patient. CMS requires a person centered approach; in practice the approach is insurance centered.
9. Those who need chronic disease management (ie longer term care in a SNF) are told that is not covered by Medicare. CMS requires notification to each about Medi-Cal. But these Post acute SNF want to preserve beds for the next influx of (more profitable then Medi-cal) Medicare short stay "rehab" beneficiaries. Even if the SNF is certified to bill Medi-Cal and has a percentage of long term residents under LTC(Long term care) Medi-Cal reimbursement, the case manager is told they will have go elsewhere, here is a list of SNF in a very impacted Bay Area. This violates Federal Nursing Home Rights.
10. A patient who is eligible for Medi-Cal should be given assistance to applying; this person has rights to not be moved or coerced to leave without consent. It is illegal to discharge a person without consent, and a full discharge plan evaluation. This does not occur. Nor is the conversation about going home a supportive one.

11. Medicare is a fast track, allowing, in general, 100 days or less for rehab. By contrast Laguna Honda with mostly persons coming to rehab under Medi-Cal the approach is better and drawn out, ,with longer time lines. The process of discharge planning is professional by comparison. Ombudsmen have participated in advocating for residents on the discharge track at LHH, to get a resident voice heard and integrated into the plan. In addition LHH has resources for placement.
12. Persons discharged home from post acute community SNFs have called the Ombudsman Office complaining that they were waiting three days until a home health agency showed up. In a few cases the home health agency as ordered had a waiting list and there was no backup plan. Many persons discharged home live alone . There is no support for functional limitations: so a person sits unable to walk ; or lies in bed. This may seem anecdotal. But most agencies who serve these individuals or Adult Protective Services(APS) who gets the new referral can attest to the dismal experiences some have had in the transition home. There is no wait for needed care in good discharge planning.

In summary, the use of the community SNFs as "post acute partners" to the hospital is in disarray. Persons sent there are at risk of effects of disorganization, communication break downs, and poor care coordination, of consequences of post acute medical events and acquired disabilities with pre-existing chronic diseases.

Post Script

Ombudsman Resources:

In San Francisco, there are 4 FTE Staff including Director to visit and cover all RCFE/Assisted living ; skilled nursing; and all facilities where an abuse report is received. In addition there are three per diem Ombudsman who specialize in Cantonese, or Spanish, or RCFE. The Program does not have resources to have one Ombudsman assigned on daily basis to each SNF. Scarcity of Ombudsman staff, with augmentation by trained volunteers who visit once a week, requires a coverage plan allocating visits to each facility.

Persons admitted to (SNF) Rehab do not stay long enough in many cases to meet an Ombudsman, to work a case of appeal or complaint using a consecutive day approach.

As of January 1, 2018 AB 940 California goes into effect. This will require all SNF to send discharge notices to the local Ombudsman Office. Already a requirement in CMS regulation, November ,2106, only LHH and ZFGH 4A SNF https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB940

Carroll, John (BOS)

From: Carroll, John (BOS)
Sent: Wednesday, November 29, 2017 11:14 AM
To: 'Aaronson, Mark N.'
Subject: RE: Board of Supervisors File No. 170773 for Public Safety and Neighborhood Services Committee Hearing on Nov. 29, 2017

Categories: 2017.11.29 - PSNS, 170773

Thanks for your comment letter. I have added your message to the official file for each hearing. Please bring at least seven copies of the correspondence for the members of the committee.

I invite you to review the entire matter on our Legislative Research Center by following the links below:

Board of Supervisors File No. 170773

John Carroll
Assistant Clerk
Board of Supervisors
San Francisco City Hall, Room 244
San Francisco, CA 94102
(415)554-4445 - Direct | (415)554-5163 - Fax
john.carroll@sfgov.org | bos.legislation@sfgov.org

Click here to complete a Board of Supervisors Customer Service Satisfaction form.

The Legislative Research Center provides 24-hour access to Board of Supervisors legislation and archived matters since August 1998.

From: Aaronson, Mark N. [mailto:aaronson@uchastings.edu]
Sent: Tuesday, November 28, 2017 4:14 PM
To: Carroll, John (BOS) <john.carroll@sfgov.org>
Subject: Board of Supervisors File No. 170773 for Public Safety and Neighborhood Services Committee Hearing on Nov. 29, 2017

Dear Mr. Carroll,

On behalf of San Franciscans for Healthcare, Housing, Jobs and Justice (SFHHJJ), I am submitting the two attached documents for consideration and filing at the Public Safety and Neighborhood Services Committee hearing tomorrow at 1:00 p.m. They will be referenced as part of the testimony provided by SFHHJJ speakers. We also will have hard copies for distribution. Thank you very much for your attention to this matter.

Sincerely yours,

Mark N. Aaronson
UC Hastings CED Clinic
100 McAllister St., Suite 300
S.F., CA 94102
(415) 581-8924

San Franciscans for Healthcare, Housing, Jobs and Justice (SFHHJJ)
c/o Jobs with Justice, 209 Golden Gate Avenue, San Francisco, CA 94102
Contact: Gordon Mar, gordon@jwjsf.org, (415) 840-7420

The Loss and Demise of Post-Acute Care Beds in San Francisco*

The problem:

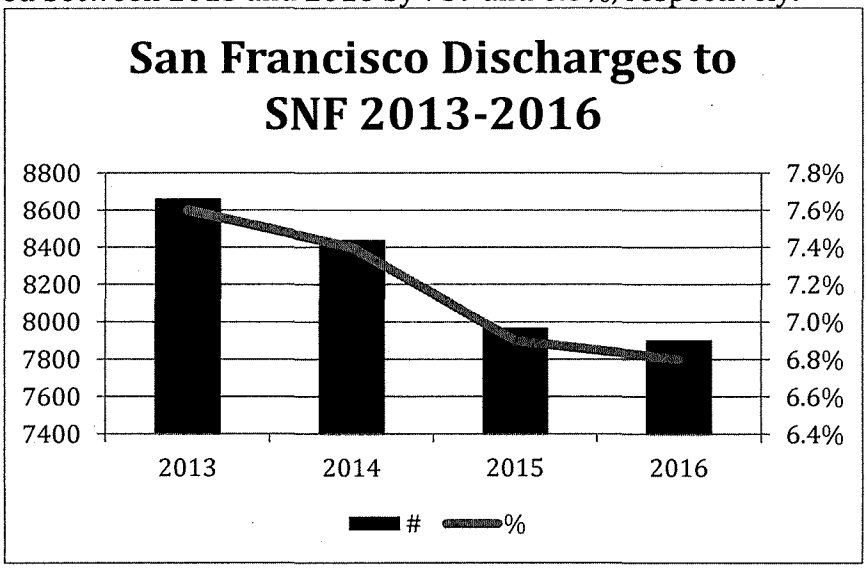
- **Short-term:** Until put on hold, CPMC Sutter had planned to close St. Luke's Skilled Nursing Unit in October 2017, which would have resulted in the closure of 79 post-acute beds, including 40 sub-acute beds, without providing any sub-acute options within the CPMC system. Once all current patients die or leave, CPMC intends to no longer provide sub-acute care. CPMC's ending this service will make San Francisco County the only county in California to have no sub-acute beds.

Definitions of care levels:

- **Post-acute:** a range of medical services that support an individual's continued recovery from illness after a stay in an acute care hospital
- **Skilled nursing:** accommodates needs such as physical or occupational therapy, wound care and intravenous therapy, and assistance with activities of daily living (bathing, eating, dressing, toilet hygiene)
- **Sub-acute:** a category of skilled nursing for medically fragile patients with needs such as ventilator care, complex wound management, and tube feeding

The facts:

- The number of licensed skilled nursing beds, including sub-acute beds, in San Francisco decreased from 3,502 in 2003 to 2,542 in 2013. Not all licensed beds are staffed so the number of available beds is even lower.
- There are only 40 sub-acute beds in San Francisco, all of which are at St. Luke's. Most other California counties have more sub-acute beds. For example, Los Angeles County has 2,193 sub-acute beds, 55 times as many as SF despite having just 9.6 times as many discharges as SF.
- The number and percent of total discharges from San Francisco hospitals to SNFs decreased between 2013 and 2016 by 759 and 0.8%, respectively.



- A smaller proportion of patients discharged from hospitals in San Francisco in 2016 went to SNFs compared to the rest of the state (6.8% versus 8.8%). It is unclear how many of these SNFs were located in San Francisco.

DISPOSITION	Statewide	San Francisco
Routine (home)	70.8%	68.9%
Home health services	10.4%	12.9%
Acute care hospital	2.3%	3.1%
Skilled Nursing Facility	8.8%	6.8%
Residential care	0.4%	0.7%
Critical Access Hospital	0.0%	0.0%
Inpatient rehab	0.9%	1.2%
Other*	6.3%	6.3%

*Other includes prison/jail, against medical advice, cancer center, hospice care, psychiatric care, disaster care site, and died.

- Many patients who are discharged to sub-acute care or SNF spend a long time in the hospital prior to discharge. The following table shows the length of stay (LOS) for patients discharged from UCSF hospital to sub-acute care and SNF between 2012 and 2016. This single hospital example points to the additional acute care hospital resource and cost consequences when there are delays in transferring dischargeable patients to appropriate post-acute care facilities.

LOS (days)	Sub-acute care	SNF
<10	38%	62%
10 to 19	26%	23%
20 to 29	12%	8%
30 to 49	12%	4%
50 to 99	7%	2%
100 to 149	4%	0%
150 to 199	0%	0%
> = 200	1%	0%

*This Fact Sheet was prepared for SFHHJJ by Dr. Grace Hunter, an internal medicine resident at UCSF. The tables are based on data internal to UCSF or from California's Office of State Health Planning and Development (OSHPD).

San Franciscans for Healthcare, Housing, Jobs and Justice (SFHHJJ)
c/o Jobs with Justice, 209 Golden Gate Avenue, San Francisco, CA 94102 Contact:
Gordon Mar, gordon@jwjsf.org, (415) 840-7420

November 28, 2017

SFHHJJ Proposals for Action by Board of Supervisors regarding the Loss and Demise of Post-Acute Care Beds in San Francisco

1. Issue a resolution that Sutter/CPMC (1) accept new San Francisco-resident patients, both from within the CPMC system and from other San Francisco hospitals, into the Sub-Acute Care Unit at St. Luke's Hospital and (2) maintain the number of medical personnel and other resources needed to operate at the highest quality level a 40 SNF-bed Sub-Acute Care Unit at St. Luke's or at a successor CPMC site.

2. Issue a resolution that there now is a crisis in the availability of hospital-based SNF including sub-acute care beds within the City and County of San Francisco and the San Francisco Bay Area, which will worsen in the next several years.

3. Direct the Department of Public Health to prepare by the end of the 2017 calendar year a report identifying all beds in San Francisco hospitals that are licensed or could be re-licensed for use as SNF beds including for sub-acute care patients.

4. Direct the Department of Public Health, in consultation with labor and grassroots community groups as well as healthcare providers and associations, to take actions to develop both short-term and long-term solutions for insuring a sufficient number and range of post-acute care beds and facilities within the City and County of San Francisco for San Francisco residents discharged from San Francisco hospitals.

5. Direct the Department of Public Health to analyze and propose solutions to the insufficient number and range of post-acute care beds and facilities the following along with other options:
    a. Cooperation agreements among private and public hospitals to operate and fund jointly hospital-based SNF including sub-acute care beds and facilities within the City and County of San Francisco;
    b. The enactment of local legislation requiring the imposition of fines whenever a private hospital or healthcare facility removes a SNF bed from service without guaranteeing beforehand the availability of a similarly staffed bed elsewhere within the City and County of San Francisco.
    c. The enactment of local legislation that mandates a minimum number and range of hospital-based post-acute care beds that public and private hospitals within the City and County of San Francisco must create and maintain.

Carroll, John (BOS)

From: Carroll, John (BOS)
Sent: Wednesday, November 22, 2017 1:44 PM
To: 'Teresa Palmer'
Subject: RE: Overview of Long-Term Care and Post Acute Care Delivery In San Francisco; Teresa Palmer M.D. (attachment)

Categories: 170773, 170788

Thanks for your comment letter. I have added your message to the official file for each hearing.

I invite you to review the entire matter on our Legislative Research Center by following the links below:

Board of Supervisors File No. 170773
Board of Supervisors File No. 170788

John Carroll
Assistant Clerk
Board of Supervisors
San Francisco City Hall, Room 244
San Francisco, CA 94102
(415)554-4445 - Direct | (415)554-5163 - Fax
john.carroll@sfgov.org | bos.legislation@sfgov.org

Click here to complete a Board of Supervisors Customer Service Satisfaction form.

The Legislative Research Center provides 24-hour access to Board of Supervisors legislation and archived matters since August 1998.

From: Teresa Palmer [mailto:teresapalmer2014@gmail.com]
Sent: Wednesday, November 22, 2017 1:23 PM
To: Ronen, Hillary <hillary.ronen@sfgov.org>; Safai, Ahsha (BOS) <ahsha.safai@sfgov.org>; Yee, Norman (BOS) <norman.yee@sfgov.org>; Fewer, Sandra (BOS) <sandra.fewer@sfgov.org>; Sheehy, Jeff (BOS) <jeff.sheehy@sfgov.org>; Breed, London (BOS) <london.breed@sfgov.org>; Farrell, Mark (BOS) <mark.farrell@sfgov.org>; Kim, Jane (BOS) <jane.kim@sfgov.org>; Peskin, Aaron (BOS) <aaron.peskin@sfgov.org>; Tang, Katy (BOS) <katy.tang@sfgov.org>; Morewitz, Mark (DPH) <mark.morewitz@sfdph.org>; Garcia, Barbara (DPH) <barbara.garcia@sfdph.org>; McSpadden, Shireen (HSA) <shireen.mcspadden@sfgov.org>; Carroll, John (BOS) <john.carroll@sfgov.org>
Subject: Overview of Long-Term Care and Post Acute Care Delivery In San Francisco; Teresa Palmer M.D. (attachment)

To:

1. Supervisors Hilary Ronen, Ahsha Safai, Norman Yee, Sandra Fewer, Jeff Sheehy, Mark Farrell, Jane Kim, Katy Tang, Aaron Peskin, Malia Cohen, London Breed

(Note-Mr. Carroll:
In anticipation of 11/29 and 12/7 Meetings of the Neighborhood and Public Services Safety Committee of the Board of Supervisors
FIle #s:1.170773. (11/29)
2. Please also file for December 7 meeting on Residential Care:
https://sfgov.legistar.com/LegislationDetail.aspx?ID=3093305&GUID=628500B9-45FB-4D6B-94EF-EAED965B792D&Options=&Search=

Title:	Hearing to consider the state of, and understand the efforts of City departments regarding, institutional housing, particularly assisted living, residential care facilities, and small beds for seniors in San Francisco; and requesting the Department of Aging and Adult Services, and Department of Public Health to report.
Sponsors:	Norman Yee, Aaron Peskin, Sandra Lee Fewer, Jeff Sheehy, Hillary Ronen, Ahsha Safai

2. San Francisco Health Commission members Care of Mr. Morowitz

3. Director of Public Health Barbara Garcia

4.DAAS Director Shireen McSpadden

From:
Teresa Palmer M.D.
teresapalmer2014@gmail.com. 415-260-8446

1845 Hayes St.
San Francisco 94117

As a geriatrician who has worked for 30 years in San Francisco, as the daughter of an elderly nursing home resident, and as an aging person who loves San Francisco, here is my best effort to summarize the issues around long term and post acute care that face us now in San Francisco, and as many solutions and ideas as I could come up with.

For those of you who need to know more about this, I hope this can serve as a primer. For all of you who want to find solutions, I hope this helps. I want to work with you.

Even with current Trumpian threats to health and other funding, we must plan for what we need or there is absolutely no hope in getting it.

None of us are getting younger.....let us grow old together in a City that can pride itself on being a good place for all of us.

I am the sole author of this, and any errors are mine.

Thanks a lot,
Teresa Palmer MD

No Room at the Inn:
Overview of Long-Term Care and Post-Acute Care Issues in San Francisco

November 20, 2017

Teresa Palmer, MD

Overview:

A civilized society cherishes and cares for all of its members. For the "Silver Tsunami" of baby boomers and their elders, a nationwide failure to cope is in process. Specific aspects of life in San Francisco, such as very high property costs, exacerbate our local failures. As residents of the City and County of San Francisco, we must find a way to care for seniors, disabled people, and others who most need care. The people of San Francisco do not wish to live in a walled fortress where all but the very well off are sent away, out of county.

1. The Numbers of Aging At-Risk and Underserved People Are Continuing to Increase While Services Are Not: Comprehensive Increases in Services Are Needed.

Predictable increases in aged, poor, sick, and homeless people are occurring in San Francisco, even as desperately needed services are shut down or remain too expensive for those in need. Given the increasing complexity of cognitive, medical, and psychiatric problems that occur with aging, especially aging in poverty, it is very crucial to have appropriate medical, psychiatric, and social supervision for those who cannot be completely independent.

Our acute hospitals are excellent at performing "medical rescue" for a single acute illness, but what then? The long-term and post-acute care continuum ranges from a few hours of help at home by family or caregivers, all the way to 24/7 skilled nursing and medical care for chronic, ventilator-dependent patients in a Skilled Nursing Facility (SNF) sub-acute unit.

The increasing need for long-term and post-acute care has a detailed list of causes:

a. Rapidly aging population, with low proximity of caregiving family nearby.

b. 50% of those over age 85 develop Alzheimer's or similar memory issues.

c. Inequity between the cost of housing (both for people and care facilities) and income. While especially true for the Medi-Cal-eligible population, care and placement may not be entirely affordable even for those who earn $100,000 annually. Residential Care or 24-hour care at home costs a minimum of $2,500 to $6,500 a month (even with a minimum wage of $14 to $15 an hour and some unpaid help from family members). Many people need more than the minimum amount of care.

d. Medi-Cal, which pays for chronic care at Skilled Nursing Facilities (SNF), does not pay for residential care outside of a SNF. Medicare pays only for temporary rehab. Major medical insurance, like Medicare, does not pay for long-term care, only temporary rehab, unless people purchase separate and extremely expensive long-term-care insurance.

   For the middle class, even Medi-Cal may not be available, due to the extremely strict limits on assets (less than $2,000 in savings). Due to its low reimbursement rate, most nursing homes limit the number of people on Medi-Cal that they admit, and ask for financial records to prove that a family can pay the monthly cost ($10,000 to $15,000 per month).

   Those whose sole source of income is social security disability, often less than $1,000 per month, cannot even pay for a single room occupancy (SRO) hotel (now at least $1,400 per month), let alone the costs of residential care (over $2,500 per month).

e. Emphasis on profit over breadth of service by insurance companies and non-profit private hospital corporations. This has resulted in a narrow focus on short-stay acute care in the hospital, and a subsequent severe shortage/shut-down of hospital-based SNF's, and sub-acute SNF beds, as well as acute psychiatric beds.

f. Public sector: Funding instability and cuts have worsened poor integration of the existing rich, but overburdened, array of public services in San Francisco. To save money, public SNF beds (Laguna Honda Hospital) have been cut. Many in the disability/independent living community supported this, as promises were made about using the savings to increase care at home. Now we have shortages in both home-based care and SNF beds for low- and moderate-income people.

g. Lack of accessibility to mental health services and treatment on demand for substance abuse has led to a chronically ill sub-population that is harder to treat and house. Advancing age, and age-related illness, add to the complexity.

h. Chronic brain disease/cognitive impairments such as Alzheimer's disease are not billable to insurance as a "psychiatric" diagnosis, even when the behavioral manifestations are extreme and require a level of care that is only available in an acute psychiatric unit. The only exception to this is for 72 hours, but only ***if*** the individual is considered an imminent threat or gravely disabled. However, discharge from the hospital without an effort to do highly individualized assessment and careful placement often leads to injury or death from falls, elopement, aggression to others, or self neglect.

Solution(s):

Everyone in the health care sector and public /nonprofit planning sector must do their share to provide needed services:

A. The Department of Public Health must exhibit leadership in planning for long-term and post-acute care needs of the sickest among us, and must be assertive with corporate providers of health care in the community.

B. Private-sector "non-profit" hospital corporations and health care foundations must prioritize the person in the community, and not prioritize the profit in it. In San Francisco, this clearly involves a commitment by ***all*** hospitals to fund hospital-based SNF units, sub-acute SNF units, and acute psychiatric beds in proportion to their acute care and community outpatient caseloads.

C. Land or space for Residential Care Facilities for the Elderly (RCFE's) and SNF's must be made available in every neighborhood. Seniors and others who most need care should be close to their families and their home neighborhood. Planning regulations must be changed to accomplish this.

D. A sufficient quantity of hospital-based sub-acute SNF beds must be opened. Currently, there are no sub-acute SNF units in San Francisco except for the remaining beds at CPMC–St. Luke's Hospital that will be shut down when the existing people in them leave or die. All others who need this care must leave the county.

E. Acute psychiatric beds must be re-opened, including gero-psychiatry. There is only one 12-bed acute gero-psychiatry unit in San Francisco at this time (at the Jewish Home SNF).

F. Local and state legislative solutions may include use of licensing authority; planning and building codes to reopen post-acute SNF and sub-acute SNF care units on hospital campuses; and to place chronic care sites in new buildings, available public spaces, and community centers.

G. Funding assistance for the housing costs of residential care providers must be found. Too many small providers have found that selling their property and leaving the business makes more sense than continuing.

H. The Board of Supervisors and our state representatives must work with the California Department of Public Health to assist in the existing, but underused, process to make waivers of Medicare and Medi-Cal dollars available for residential settings for those in need.

2. We Cannot Afford the Human or Ethical Cost of Funding One Type of Needed Care at the Expense of Another: All Are Needed.

Those proposals that pit funding for one aspect of the continuum of post-acute and long-term care against another are generally not person-centered, but are "industry-" or "profit-driven," with the ethically unacceptable goal of shifting responsibility for less profitable, more expensive services to someone else. To save money, especially for those who cannot pay, a lower level of care, inferior care, or care far out of town are offered instead. An example of this is CPMC Sutter's actions toward the patients at St. Luke Hospital's sub-acute SNF unit. Another example of this is displacement of long-term beds in nursing homes by more profitable (Medicare funded) short-stay rehab because hospitals have shut down their SNF rehab beds to make more profit from acute care.

Many studies that discuss the huge numbers of aging demented people now and in the future in San Francisco point out that "there will never be enough SNF beds for all of them." Then there is a discussion about why demented people should not go to SNF's (since they are "just demented," the logic goes, they will do fine in less medically skilled and expensive settings).

This is disingenuous, as dementia is a progressive disease that occurs in people who are aging and also getting more frail from other age-related conditions. As time goes on it takes more and more resources to maintain them at home (if they have one), and for many this becomes unsafe or impossible.

While it may be possible to delay the need to enter a nursing home by optimal support in the community, timely availability of an SNF bed is essential for the safety of those with advancing dementia.

We certainly need to get better at supporting the increasing number of people with these conditions (and their families) to live full and unrestricted lives outside of nursing homes as long as possible. But for many, a nursing home (SNF) will be the most humane placement toward the end of their journey.

Solution(s):

A. People need different kinds of help as they age. "Too little, too late" is often the story for low- and moderate-income people. People who have hard lives may need more help. People who get services and support in a timely fashion retain their ability to live outside a nursing home longer. We must increase funding for adequate and timely services for the full continuum of care for low- and moderate-income people as they age.

B. Funding of adequate home and community health services must be increased for both low- and moderate-income people, but not at the expense of adequate SNF beds.

3. Lack of Support for Seniors and Others Who Most Need Care Is a Part of the Larger Picture of Economic Displacement Now Occurring in San Francisco:

The egregious lack of care and placement options in San Francisco is very much a part of the larger issue of the displacement of all low- and moderate-income people in the City: If it is just not affordable to age in place, one must leave the county.

Levels of care that are needed for seniors and physically frail people:

a. **Help at Home:** For Medi-Cal eligible patients, "In Home Support Services" (IHSS) will provide up to 240 hours a month (8 hours a day) of assistance from an aide, who has limited training in performing personal care. IHSS caregivers make minimum wage, and many recipients "pad" the hourly wage (illegally) to keep a good worker. The system is chronically stressed, which results in persons in need getting awarded too few hours, and there is a chronic shortage of social workers to supervise the workers. Nurse visits are available for those meeting criteria.

   Medicare and major medical insurance will only pay for very temporary nursing help at home after an illness. Private agencies generally charge at least $25 an hour for help at home. This leaves many low- and moderate-income people either totally dependent on family and friends, or dependent on "off the books" arrangements.

b. **Other Funds/Services for Those at Home and in the Community:** In general these programs are to support a person at home, although some are available to those in residential care facilities. The purpose is to prevent the need for either SNF care or Sub-acute SNF care. In general these programs provide "waivers" to allow the use of Medicare and/or Medi-Cal dollars. They are usually available only to people who are very low income. Names of these programs include: **Medicare Shared Savings Program** and/or **Multipurpose Senior Services Waiver** (MSSP); **In-Home Operations Waiver** (IHO); **Home- and Community-Based Alternatives Waiver**; **Assisted Living Waiver**; **Community-Based Adult Day Services**, and others. Transition to the home may be accomplished, for a new disability, by providing time in a Skilled Nursing Facility to stabilize the person, get equipment into the home, and train paid and unpaid caregivers.

c. **Supportive Housing:** These are individual residences such as Single Room Occupancy Hotels (SROs) which have a social worker, or at least a trained front desk person, on site during normal working hours. Medical clinic personnel are either nearby or do home visits during normal working hours. These are usually publicly funded. These units are usually full, and have waiting lists (often with long waits). Waiting lists in many of these are so long they are no longer open to new people.

d. **Assisted Living:** This is a general term, and in the private sector generally means minimal daily help with personal care and medications. Extra help with specific services can be offered, usually for an increased monthly cost. Example: assistance with medication, dressing, or bathing. These are usually private facilities and purchase of additional services can be expensive. Staff are often undertrained.

e. **Residential Care Facilities for the Elderly (RCFE's):** These facilities are not covered by medical insurance, including Medi-Cal. A Medi-Cal waiver with use of funds to cover some of the care is possible, as discussed above. The intensity of help with medications and personal care is greater than that in assisted living, but there is little or no skilled medical help (licensed vocational nurses or registered nurses). Facilities having less than six beds have less-stringent licensure requirements than facilities that have more than six beds. All are considered "non-medical" facilities, although for limited hours every day staff trained to administer oral medication and check vital signs are present.

   A staff member must be present and awake at night, but the staffing ratios are low, especially after day shift, and on weekends and holidays. Residents are generally alone in their (often shared) rooms evenings and nights.

   RCFE care can be enhanced to handle specialized subpopulations (such as dementia patients needing "memory care," or end-of-life patients needing hospice services) by offering specialized staff training, increased staff-to-patient ratios, and increased presence of licensed nursing and medical staff. The cost to the patient is increased. Insurance funding of hospice services is available, but not for dementia services.

   In general, skilled or formal rehabilitation modalities, even supervised walking for exercise, are not offered at typical RCFE's, as there are no licensed, or even consistently responsible, staff present to supervise the patient in performing the exercises, or to even know whether exercises are being done.

f. **Skilled Nursing Facilities (SNF's):** Licensed nursing staff are present 24/7; and rehab, dietary, and activity therapists are available. A doctor must visit at least once a month and when patients are ill. Staffing ratios are higher and more skilled than RCFE's.

   Hospital-based SNF's tend to have the most skilled and most available rehab, nursing, and medical teams.

   To be eligible for a SNF, patients must need help with multiple Activities of Daily Living (ADLs), and must need attention from licensed nurses ("skilled care").

   Hospital-based SNF's (and community-based "freestanding" SNF's with post-hospital "rehab" beds) accept people who need active rehab five days a week, or have a medical condition that requires intravenous treatment and/or extra care by licensed nurses. Medicare pays for this "skilled rehab" after hospitalization for up to 100 days.

People who need supervision 24/7, who do not need rehab, and only need a few hours of skilled care daily are called "custodial" or "long-term care" patients.

In general, there is more profit from (Medicare-funded) short-stay Post-Hospital Rehab than in (Medi-Cal or cash funded) long-term, or "custodial" SNF care. So, as hospital-based SNF beds are shut down, more community-based SNF's do short-stay post-hospital "rehab" — resulting in long-term care beds in the community being lost.

"Aging in place" or "Home- and Community-Based Care" are popular terms to describe care at home, in a residential setting, or anything other than a SNF. This is, in theory, less expensive than SNF care, and is what most people say they want. However, the enhancements needed at home or in an RCFE to adequately care for a demented person who is behaviorally disturbed with worsening cognition, or for a frail elderly or disabled person with multi-organ disease, may cost more than an SNF placement.

g. **Sub-acute SNF Units:** Specialized SNF units where patients with very complex skilled medical and nursing needs can stay either temporarily until they improve, or long term if they do not. Complex open wounds, need for IV nutrition, or breathing support from ventilators through a tracheostomy are some of the qualifying conditions.

   Sub-acute SNF's located on a full-service hospital campus ("hospital-based" units) are best able to handle these complicated patients due to close proximity to all medical personnel and intensive care units (ICU's).

   Some sub-acute units aren't equipped to handle some types of patients, for instance those with tracheostomies who need frequent suctioning of secretions, as there aren't enough staff to do this. (Laguna Honda Hospital is an example of this: It has sub-acute SNF beds, but limitations are placed on accepting or keeping patients with tracheostomies.)

Solution(s):

A. City leaders must assertively advocate for changes in state and federal laws about post-acute and long-term care funding for low- and moderate-income people for all aspects of the continuum of care. Even in the face of federal threats to health care, we must advocate and plan for what we need.

B. As ("non-profit") private and public hospitals seek to give priority to their (most profitable) acute services, public leverage (land use agreements, building codes, mitigation payments, organized community pressure) must enforce the provision of proportional hospital-based post-acute and long-term care services. This is part of public and corporate responsibility to the communities these entities are supposed to be serving.

C. Patch funding, land use agreements, and property/business tax codes need to be modified to help bring in providers of residential care.

D. More funds from waiver programs and non-profit foundations need to underwrite the monthly cost of residential care for ***both*** low- and moderate-income people.

E. Consideration should be given to re-opening an Adult Day Health Care (ADHC) unit at Laguna Honda Hospital which was prematurely and inappropriately closed in approximately 2008 that had predominantly served people with dementias.

F. The euphemism "Regional Solutions" is used by the Hospital Council and Health Commission to describe discharging patients out of county, especially when the care — such as hospital-based SNF and sub-acute SNF care — cuts into revenue streams of large hospitals. Forcing people to leave the county for needed care is unacceptable. There must be enough of each type of care available in-county, in a timely fashion, to serve each individual whose healthcare needs increase. Beware of this euphemism.

   The PACC's *draft* final report recommended "creating a formal governance structure to oversee regional SNF patient placement practices and protocols" for those placed out-of-county for SNF and sub-acute care. The

PACC report also indicated San Franciscans "placed in regional SNF facilities should, however, be transferred back to a corresponding facility in San Francisco as space becomes available."

To facilitate return of San Franciscans as space becomes available, a formal "Certificate of Preference" system must be developed to give patients placed out of county preference for return to San Francisco-based facilities. Such a preference program should be prioritized for rapid development and implementation.

Importantly, since DAAS and DPH have jointly funded development of the *SF GetCare* database developed by RTZ Associates at a cost of millions of dollars, RTZ should be awarded a contract to enhance the *SF GetCare* database to track the Certificates of Preference, and each private-sector hospital in San Francisco should be given access to the database and be required to use it to track "regional" placements. DPH should be assigned as the lead agency to oversee governance of placement practices and protocols.

Consideration should be given to retroactively issuing "Certificates of Preference" to people previously discharged out-of-county from both our public hospitals, and private-sector hospitals, as an issue of equity.

4. Acute Hospitalization May Be an Opportunity to Reverse a Downward Spiral, and Superficial Care of Complex Patients Is a Missed Opportunity:

Not only does a narrow focus on short-stay acute care predispose to shorter hospital stays, the shut down of hospital-based SNF's and acute psychiatric units have led to a shortage of staff geriatricians and psychiatrists who are willing to consult on hospitalized patients.

Hospitalization is a seminal event in the life of a person, and premature discharge or discharge to an inappropriate setting can do more harm than good. In lay terms, if a person is discharged without totally understanding what went wrong and why it went wrong, a repeat hospitalization, death, or worsening illness is likely to ensue.

The transitional period between full acute hospitalization and return home or to another long-term location must be approached with a rich array of options. When needed, comprehensive assessment of the person, of their decision-making ability, and/or an array of specialty consultations takes time. For the elderly and chronically ill, healing takes time. A person's ability to recover function after an insult/hospitalization is not always immediately clear, especially when — as in the aged or mentally ill — pre-existing chronic illness and multiple organ systems are involved.

The need for emergent hospitalization is often a sign of needing more than one kind of help. If the need for acute hospitalization for treatment is brief, but a person is not at baseline or failing in their usual environment, the best way to do a full assessment and timely rehab is often to begin either during the acute stay or "in house" *immediately* upon discharge to the hospital-based SNF, the sub-acute SNF unit, or to an acute psychiatric unit.

The Hospital Council has recommended a "Roving Team" to compensate for shortages of comprehensive discharge planning, geriatric and psychiatric assessments, rehab and psychiatric care that the hospitals themselves have caused to preserve revenue. This proposed "Roving Team" would be staffed by public employees and would remove all responsibility from private-sector hospital's staff for discharge planning of "difficult" patients. In this scheme, frail cognitively-impaired patients are grouped with substance abusers and behaviorally-disturbed mentally ill people.

For those requiring it, a comprehensive assessment and consultation is not quickly available in the community ***after*** hospital discharge with some exceptions: A few geriatric clinics (which are generally full); some public mental health clinics (which are bursting at the seams); and PACE programs (Programs of All Inclusive Care for the Elderly), which have strict enrollment criteria.

In general, university and private (corporate, non-profit) health care providers avoid having overly large geriatric clinics, because Medicare limits the charges — and younger patients with major medical insurance brings in more revenue.

PACE can offer comprehensive assessments and wrap-around care immediately after hospital discharge. However, On Lok Lifeways here in San Francisco will, for the most complex patients, direct that a patient either spend additional days in the acute hospital or transfer to a hospital-based or rehab SNF until further stabilization. Also, On Lok Lifeways does not offer housing, does not enroll people who have active mental illness or substance abuse as a primary diagnosis, and only initially enrolls people who can live safely at home with the services the program provides.

Solution(s):

A. Many hospital-based SNF, sub-acute SNF, and acute psychiatric beds (especially gero-psychiatry) must be re-opened. Timely use of these services allows frail people at risk of long-term nursing home care to remain in the community longer. Long-term SNF beds in the community also must increase; however, some beds (now being used for short-stay post-hospital rehab in community SNFs) will become available when hospital-based SNF's re-open.

B. Barriers to expanding PACE Programs, dedicated geriatric clinics, adult day health center, mental health centers with geriatric capability and comprehensive post-discharge care capability, and other models of care which offer "wrap around" services after hospitalization (or ideally, prevent hospitalization) to seniors and others who need care must be explored for both low- and moderate-income people.

5. Immediate Short-Term Post-Acute Care Must Be Person-Centered and Meet the Needs of Complex and Frail People. Residential Settings Should Only Be Used for Post-Acute Care When the Needs of the Person Can Be Met, and Not as a General Practice to Save Money:

Post-acute transitional care settings (i.e., care immediately after acute hospital discharge) must fully meet the needs of complex sick and/or elderly patients. Precipitous discharge from the hospital without adequate assessment and stabilization is unfortunately a common story.

Recently, the Hospital Council of Northern California "Post-Acute Care Collaborative" (PACC) recommended use of (typically understaffed and underfunded ***non-medical)*** residential settings to get people out of acute hospitals. The Hospital Council's PACC made these recommendations in order to ***avoid*** re-opening hospital-based SNF beds in favor of maintaining acute hospital beds to maximize revenue, and ***not*** to institute best practice models of care. Furthermore, they selected a screening tool (LOCUS), which has been validated ***only*** for psychiatrically ill patients, in spite of the increasing population of demented people who need nuanced discharge planning. An alternative assessment tool should be identified, and used instead of the LOCUS tool.

Widespread use of short-stay residential beds as a "holding place" for newly discharged hospital patients is likely to take needed beds away from those who need long-term care in these facilities.

There is a grave risk that patients discharged from hospitals who need more than a residential setting to stabilize medically and psychiatrically will be warehoused at this lower level of care, either to get sicker and return to the acute hospital, or die.

Furthermore, disaster often results from mixing younger and vigorous people who have behavioral disturbances with frail demented people who have no sense of personal space.

Multiple studies have documented that post-acute hospital-based SNF care — with a rich interdisciplinary team, immediate rehab activities, and easy access to re-hospitalization — is the needed level of care for those with complex neurologic insults such as strokes, and for frail elderly with multisystem disease. This provides both the family and the patient the optimal care while assessing what will be needed for safety and quality of life once stability is achieved and longer-term discharge is possible.

The ethical implications of differentially discharging low-income sick people to understaffed and under-skilled residential care facilities are chilling.

Solution(s):

Although it may be "cost effective" on paper, using short-term residential placement as a general discharge plan for low-income people who get "stuck" in the acute hospital, or who do not wish to leave the county, may result in doing more harm than good. The most vociferous advocates of post-acute short-term residential placement are those who have profited by shutting down hospital-based SNF's, sub-acute SNF units, and acute psychiatric units, including gero-psychiatric units. We must beware of degrading or denying care to complex people who need more than a residential facility can provide.

6. Specialized Long-Term Residential Care Units Can Be a Boon to Dementia Patients, But Standards Must Be Strictly Maintained:

The need for specialized long-term residential settings for those who do not do well in a SNF environment, (specifically people with cognitive impairment/Alzheimer's with behavioral issues) is increasing as the population of San Francisco ages. "Memory Care" is the common term. Extra space, and ideally space outdoors to ambulate without getting lost, are ideal attributes of these settings.

Residential care can be set up for a "memory unit" by using visiting (or extra on-staff) licensed nurses, specially trained and supervised staff, and increased licensed staff on-site at all hours. Hospice care, permitted by hospice waivers in residential facilities, will bring in additional staff that can be used to allow a comfortable death in a person's familiar environment.

Again, this type of care approaches traditional SNF care in its cost and complexity, and is best suited for those people who do not do well in a SNF, and who are not medically complex (or at a minimum, whose medical conditions are under good control). Criteria for admission should include current physical stability while staff grows to understand each person's needs.

The Irene Swindells Alzheimer's Residential Care Program on the California Campus of CPMC/Sutter is an outstanding example of this type of unit, and derives benefit also from its hospital campus location and proximity to the full range of hospital services. However, Medi-Cal and other medical insurance does not pay the high monthly cost of this care — at minimum, $6,500 monthly — and some families are dependent on a non-profit foundation to assist with the monthly cost.

CPMC–Sutter has announced the planned closure of its Swindells facility in 2018 to make room for condominiums. New admissions to Swindells have been stopped, despite the demand. Sadly, many other residential care facilities in San Francisco that charge extra for "memory care" do not have this rich, well-trained array of staff, along with safe space for people to walk around outside.

Solution(s):

A. CPMC/Sutter must not shut down its Swindells Alzheimer's Residential Care Program, which is a model facility.

B. Funding for state-of-the-art residential facilities that specialize in "memory care" for those who cannot pay must be made available in the form of non-profit foundation help, waivers for the monthly cost, and public and private donation of space.

7. Assistance to Home Care Entrepreneurs to Increase Long Term Residential Placements Is Needed:

Small-bed home care (e.g., "board-and-care") facilities are no longer a realistic business opportunity for San Francisco families, although an entrepreneurial, dedicated family is often able to offer the best and most personal care. The cost of housing and required renovations, and the cost of maintaining adequately-trained staff, is prohibitive when compared to the income of those that need the care most: Elderly and disabled moderate- and low-income people.

Multiple smaller residential care facilities have shut down in recent years, as the cost of doing business and following the many regulations outweighed the high value of residential property in San Francisco. So, properties were sold.

However, given the frailty and vulnerability seen in typical RCFE's, the need for strict regulations and monitoring — including comprehensive and regular staff training — is unquestionable. There is limited or no access to licensed staff (registered nurses and licensed vocational nurses) to do skilled medical assessments of patients who appear ill or who are exhibiting new behavioral symptoms. Thus, the possibility of neglect, victimization, or abuse is huge without adequate staff training and oversight.

Solution(s):

New programs of funding and support that could relieve the financial burdens of offering care in a home-like setting are needed. Standards of monitoring and staff training must be maintained. The "Silver Tsunami" of baby boomers with Alzheimer's Disease would ideally be served in home-like residential facilities near their families everywhere in the city.

***Possibilities*:**

A. Use of "below market rate" space in new buildings and grants to build out unused space in neighborhood and community centers;

B. "Tuition" stipends via increased funding for waivers and non-profit foundations.

C. Adjustment of land use regulations and property taxes to incentivize opening of home care businesses.

Selected References:

1. "*Addressing San Francisco's Vulnerable Post-Acute Care Patients: Analysis and Recommendations of the San Francisco Post Acute Care Collaborative*," final draft for December 2017; Hospital Council of Northern and Central California.

2. "*20/20 Foresight: San Francisco's Strategy for Excellence in Dementia Care*" (parts one and two), by Alzheimer's/Dementia Expert Panel for the Department of Aging and Adult Services, December 2009.

Carroll, John (BOS)

From: Carroll, John (BOS)
Sent: Thursday, September 21, 2017 12:34 PM
To: 'patientsarefirst@gmail.com'
Cc: Board of Supervisors, (BOS)
Subject: RE: Family Council Update for St. Luke's Hospital Sub-acute Facility

Categories: 170773

Thank you for your message. It is added to the official file for this matter.

I invite you to review the entire matter on our Legislative Research Center by following the link below:

Board of Supervisors File No. 170773

John Carroll
Assistant Clerk
Board of Supervisors
San Francisco City Hall, Room 244
San Francisco, CA 94102
(415)554-4445 - Direct | (415)554-5163 - Fax
john.carroll@sfgov.org | bos.legislation@sfgov.org

Click here to complete a Board of Supervisors Customer Service Satisfaction form.

The Legislative Research Center provides 24-hour access to Board of Supervisors legislation and archived matters since August 1998.

From: Board of Supervisors, (BOS)
Sent: Wednesday, September 20, 2017 9:01 AM
To: BOS-Supervisors <bos-supervisors@sfgov.org>; Carroll, John (BOS) <john.carroll@sfgov.org>
Subject: FW: Family Council Update for St. Luke's Hospital Sub-acute Facility

From: Patients Are First [mailto:patientsarefirst@gmail.com]
Sent: Wednesday, September 20, 2017 12:23 AM
To: Breed, London (BOS) <london.breed@sfgov.org>; Cohen, Malia (BOS) <malia.cohen@sfgov.org>; Farrell, Mark (BOS) <mark.farrell@sfgov.org>; Fewer, Sandra (BOS) <sandra.fewer@sfgov.org>; Kim, Jane (BOS) <jane.kim@sfgov.org>; Peskin, Aaron (BOS) <aaron.peskin@sfgov.org>; Ronen, Hillary <hillary.ronen@sfgov.org>; Safai, Ahsha (BOS) <ahsha.safai@sfgov.org>; Sheehy, Jeff (BOS) <jeff.sheehy@sfgov.org>; Tang, Katy (BOS) <katy.tang@sfgov.org>; Yee, Norman (BOS) <norman.yee@sfgov.org>; Board of Supervisors, (BOS) <board.of.supervisors@sfgov.org>
Cc: Sandoval, Suhagey (BOS) <suhagey.sandoval@sfgov.org>; Goossen, Carolyn (BOS) <carolyn.goossen@sfgov.org>;

Macksood, James <MacksoJ@sutterhealth.org>; Bumatay, Susan <BumataS@sutterhealth.org>; orda@sutterhealth.org; andersjx@sutterhealth.org
Subject: Family Council Update for St. Luke's Hospital Sub-acute Facility

Dear Supervisors,

Attached is a letter providing an update of our recent meeting with the CPMC Subacute Care Team along with requests from family members to CPMC.

Respectfully submitted,

Raquel Rivera
Family Council Coordinator
St. Luke's Hospital Sub-Acute Facility

FAMILY COUNCIL
St. Luke's Sub-Acute & Skilled Nursing Facility

September 19, 2017

Via Email

President and Supervisor London Breed
Supervisor Ahsha Safai
Supervisor Hillary Ronnen
Supervisor Sandra Lee Fewer
Supervisor Jeff Sheehy
Supervisor Norman Yee
Supervisor Malia Cohen
Supervisor Mark Farrell
Supervisor Jane Kim
Supervisor Aaron Peskin
Supervisor Katy Tang

RE: St. Luke's Family Council Update

Dear Supervisors:

There was another day of havoc at St. Luke's Hospital. The CPMC Subacute Care Team conducted a meeting for the patients and their family members on Wednesday, September 13, 2017. The care team consisted of Jim Macksood, Susan Bumatay, Austin Ord, Joshua Anderson, Liz Cong, and Emie Maninang.

Raquel Rivera, the Family Council Coordinator, contacted Jim Macksood on Monday, September 11, 2017 to have the hospital meeting changed from 4:00 pm to 6:30 pm as the later time was more suitable for family members who work. Mr. Macksood confirmed with Raquel on Tuesday, September 12, 2017 via text that the time changed to 6:30 pm.

Tony Rivera, the Family Council Co-Coordinator, arrived at the hospital at approximately 5:30 pm and noticed that some family members were leaving. He was told by the leaving family members that the meeting was over, and that it started at 4:00 pm. Tony also spoke with the Ombudsman, Benson Nadell, who was on his way out of the hospital. Mr. Nadell stated that Liz Cong called that day and said the meeting was at 5:00 pm. However, there was no scheduled meeting for 5:00 pm. Mr. Nadell was upset that he was not present for the meeting. The Family Council Coordinators were not in attendance as well. Family members who arrived at 4:00 pm were upset that the Family Council Coordinators were not in attendance and were confused by this ordeal. This has

left a bad taste with the family members as this confusion caused by the care team disrupted the Family Council. Gloria and Tony, who are the Family Council Co-Coordinators, approached Mr. Macksood to find out why Ms. Cong told the Ombudsman's office that the meeting was at 5:00 pm. Mr. Macksood denied it. Mr. Macksood approached Ms. Cong while the meeting was in session and whispered something in her ear which was witnessed by multiple people in the meeting. Ms. Cong stood up and left the meeting and did not return.

In addition, CPMC had a sign-in sheet indicating the meeting time at 6:30 pm. The family members who arrived at 4 pm and 5 pm signed the 6:30 pm sign-in sheet.

The Family Council sent an email that "The families request that CEO Warren Browner be present for the meeting tonight at 6:30 pm" which was scheduled by CPMC. Mr. Macksood replied that "Dr. Browner won't be able to attend the meeting tonight."

CPMC did not work with the Family Council to coordinate this meeting. CPMC continues to cause confusion, frustration and anxiety to the families.

Questions and Concerns by Family Members and CPMC's Responses

Family members addressed concerns regarding understaffing in the subacute unit and an explanation as to why the level of care has gone down. CPMC responded that they are working with human resources, community relations and union representatives to assure staffing ratios and quality and competency of staff are being provided and that they have a safe level of staffing based on regulations. They indicated that no new staff or floating nurses are in the unit right now and report staff to CMS regularly to meet the mandated ratio of care based on the census that they have. They further stated that they will look into staffing and get back to families. **Family members have repeatedly expressed this issue at several hearings and at the last meeting with CEO Dr. Warren Browner and have yet to receive an adequate response or action.**

Families expressed fear that they will have to experience another potential transfer/discharge issue in June of 2018. Families requested a letter clarifying that patients will remain at one of the CPMC hospital-based facilities for as long as they need care regardless of the June 30, 2018 date. **Family members expressed this issue at the last Board of Supervisors hearing and again at the recent meeting with the CPMC Subacute Care Team and have yet to receive a revised letter.**

The families questioned the purpose of these meetings. CPMC responded that they would like to meet with the families to listen to their concerns and take down any questions they may have. As they get closer to everything, they would like to meet

regularly and keep families informed, get their opinions and thoughts, and make it convenient for them to communicate. As stated in the attached letter by CPMC: "During the discussions it was agreed that to be respectful of everyone's time, we will schedule meetings when there is substantive information to share." **These meetings are not eventful for the families if they will not provide adequate responses other than repeating what has been said at the hearings and prior meeting.**

The families requested that all patients at St. Luke's subacute unit be kept together as they have been a community and are a family to one another. If, at all possible, they would prefer to stay at St. Luke's Hospital and then transferred to the Mission Bernal campus, conveniently located next to St. Luke's Hospital. CPMC responded that all patients will be kept together. They still have a lot of planning to do with the Department of Public Health (DPH). CPMC stated they are open to listen to input as the process moves along. CPMC and DPH still have to find out which of the **four (4)** CPMC campuses they will be able to move patients to and intend to keep families informed every step of the way. **It has been stated by CEO Dr. Browner that one of the CPMC campuses, Pacific Campus, will be closed. Why are the CPMC Subacute Care Team referring to four campuses when it should be three? These inaccurate statements cause confusion and frustration with the families.**

The family members expressed that we are all a family and are willing to speak about general common concerns together as a group. We agree that all confidential patient matters such as individual patient medical records, etc., should be kept confidential and communicated to specific family members only. However, it was made clear that as far as scheduling future meetings with the family council, one person as point of contact will be designated and that person will report to the group through an email set up for the family council. **The Family council will provide one contact person to CPMC and meeting date and time convenient for the families. Families expressed that they have lost faith and trust in CPMC and asked that they understand how stressful this situation has been to them and their families.**

FAMILY COUNCIL REQUESTS

The Family Council submits the following requests:

- Clarification in writing that the subacute patients residing at St. Luke's Hospital will be staying at one of CPMC's three permanent hospital-based campuses for as long as they need care, regardless of the June 30, 2018 target date within which CPMC needs to comply for their license and other requirements;
- That the sub-acute patients remain together in the same unit now and during the transfer to the new facility;

- Adequate level of staffing and care to meet the patients' needs on a daily basis, including evenings and weekends;
- Patients that were involuntarily transferred due to the closure announcement be returned to St. Luke's Hospital immediately;
- Consideration for the sub-acute patients to be permanently transferred to the Mission Bernal hospital campus because of its rather close proximity to the current facility minimizing transfer trauma and anxiety, and its central location with easily accessible public transportation routes currently used by family members who have their routines in place;
- Certified translators not associated with CPMC for future family council meetings (a family member complained of an interpreter contracted by CPMC who took notes and did not translate the Family Council meeting that was in progress);
- CPMC to work cohesively with the Family Council to organize future meetings;
- The sub-acute unit should remain open to new patients. This will provide that an adequate level of staffing is maintained for continuous care of the patients that are in the unit and address this dire need in the County of San Francisco.

The family members respectfully submit this update for your review and consideration.

Sincerely,

Raquel Rivera
Family Council Coordinator
(415) 273-9883
patientsarefirst@gmail.com

cc: Jim Macksood
Susan Bumatay
Josh Anderson
Austin Ord

Carroll, John (BOS)

From:	Board of Supervisors, (BOS)
Sent:	Tuesday, September 12, 2017 6:26 PM
To:	BOS-Supervisors; Carroll, John (BOS)
Subject:	FW: Petitions and Communications Submission — : CORRECTION TO TESTIMONY — Please Don't Be Bamboozeled by CMPC's Claim It Will Keep Its Sub-Acute and SNF Units at St.Luke's or Elsewhere Open : Public Testimony
Attachments:	Testimony to Full Board of Supes on St Luke's SNF 17-09-11.pdf
Categories:	170773

From: Patrick Monette-Shaw [mailto:pmonette-shaw@earthlink.net]
Sent: Tuesday, September 12, 2017 2:42 PM
To: Board of Supervisors, (BOS) <board.of.supervisors@sfgov.org>
Subject: Petitions and Communications Submission — : CORRECTION TO TESTIMONY — Please Don't Be Bamboozeled by CMPC's Claim It Will Keep Its Sub-Acute and SNF Units at St.Luke's or Elsewhere Open : Public Testimony

Please post both this cover e-mail and the attached PDF file to the next Petitions and Communications section on the Board of Supervisors upcoming agenda.

Thanks,
Patrick Monette-Shaw

-------- Forwarded Message --------
Subject: CORRECTION TO TESTIMONY — Please Don't Be Bamboozeled by CMPC's Claim It Will Keep Its Sub-Acute and SNF Units at St.Luke's or Elsewhere Open : Public Testimony
Date: Tue, 12 Sep 2017 12:14:38 -0700
From: Patrick Monette-Shaw <pmonette-shaw@earthlink.net>
To: Sandra.Fewer@sfgov.org, Mark.Farrell@sfgov.org, Aaron.Peskin@sfgov.org, Katy.Tang@sfgov.org, London.Breed@sfgov.org, Jane.Kim@sfgov.org, Norman.Yee@sfgov.org, jeff.sheehy@sfgov.org, Hillary.Ronen@sfgov.org, Malia.Cohen@sfgov.org, Ahsha.Safai@sfgov.org
CC: angela.calvillo@sfgov.org, carolyn.goossen@sfgov.org, sheila.chung.hagen@sfgov.org, lee.hepner@sfgov.org, Suhagey.Sandoval@sfgov.org

When I e-mailed this yesterday, the illustration on page 1 showing the LTCCC's June 3, 2009 draft Resolution was mangled in conversion to PDF. A corrected PDF file is attached.

September 11, 2017

Board of Supervisors:
The Honorable Sandra Lee Fewer, Supervisor District 1
The Honorable Mark Farrell, Supervisor District 2
The Honorable Aaron Peskin, Supervisor District 3
The Honorable Katy Tang, Supervisor District 4
The Honorable London Breed, Supervisor District 5
The Honorable Jane Kim, Supervisor District 6
The Honorable Norman Yee, Supervisor District 7
The Honorable Jeff Sheehy, Supervisor District 8
The Honorable Hillary Ronen, Supervisor District 9
The Honorable Malia Cohen, Supervisor District 10
The Honorable Ahsha Safaí, Supervisor, District 11

Please don't be bamboozeled by CMPC's claim today it will keep its sub-acute and SNF units at St.Luke's or elsewhere open beyond June 30, 2018.

My attached testimony explains this in short detail. Please read it.

Patrick Monette-Shaw

Patrick Monette-Shaw

975 Sutter Street, Apt. 6
San Francisco, CA 94109
Phone: (415) 292-6969 • e-mail: pmonette-shaw@eartlink.net

September 11, 2017

San Francisco Board of Supervisors
The Honorable Sandra Lee Fewer, Supervisor District 1
The Honorable Mark Farrell, Supervisor District 2
The Honorable Aaron Peskin, Supervisor District 3
The Honorable Katy Tang, Supervisor District 4
The Honorable London Breed, Supervisor District 5
The Honorable Jane Kim, Supervisor District 6
The Honorable Norman Yee, Supervisor District 7
The Honorable Jeff Sheehy, Supervisor District 8
The Honorable Hillary Ronen, Supervisor District 9
The Honorable Malia Cohen, Supervisor District 10
The Honorable Ahsha Safaí, Supervisor, District 11
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

"Benson Nadell, the Long-Term Care Ombudsman for San Francisco, presented terrific testimony on September 5 to the Health Commission on the Sub-Acute and SNF units closure at St. Luke's, noting that the Mayor's Long-Term Care Coordinating Council has been 'confused,' 'enthralled,' and 'under the spell' of various policy initiatives, which has indirectly led to the consequence that CPMC's business plans are driving closure of St. Luke's SNF."

Re: **Committee of the Whole Hearing on St. Luke's Hospital Sub-Acute and SNF Unit Closure**

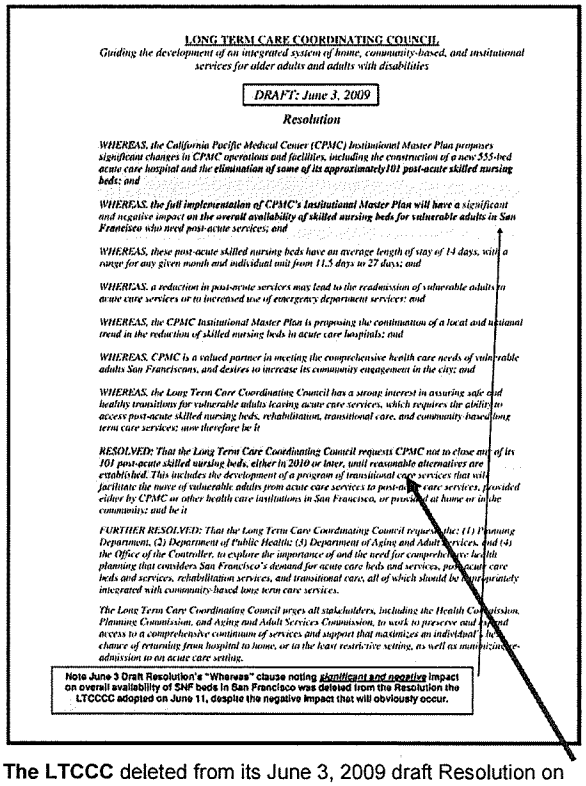
Dear Board of Supervisors,

At least 605[1] patients have been discharged out-of-county from just San Francisco's two public hospitals (LHH and SFGH) alone since July 1, 2006, and the number of additional patients discharged out-of-county from private-sector hospitals has not been reported.

Clearly there is a crisis with an inadequate amount of skilled nursing beds and healthcare planning dating back to at least 2004, 13 years ago, and much of that crisis has been the result of the Mayor's Long-Term Care Coordinating Council (LTCCC) that then-Mayor Gavin Newsom established in November 2004!

All along, the LTCCC was charged with guiding development of an integrated system, including institutional-based services. And also all along, the LTCCC's sheer hatred of skilled nursing facilities (SNF) has interfered with its duties to guide development of SNF settings.

As the illustration to the right shows, the LTCCC deleted the first two WHEREAS findings from its draft June 2009 resolution in the final resolution adopted on June 11, 2009 regarding CPMC's institutional master plan, noting that closing CPMC's post-acute SNF beds would have a significant and negative impact on SNF bed availability for vulnerable San Franciscans who need post-acute care services.



LONG TERM CARE COORDINATING COUNCIL
Guiding the development of an integrated system of home, community-based, and institutional services for older adults and adults with disabilities

DRAFT: June 3, 2009

Resolution

WHEREAS, the California Pacific Medical Center (CPMC) Institutional Master Plan proposes significant changes in CPMC operations and facilities, including the construction of a new 555-bed acute care hospital and the elimination of some of its approximately101 post-acute skilled nursing beds; and

WHEREAS, the full implementation of CPMC's Institutional Master Plan will have a significant and negative impact on the overall availability of skilled nursing beds for vulnerable adults in San Francisco who need post-acute services; and

WHEREAS, these post-acute skilled nursing beds have an average length of stay of 14 days, with a range for any given month and individual unit from 11.5 days to 27 days; and

WHEREAS, a reduction in post-acute services may lead to the readmission of vulnerable adults to acute care services or to increased use of emergency department services; and

WHEREAS, the CPMC Institutional Master Plan is proposing the continuation of a local and national trend in the reduction of skilled nursing beds in acute care hospitals; and

WHEREAS, CPMC is a valued partner in meeting the comprehensive health care needs of vulnerable adults San Franciscans, and desires to increase its community engagement in the city; and

WHEREAS, the Long Term Care Coordinating Council has a strong interest in assuring safe and healthy transitions for vulnerable adults leaving acute care services, which requires the ability to access post-acute skilled nursing beds, rehabilitation, transitional care, and community-based long term care services; now therefore be it

RESOLVED: That the Long Term Care Coordinating Council requests CPMC not to close any of its 101 post-acute skilled nursing beds, either in 2010 or later, until reasonable alternatives are established. This includes the development of a program of transitional care services that will facilitate the move of vulnerable adults from acute care services to post-acute care services, provided either by CPMC or other health care institutions in San Francisco, or provided at home or in the community; and be it

FURTHER RESOLVED: That the Long Term Care Coordinating Council requests the: (1) Planning Department, (2) Department of Public Health; (3) Department of Aging and Adult Services, and (4) the Office of the Controller, to explore the importance of and the need for comprehensive health planning that considers San Francisco's demand for acute care beds and services, post-acute care beds and services, rehabilitation services, and transitional care, all of which should be appropriately integrated with community-based long term care services.

The Long Term Care Coordinating Council urges all stakeholders, including the Health Commission, Planning Commission, and Aging and Adult Services Commission, to work to preserve and expand access to a comprehensive continuum of services and support that maximizes an individual's best chance of returning from hospital to home, or to the least restrictive setting, as well as minimizes re-admission to an acute care setting.

Note June 3 Draft Resolution's "Whereas" clause noting *significant and negative* impact on overall availability of SNF beds in San Francisco was deleted from the Resolution the LTCCCC adopted on June 11, despite the negative impact that will obviously occur.

The LTCCC deleted from its June 3, 2009 draft Resolution on CPMC the first two WHEREAS findings from the final Resolution adopted on June 11, 2009, but retained a RESOLVED clause that requested CPMC ***not close*** any of its post-acute SNF beds until reasonable alternatives were established.

Benson Nadell's Astute Testimony

Benson Nadell, the Long-Term Care Ombudsman for San Francisco, presented terrific testimony on September 5 to the Health Commission on the Sub-Acute and SNF units closure at St. Luke's, noting that the Mayor's Long-Term Care Coordinating Council has been "confused," enthralled," and "under the spell" of various policy initiatives, which has indirectly led to the consequence that CPMC's business plans are driving closure of St. Luke's SNF and sub-acute units.

Nadell implies the focus by the Department of Public Health and the PACC on post-acute care has confounded issues, noting "***post-acute care isn't long-term care, or focused on chronic disease management***," particularly for the many patients having complex medical conditions.

"Nadell implies that the focus by the Department of Public Health and the PACC have confounded issues, noting 'post-acute care is not long-term care, or focused on chronic disease management for patients having complex medical conditions.'"

Nadell stopped short of indicating it was San Francisco's Health Commission itself that recommended in the Prop. Q Resolution it adopted on May 19, 2015 in response to the closure of St. Mary's 32-bed SNF unit, that a Post-Acute Care Project work group be formed to research skilled nursing and post-acute care services, and to identify ***gaps*** in post-acute care services. It was the Health Commission itself that has confounded issues. The Health Commission must know that "post-acute care" is NOT the same thing as "long-term care"! ***The "gaps" have worsened since.***

"Nadell stopped short of indicating it was the Health Commission itself that has confounded issues. The Commission must know that 'post-acute care' is NOT the same thing as 'long-term care'!"

Of interest, the LTCCC's 2009 Resolution FURTHER RESOLVED for the need for citywide health planning to consider San Francisco's demand for acute care beds and services, ***alternatives*** for acute care beds (when you need acute care, what alternative could there possibly be for hospital-based acute services?), post-acute care beds and services, rehabilitation services, and transitional care, but the resolution pointedly excluded calling for citywide planning to consider demand for SNF-care beds!

"The LTCCC's 2009 Resolution pointedly excluded calling for citywide planning to consider demand for SNF-care beds!"

Duplication of Planning Efforts

Although the LTCCC was charged with identifying the number of people who could potentially be served in the community with adequate services and supports when it was formed in 2004, the LTCCC has essentially failed to do so. Then in May 2015, the Health Commission passed Resolution # 15-8 regarding the closure of St. Mary's SNF unit that included a Resolved statement directing DPH to "to research the needs for short-term SNF and post-acute care services in San Francisco, and submit a report with recommendations back to the Health Commission within six months," which led to the February 2016 report "*Framing San Francisco's Post-Acute Care Challenge*." That February 2016 report further blurred the distinction that post-acute care is ***not*** the same thing as long-term care!

DPH's Office of Policy and Planning reported as late as August 15, 2017 that San Francisco needs to increase it's supply of skilled nursing beds by 1,644 — to 4,083 — by the year 2030, just 13 years from now. The Board of Supervisors must act now to prevent this shortage of SNF facilities. Eliminating St. Luke's skilled nursing and sub-acute beds in June 2018 will not help — it will exacerbate — this situation.

For over a dozen years, the LTCCC, DPH and the Department of Aging and Adult Services have been speechifying and study-izing the needs for sub-acute, SNF, and post-acute care, and nothing appears to have been done — because no additional other post-acute care alternatives have been brought on-line in San Francisco.

"DPH's Office of Policy and Planning reported as late as August 15, 2017 that San Francisco needs to increase it's supply of skilled nursing beds by 1,644 — to 4,083 — by the year 2030, just 13 years from now. The Board of Supervisors must act now to prevent this critical shortage!"

Resolution #15-8 contained a WHEREAS finding that San Francisco's Health Care Services Master Plan indicates there will be an increased need for SNF beds in the future, as DPH has warned the Health Commission about for years and years. That Resolution also stated:

> "***RESOLVED***, *The closure of short-term SNF beds without ensuring an appropriate level of post-acute care services available may result in short-term skilled nursing needs of the community not being met.*"

Here we are, with both long- and short-term skilled nursing needs obviously not being met, and which will be exacerbated if the St. Luke's sub-acute and SNF units are closed. Although St. Luke's closure appears to have been postponed from October 31 to December 31, 2017 — and again postponed today until June 30, 2018 — San Francisco will eventually be left without any sub-acute beds in a hospital-based facility with ready access to an ICU.

Now 14 months after the Budget and Legislative Analyst issued its audit report "*Performance Audit of Senior Services in San Francisco*" on July 13, 2016, no gap analysis — including a gap analysis similar to the one Rapid City, SD performed to assess expressed preferences for assisted living and skilled nursing facility level of care — has been performed, completed, or submitted to the Board of Supervisors.

"Although St. Luke's closure appears to have been postponed to June 30, 2018 — San Francisco will eventually be left without any sub-acute beds in a hospital-based facility with ready access to an in-house ICU!"

Actions for the Full Board of Supervisors

I respectfully request that the Board of Supervisors consider these additional legislative actions, along with others it may be considering:

1. The full Board of Supervisors direct its Public Safety and Neighborhood Services subcommittee to continue holding quarterly hearings on the provision of sub-acute and SNF services in-county, in part to develop solutions to solve the growing crisis of an insufficient capacity of SNF beds that are ***not*** meeting community needs.
2. The Board of Supervisors issue a Resolution that while the imminent closure of St. Luke's sub-acute and SNF units precipitated this hearing, the provision of sub-acute care and SNF services for future generations of San Franciscans is also at grave risk and of great on-going concern, and must be addressed now.
3. Direct the Department of Public Health to require that all private-sector, non-profit hospitals in San Francisco provide the total number of out-of-county discharges made by each hospital since July 1, 2006 to ascertain the severity of out-of-county discharges that have occurred over the past 11 years. Without a full accounting of the mounts of out-of-county discharges, there's an absence of historical perspective on the critical lack of what in-county SNF capacity is.
4. Direct the Department of Public Health ascertain from each public- and private-sector hospital the number of hospital re-admissions since July 2006 that may have involved premature discharges following initial hospital admission and discharge.
5. Direct the Department of Aging and Adult Services, Human Service Department, and the Department of Public Health expedite by January 1, 2018 performing a "gap analysis" of unmet needs in response to the Board of Supervisors Budget and Legislative Analyst's audit report "*Performance Audit of Senior Services in San Francisco*," dated July 13, 2016, including a gap analysis similar to the one Rapid City, SD performed to assess expressed preference of assisted living and skilled nursing facility level of care.
6. Request that the Hospital Council of Northern and Central California update its now 40-year-old report, "San Francisco Nursing Facility Bed Study that has not been updated since it was published in May 1977, or in the alternative, direct DPH's Office of Policy and Planning research department to conduct such an analysis using the same methodology used in 1977.
7. The Board of Supervisors should consider legislation and a potential charter change to be put before voters to require that the new Dignity Fund funded by the General Fund be amended to permit use of Dignity Fund expenditures for hospital-based medical, sub-acute care, and skilled nursing care services; or in the alternative, the Board of Supervisors should consider placing a new Bond measure before voters to develop additional skilled nursing facility and sub-acute facility capacity in the City with a component to augment Bond funding with funding from private-sector, non-profit hospital-based facilities.
8. The Board of Supervisors should consider legislation requiring that meetings of the Post-Acute Care Collaborative, and any successive planning and advisory bodies concerning development of post-acute care and SNF facilities publicly notice their meeting agenda's 72-hours in advance of meetings, comply with the Sunshine Ordinance and Brown Act, and make their meetings open to the public.
9. The Board of Supervisors consider legislation requiring that the Board of Supervisors Public Safety and Neighborhood Services subcommittee (or any successive subcommittee overseeing healthcare policy issues for the Board of Supervisors) be added to the joint Health Commission and Planning Commission deliberations of the City's *Health Care Services Master Plan* working group as policies and recommendations are being developed prior to submission to the full Board of Supervisors.

"Now 14 months after the Budget and Legislative Analyst issued its audit report of senior services, no gap analysis has been performed, completed, or submitted to the Board of Supervisors!"

"The full Board of Supervisors should direct its Public Safety and Neighborhood Services subcommittee to continue holding quarterly hearings on the provision of sub-acute and SNF services in-county!"

CPMC's just-announced extension to ***not*** evict St. Luke's patients until June 2018 gives patients, their families, and the Board of Supervisors some breathing room, but that will quickly evaporate over the next nine months.

Respectfully submitted,

Patrick Monette-Shaw
Columnist, Westside Observer Newspaper

cc: Angela Calvillo, Clerk of the Board

[1] **Source:** Department of Public Health updated response to records request received on 9/11/17, the anniversary of 9/11.

RECEIVED IN BOARD 9.12.17

My name is Gary Birnbaum. I have been a physician and a part of the St. Luke's subacute team since 1996, and since 2008, I have been the medical director.

The plan to close the SNF/Subacute unit is not new. 12 years ago when CPMC took over St. Luke's, the rationale was that the subacute unit was losing money. Bryant Godedell, the temporary CEO of St. Luke's at the time, clarified. The unit actually contributed $2million over direct costs, however, when loaded with indirect costs, CPMC was able to show a loss for the unit. Sutter's indirect cost allocations only exacerbated the "issue". Ironic that the profits of the unit became the focus of a not-for-profit hospital.

Two things make the St. Luke's subacute unit unique to any other:

1. The physicians, the nurses and the staff on the floor. The subacute physicians are personal physicians who accept responsibility from admission to discharge. The RNs, LVNs and CNAs work on the subacute unit because they want to. They are my eyes and ears 24/7. Many have worked in the unit more years than I have. There is a difference in care when patients are cared for by physicians ~~who know them~~. RNs, LVN CNA
2. The unit is hospital based. Many patients come from either neurosurgery or stroke neurology or the ICU with multi-system disease. Most are on ventilators with tube feeding. We have developed a working relationship with hospitalists and the attending intensivists pulmonologists. A complex subacute patient is seen by the same cardiology group, the same neurosurgeons, the same infectious disease doctors with ready consultation from stroke neurology. These are the same doctors that saw them in the ICU from whichever campus they were first admitted. Many patients have moved from the ICU to the subacute unit and back to ICU. All this occurred almost seamlessly and the ability for rapid response team in conjunction with the hospitalists who know these patients, had the patients back in the ICU within minutes.

I have with me here today, Jocelyn Won who came to the subacute unit after a severe thyroid storm leaving her on a ventilator. With liver failure and renal

If any questions please

failure, she required several rapid trips back to the ICU. I can say with 100% certainty that had she not been in the hospital based unit, and not just any hospital based unit, but our unit, she would not be here today. I am honored to be part of the team that saved her life. Subsequently, she was able to do something I think every person in this room would have wanted to do. She joined a group of 50 Americans of Asian descent to walk with then President Obama across that bridge in Selma. It reminds us all of what one should do when basic human rights are being restricted. It is sad that there are people here today who need to be reminded that healthcare, and I mean excellent healthcare, is a right and not a privilege.

Then there is the case of Donella Komisar. She was the last true outside of CPMC patient admitted from UCSF at the end of 2011. She came to us with Amsan, an uncommon neuro-degenerative disease similar to Guillume Burret, on a ventilator with total parenteral nutrition, completely paralyzed and not nearly as stable as she had been billed by the intensivists at UCSF. One day her GI tract dialated up and came close to almost exploding. Today she is an artist, a gardener, the matriarch of her family and a fantastic cook. She is a woman of Native American descent who just so happens to make the best matzah ball soup.

The case of Mr. Phillips who occupied the same room shortly after Ms. Won vacated it. He was weaned from a ventilator after we helped him lose 100 lbs and convincing a large extended family not to stop bringing treats, no matter what he tried to tell them. One morning, I saw him at 9:00am. All his vital signs were stable; he looked stable. 25 minutes later while I was in the nursing station, he was in septic shock from a urinary tract infection. The nurse had already called a rapid response and he was up in the ICU within 5 minutes. He has been out of the subacute unit several years; he has had other hospitalizations, but he has not been reintubated.

There have been many, many more.

A 75 year old man who was septic on a ventilator with a history of depression. His wife died while he was in our care and he wanted his life support removed. We treated his depression, weaned him from the ventilator, and he walked out the door, living an additional 4 years and having married his college sweetheart.

A young mother who 5 days after a totally normal pregnancy developed every conceivable post partem neurologic complication associated with a normal pregnancy. She was airlifted to St. Luke's. She was paralyzed on a ventilator who subsequently walked out the door only needing to take an aspirin.

I would like to challenge anybody at Sutter to place a "value" on any of these lives and explain to me how these lives don't fit their business plan.

Part of a tertiary care system, includes the care for patients who should not be in the ICU for months on end, but who need to be close to one. There isn't a single facility on the list provided to the families that meets these needs. Many don't even have subacute units, but are just SNFs. Interestingly, CPMC just gave the junior administrator who composed that list an award.....showing us that the Peter principle is alive and well.....or how managers rise to the level of their incompetence.

With no definitive plan in place for the subacute unit, I initiated a meeting in early 2016 with Warren Browner MD and asked Benson Chen, MD, who is in charge of all ICU TCU (transition care), to join us. At this meeting, Warren said to me "oh Gary, it isn't a matter of if, it is a matter of where." The "where" being definitely within the CPMC system. We discussed several options, but Dr. Browner couldn't commit to an exact location because there was some shifting of census patterns and not about bed counts. Dr. Chen, who had concerns about where the increasing number of ICU patients who needed the type of care we developed and offered would go post ICU, and I left the room reassured.

Moving forward, I see multiple options for the city, Sutter, and St. Luke's. Barriers in the road should not mean the end of the road, but should be looked at as a detour still leading us to the same end.....that of a hospital based SNF/subacute unit

Obviously decisions are not made at CPMC, but are made in the board room of Sutter in Sacramento.

What to do now? Blame can be assigned to all participants from the vague noncommittal wording from the blue ribbon commission to the other hospitals in the City of SF thinking they could drop the problem on Sutter's doorstep, to the publicly funded hospitals UCSF and SF General, and to DPH and the Health Commission.

1. Keeping the SNF/subacute unit open and increasing the subacute back to 60 beds as it will be accepting patients from the outside. The SNF could be admitting CPMC patients by risk stratification to those who have a high possibility of returning from the SNF to the acute.
2. On a temporary basis until a long term permanent solution is found, the 1970 tower could house the SNF and the subacute until 2030. With an independent evaluation as to the safety of the building.
3. A new professional building and a new SNF/subacute unit built on the footprints of the 1955, 1912, and the Hartsel building.
4. The SNF and subacute units could be partially funded by the other hospitals that will benefit the City of SF and by private donation from those individuals who have accumulated phenomenal wealth and who have shown a predisposition towards naming medical facilities.
5. Other possibilities include utilizing the 1970's General which has space available, a new SNF for the Chinese Hospital which is sitting empty, or a more private option with the Kentfield LTAC at St. Mary's getting more space in a hospital that has it to rent. If any form of public/private

partnership comes about, there has to be union wages for all and open elections for union representation,.

Time is of the essence and any resolution from today's meeting should have the formation of the committee with representation from all interested parties. Sutter needs to be represented by the people who can make decisions and control the Sutter money. The committee must be given a strict time frame and the board should be able to enforce penalties for non-compliance. Each meeting must have a concrete result, not just a plan for a new meeting.

I think the CEO of Sutter, Sarah Krevins, should be invited to the board of supervisors meetings. Those directly underneath her in the Sutter hierarchy should participate in the actual decision making. While here, Ms. Krevins should come to the sixth floor of St. Luke's and meet with the families, see the patients and gain an understanding just what we have been doing the last 20+ years.

Sutter, in its literature tries to portray her as the super competent high-powered CEO with a soft mom's side. I can understand. I was a single dad, a doctor in private practice and also the medical director of a growing subacute unit. So if she shows up, I'll bring the milk and cookies. I am an empty nester with a little extra time on my hands.

San Franciscans for Healthcare, Housing, Jobs and Justice (SFHHJJ)
c/o Jobs with Justice, 209 Golden Gate Avenue, San Francisco, CA 94102 Contact:
Gordon Mar, gordon@jwjsf.org, (415) 840-7420

September 12, 2017

SFHHJJ Proposals for Action by Board of Supervisors regarding the Loss and Demise of Post-Acute Care Beds in San Francisco

1. Issue a resolution that Sutter/CPMC not reduce the medical personnel and other resources needed to maintain the number of staffed SNF beds in the Sub-Acute Care Unit at St. Luke's as of August 1, 2017, until there is available the same number of beds at an equivalent level of staffing and resource support elsewhere at CPMC facilities within San Francisco.

2. Issue a resolution that there now is a crisis in the availability of hospital-based SNF including sub-acute care beds within the City and County of San Francisco and the San Francisco Bay Area, which will worsen in the next several years.

3. Direct the Department of Public Health to prepare within two months a report identifying all beds in San Francisco hospitals that are licensed or could be re-licensed for use as SNF beds or "swing" beds for SNF including sub-acute care patients.

4. Direct the Department of Public Health to take actions to develop both short-term and long-term solutions for insuring a sufficient number and range of post-acute care beds and facilities within the City and County of San Francisco for San Francisco residents discharged from San Francisco hospitals.

5. Direct the Department of Public Health to analyze and propose solutions to the insufficient number and range of post-acute care beds and facilities the following along with other options:
   a. Cooperation agreements among private and public hospitals to operate and fund jointly hospital-based SNF including sub-acute care beds and facilities within the City and County of San Francisco;
   b. The enactment of local legislation requiring the imposition of fines whenever a private hospital or healthcare facility removes a SNF bed from service without guaranteeing beforehand the availability of a similarly staffed bed elsewhere within the City and County of San Francisco.
   c. The enactment of local legislation that mandates the minimum number of and range of hospital-based post-acute care beds that public and private hospitals within the City and County of San Francisco must create and maintain.

San Franciscans for Healthcare, Housing, Jobs and Justice (SFHHJJ)
c/o Jobs with Justice, 209 Golden Gate Avenue, San Francisco, CA 94102
Contact: Gordon Mar, gordon@jwjsf.org, (415) 840-7420

The Loss and Demise of Post-Acute Care Beds in San Francisco

The problem:

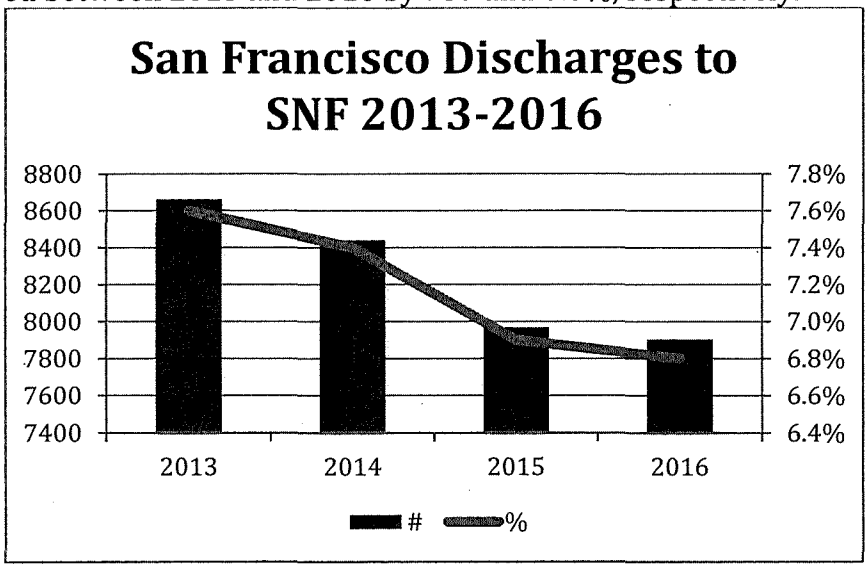
- **Short-term:** CPMC Sutter plans to close St. Luke's Skilled Nursing Unit in October 2017, resulting in the closure of 79 post-acute beds, including 40 sub-acute beds, in San Francisco County. Closing this unit will make San Francisco County the only county in California to have no sub-acute beds.
- **Bigger picture:** San Francisco has a shortage of post-acute care beds, including skilled nursing and sub-acute beds. As a result, patients that require post-acute care wait in acute care hospitals for beds in San Francisco to open up and/or be sent to facilities outside of San Francisco County.

Definitions of care levels:

- **Post-acute:** a range of medical services that support an individual's continued recovery from illness after a stay in an acute care hospital
- **Skilled nursing:** accommodates needs such as physical or occupational therapy, wound care and intravenous therapy, and assistance with activities of daily living (bathing, eating, dressing, toilet hygiene)
- **Sub-acute:** a category of skilled nursing for medically fragile patients with needs such as ventilator care, complex wound management, and tube feeding

The facts:

- The number of licensed skilled nursing beds, including sub-acute beds, in San Francisco decreased from 3,502 in 2003 to 2,542 in 2013. Not all licensed beds are staffed so the number of available beds is even lower.
- There are only 40 sub-acute beds in San Francisco, all of which are at St. Luke's. Most other California counties have more sub-acute beds. For example, Los Angeles County has 2,193 sub-acute beds, 55 times as many as SF despite having just 9.6 times as many discharges as SF.
- The number and percent of total discharges from San Francisco hospitals to SNFs decreased between 2013 and 2016 by 759 and 0.8%, respectively.



- A smaller proportion of patients discharged from hospitals in San Francisco in 2016 went to SNFs compared to the rest of the state (6.8% versus 8.8%). It is unclear how many of these SNFs were located in San Francisco.

DISPOSITION	Statewide	San Francisco
Routine (home)	70.8%	68.9%
Home health services	10.4%	12.9%
Acute care hospital	2.3%	3.1%
Skilled Nursing Facility	8.8%	6.8%
Residential care	0.4%	0.7%
Critical Access Hospital	0.0%	0.0%
Inpatient rehab	0.9%	1.2%
Other*	6.3%	6.3%

*Other includes prison/jail, against medical advice, cancer center, hospice care, psychiatric care, disaster care site, and died.

- Many patients who are discharged to sub-acute care or SNF spend a long time in the hospital prior to discharge. The following table shows the length of stay (LOS) for patients discharged from UCSF hospital to sub-acute care and SNF between 2012 and 2016. This single hospital example points to the additional acute care hospital resource and cost consequences when there are delays in transferring dischargeable patients to appropriate post-acute care facilities.

LOS (days)	Sub-acute care	SNF
<10	38%	62%
10 to 19	26%	23%
20 to 29	12%	8%
30 to 49	12%	4%
50 to 99	7%	2%
100 to 149	4%	0%
150 to 199	0%	0%
> = 200	1%	0%

This Fact Sheet was prepared by Dr. Grace Hunter, a hospitalist and researcher at UCSF, for San Franciscans for Healthcare, Housing, Jobs and Justice (SFHHJJ).

FAMILY COUNCIL STATEMENT FOR SF HEALTH COMMISSION HEARING ON SEPTEMBER 5, 2017

Good afternoon Commissioners. My name is Raquel Rivera and I am the Family Council Coordinator for St. Luke's sub-acute unit. My sister Sandy is a patient there. We would like to thank the Commissioners for allowing the Family Council to make this presentation before you. The families want to start by sharing a video of some patients' critical conditions and needs.

[VIDEO]

I would like to point out that Raymond Orello, a sub-acute patient of 9 years at St. Luke's Hospital was transferred in July to another facility in San Jose and we were not able to include him in the video but we were able to visit him. I asked Raymond where was his family and he stated that they are all in the cemetery. He said that he felt pressured to move because the social worker appeared in his room with a priest. She told him the longer you wait, the farther you'll have to go, as far as Sacramento so he felt that he had no choice. He also stated that since the move, his health has deteriorated. He is in a lot of discomfort. Raymond requested to have the same oxygen equipment that he had at St. Luke's which worked better for him because the one he has now makes it difficult for him to breathe or talk. In one incident at the new facility, the tube that provides him oxygen disconnected and fell on the floor and he could not breathe. He was banging on the side of the bed for help and the nurse came and connected his life support back. He was told that if he needs different oxygen equipment, he would have to leave to another facility. He said he no longer has the will to live and he is just waiting to die. Here's an example of transfer trauma.

1. CPMC was inconsistent with their information on the closure, the transfer of patients, and the facilities to choose from.

    a. For example, we were informed, through a packet, that was either left in the patient's room or mailed that the deadline was October 31st which caused anxiety and stress on the patients and their families because it was very short notice and unexpected! No one saw this coming!

b. Now, we are being told 2 months later AFTER our Family Council meeting that it's a soft date and that patients will continue to be cared for until they find another facility for them.

c. We keep hearing about "transition" and reducing transition trauma and provide follow-up. This certainly didn't happen in the case of Raymond Orello. I'm afraid he will die soon.

d. The template list of facilities they provided to every family member with different needs had to contact each facility themselves to see if their loved one could be accommodated. Most if not all locations would not take our family members due to either insurance issues or other specific patient needs. Now, the case manager and administrators are stating they will research the facilities. So then why did the social worker contact my mother recently a second time about a location in San Jose for my sister knowing that is too far away! They are still not listening to the families' needs! They are being robotic!

2. CPMC acquired St. Luke's with the sub-acute unit already there. It should have been included in the new hospital plans.

3. CPMC states that they have no room or beds available for any of the sub-acute patients. They should have put aside those beds in the first place when they made their plans and should be required to do so now.

4. CPMC does not have an action plan for the sub-acute patients when they decide to close on October 31st. We request that the sub-acute unit at St. Luke's remain open past the deadline as there is no urgent reason to close it on October 31st until a thought out alternative is found.

5. St. Luke's is the only hospital based sub-acute facility in San Francisco and closing this facility will leave the City and County without the needed services that could determine the difference between life and death of a patient.

6. Moving these critical patients out of San Francisco will be detrimental to their health with the uncertainty of a new location and skilled

nursing staff. It would leave them extremely medical fragile and stranded in another community many miles away from family and friends. They will die as they will no longer be in their familiar surroundings receiving the same level of care from staff and support from their families.

7. Many of these families live and work in San Francisco and rely on public transportation and the fact that St. Luke's is easily accessible.

8. CEO Warren Browner speaks that it's not about money that it's about no room and no beds. Tell me who made the rule that you need to have 274 of just acute beds? So if it is about the beds, why can't you make it 234 acute and 40 sub-acute and why don't you renew the license to the new hospital? Is it really about no room or is it about profits?

9. St Luke's should set the example for other hospitals and set the trend of providing this needed service to the community. You know how much a big deal that would be. You would be a hero. You keep illustrating that it has been a privilege for our families to stay as long as they have in St Luke's. So why stop now? You have not given the exact reason on why you are closing sub-acute?

10. To Mayor Lee, Board of Supervisors, Dept. of Public Health and the Health Commission: In the beginning, the sub-acute unit was included in the new hospital. Somewhere down the line, a meeting was held behind closed doors that took sub-acute away. That means a change can be done. We ask that you please go back behind closed doors and change it back to include sub-acute patients from the 6th floor into the new hospital.

11. Why is the health system of a great city like San Francisco turning its back on its most vulnerable citizens? One of the world's greatest cities should not be sending its most fragile residents into exile because they need extra care.

12. Dr. Birnbaum, who knows our loved ones better than anyone, has testified that they are likely to die if they are moved. For our family members, the planned transfers come with a death sentence.

13. Commissioners, unless you help stop the closure, my sister and all of the other residents will be separated from everyone and everything they care about; their families, their roommates, their surroundings and routines. They will also lose the trusted caregivers who are their lifeline and have to rely on strangers who know nothing about them.

SOLUTIONS

1. The sub-acute needs to be:

    a. In the City and County of San Francisco.

    b. The placement is hospital based and with equivalent intensity of care as is now occurring.

    c. That the site be easily accessible by public transportation.

2. Sutter should be required to renew their license for sub-acute/ skilled nursing to continue until a solution is found. They are choosing not to. The Development Agreement does not state that they cannot continue these services.

3. Sutter should be required to maintain the current level of sub-acute services and plan for future growth in their new hospitals.

4. For the sake of the residents whose lives depend on your actions and their family members, please intervene and ensure that CPMC/Sutter keep St. Luke's sub-acute open.

In conclusion, we respectfully ask the Commission to please consider our loved ones when you enter your vote. You are our last hope. All of the residents and families desperately need you to stand up and stop this injustice. Please stand with us in doing so. Their lives depend on it! Thank you.

St Luke's Sub-Acute SNF Closure.
September 5, 2017

From: Benson Nadell; Program Director;San Francisco LTC Ombudsman Program; Felton

I wish to enter the following points into public testimony pertaining to the confusing events leading up to this untenable decision by Sutter CPMC

As far back as the Lewin Report of 2009, there was criticism of SNF beds being omitted in the Master Plan, with a recommendation for more than those earmarked at the seismically safe Davies Campus. That report recommended that the Long Term Care Coordinating Council take a position. This was a bad referral.

At the time, The LTCCC was enthralled by Omstead Decision, The Davis and Chambers Class Action Lawsuit Settlement Agreements and a confusion between persons with disability being warehoused in institutions, and persons with complex medical conditions being professionally managed by round the clock nursing care. This Ombudsman has advocated for quality of care and life in SNF for years. At the time, I too thought it a good idea for as many as possible to be given the option of keeping their homes as receiving effective care-coordination-given the trend of SNF beds dwindling in number. There were many insoluble complex details in this home and community based emphasis on LTCCC. One was that the one-one staffing available to persons under IHSS was restricted to those eligible for M-Cal. The Medicaid Expansion, which ended at age 65 allowed for more to receive IHSS. The LTCCC was also under the spell of the various SCAN Foundation policy initiatives which were aligned CMS directions in getting persons out of nursing homes. This Ombudsman realized that living in most nursing homes, with shared bed rooms, unresponsive staff, absentee doctors, with little bed side manner, a reliance on behavioral control medications was an untenable way for persons to receive needed complex chronic disease management. The Ombudsman Program under Federal Law receives complaints about rights violations; under California Law, mandated abuse and neglect reports.

During this period there was confusion between two stereotypes: persons were no longer in nursing homes because they were disabled. No longer are there nursing homes for " custodial care". At the same time , with many living alone, there was an emphasis in self-direction and choice. But choice for many who acquire disability through an acute medical event, and live alone require supports which are often more complex than available through the city. The two law suits were focused on LHH with the city providing TCM and eventually funding for an expanded Community Living Fund. This was a good thing for persons at LHH who wished to, and were capable of returning to the community- often with new housing through Direct Access to Housing. In 2017 there is now competition with this housing with those coming through the new homeless department.

By contrast persons coming through other hospital systems were not able to access such Public Health and local funding(As of the present, IoA Community Living Fund, is taking referrals through DAAS Central Intake hub, with a wait-list).

The other stereo typifying narrative is that most elderly filing through hospital are on Medicare, and that with the reduction of length of stay those persons can now be discharged to community SNF which are

now the Post Acute Partners of most hospitals in SF. Post Acute is not long term care or focused on chronic disease management. These beds in the remaining free standing SNF are now utilized for shorter term stays of rehabilitation and recovery. Hospital based SNF had daily doctors; free-standing SNF did not. In addition staffing patterns , with high turnover, and poor supervision prevailed in these community based SNF.

No! Persons do not get a 100 days, under the various Medicare management care arrangements, a co-pay kicks in for the 21 day and beyond. Many do not have supplementary coverage. In addition those in these

Post- acute setting must make progress, get out of bed, and learn to climb stairs, let alone be able to transfer in and out of bed. Many do not reach that threshold and become uncovered. The Ombudsman Program receives complaints around this concatenation of factors:People are not ready; they have stairs, the home health agency did not arrive for days, the discharge plans did not cover details like meals, shopping food. In addition this Post Acute model of care did not result in ramping up of staff. Person are caught up in patterns of poor care and communication, lack of good interdisciplinary process. In addition the filing of appeal for more coverage, did not rely of person centered interviews but records electronically filed. It was bewildering for many.

The hospitals drove this process without any through- put on the process, except for bundled payment cases for elective surgery. This was a Medicare world gone awry.

What about complex medical coordination? That is long term care based on management of chronic illnesses. That is covered by Medi-Cal . Most of the Post Acute Partnering SNF did not want any more Medi-Cal persons occupying those Medicare utilized beds. So despite being Certified for billing Medi-Cal and already having residents who were long term care, these community based SNF are pressuring persons to get out, leave. If the person called the Ombudsman Program they would get the needed advocacy. These Post Acute SNF would complain that the Ombudsman was messing up their business plan. It must not be forgotten, under CMS and Title 22 All SNF have strong consumer and rights protections , which when enforced, can in this person centered comprehensive care environment, conflict with the business of patient flow in this Post Acute Environment.

This business plan in the aggregate is the consequence of combined hospital policies. If there is any direct causative factor for the elimination of the remaining long term care facilities, is lies with hospital decisions.

CPMC has closed most of its hospital based SNF which provided in-hospital rehabilitation. This cascaded into this new Post Acute World.

What about custodial care? there are no affordable or low income assisted living facilities . With small board and care homes there is no requirement for specialized staff to trouble shoot emerging chronic health conditions. Hospital emergency rooms only admit in patient those with traumatic or serious acute events. Many living in board and care are sent back to these sub standard setting by hospital ED, with no discharge plan other than instructions for a person unable to self manage care. The larger Assisted living type RCFE are expensive and with the absence of any comprehensive M-Cal Assisted Living, with rates set using regional market price average, many low income and moderate income, being asked to leave community SNF, have nowhere to go. Again, corporate hospital organizations say their responsibility stops at their doors. But ask any hospital –based MSW Discharge planner about this bleak landscape and they shake their heads.

No longer are persons in SNF for assistance with ADL alone. Now persons must be really sick with chronic medical problems.

So with Sutter-CPMC closing the Sub-Acute Unit of SNF beds, what strikes the Ombudsman Program is that these persons are the most dependent and most vulnerable. This is a long term care unit with specialized services under Medi-Cal. This is not a post acute setting where Medicare coverage dwindles after a few weeks. We must not confuse post acute with sub-acute. We must not confuse the Medicare silo of payments and services from the Medi-Cal one which pays long term care. If one reviews the recent history of Sutter CPMC with St Luke's, going back to the anti-trust suit, and the concessions with the then Board of Supervisors, St Lukes was always seen as a community hospital with a long list of services, which since 2000 have been eliminated piece meal by the Corporate Culture of Sutter –CPMC. The announced closing of the sub-acute unit, is of a piece with that top - down culture

Sutter CPMC has been contributory to the loss of long term care SNF beds in the community SNF indirectly, through the closing of their in-house DP/SNF beds at the California Campus and at St Luke's 8th floor. And now in its myopic , is closing the sub acute long term care unit at St Luke's.

Sure CPMC made a deal with City and County- money was contributed to certain NCO providing community services, from 2014-2016. But there is no answer to those in the future who may need sub-acute care. Other hospitals with sub-acute patients do not have adequate data after discharge. If those candidates were discharged to distances outside City and County there is no data as to mortality longevity or longitudinal stability. In the absence of such data, a false conclusion will be made that sub acute care is not necessary.

Go back to the Lewin Study; go back to recommendations for Hospital Council Report of 1997; To the Post Acute Report from 2/16. In an era of scarcity- cutting specialized beds is good for CPMC but not for the people of San Francisco.

No no ..This is not a matter of persons with disability being warehoused in institutions. It is a matter of those who need round the clock professional health care to maintain chronic illnesses: those on continuous oxygen, on ventilators, who need suctioning, who have tubes in their trachea. What Sutter CPMC is proposing is these persons being separated from daily visits from supportive families; being sent to free standing SNF in a world of Post Acute Care, where those with long term care needs are in the way of aggressive business plans.

HEALTH COMMISSION TESTIMONY

September 5, 2017

My purpose is to try to establish some context for the issues the Health Commission is considering

We no longer have health care planning

- The days of Health Systems Agencies (HSAs), Certificates of Need (CoN), etc. are long gone and have been replaced by market-based approaches to health care
    - Even ostensibly non-profit agencies function more like for-profit organizations where the bottom line too often takes precedence over patient care as a fundamental basis for decisions
    - It's part of why we are in the situation we are in today over CPMC's decision to close SNF/subacute care at St. Luke's
- In the absence of health care planning, our coalition and the city had to resort to local authority over land use planning to negotiate an agreement with CPMC regarding their plans to build new hospitals in order to comply with state requirements for seismic safety standards
    - It's imperfect, but it's what we had to work with
    - Dr. Browner, in his testimony at the Health Commission's August 15 Prop. Q hearing, laid some of the responsibility for their decision to close SNF/subacute beds at St. Luke's on that negotiated agreement because it resulted in fewer beds at the combined new campuses on Van Ness and at St. Luke's
    - To be clear, the coalition has never believed the issue about closing SNF/subacute beds at St. Luke's has any basis in the Development Agreement, in part because the agreement is silent on the matter
    - ***This is fundamentally a humanitarian and public health issue, as testimony at the last Health Commission hearing made abundantly clear***

What can be done?

We recognize that the Health Commission is challenged to carry out its responsibility to represent the larger public health interest in the ability of the

healthcare system as a whole to provide the best care possible to San Francisco residents, since Prop Q, the Development Agreement and the Health Care Services Master Plan do not provide the legal authority to require it

- However, as we listen to the testimony of families of patients—or, as you have seen in the video profiles of some of the patients and their families—that must be the starting point for any future actions
    - And, it's not just these patients but others who were not admitted and as a result were dispersed around the bay area and state
    - It's also about the potential complete absence of hospital-based SNF/subacute beds in San Francisco as the population ages and grows in the coming years, as documented by the health department and coalition testimony
- Accordingly, we urge the Health Commission to regard this as a citywide public health crisis and to use whatever authority and influence you have to ensure that post-acute care planning in San Francisco is invested with a sense of urgency appropriate to the situation, with the public health department being a vigorous participant in that process
    - We support, for example, the recommendation in your draft resolution for a "cooperation agreement among private and public hospitals to operate and fund jointly SNF subacute beds and facilities *within* the City and County of San Francisco," which could be a centerpiece in coming to terms with the problem
    - We also recognize that your Prop Q determination and resolution will serve as a basis for future Board of Supervisors hearings, where they can take up the issues with their scope of authority
- Finally, if this is a citywide issue, on what basis do we insist that CPMC keep open their SNF/subacute unit at St. Luke's?
    - Apparently, there have been some informal discussions about CPMC delaying the closure but only if there is a concrete, local alternative for the current patients
    - I would turn that around and suggest that CPMC's initial contribution to an essential public/private collaboration "to operate and jointly fund subacute beds and facilities" could be a commitment to maintaining the current patients at St. Luke's until an accelerated process, in which they participate, creates that alternative
    - I don't think this is too much to expect. As a UC Hastings report documented during negotiations over the Development Agreement,

CPMC is the most profitable among ostensibly non-profit hospitals in San Francisco, and Sutter Health is also one of the most profitable networks in the state.

- We should expect this commitment from a non-profit hospital

Patrick Monette-Shaw

975 Sutter Street, Apt. 6
San Francisco, CA 94109
Phone: (415) 292-6969 • e-mail: pmonette-shaw@eartlink.net

September 4, 2017

San Francisco Public Health Commission
Edward A. Chow, President
David Pating, M.D., Vice President
Dan Bernal, Commissioner
Cecilia Chung, Commissioner
Judith Karshmer, Ph.D., Commissioner
James Loyce, Jr., Commissioner
David. J. Sanchez, Jr., Ph.D., Commissioner
101 Grove Street
San Francisco, CA 94102

Re: **Prop. Q Hearing 9/5/17 on Closure of St. Luke's Hospital's SNF and Sub-Acute Units**

Dear President Chow and Members of the Health Commission,

Since the Health Commission's August 15, 2017 Prop. Q hearing on the closure of St. Luke's Hospital's sub-acute and SNF units, the Department of Public Health has kindly provided me with updated data, which corrects my previous testimony to you submitted on August 14 that between LHH and SFGH only 291 patients were dumped out-of-county from our two public hospitals.

541 Out-of-County Discharges ... and Counting

DPH's updated data shown in Figure 1 shows there have been at least 541 such out-of-county discharges. The number discharged out of county from SFGH is likely to be higher, because the data for FY 12-13 and FY 13-14 appear to be outliers. DPH is checking those two years again, because the number of SFGH out-of-county discharges for all other years averaged 47.7 discharges in each other year. I suspect the total may climb by an additional 100.

Table 1: Public Hospital's Out-of-County Discharges, FY 2012–2013 — FY 2016–2017

	Fiscal Year	Laguna Honda Hospital	SFGH[1]	Private-Sector Hospitals	Total
1	FY 06–07	35	?	?	35
2	FY 07–08	36	?	?	36
3	FY 08–09	14	?	?	14
4	FY 09–10	18	27	?	45
5	FY 10–11	6	54	?	60
6	FY 11–12	19	41	?	60
7	FY 12–13	26	7	?	33
8	FY 13–14	28	1	?	29
9	FY 14–15	25	68	?	93
10	FY 15–16	20	56	?	76
11	FY 16–17	20	40	?	60
	Total[2]	247	294	?	541

[1] San Francisco residents discharged from SFGH but not admitted to LHH. Data prior to FY 09-10 for SFGH unavailable; not tracked electronically. Subject to change, since years 7 and 8 appear to be outliers that are being re-checked.

[2] Data excludes out-of-county patient diversions prior to hospitalization via the Diversion and Community Integration Program (DCIP), and "Transitions" and successor programs, and excludes out-of-county placements chosen by families due to a lack of appropriate level of care beds in San Francisco.

Source: San Francisco Department of Public Health responses to records requests.
Updated: August 25, 2017

Previous Health Commission "Prop. Q" Hearings History

The Health Commission's previous Prop. Q hearings have been, largely, ineffective for a number of years. *This Commission must vastly strengthen its proposed Resolution regarding the St. Luke's closure of its sub-acute and SNF units, and quickly! While the revised Resolution is much stronger than the August 15 draft Resolution, it still needs to be strengthened!*

Table 2: Sad History of Past Health Commission Prop. Q Hearings

Date Adopted	H.C. Resolution Number	Corporation	Facility / Purpose of Prop. Q Hearing	"Where-as Clauses" Included (Among Others):	Number of Beds	Health Commission Secretary	Detrimental Impact?
4/4/1995	10-95	Sutter Health	Transfer of SNF beds and acute rehabilitation at CPMC's Garden Campus unit and SNF unit at CPMC's California campus to be leased to the Guardian Foundation under the Guardian Foundation's own license.	• Creation of new Alzheimer's residential care program • Extended HIV convalescent and hospice patients • Expanded service for long-term Medi-Cal patients	?	Sandy Ouye Mori	No
11/13/2007	14-07	Dignity Health	St. Francis Memorial Hospital SNF	• St. Francis has been referring SNF patients to St. Mary's • Secured "bed hold" contract with Kindred Healthcare • See **Resolved** statement[1]	34	Michelle Seaton	Yes
7/15/2014	14-8[2]	Sutter Health	Closure of 24 CPMC SNF beds at California Campus; transferred 18 to St. Luke's and 3 to Davies Campus	• Reduced CPMC's 212 licensed SNF beds • Reduced CPMC's 98 staffed beds to 75 (loss of 24 beds)	24	Mark Morewitz	Yes
5/19/2015	15-8	Dignity Health	St. Mary's Hospital Short-Term SNF Beds	• "While institutional post-acute care continues to decrease, the availability of community-based post-acute care will need to rise to maintain the capacity to care for the population; ..." See **Resolved** statement[3]	32	Mark Morewitz	**Commission Waffled** No Ruling
					Total SNF Beds Lost:	**90**	

[1] **Resolved,** that the plans made for discharge of St. Francis Memorial Hospital patients may not provide the same standard of care, and may result in unintended readmissions of patients who need a higher level of care; ...

[2] Starting in July 2014, the Health Commission reversed its numbering scheme to include the calendar year first, followed by the Resolution number issued in a given year.

[3] **Resolved,** The closure of short-term SNF beds without ensuring an appropriate level of post-acute care services available may result in short-term skilled nursing needs of the community not being met (in lieu of ruling with an up-or-down vote of "will" or "will not" have detrimental impact).

Source: San Francisco Health Commission; blue rows are Health Commission Resolutions provided under a records request placed July 29, 2014 for all Prop. Q hearings prior to July 2014 dataing back to 2002. No additional Prop Q. hearing Resolutions were located by the Health Commission's secretary other than the two shown.

Table 2 above summarizes a portion of an article I wrote in June 2015 — "*Detrimental Skilled Nursing Facility Cuts* — following the Health Commission's Prop. Q hearing on the proposed closure of St. Mary's SNF unit. Just four Prop. Q hearings have been held since 1995. How did we lose so many private-sector hospital-based SNF beds without Prop. Q hearings?

According to the Health Commission's Executive Secretary, the Commission appears to have only held four Prop. Q hearings during the past 22 years since 1995. It's not known how many Prop. Q hearings the Commission may have held in the seven years between 1988 and 1995, if any.

Nearly three decades have passed since voters passed Prop. Q in 1988 and this Commission has held just four Prop. Q hearings during that time.

"This Health Commission ruled three years ago that closure of CPMC's SNF unit at its California Campus had caused a detrimental impact. You must do so again regarding the closure of CPMC's St. Luke's sub-acute and SNF units."

Recommended Edits to Health Commission's Proposed Prop. Q Resolution on St. Luke's SNF Closure

This Commission ruled three years ago in your Resolution #14-8 on July 15, 2015 that CPMC's SNF unit closure at its California Campus ***had*** caused a detrimental impact. This Commission must do so again regarding the closure of CPMC's St. Luke's sub-acute and SNF units.

The Health Commission should amend its proposed Resolution on the closure of St. Luke's services by including:

Additional "Whereas" Clauses:

- WHEREAS, During the initial Prop. Q hearing on May 5, 2015 regarding the closure of St. Mary's SNF beds, the Health Commission's meeting minutes report Health Commissioner Cecilia Chung had asked whether discharges to out-of-county SNF's are common due to a lack of SNF beds in San Francisco, but didn't receive a straight answer; clearly understanding the scope of out-of-county discharge data could help inform in-county, community-based post-acute care planning; and

- WHEREAS, At least 541 patients have been discharged out-of-county from just San Francisco's two public hospitals alone since July 1, 2006, and the number of additional patients discharged out-of-county from private-sector hospitals has not been reported; and

- WHEREAS, The City can not make informed legislative healthcare policy decisions in the absence of knowing just how many private-sector out-of-county discharges there has been since 2006; and

- WHEREAS, Out-of-county discharges of San Francisco residents deprives our citizens from being able to remain in their local communities close to family members, friends, and caregivers, and violates the core principles of aging with dignity and the promise of community-based integration in-county ; and

- WHEREAS, There is a known risk of "transfer trauma" to patients that may increase the incidence of morbidity and mortality, along with re-admissions to acute-care hospitals, to patients unceremoniously transferred out-of-county; and

- WHEREAS, Health Commission Resolution 15-8 adopted on May 19, 2015 directed the Department of Public Health to work with city agencies, hospitals, and community providers to research skilled nursing and post-acute care needs by creating the San Francisco Post-Acute Care Project work group; and whereas San Francisco Sunshine Ordinance §67.3(d)(4) defines *Policy Body* as "Any advisory board, commission, committee or body, created by the initiative of a policy body," the PACC (as an advisory committee, or minimally as a "Passive Meeting Body) should publicly notice and open its PACC meetings to members of the public to improve public accountability and transparency as the Mayor's LTCCC does; and

- WHEREAS, Then-Mayor Gavin Newsom created a 41-member Long-Term Care Coordinating Council (LTCCC) in November 2004, which was charged with facilitating improved coordination of home, community-based, and institutional services for older adults and adults with disabilities, and was further charged with guiding the development of long-term care services, including in institutional settings such as SNF's; and

- WHEREAS, On June 11, 2009, the LTCCC passed a resolution calling for citywide health planning for acute care, post-acute care, rehabilitation services, and transitional care, but pointedly eliminated calling for planning for SNF level of care, an obvious planning need, by eliminating from its final resolution a finding in its June 3, 2009 draft resolution that CMPC's plans "will have a significant and negative impact on the overall availability" of SNF beds for vulnerable adults; and

- WHEREAS, Sub-acute patients deserve to be located in a hospital-based facility with ready access to an ICU; and

- WHEREAS, This Health Commission is concerned not only about the current patients in St. Luke's SNF and sub-acute units, but is also concerned about the SNF and sub-acute capacity in-county for future generations of San Franciscans; and

- WHEREAS, On November 13, 2007 this Health Commission adopted Resolution 14-7 regarding the closure of St. Francis Memorial Hospital's SNF unit, expressing our concern that patients may be discharged to facilities that may not provide the same standard of care, and ***that*** may result in unintended re-admission of patients to acute-care hospitals who need a higher level of care, an ongoing concern of this Commission; and

"On November 13, 2007 this Health Commission expressed concern that patients may be discharged to facilities that may not provide the same standard of care, and *that* may result in unintended readmission of patients."

- WHEREAS, It has been 40 years since the San Francisco Section of the Hospital Council of Northern and Central California's West Bay Hospital Conference published its report "*San Francisco Nursing Facility Bed Study: Comprehensive Report Summary*" in May 1997, which has not been updated since; and

- WHEREAS, The Post-Acute Care Task Force, and subsequently the PACC, was charged with identifying gaps in post-acute care services, as had the LTCCC when it was formed 13 years ago; and

- WHEREAS, Supervisor Aaron Peskin introduced Motion 15-135 in September 2015 directing the Board of Supervisors Budget and Legislative Analyst (BLA) to conduct a performance audit of services to seniors. The BLA's report "*Performance Audit of Senior Services in San Francisco*" dated July 13, 2016 noted a "gap analysis" had not been performed to estimate the unmet need for particular services, which is the gap between the number of individuals currently receiving services, and the total population that might benefit from, or be eligible for, a particular service; and

"The Board of Supervisors BLA report dated July 13, 2016 noted a 'gap analysis' had not been performed to estimate the unmet need for particular services."

- WHEREAS, the *Mission Local* newspaper reported on September 4, 2017 that CPMC's Dr. Browner cavalierly told the St. Luke's Family Member Council on August 31, "For the past many years, you and your families have enjoyed the ***privilege*** of being in San Francisco"; and

Additional "Resolved" Clauses:

- FURTHER RESOLVED, This Health Commission believes that healthcare is a basic right, not a "privilege," as Dr. Browner unfortunately stated; and be it

"This Commission believes that healthcare is a basic right, not a 'privilege'."

- FURTHER RESOLVED, That this Health Commission urges the Hospital Council of Northern and Central San Francisco to publicly notice its upcoming PACC meetings and make those meetings open to members of the public, as are meetings of San Francisco's Long-Term Care Coordinating Council (LTCCC); and be it

- FURTHER RESOLVED, That St. Luke's Hospital and CPMC delay discharge of St. Luke's current sub-acute and SNF patients until such time as other in-county sub-acute and post-acute facilities are identified and brought on line; and be it

- FURTHER RESOLVED, That plans for discharge of St. Luke's Hospital sub-acute and SNF patients may not provide the same standards of care, and may result in unintended readmission of patients who need higher levels of care; and be it

- FURTHER RESOLVED, That St. Luke's Hospital and CPMC actively identify hospital-based sub-acute units with ready access to an ICU prior to discharge of any of St. Luke's current sub-acute patients; and be it

- FURTHER RESOLVED, That this Health Commission requests that the Hospital Council of Northern and Central California prepare an update to its 40-year-old "*San Francisco Nursing Facility Bed Study: Comprehensive Report Summary*" by January 1, 2018; and be it

"This Health Commission requests that DPH's Office of Planning and Policy survey of all private-sector hospitals in San Francisco and report back on the total number of out-of-county discharges that have been made in each fiscal year since FY 2006–2007 by each hospital."

- FURTHER RESOLVED, This Commission believes that replacement of St. Luke's sub-acute beds must be hospital-based and must be located in-county; and be it

- FURTHER RESOLVED, That this Health Commission requests that DPH's Office of Planning and Policy in collaboration with the PACC and the Hospital Council of Northern and Central California, conduct a survey of all private-sector hospitals in San Francisco and report back to the Health Commission no later than December 1, 2017 on the total number of out-of-county discharges that have been made in each fiscal year since FY 2006–2007 by each member hospital, including data on the types of facilities patients were discharged to; and be it

- FURTHER RESOLVED, That this Health Commission requests that the Mayor's Long-Term Care Coordinating Council, the Community Living Fund (CLF), and the Advisory Body to the City's New Dignity Fund, report back to this Commission during a subsequent hearing what efforts they have collectively made in the 13 years since 2004 to preserve in-county skilled nursing facility and sub-acute services for those who prefer to receive those services in-county; and

- FURTHER RESOLVED, Given that the Post-Acute Care Task Force, and subsequently the PACC, were charged with identifying gaps in post-acute care services, this Health Commission requests that DPH's Office of Planning and Policy in collaboration with the Department of Aging and Adult services and conduct a meaningful "gap analysis," as recommended by the BLA, by January 1, 2018, and specifically perform a gap study — as Rapid City, SD did — to assess expressed needs for assisted living and skilled nursing facility care in-county; and

The Health Commssion should incorporate these "whereas" findings and enhanced "resolved" clauses now, while you have this opportunity at hand to delve deeper into additional post-acute care planning issues prior to updating the City's *Health Care Services Master Plan.*

"This Health Commission believes that replacement of St. Luke's sub-acute beds must be hospital-based and must be located in-county as a basic right."

Respectfully submitted,

Patrick Monette-Shaw
Columnist
Westside Observer Newspaper

cc: The Honorable Hillary Ronen, Supervisor, District 9
The Honorable Ahsha Safai, Supervisor, District 11
The Honorable Sandra Lee Fewer, Supervisor, District 1
The Honorable Jeff Sheehy, Supervisor, District 8
The Honorable Aaron Peskin, Supervisor, District 3
Carolyn Goossen, Legislative Aide to Supervisor Hillary Ronen
Lee Hepner, Legislative Aide to Supervisor Aaron Peskin

Hospital Council
of Northern & Central California
Excellence Through Leadership & Collaboration

September 1, 2017

Dr. Edward Chow, Health Commission President
San Francisco Health Commission
101 Grove Street, Room 309
San Francisco, CA 94102

Dear President Chow,

The San Francisco Post-Acute Care Collaborative (PACC), convened by the San Francisco Hospital Council of Northern and Central California, launched in March 2017 and is scheduled to run through December 2017. The PACC is meeting monthly to develop comprehensive and actionable solutions to the city's urgent post-acute care challenges for high-risk, vulnerable patients.

Since the PACC mandate addresses all post-acute issues and in connection with the hearing of the planned closure of St. Luke's subacute unit, the PACC held a special meeting on August 23, 2017. The goal of the meeting was to engage PACC members in a planning discussion regarding San Francisco's future subacute care needs. To guide the discussion and review of potential subacute care solutions for the city, PACC members and invited stakeholders drafted the following positional statement.

> Subacute care is critical for the patients and their families who rely on it. Given a range of factors affecting the post-acute care landscape in San Francisco, such as multiple high-risk post-acute care populations, subacute care volume, and the geographic size and limited facility options in city, the PACC recommends a regional approach to meet future subacute care needs.
>
> In addition, the PACC proposes that the proximity of subacute care placements be guided by measures that assess a patient support system's access to the facility (e.g., proximity, transportation), cultural and/or language needs, and financial resources.

Proposed Short-Term Subacute Care Options

Meeting attendees reviewed draft short- and long-term solutions to San Francisco's subacute care need and identified the following short-term options, ordered by priority, as the most financially sustainable and impactful.

1. **<u>Utilize Existing Bay Area Facilities to Provide Subacute Care</u>**
   - Coordinate with neighboring counties Alameda, San Mateo, and Santa Clara to purchase or lease subacute beds to support an expansion of existing freestanding or hospital-based subacute beds for San Francisco residents.

- Advocate for regional Medi-Cal enrollment and create Medi-Cal Health Plan letters of agreement that facilitate the timely transfer of Medi-Cal managed care benefits across counties.
- Create a formal governance structure to oversee regional placement practices and protocol.
- Establish a transportation fund for families/support systems experiencing economic hardship, so they can visit their loved ones placed in out-of-county subacute care facilities.

2. **Utilize Existing Facilities to Provide Subacute Care in San Francisco**
   - Create a public-private partnership model that uses existing health care facilities to provide subacute care in San Francisco.
   - Utilize unused space in hospitals, medical offices, and/or freestanding skilled nursing facilities to create a new subacute unit managed by freestanding SNF providers.
   - Create a local transitional subacute unit (average length of stay three months) to manage patients with subacute care length of stay needs longer than the Long-Term Acute Care Hospital length of stay (25-30 days), but no longer than three months. Eligible patients include those who need several months to be stabilized or weaned off ventilators before discharge home or to a long-term care facility.

3. **Fund a navigator/community liaison to work with San Francisco subacute care patients and their families/support systems**
   - Support a navigator/community liaison that will guide and assist subacute patients and their families pursuing the Home and Community-Based Alternatives Waiver (e.g. setting up and coordinating care for the patient at home in accordance with the requirements of the waiver, etc.).

The PACC is pleased to provide these recommendations on this important issue and looks forward to sharing the PACC final report later this year.

Kelly Hiramoto
Co-Chair, PACC
Director, Transitions Division
San Francisco Department of Public Health

Daniel Ruth
Co-Chair, PACC
President/Chief Executive Officer
The Jewish Home of San Francisco

David Serrano Sewell
Regional Vice-President
Hospital Council of Northern and Central California

CPMC's number of licensed beds will decline considerably by 2019

Current

Campus	Acute Licensed/In use	Skilled Nursing
Pacific	309/247	0
California	299/182	0
Davies	185/125	38
St. Luke's	149/96	79
TOTAL	942/650	117

Future

Campus	Acute Licensed	Skilled Nursing
Van Ness/Geary	274	0
Davies	185	38
Mission Bernal	120	0
TOTAL	534	38

Carroll, John (BOS)

From: Teresa Palmer <teresapalmer2014@gmail.com>
Sent: Friday, August 18, 2017 1:41 PM
To: Ronen, Hillary; Goossen, Carolyn (BOS); David Chiu; catherine.arbona@asm.ca.gov; Sheehy, Jeff (BOS); Fewer, Sandra (BOS); Major, Erica (BOS); Carroll, John (BOS); Fewer, Sandra (BOS); Safai, Ahsha (BOS); Morewitz, Mark (DPH)
Subject: St. Luke's Hospital Subacute Patients remain at risk of death: Urgent need for legal or legislative relief

To: Assemblyman David Chiu
Board of Supervisors San Francisco- Public Safety and Neighborhood Services Committee (Supervisors Fewer, Sheehy, and Ronen)
Supervisor Ahsha Safai
Health Commission Members care of Mr. Morewitz-St. Luke's Proposition Q Hearing August 15 & September 5 2017

From Teresa Palmer MD
Email teresapalmer2014@gmail.com
Phone 415-260-8446
Date: 8/18/2017

Please assist each other in urgently identifying and pursuing a legal or legislative pathway to keep the St. Luke's SNF and SNF Subacute patients safe by delaying shutdown (and preventing transfer of patients to facilities that are either too far away for families to visit or do not offer the intensity and quality of care that has resulted in their long term survival at St. Lukes).

The families remain upset and very stressed that their loved ones lives may be lost soon due to CPMC Sutter's arbitrary decision to dump them, shadowed by CPMC/Sutter and the Post Acute Care Collaborative's refusal to underwrite or EVEN DESCRIBE an "in county" solution.

At the Health Commission Proposition Q Hearing on August 15 Warren Browner of CPMC/Sutter resisted any proposal that CPMC had to do anything more than it has been doing (ie shutting down the 79 licensed beds and dumping the remaining patients). He may be relying on his interpretation of something that was said about SNF beds during the Development Agreement (DA) negotiations. If so, it should be regarded as having no binding effect since it was not part of the agreement.

If Browner is interpreting the sub-acute care section as having some kind of restraining effect on what San Francisco can do prospectively, it is an incredible stretch of the explicit language and should be totally resisted. The DA doesn't provide us with any support for what needs to be done now. But it also shouldn't be read as limiting what San Francisco can legally do in the future regarding new obligations that might be imposed if there were the political will.

Given the shortage of hospital based skilled nursing (SNF) beds in San Francisco, and the absence of subacute SNF beds other than those 40 licensed beds at St. Luke's, it makes NO sense to shut down ANY of the 79 licensed SNF (including 40 subacute) beds at St. Luke's hospital at this time.

The Post Acute Care Collaborative member hospitals must work out a plan to replace these services IN COUNTY with the assistance of member hospitals in funding as part of their "Charity Care" obligation.

The second part of the Proposition Q Hearing for St. Luke's is on September 5. On August 15, the Health Commission suggested that CPMC/Sutter and the Post Acute Care Collaborative come up with an actual plan to

offer these patients beds in county, AND keep St. Luke's subacute and SNF beds open for existing patients while this longer term solution is being worked out. However the Health Commission has no power to mandate this and Browner gave no indication that he would do this.

CPMC/Sutter will not keep the subacute patients, who are long term survivors, safe at St. Luke's (where they will get an adequate intensity of care in county) unless they are mandated to.

The Nursing Home Ombudsman has noted that death within a year is likely if these patients are transferred far from their families and/or to institutions with a lower intensity of care than St. Lukes--and this is what St. Luke's is trying to do.

The subacute families report that referrals to new facilities for their family members by the staff at CPMC are being made in bad faith to institutions that cannot offer these patients an adequate intensity of care, or are too far away for family to visit and support them.

Is there any kind of URGENT injunctive, legal or legislative relief that you can put forward to prevent the closure of these beds and the likely fatal transfer of these patients?

California Advocates for Nursing Home Reform is working with these families, and the connection there is MIchael Connors (michael@canhr.org). The Nursing Home Ombudsman is also involved.

Please: give us some idea of what you can do, and let me know any way I can help.

(Families fear death for patients told to ship out from SF examiner
www.sfexaminer.com/?p=17796

Teresa Palmer MD
Nursing Home Physician in private practice

San Franciscans for Healthcare, Housing, Jobs and Justice (SFHHJJ)
c/o Jobs with Justice, 209 Golden Gate Avenue, San Francisco, CA 94102
Contact: Gordon Mar, gordon@jwjsf.org, (415) 840-7420

August 15, 2017

SFHHJJ Proposals for Action by Public Health Commission regarding the Loss and Demise of Post-Acute Care Beds in San Francisco

1. Issue a finding that Sutter/CPMC's proposed shutdown of SNF sub-acute care beds at St. Luke's is detrimental to the public health of San Franciscans.

2. Issue a resolution or statement that there now is a crisis in the availability of SNF sub-acute care beds within the City and County of San Francisco and the San Francisco Bay Area, which will worsen in the next several years.

3. Issue a resolution or statement that Sutter/CPMC not reduce the medical personnel and other resources needed to maintain the number of staffed SNF beds in the Sub-Acute Care Unit at St. Luke's as of August 1, 2017, until there is available the same number of beds at an equivalent level of staffing and resource support elsewhere within the City and County of San Francisco.

4. Direct the Department of Public Health to prepare within two months a report identifying all beds in San Francisco hospitals that are licensed or could be re-licensed for use as SNF beds or "swing" beds for sub-acute care patients.

5. Direct the Department of Public Health to take actions to develop both short-term and long-term solutions for insuring a sufficient number and range of post-acute care beds and facilities within the City and County of San Francisco for San Francisco residents discharged from San Francisco hospitals.

6. Direct the Department of Public Health to analyze and include as proposed solutions to the insufficient number and range of post-acute care beds and facilities the following along with other options:

    a. Cooperation agreements among private and public hospitals to operate and fund jointly SNF sub-acute care beds and facilities within the City and County of San Francisco;

    b. The enactment of local legislation requiring the imposition of fines whenever a private hospital or healthcare facility removes a SNF bed from service without guaranteeing beforehand the availability of a similarly staffed bed elsewhere within the City and County of San Francisco.

San Franciscans for Healthcare, Housing, Jobs and Justice (SFHHJJ)
c/o Jobs with Justice, 209 Golden Gate Avenue, San Francisco, CA 94102
Contact: Gordon Mar, gordon@jwjsf.org, (415) 840-7420

The Loss and Demise of Post-Acute Care Beds in San Francisco

The problem:

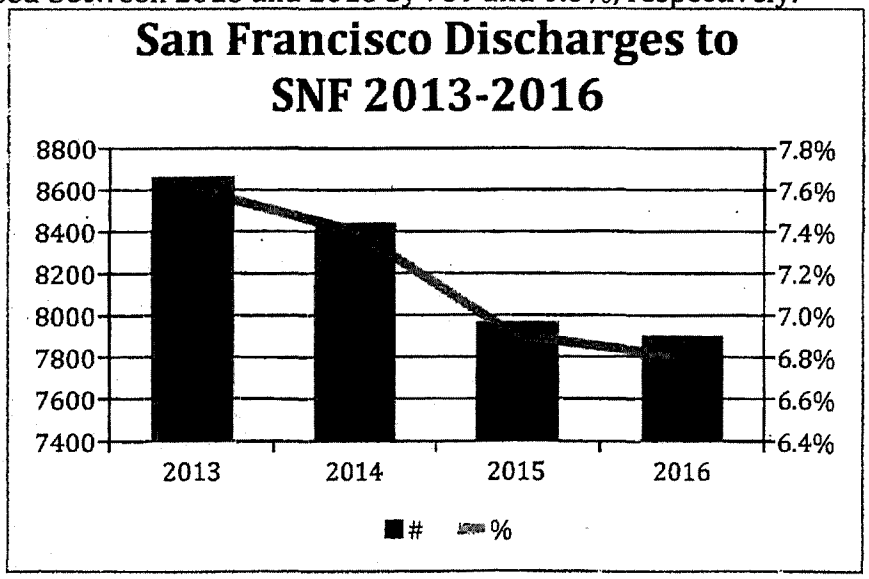
- **Short-term:** CPMC Sutter plans to close St. Luke's Skilled Nursing Unit in October 2017, resulting in the closure of 79 post-acute beds, including 40 sub-acute beds, in San Francisco County. Closing this unit will make San Francisco County the only county in California to have no sub-acute beds.
- **Bigger picture:** San Francisco has a shortage of post-acute care beds, including skilled nursing and sub-acute beds. As a result, patients that require post-acute care wait in acute care hospitals for beds in San Francisco to open up and/or be sent to facilities outside of San Francisco County.

Definitions of care levels:

- **Post-acute:** a range of medical services that support an individual's continued recovery from illness after a stay in an acute care hospital
- **Skilled nursing:** accommodates needs such as physical or occupational therapy, wound care and intravenous therapy, and assistance with activities of daily living (bathing, eating, dressing, toilet hygiene)
- **Sub-acute:** a category of skilled nursing for medically fragile patients with needs such as ventilator care, complex wound management, and tube feeding

The facts:

- The number of licensed skilled nursing beds, including sub-acute beds, in San Francisco decreased from 3,502 in 2003 to 2,542 in 2013. Not all licensed beds are staffed so the number of available beds is even lower.
- There are only 40 sub-acute beds in San Francisco, all of which are at St. Luke's. Most other California counties have more sub-acute beds. For example, Los Angeles County has 2,193 sub-acute beds, 55 times as many as SF despite having just 9.6 times as many discharges as SF.
- The number and percent of total discharges from San Francisco hospitals to SNFs decreased between 2013 and 2016 by 759 and 0.8%, respectively.



- A smaller proportion of patients discharged from hospitals in San Francisco in 2016 went to SNFs compared to the rest of the state (6.8% versus 8.8%). It is unclear how many of these SNFs were located in San Francisco.

DISPOSITION	Statewide	San Francisco
Routine (home)	70.8%	68.9%
Home health services	10.4%	12.9%
Acute care hospital	2.3%	3.1%
Skilled Nursing Facility	8.8%	6.8%
Residential care	0.4%	0.7%
Critical Access Hospital	0.0%	0.0%
Inpatient rehab	0.9%	1.2%
Other*	6.3%	6.3%

*Other includes prison/jail, against medical advice, cancer center, hospice care, psychiatric care, disaster care site, and died.

- Many patients who are discharged to sub-acute care or SNF spend a long time in the hospital prior to discharge. The following table shows the length of stay (LOS) for patients discharged from UCSF hospital to sub-acute care and SNF between 2012 and 2016. This single hospital example points to the additional acute care hospital resource and cost consequences when there are delays in transferring dischargeable patients to appropriate post-acute care facilities.

LOS (days)	Sub-acute care	SNF
<10	38%	62%
10 to 19	26%	23%
20 to 29	12%	8%
30 to 49	12%	4%
50 to 99	7%	2%
100 to 149	4%	0%
150 to 199	0%	0%
> = 200	1%	0%

This Fact Sheet was prepared for SFHHJJ by Dr. Grace Hunter, an Internal Medicine resident at UCSF. The tables are based on data internal to UCSF or from California's Office of State Health Planning and Development (OSHPD).

Article on Sub-Acute Unit at Saint Luke's Hospital

1 message

Bruce Allison <bruce94103@gmail.com> Sat, Aug 12, 2017 at 6:03 PM
To: poormagazine <poormagazine@gmail.com>, bruce94103 <bruce94103@gmail.com>, Gioioa Von Disterlo <gioioa@hotmail.com>

Saint Luke's Administration does not like old people.
By Bruce Allison and Kathryn Galves

The older we get, the sicker we get. San Francisco only has one Sub-Acute Unit in the City. Let me explain to you readers what Sub-Acute is. Take me for example: I am not a spring chicken anymore. I am an old tough bird. There are two levels of treatment if you had heart attack or you stop breathing. You get stabilized in the ICU (Intensive Care Unit) where you have tubes sticking in every part of your body from machines helping you to breath and your brain stays stimulated. Tubes going in your arms and feeding you while other tubes are giving you medicine. A tube going up your bladder to help you pee. All of these are used on you until you become fully conscious. This is called the Acute Unit. Now the Sub-Acute Unit is where you go and you may only need one or two of these devices.The main device is a respirator. You are able to talk to your family or love ones. While on this device you will need 24 hours of care per day. Medicare only pays for the first hundred days. If you don 't have Medicare it will come out of your pocket or from your Insurance. It still comes out of your pocket in the form of premiums from your insurance company. Until we get Single Payer this nightmare will continue

The only Sub -Acute Unit in the City is Saint Luke's Hospital. They have a total of 75 licensed beds for this unit. They are using only 25 of these beds. Don't listen to the mythology on one of my colleague's of a major newspaper. People have been turned away from these beds and they are planning to close the only hospital in the City that has them. The closest hospital that they would be sent to is in Sacramento. Most of these patients are great grandparents Their own children that come to visit them are 65 years old and above and the Grand kids are working parents. The patients are lucky to see their great Grand kids.

After October all this will change for the worst. Some of these patients may go down as far as Los Angeles, and the lucky ones will go down as far as Sacramento. If you are going to take them home with you, it will cost you $15,000.00 per month. Unless you are a doctor, CEO or you've won the lottery. For the rest of us, there is no hope. Why is it bad that you have to leave your parents alone? Only visit them once a month and in some cases once a year if you have to go down to Los Angeles.It will cost you $50.00 round trip per person per week if you visit your parents once a week in Sacramento via Greyhound plus The Sacramento Local bus will cost about $5.00 round trip. The nightmare begins if your loved one gets sent to Los Angeles and you don't drive. It will costs you $200.00 round trip by Greyhound or train. .Plus living expenses while you are visiting Los Angeles will $75.00 to $100.00 per day more or less. That is on the low end.

If you don't like this, and you live in San Francisco, phone your local supervisor and say, "Stop Saint Luke's from kicking out elders and save the Sub-Acute Units." Or this may happen to you because this is the **only** Sub-Acute Unit in San Francisco. Laguna Honda Hospital has turned into a rehab center.The average patient stays 30 days or less.

Bad news Bruce signing out.

July 26 TESTIMONY: PUBLIC SAFETY AND NEIGHBORHOOD SERVICES

My name is Ken Barnes, and I am a physician who practiced at St. Luke's Hospital for 32 years before my retirement a few years ago. I worked on the subacute unit for 15 years, and the SNF at St. Luke's for more years than I want to remember. I also worked for over 30 years with patients in community-based SNFs. So I bring a broad perspective to the issues facing all of us today.

Finishing in 2016, in San Francisco, there was a year-long Post-Acute Care Project that looked at both issues. In terms of the SNF issue, the need for SNF beds in San Francisco is shaped by its aging population, with studies showing people living much longer. With this aging there is an increasing incidence of chronic diseases, such as congestive heart failure, Chronic Obstructive Pulmonary Disease, diabetes and its complications, and most significantly, Alzheimer's Dementia, which is growing at an alarming rate.

In 2015 there was a report, Alzheimer's Disease Facts and Figures. This report highlighted that Alzheimer's is the most expensive chronic disease in the United States and the most common type of dementia. The report noted that by 2025 the number of people aged 65 and older with Alzheimer's is estimated to grow to 7.1 million, a 40% increase from 2015. As we know, patients with Alzheimer's, as well as other chronic diseases, need increasing amounts of personal care and supervision. The SNFs are where a large portion of these people will be cared for, now and in the future.

What has happened to SNF beds in San Francisco? Currently, according to the 2016 Post-Acute Care Project, SF has 2,542 licensed SNF beds. Based on SNF bed and population data, SF has 22 SNF beds per 1000 adults over aged 65. If SF were to maintain the current rate as the population ages, by 2030 it would need 4,287 SNF beds, an increase of 70%. If bed supply remains the same in the next 15 years, the bed rate would decrease to 13 SNF beds per 1000 people aged 65 and over. This means that there will be a shortage of 1745 beds needed in 2030 as the 113,000 people over 65 swells to a projected 192,000 in 2030.

This is a crisis, and while we agree with and appreciate the creation of the Post-Acute Care Collaborative, what is needed is action. The 2016 Post-Acute Care Project report, to review, had several key findings:

1. San Francisco is at risk for an inadequate supply of SNF beds in the future. Since 2001, the number of hospital-based SNF beds in San Francisco has fallen 43%, from 2300 to 1300, and community-based SNF beds have not kept up with the need.
2. MediCal beneficiaries with skilled needs have limited options in San Francisco.
3. Post-acute care placements for some vulnerable populations are difficult to find in SF.

There were also recommendations, both short and long-term, including:

1. Creating a city-wide Post-Acute Care collaborative of the providers of skilled care, and develop a strategy. This has not been done.
2. Exploring new incentives and funding options to address the gaps in skilled care. This, to my knowledge, has not been done.
3. Identifying the total number of long-term SNF patients in SF that could transition to the community. This is very tricky and reminds me of the movement of mental patients into the community under Ronald Regan.
4. Explore public-private partnerships to address this issue. I don't believe this has been done.
5. Developing a city-wide subacute care strategy, which has not been done.

Make no mistake about it: this is about money and profit, specifically the hospitals not wanting to lose money on patients in the SNF and subacute who are mostly covered by MediCal, putting profits above the well-being of patients. We know the MediCal reimbursement rates are not adequate, but the overall profits made by the private hospitals, who are mandated to provide charity care in order to qualify for Medicare, more than makes up for their losses on SNF beds. What do we do while the rates are low? What needs to be done in order for the reimbursements to increase? What happens to these patients?

Not only are the private hospitals and the Department of Public Health doing nothing, they are adding to the problem by closing hospital-based SNF beds, like those now at St. Luke's and in 2014 closing 101 beds at their California campus. In 2015 St. Mary's closed their 32 bed hospital-based SNF. Since 2001 the number of hospital-based SNF beds has fallen 43%, from 2,331 to 1,319, including the 420 SNF beds closed a Laguna Honda Hospital, and the number of community-based SNFs has not increased at a comparable rate.

And what is happening to patients now who need SNFs? There is mounting evidence that they are being discharged to out of county SNFs, the result being patients are separated from their families. As you may know, in 2014 this committee held a hearing related to this issue, and Supervisor Campos asked about discharge destination data: specifically, were patients going to in county SNFs or were they being shipped out of county. Does this data exist?

Which brings me to another aspect of this problem: the difference between hospital-based SNFs and community-based SNFs. While Alzheimer's and Parkinson's patients can usually be cared for in the community, those with more severe diseases, like heart and lung problems, will need more care in the SNFs, and should be in hospital-based SNFs, which are better staffed, both by nurses and physicians. With the aging population and the growth of people with serious chronic diseases, we need MORE SNF beds in hospitals, not less.

The subacute is an entirely different situation, and I will make a few brief comments. What would happen if the subacute at St. Luke's is closed? There is the issue of the 30+ patients still there, which the families of these patients will address. There is also the issue of new patients needing these services. CPMC closed admissions to patients outside of its hospitals in 2012. It appears that patients in need of these services are going to subacute facilities outside of San Francisco, much like the patients in need of skilled care, again separating patients from their families. The need for these services is not going to go away with the closure of the subacute at St. Luke's. And as severe chronic lung, heart, and neurological diseases increase, there will in fact be a greater demand for these services. The closure of this unit will be detrimental to the health of the people of San Francisco.

The subacute at St. Luke's was and is for people with life-threatening problems, as outlined by Dr. Birnbaum earlier. There is the person with an acute stroke who has not awakened yet, but does so while placed on the subacute, receives physical therapy, and goes home. There is the person who has respiratory failure in need of ventilator, but is not yet ready to be taken off the ventilator. They go to the subacute, are able to wean from the ventilator, and go home. There is the patient for whom the family is not ready to let go; they go to the subacute and the family has the time to grieve their loss and let go. And there are the patients who need care like ventilators to stay alive and interact and be loved by their families. Importantly, the clinical conditions of patients on the subacute can change rapidly, and having a doctor nearby can mean the difference between life and death. Thus, adequate staffing of a subacute, both in terms of nursing and physician care, is mandatory for the care of these patients, and having a subacute in a hospital or well-staffed facility is imperative for high-quality care.

So, it begs the question: what is the hurry in closing this unit at St. Luke's? It was originally going to be closed when the new St. Luke's opened in 2019, so why close it now? It is clearly a needed facility, and to not have one in San Francisco just doesn't make sense. It needs to remain at St. Luke's and open its doors to all in San Francisco who need its services. Your challenge and responsibility to make sure its doors remain open.

Patrick Monette-Shaw

975 Sutter Street, Apt. 6
San Francisco, CA 94109
Phone: (415) 292-6969 • e-mail: pmonette-shaw@eartlink.net

File No. 170773
Received via email
7/23/2017

July 23, 2017

Public Safety and Neighborhood Services Committee, Board of Supervisors
The Honorable Hillary Ronen, Chair
The Honorable Jeff Sheehy, Member
The Honorable Sandra Lee Fewer, Member
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

"This is about patient outcomes and out-of-county patient dumping, not jobs."

Re: **Premature Closure of St. Luke's Hospital's SNF and Sub-Acute Unit**

Dear Chair Ronen and Members of the Public Safety and Neighborhood Services Committee,

Although there is a strong correlation between the relationships patients have with their caregivers in hospitals and skilled nursing facilities to improve patient outcomes and regain optimal health, the primary focus of today's hearing should be on out-of-county patient dumping and the massive loss of in-county skilled nursing facility capacity, and only secondarily focus on the potential for loss of caregiver jobs. Ultimately this is about patient outcomes, and only to a lesser extent preservation of labor-harmony jobs. ***It's entirely possible thousands of San Franciscans have been dumped out of county***.

This Committee needs to ascertain just how many out-of-*county discharges there have been from both our two public* hospitals, and private-sector hospitals in San Francisco, dating back to July 1, 2006. As previous Civil Grand Juries have noted: "You can't fix what you don't measure."

Table 1 illustrates that there have been nearly 300 patients dumped out of county across the past five fiscal years, just from our two public hospitals alone. That's not counting out-of-county diversions in the Diversion and Community Integration Program (DCIP) prior to hospitalization. The Department of Public Health and the Department of Aging and Adult Services have refused to provide data on how many out-of-county discharges there were in the six fiscal years between FY 2006–2007 and FY 2011–2012, even though it most likely has that data.

Table 1: Public Hospital's Out-of-County Discharges, FY 2012–2013 — FY 2016–2017

Fiscal Year	Laguna Honda Hospital	SFGH[1]	Private-Sector Hospitals	Total
FY 06–07 — FY 11–12[2]	?	?	?	?
FY 12–13	26	7	?	33
FY 13–14	28	1	?	29
FY 14–15	25	68	?	93
FY 15–16	20	56	?	76
FY 16–17	20	40	?	60
Total[3]	119	172	?	291

[1] San Francisco residents discharged from SFGH but not admitted to LHH.

[2] DPH's SF*GetCare* database has discharge destination data for six-year period, but refuses to provide it.

[3] Data excludes out-of-county patient diversions prior to hospitalization via the Diversion and Community Integration Program (DCIP), and "Transitions" and successor programs, and excludes out-of-county placements chosen by families due to a lack of appropriate level of care beds in San Francisco.

Source: San Francisco Department of Public Health responses to records requests.
Updated: July 21, 2017

That six-year period is when DPH and LHH discharged a massive number of patients due to the elimination of 420 skilled nursing beds at LHH. How many of those patients were dumped out of county? And how many patients have private-sector hospitals also discharged out of county across the same periods?

DPH and DAAS have paid at least $7.8 million between July 1, 2002 and April 10, 2017 to RTZ Associates to develop over a dozen different components of the SF*GetCare* database, a database prototyped from a Microsoft Access database I helped develop while I was an employee at Laguna Honda Hospital that I know contains discharge destination information, including the names of cities discharged to.

"This Committee needs to ascertain how many San Franciscans were discharged out of county since July 1, 2006 from all hospitals in the City. You can't fix what's not being measured or isn't reported."

On March 20, 2014 this Committee held a hearing on a request from DPH and DAAS to increase the Community Living Fund's general fund allocation for FY 2014–2015 by $3 million. Then-Supervisor David Campos peppered Director of Public Health Barbara Garcia and DAAS' Executive Director, Anne Hinton, on discharge destination data during that hearing in an effort to learn whether patients are being "integrated" into San Francisco communities, or whether they are being "integrated" into out-of-county communities.

Hinton claimed she would have no way of knowing despite DAAS' contract with RTZ for SF*GetCare* database enhancements that tack discharge locations, which claim was complete nonsense. Kelly Hiramoto, the then-Acting Director of Transitions for DPH's San Francisco Health Network claimed May 29, 2014 that "*The data that was collected is incomplete. The software program designed to capture the data* ***did not work as designed***." Ignoring momentarily the issue of reputational harm raised

by Hiramoto's false allegation, RTZ's founder, Dr. Rick Zawadski (rick@rtzassociates.com) indicated on June 23, 2014 that "*RTZ Associates stands behind the functionality and integrity of the software we have developed for the City of San Francisco. Any data fields related to LHH Diversions requested by the City of San Francisco are fully functional and work as designed.*" It's clear the City has this data, but won't provide it.

Recommended Actions Following Today's Hearing

The Board of Supervisors and your subcommittee should follow up and require — for reasons below — that the:

1. **Public Health Commission:** Be **required** to comply with explicit provisions in the 1998 "Proposition Q" ballot measure to take an up-or-down vote at its August 15, 2017 meeting about whether the closure of St. Luke's sub-acute and SNF unit ***will*** or ***will not*** have a detrimental effect on the healthcare of San Franciscans, as required by Prop. Q.

   "This Committee should direct the Health Commission to comply with Prop. Q and perform its ministerial duties to rule one way or another on whether closure of St. Luke's SNF will, or will not, have a detrimental effect on San Franciscans."

   In May 2015, the Health Commission claimed it received secret attorney-client privileged "***advice***"from the City Attorney saying the Health Commission did **not** have to rule whether there would or would not be a detrimental effect on the closure of St. Mary's 32-bed SNF unit. [Subsequently, the City Attorney's Office confirmed it has issued no formal written opinion regarding Prop. Q's explicit requirements since it passed in 1998.] This sub-committee should direct the Health Commission to comply with Prop. Q and perform its ministerial duties to rule one way or another on whether closure of St. Luke's SNF will have a detrimental effect.

2. **Department of Public Health**: Report to you **all** out-of-county patient discharges of San Francisco citizens from LHH and SFGH between July 1, 2006 and today's date.

3. **Department of Public Health**: Coordinate with **all** private-sector hospitals to obtain and report all out-of-county patient discharges of San Francisco citizens from private-sector hospitals between July 1, 2006 and today's date.

   After all, a February 2016 report to the Health Commission — *Framing San Francisco's Post-Acute Care Challenge* — noted that private-sector hospitals cited out-of-county placement as necessary to transfer patients from acute care to lower levels of care. All acute care hospitals other than CPMC transfer sub-acute patients out-of-county. The number of private-sector out-of-county discharges weren't reported. DPH must obtain this data from all private-sector hospitals.

4. **Mayor's Long-Term Care Coordinating Council (LTCCC), the Community Living Fund (CLF), and the Advisory Body to the City's New Dignity Fund**: Although the LTCCC is charged with guiding the development of long-term care services, including in institutional settings such as SNF's, it has instead all along been overtly hostile to all SNF facilities.

   The most-recently released CLF *Client Satisfaction Survey* conducted by the Institute on Aging (IOA) was conducted in June 2015 to assess CLF-funded services. Notably, the Client Satisfaction Survey revealed 10% of CLF clients would ***not*** recommend the CLF/IOA's program to a friend or family member. Of survey respondents, only 21% said that the services they received ***had*** helped them maintain or improve their quality of life, and only 17% said that the services they received ***had*** helped them stay in their home. Budget data reveals that of $33.1 million in CLF expenses from inception through June 30, 2016, just $10.7 million (32.3%) went to "Purchase of Services" for CLF clients. This Neighborhood Services Committee should demand: "Show us where the money went"!

   The City's new "*Dignity Fund*" passed by voters in November 2016 will have been awarded a cumulative $575 million by FY 2026–2027. But it expressly prohibits expending funds to care for the elderly in skilled nursing facilities, or any other medical facilities, including post-acute care facilities. The Dignity Fund does not intend to measure unmet needs for either post-acute care or SNF facilities.

   These three entities should be required to report to this Board of Supervisors sub-committee in a subsequent hearing what efforts they have collectively made since 2007 to preserve in-county skilled nursing facility and sub-acute services for those who prefer to receive those services in-county.

5. **Department of Aging and Adult Services**: In September 2015 Supervisor Aaron Peskin introduced Motion 15-135 directing the Board of Supervisors Budget and Legislative Analyst (BLA) to conduct a performance audit of services to seniors. The BLA's report "*Performance Audit of Senior Services in San Francisco*" dated July 13, 2016 noted a "gap analysis" had not been performed:

   > "***The purpose of a service Gap Analysis is to estimate the unmet need for a particular service, which is the gap between the number of individuals currently receiving services, and the total population that might benefit from, or be eligible for, a particular service.*** *Without a Gap Analysis, the department lacks critical information when making decisions as to where it might best allocate existing service resources and what additional level of resources to request.*"

   The Public Safety and Neighborhood Services Committee should require the Department of Aging and Adult Services to ***immediately*** conduct a meaningful "gap analysis," as recommended by the BLA. Page 18 of the BLA's performance audit included Table 1.2, *Gap Ratings for Senior Service Areas (Rapid City, SD)* as an example. The Rapid City gap analysis contained 17 categories of services seniors are interested in, including a category specifically regarding expressed needs for assisted living and skilled nursing facility care. If Rapid City, SD can collect data on skilled nursing facility needs and preferences as part of its gap analysis, why can't San Francisco measure that gap here, too? If San Francisco isn't measuring that gap analysis, and also isn't measuring the number of out-of-county patient discharges, how can San Franciscans feel confident the City is doing everything it can to keep residents who need SNF care in-county?

6. **Department of Public Health and Health Commission**: The "*Framing San Francisco's Post-Acute Care Challenge*" report presented to the Health Commission in February 2016 recommended that because San Francisco is at risk of an inadequate number of SNF beds, that a new Post-Acute Care Collaborative explore options to bring new SNF capacity to market. The report noted between 2001 and 2015 there was a 43.4% decline in San Francisco's SNF beds — from 2,331 to 1,319, a loss of 1,012 beds — primarily driven by SNF closures within acute-care hospitals. Eliminating St. Luke's 79-bed license will push the acute-care hospital SNF unit closures even higher.

   "Between 2001 and 2015 there was a 43.4% decline in San Francisco's SNF beds — from 2,331 to 1,319, a loss of 1,012 beds — primarily driven by SNF closures within acute-care hospitals."

   The reported noted that based on current utilization rates, San Francisco faces a 68.6% deficit — a 1,745 shortage — in SNF beds needed in 2030, driven by projections San Francisco's current 113,000 people age 65 and older is expected to grow to 192,000 (20% of our total population) by 2030, a 69.9% increase

   No follow-up recommendations have been presented to the Health Commission, which hasn't discussed post-acute care since 2016. The report was authored by the usual suspect "*advisors*" from private-sector hospitals and the LTCCC.

   This Committee should require DPH and the Health Commission explain to you in a follow-up hearing why no actions to increase post-acute care options — including a new dedicated SNF for post-acute care funded by private-sector hospitals — have been presented for discussion and action to the Health Commission since its February 2016 meeting.

False Promises of Community-Based Alternatives (Trumpian "Alternative Facts")

It's time to stop the lie that elderly and disabled San Franciscans are being "integrated" into community living in San Francisco with appropriate community-based alternative "services and supports," given ample evidence of a significant number of out-of-county discharges.

"It's time to stop the lie that elderly and disabled San Franciscans are being 'integrated' into community living in San Francisco with appropriate community-based alternative 'services and supports'."

Similar to Ronald Reagan's closure of state mental hospitals with his false promise of community-based mental health alternatives, there has never been adequate alternatives for community-based long-term skilled nursing care. Just as mental health clients were dumped on the streets, we have now been reduced to dumping elderly and disabled San Franciscans into out-of-county facilities since there is an insufficient supply of in-county facilities to meet the demand for SNF care.

According to many observers, "community based" alternatives is the same argument Reagan used to shut down mental institutions, but it's merely a euphemism for not doing anything.

Dumping Mom and Dad Out of County

It has now been 17 months since the "*Framing San Francisco's Post-Acute Care Challenge*" report was presented to the Health Commission. No progress has been made on actions recommended in that report.

It's been 13 years since the Mayor's Long-Term Care Coordinating Council was created in 2004, and a full decade since the Community Living Fund was created 2007. Nor has any progress has been made to mitigate the damage from successive closures of hospital-based SNFs in San Francisco since 2001, damage which has resulted and will continue to accrue.

As Dr. Teresa Palmer has questioned: "*Do we really want to exile the aging to out-of-county facilities because San Francisco cannot take care of them?*" Because the Health Commission has rubber-stamped closures of SNF's like St. Luke's?

"If we can set aside $575 million for the Dignity Fund, the City should find $250 million — and the political will — to build additional SNF-bed capacity in the City."

Given the progressive loss of over 1,000 hospital-based SNF beds since 2001, it has exacerbated the entire SNF bed shortage in San Francisco at every level, including short-term care, long-term care, and rehabilitation care SNF beds, because the range of SNF care units — hospital-based SNF's; sub-acute SNF's; and free-standing short-term, long-term, and rehabilitation SNF's — are all interdependent on each other.

St. Luke's SNF is the only remaining sub-acute SNF left in the City providing such things as ventilator care among other sub-acute services, and if it closes not only will 44 of its current patients face out-of-county discharge as far away as Sacramento, St. Luke's will, essentially, be abandoning its license from the State for a 79-bed SNF. St. Luke's, like other private-sector hospitals, deliberately does not fully staff all of its licensed bed capacity as a way to save money.

Patients in St. Luke's SNF have a much higher level of acuity, and are much sicker. Closing St. Luke's 79-bed license SNF prematurely will just worsen the shortage of SNF beds throughout the City — to at least 1,824 beds short — and also worsen the availability of all other short-term care, long-term care, and rehabilitation care SNF beds.

It's time the City find the political will to fund construction of the 420 SNF beds eliminated from the Laguna Honda Hospital replacement project. Were that to cost $250 million, it would represent just 2.5% of San Francisco's now $10.1 ***billion*** annual budget. Although the Dignity Fund will be awarded $575 million by FY 2026–2027 from General Fund set-asides, it expressly prohibits using those funds for hospital- and SNF-based medical services.

If we can set aside $575 million for the Dignity Fund, the City should find $250 million — and the political will — to build additional SNF-bed capacity in the City, and ***require private-sector hospitals to contribute towards that funding***.

Respectfully submitted,

Patrick Monette-Shaw
Columnist, Westside Observer Newspaper

cc: The Honorable Ahsha Safai, Supervisor, District 11
The Honorable Aaron Peskin, Supervisor, District 3
Erica Major, Clerk of the Public Safety and Neighborhood Services Committee
John Carroll, Assistant Clerk, Board of Supervisors
Carolyn Goossen, Legislative Aide to Supervisor Hillary Ronen
Lee Hepner, Legislative Aide to Supervisor Aaron Peskin

Further Reading:

Hinton, Anne and Wong, Carrie. (2015, September 29). *Community Living Fund (CLF): Program for Case Management and Purchase of Resources and Services, Six Month Report: Jan-June, 2015*. Department of Aging and Adult Services. Includes *CLF Client Satisfaction Survey* administered in June 2015 by the Institute on Aging.

Patil, Sneha and Parrish, Monique. (2016, February 10). *Framing San Francisco's Post-Acute Care Challenge*. Written and published by Post-Acute Care Project Team.

Performance Audit of Senior Services in San Francisco. (2016, July 13). San Francisco Budget and Legislative Analyst.

Monette-Shaw, Patrick. (2017, May). *Where's Our Torchbearer for the Elderly?*. Contains discussion of Community Living Fund, Dignity Fund, Mayor's Long-Term Care Coordinating Council, out-of-county discharges, and demographic changes at Laguna Honda Hospital. Active hyperlinks at http://www.stopLHHdownsize.com/ or printer-friendly file at http://www.stoplhhdownsize.com/Where's_Our_Torchbearer_for_the_Eldery.pdf

Carroll, John (BOS)

From: Major, Erica (BOS)
Sent: Friday, July 21, 2017 8:07 AM
To: Teresa Palmer; Safai, Ahsha (BOS)
Cc: Ronen, Hillary; Sheehy, Jeff (BOS); Fewer, Sandra (BOS); Carroll, John (BOS)
Subject: RE: Information pertaining to 7/26/17 meeting on St. Luke's SNF closure-please read prior to meeting.

Hi Teresa,

Thank you for your testimony, this will be added to the official file. Looping in the contact for Public Safety and Neighborhood Services Committee, John Carroll.

John – Please add to the official File No. 170773.

ERICA MAJOR
Assistant Clerk
Board of Supervisors
1 Dr. Carlton B. Goodlett Place, City Hall, Room 244 San Francisco, CA 94102
Phone: (415) 554-4441 | Fax: (415) 554-5163
Erica.Major@sfgov.org | www.sfbos.org


Click here to complete a Board of Supervisors Customer Service Satisfaction form.

The Legislative Research Center provides 24-hour access to Board of Supervisors legislation, and archived matters since August 1998.

From: Teresa Palmer [mailto:teresapalmer2014@gmail.com]
Sent: Thursday, July 20, 2017 10:55 PM
To: Safai, Ahsha (BOS) <ahsha.safai@sfgov.org>
Cc: Ronen, Hillary <hillary.ronen@sfgov.org>; Sheehy, Jeff (BOS) <jeff.sheehy@sfgov.org>; Fewer, Sandra (BOS) <sandra.fewer@SFGOV1.onmicrosoft.com>; Major, Erica (BOS) <erica.major@sfgov.org>
Subject: Information pertaining to 7/26/17 meeting on St. Luke's SNF closure-please read prior to meeting.

Dear Mr. Safai:

I am a geriatric physican who has practiced for 30 years in San Francisco, a long time San Franciscan, and the aging daughter to a mother who recently needed nursing home placement. I am extremely upset that due to CPMC/St. Luke's actions, more skilled nursing home beds are being lost. This is not in the best interest of the people of San Francisco, and I cannot believe a hospital corporation that is supposed to be non profit is getting away with this.

St Lukes SNF/subacute was not supposed to close until 2019 when new hospital was open (even though there are no additional SNF beds at the new hospital). The 80 page study by the DPH :Post-Acute Care Final Report in 2016 (https://www.sfdph.org/dph/comupg/knowlcol/pac-project/default.asp) identified many progressively worsening issues from cannot

inadequate SNF services in San Francisco: worse of course especially for the most vulnerable.

I do not believe that ANY progress has been made in the actions recommended in this 2016 study by DPH. I believe DPH has not even met to EVEN BEGIN the process of mitigating the damage that successive closures of hospital based SNFs in San Francisco are and will cause.

The folks who will be most affected are not only the homeless and marginally housed, but any aging person WITHOUT a very high income in San Francisco who becomes unable to care for themselves at home.

Do we really want to exile the aging to out of county facilities because San Francisco cannot take care of them? ?Because we rubber stamped closures of SNFs like this?

Oh, and after St. Luke's closes, if anyone needs a SNF ventilator unit they will have to die in the ICU or leave the county immediately, because St. Luke's subacute unit was the only ventilator unit in county. Sayonara!

Any hospital based SNF closure rolls downhill to freestanding nursing homes, where long term nursing home beds are lost in order to do post hospital rehab. And it rolls downhill to the general public who must wait in crowded emergency rooms. Those who need long term care and cannot get it end up in a nightmarish scenario of cycling in and out of the emergency room/ acute hospital because they cannot maintain themselves in a stable state at home, until they finally die of their infected bedsores or the equivalent.

Sounds kind of medieval doesn't it?

Furthermore, Dr. Chow of the health commission is probably due to repeat his violation of the voter's will in the upcoming proposition Q hearings: in the past he has said, DESPITE THIS LAW, that the health commission does NOT have to rule whether the closing of a facility is detrimental or not. A nice perfection of the rubber stamp for CPMC/Sutter it seems....

CPMC/Sutter has already removed any mention of St. Luke's post acute/SNF/subacute services from the St. Luke's website as if they never existed-in spite of the fact that final closure is not scheduled until October and the proposition Q hearings start August 15. Apparently they can do this with no accountability and it is a fait accompli?

Who will be at your subcommittee meeting who has the authority to answer questions about this? How can CPMC/St. Luke's be stopped from putting profits over people?

Thank you very much,

Teresa Palmer MD
1845 HAyes St.
San Francisco, California, 94117
phone 415-260-8446
email teresapalmer 2014@igc.com

Hospital Council
of Northern & Central California
Excellence Through Leadership & Collaboration

Post-Acute Care Collaborative Fact Sheet and Update (June 2017)

SUMMARY

The San Francisco Post-Acute Care Collaborative (PACC) seeks to identify solutions to improve the availability and accessibility of post-acute care services for vulnerable populations and Medi-Cal beneficiaries in San Francisco.

The goal is to advance responsive post-acute care policy, research, and make operational recommendations.

Sponsored by the S.F. Section of the Hospital Council of Northern and Central California (Hospital Council), the PACC includes key City leaders from private non-profit hospitals, the S.F. Department of Public Health (DPH) and S.F. Department of Aging and Adult Services (DAAS), a major skilled nursing facility, and others.

Kelly Hiramoto, Director, Transitions Program, DPH and Daniel Ruth, President and Chief Executive Officer, Jewish Home, are PACC Co-Chairs.

The ten-month project, March – December 2017, includes monthly meetings with PACC members, and the project team comprising the PACC Co-Chairs, a project manager consultant, a special advisor from DPH, and the Regional Vice President of the Hospital Council of Northern & Central California. The PACC will issue a report to the Health Commission and the Hospital Council.

Important work continues, the *initial* efforts suggest:

- The need for and policies that support, public/private collaboration
- The greatest post-acute care placement resource need is affordable community-based supported living settings with 24/7 supervision/care, for cognitively impaired patients, especially low-income/Medi-Cal patients.
- Options to address post-acute care placement and support needs for behaviorally challenged patients –any diagnosis—are critical.

Below is a brief update on PACC activities to date.

PACC MATERIALS

Prior to beginning its work, the PACC was provided post-acute care information from several sources detailing the range of current post-acute care resources, as well as the trajectory of many high-risk post-acute care patients.

- *Framing San Francisco's Post-Acute Care Challenge (report adopted at the February 2016 Health Commission, recommending the PACCs creation)*
- *Difficult-to-Transition San Francisco Post-Acute Care Patient Flowchart (Low-Income, Medi-Cal/Medicare, Unstable Housing, Short and Long-Term Post-Acute Care Medical Needs)*

- *San Francisco Post-Acute Care Services/Programs Working Dashboard (Profiles Medical, Social, Placement, and Housing Post-Acute Care Programs and Services in San Francisco)*
- *San Francisco Supported Community Living Programs & Program Gaps*

KEY INFORMANT INTERVIEWS

Between April and June 2017, project team members conducted 15 key informant interviews and site visits, representing a broad range of post-acute care stakeholders and leading programs from the following: S.F. Department of Homelessness and Supportive Housing, DPH, DAAS, Whole Person Care Pilot, S.F. Medical Respite Program, Institute on Aging, Kindred Tunnell Skilled Nursing Facility, Kindred Lawton Skilled Nursing Facility, Direct Access to Housing Tours (990 Polk and Richardson Building), Dignity Fund, Hummingbird Place, Progress Foundation, On Lok, and Jewish Home.

The emerging themes from the interviews underscore the need for public-private program collaboration to address post-acute care challenges for high-risk post-acute care patients.

POST-ACUTE CARE HOSPITAL SURVEY

To understand the difficulties San Francisco hospitals experience transitioning high-risk post-acute care patients, PACC members completed an online point-in-time (April 27, 2017) Post-Acute Care Hospital Survey to illuminate the numbers of post-acute care patients waiting for placement and their payer sources, specific behavioral challenges presented by this patient group, reasons hospitals had difficulty placing these patients, and patient acuity levels.

Key takeaways are:

- 117 patients waiting on a given day in San Francisco hospitals
- Almost 50% of patients waiting require 24/7 supervision & custodial care
- After excluding ZSFG patients, the proportion of patients with dementia (33%) and patients who require 24/7 supervision (55%) remains constant
- The most difficult to place post-acute care patients are those who are low-income/Medi-Cal requiring 24/7 supervision to address ADL needs
- While mental illness, homelessness, substance abuse are big challenges, the greatest post-acute care placement resource need at this time are affordable community-based setting with 24/7 supervision and care

NEXT STEPS

Through a guided strategic process, at the June 15 meeting the members identified two consensus post-acute care high-risk populations and created two PACC workgroups to respond, with the goal of developing implementable, financially viable solutions.

Workgroup A: Cognitively impaired post-acute care patients requiring 24/7 supervision

Workgroup B: Behaviorally challenged disturbed post-acute care patients—any diagnosis

Workgroups will begin developing solutions to address the subgroups and gaps in care at the July 2017 PACC meeting. With support and guidance from the project team, workgroups will identify short- and long-term as well as internal and external solutions to their population needs and gaps in care.

A final report presenting these solutions is due in November 2017.

PACC MISSION, VISION, VALUES

At the first meeting, the PACC adopted the following to guide their recommendations.

Mission Statement: To identify implementable, financially sustainable solutions to the post- acute care challenge for high-risk individuals in the City and County of San Francisco (high-risk individuals defined as non-benefited, under-benefited and/or hard to transition).

Vision Statement: Empowered individuals and families through strengthened social supports, collaboration, and partnership.

Values:

- Health Care Access
- Quality of Life
- Serving Others
- Transforming & Enriching the Lives of Older Adults & Persons with Disabilities
- Building Relationships
- Honoring Diversity, Culture, and Under-Served Populations
- People First
- Transparency

PACC BACKBROUND

The PACC is a result of the San Francisco Post-Acute Care Project launched by DPH in August 2015. The project concluded in December 2015 with the report, "Framing San Francisco's Post-Acute Care Challenge," which addresses the impact of reduced skilled nursing facility beds on the need, supply, and gaps in post-acute care for in the City, now and in the future. Key report findings include:

- San Francisco is at risk for an inadequate supply of skilled nursing beds due to a growing older population coupled with the high-cost of doing business in the City, low reimbursement rates
- Medi-Cal Beneficiaries with skilled nursing needs have limited options
- Vulnerable populations are difficult to place in skilled nursing and long-term care
- The creation of the Post-Acute Care Collaborative to convene interested parties and make recommendations

In February 2016, the Health Commission adopted the report and endorsed the recommendation to create a San Francisco Post-Acute Care Collaborative. The Hospital Council is convening and providing the financial support for this effort.

///

Hospital Council
of Northern & Central California

Excellence Through Leadership & Collaboration

POST-ACUTE CARE COLLABORATIVE (PACC)

Matija Cale, RN, MS
Senior Manager, Concurrent Review
San Francisco Health Plan

Claire Day (adjunct member)
Chief Program Officer
Alzheimer's Association

Kelly Hiramoto, LCSW, PACC Co-Chair
Director Transitions Program
S.F. Department of Public Health

Mivic Hirose, RN
Executive Administrator
Laguna Honda Hospital and Rehabilitation Center
San Francisco Department of Public Health

Shireen McSpadden
Executive Director
Department of Aging and Adult Services

Austin Ord
Director of Post-Acute Care
Bay Area Care Coordination
CPMC – Sutter Health

Elizabeth Polek, MBA, LCSW
Director of Patient Transition Management
UCSF Medical Center

Daniel Ruth, PACC Co-Chair
President/CEO
Jewish Home of San Francisco

Lauren Suarez
CEO
Kentfield Hospital

Margaret G. Williams, RN, MBA, NE-BC, CPHQ
Care Coordination Contracted Consultant
Kaiser Permanente Greater San Francisco

Ruth Zaltsmann, MS, RN
MKT BPCI Clinical Program Manager
St. Mary's Medical Center-SF/Saint Francis Memorial Hospital

PROJECT TEAM

Monique Parrish, DrPH, MPH, LCSW
Collaborative Project Manager
LifeCourse Strategies

David Serrano Sewell
Regional Vice President
Hospital Council of Northern and Central California

Sneha Patil, MPH
Special Advisor to PACC
Senior Health Program Planner
Office of Policy and Planning
San Francisco Department of Public Health

BOARD of SUPERVISORS

City Hall
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco 94102-4689
Tel. No. 554-5184
Fax No. 554-5163
TDD/TTY No. 554-5227

MEMORANDUM

TO: Barbara A. Garcia, Director, Department of Public Health
Trent Rhorer, Executive Director, Human Services Agency
Todd Rufo, Director, Office of Economic and Workforce Development

FROM: Erica Major, Assistant Clerk, Public Safety and Neighborhood Services Committee, Board of Supervisors

DATE: June 26, 2017

SUBJECT: HEARING MATTER INTRODUCED

The Board of Supervisors' Public Safety and Neighborhood Services Committee has received the following hearing request, introduced by Supervisor Safaí on June 20, 2017:

File No. 170773

Hearing to discuss the closing of the skilled nursing and sub-acute units in St. Luke's Hospital; and requesting the Department of Public Health, Human Services Agency, and the Office of Economic and Workforce Development to report.

If you have any comments or reports to be included with the file, please forward them to me at the Board of Supervisors, City Hall, Room 244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102.

c: Greg Wagner, Department of Public Health
Coleen Chawla, Department of Public Health
Krista Ballard, Human Services Agency
Ken Rich, Office of Economic and Workforce Development
Lisa Pagan, Office of Economic and Workforce Development

Print Form

Introduction Form

By a Member of the Board of Supervisors or the Mayor

RECEIVED
BOARD OF SUPERVISORS
SAN FRANCISCO
2017 JUN 20 PM 2:08
Time stamp or meeting date

I hereby submit the following item for introduction (select only one):

- ☐ 1. For reference to Committee. (An Ordinance, Resolution, Motion, or Charter Amendment)
- ☐ 2. Request for next printed agenda Without Reference to Committee.
- ☒ 3. Request for hearing on a subject matter at Committee.
- ☐ 4. Request for letter beginning "Supervisor [ ] inquires"
- ☐ 5. City Attorney request.
- ☐ 6. Call File No. [ ] from Committee.
- ☐ 7. Budget Analyst request (attach written motion).
- ☐ 8. Substitute Legislation File No. [ ]
- ☐ 9. Reactivate File No. [ ]
- ☐ 10. Question(s) submitted for Mayoral Appearance before the BOS on [ ]

Please check the appropriate boxes. The proposed legislation should be forwarded to the following:

☐ Small Business Commission ☐ Youth Commission ☐ Ethics Commission

☐ Planning Commission ☐ Building Inspection Commission

Note: For the Imperative Agenda (a resolution not on the printed agenda), use a Imperative Form.

Sponsor(s):

Supervisor Ahsha Safai

Subject:

The closing of the skilled nursing and sub-acute units in St. Luke's Hospital.

The text is listed below or attached:

Requesting that the Board of Supervisors convene to have a hearing discussing the closing of the skilled nursing and sub-acute units in St. Luke's Hospital.

Signature of Sponsoring Supervisor:

For Clerk's Use Only: