File No. 170788 **Committee Item No.** 2
Board Item No. _____

COMMITTEE/BOARD OF SUPERVISORS

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Prepared by: John Carroll **Date:** December 1, 2017
Prepared by: _____ **Date:** _____

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: 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)

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

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: Shireen McSpadden, Executive Director, Department of Aging and Adult Services
Barbara A. Garcia, Director, Department of Public Health

FROM: Erica Major, Assistant Clerk, Public Safety and Neighborhood Services Committee, Board of Supervisors

DATE: July 3, 2017

SUBJECT: HEARING MATTER INTRODUCED

The Board of Supervisors' Public Safety and Neighborhood Services Committee has received the following hearing request, introduced by Supervisor Yee on June 27, 2017:

File No. 170788

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.

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: Bridget Badasow, Department of Aging and Adult Services
Greg Wagner, Department of Public Health
Coleen Chawla, Department of Public Health

Print Form

Introduction Form

By a Member of the Board of Supervisors or Mayor

RECEIVED
6/27/2017
@6:02pm

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 [ ] inquiries"
- ☐ 5. City Attorney Request.
- ☐ 6. Call File No. [ ] from Committee.
- ☐ 7. Budget Analyst request (attached 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 the Imperative Form.

Sponsor(s):

Yee, Peskin, Fewer; Sheehy, Ronen, Safai

Subject:

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.

The text is listed:

Signature of Sponsoring Supervisor: [signature]

For Clerk's Use Only