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.