Presented in Committee
July 26, 2017

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.

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POST-ACUTE CARE COLLABORATIVE (PACC)

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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

Presented in Committee
July 26, 2017

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.