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)
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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.

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

The problem:

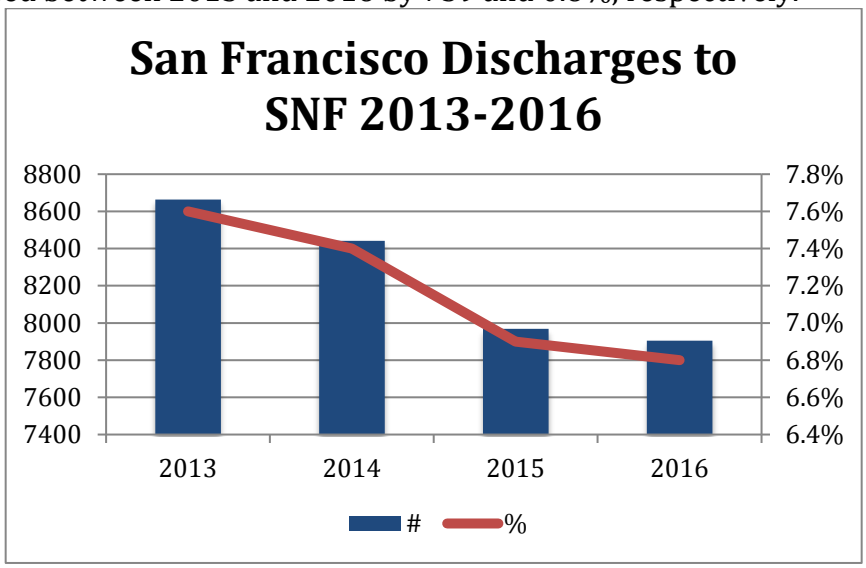
- **Short-term:** CPMC Sutter plans to close St. Luke's Skilled Nursing Unit in October 2017, resulting in the closure of 79 post-acute beds, including 40 sub-acute beds, in San Francisco County. Closing this unit will make San Francisco County the only county in California to have no sub-acute beds.
- **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).

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.