Carroll, John (BOS)

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

Categories: 2017.11.29 - PSNS, 170773

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

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

Board of Supervisors File No. 170773

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

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

November 28, 2017

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

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

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

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

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

My written testimony addresses:

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

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

Respectfully submitted,

Patrick Monette-Shaw
Columnist
Westside Observer Newspaper

Patrick Monette-Shaw

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November 28, 2017

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Major Concerns

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

1. **A Plan Be Developed to Rapidly Identify and Build Additional In-County SNF Facilities:** The Department of Public Health and Health Commission created the PACC two-and-a-half years ago. The PACC's draft final report fails to address building out additional in-county SNF facilities as rapidly as possible. Clearly, while sub-acute in-county facilities are critically needed, so too are in-county SNF facilities, which must be expanded quickly.
2. **"Regional Solutions" for SNF and Sub-Acute Care Facilities Are Inappropriate:** We've heard too much about trying to find "regional solutions" to solve the lack of a sufficient number of SNF units in San Francisco. DPH Director Garcia regurgitated at the Board of Supervisors Committee of the Whole hearing on September 12 the PACC's, the Health Commission's, and Supervisor Yee's assertion that a "***regional*** solution" for SNF level-of-care should be pursued. ***That just portends even more out-of-county discharges.***
3. **Developing Additional Sub-Acute Units Should Not Focus Only on Mental Health Patients:** Director of Public Health Barbara Garcia testified September 12 in her remarks to the Board of Supervisors (presumably under oath) that DPH is working with Dignity Health on trying to develop a sub-acute unit, ***but only for mental health patients***. DPH and the PACC do not appear to be looking for solutions for sub-acute patients who do **not** have a mental health diagnosis. This Committee needs to ascertain from Garcia whether DPH is working on establishing any public/private partnership to open additional sub-acute facilities (should St. Luke's/CPMC succeed in closing St. Luke's sub-acute unit) for **all** San Franciscans, not just those who have mental health diagnoses.
4. **A "Certificates of Preference" Program Must Be Established:** To its credit, the PACCs draft final report does recommend that if patients are dumped into out-of-county facilities, patients in "*regional SNF facilities should, however, be transferred back to a corresponding facility in San Francisco as space becomes available*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Respectfully submitted,

Patrick Monette-Shaw
Columnist, Westside Observer Newspaper

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

Carroll, John (BOS)

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

Categories: 2017.11.29 - PSNS, 170773

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

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

Board of Supervisors File No. 170773

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

Dear Mr. Carroll,

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

Sincerely yours,

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

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

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

The problem:

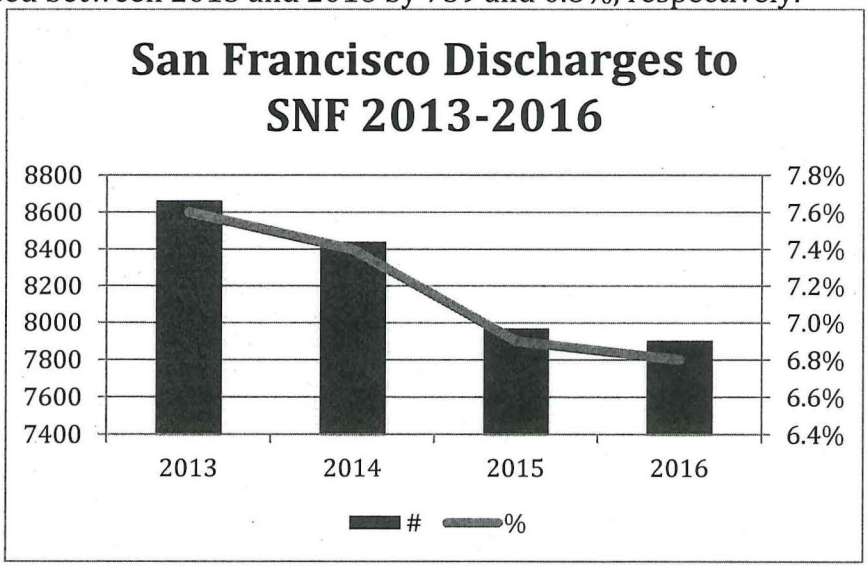
- **Short-term:** Until put on hold, CPMC Sutter had planned to close St. Luke's Skilled Nursing Unit in October 2017, which would have resulted in the closure of 79 post-acute beds, including 40 sub-acute beds, without providing any sub-acute options within the CPMC system. Once all current patients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

Definitions of care levels:

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

The facts:

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



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

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

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

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

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

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

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

November 28, 2017

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

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

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

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

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

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

Carroll, John (BOS)

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

Categories: 2017.11.29 - PSNS, 170773

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

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

Board of Supervisors File No. 170773

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

Dear Mr. Carroll,

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

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

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

Thanks you very much

Sincerely

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

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

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

Board of Supervisors
November 29, 2017

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

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Concerns and Requests About CPMC Subacute SNF Care

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

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

Shutting Down Hospital Based Skilled Nursing Facilities

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

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

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

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

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

Critique of "Solutions" by the Hospital Council

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

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

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

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

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

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

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

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

Summary of Grievances Received by S.F. Ombudsman

Post Acute SNF Rehab in Community SNFs:

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

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

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

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

Post Script

Ombudsman Resources:

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

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

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

Carroll, John (BOS)

From: Carroll, John (BOS)
Sent: Wednesday, November 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

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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:

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.