RESIDENTIAL CARE FACILITIES FOR THE ELDERLY

Department of Aging and Adult Services
Department of Public Health
Hospital Council of Northern and Central California

PUBLIC SAFETY AND NEIGHBORHOOD SERVICES COMMITTEE
DECEMBER 7, 2017

Overview

- Residential Care Facilities for the Elderly (RCFEs) provide an important level of care, in-between adults who can live safely at home and adults who need 24/7 medical care

- The majority of people want to remain in their homes as they age, referred to as "aging-in-place"

- As adults age, they may require a range of services that and supports known as long-term care

- RCFEs provide long-term care for people who can no longer live safely at home and who need 24/7 supervision but who don't require 24/7 medical care

Long-Term Care Definitions

- **Long-Term Care** - variety of services which help meet medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves
- **Post-Acute Care** – medical services that support recovery from illness following a hospitalization
- **Residential Care Facilities for the Elderly (RCFE)** – also known as "Assisted Living" or "Board and Care Homes" provide a range of services to individuals who require support with Activities of Daily Living
- **Skilled Nursing Facilities (SNF)** – provides skilled nursing care and/or rehabilitation services, and assistance with Activities of Daily Living
- **Activities of Daily Living (ADLs)** - dressing, bathing, toileting, eating, transferring to or from a bed or chair, grooming

Long-Term Care Services

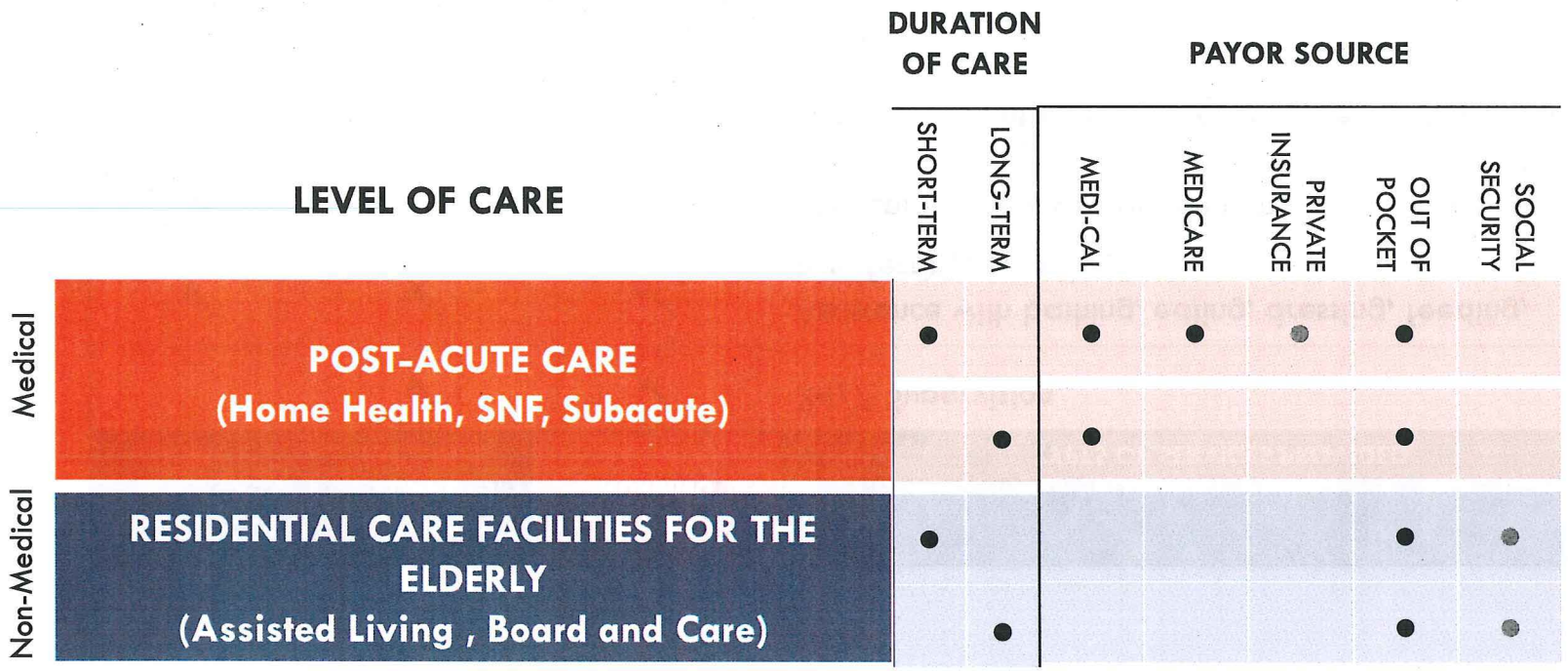
Medical Services	Non-Medical Services
• Skilled nursing services (ex. wound care, IV injections) • Rehabilitation - speech, occupational, and physical therapy • Medication management • Durable medical equipment • Health promotion/disease prevention • Hospice care	• Assistance with Activities of Daily Living (ADLs) - dressing, bathing, toileting, eating, transferring to or from a bed or chair, • Home-delivered meals • Transportation and access • Home repairs and modifications • Financial and or legal services

Long-Term Care is Provided in Different Settings

HOME *	RESIDENTIAL CARE FACILITIES	SKILLED NURSING FACILITY	TYPES OF SERVICES PROVIDED
	✓	✓	24/7 Supervision
✓	✓	✓	Assistance with bathing, eating, dressing, feeding, transferring, toilet hygiene
✓		✓	Physical therapy, occupational therapy, speech therapy
✓		✓	Wound care, intravenous therapy, injections, monitoring of vital signs

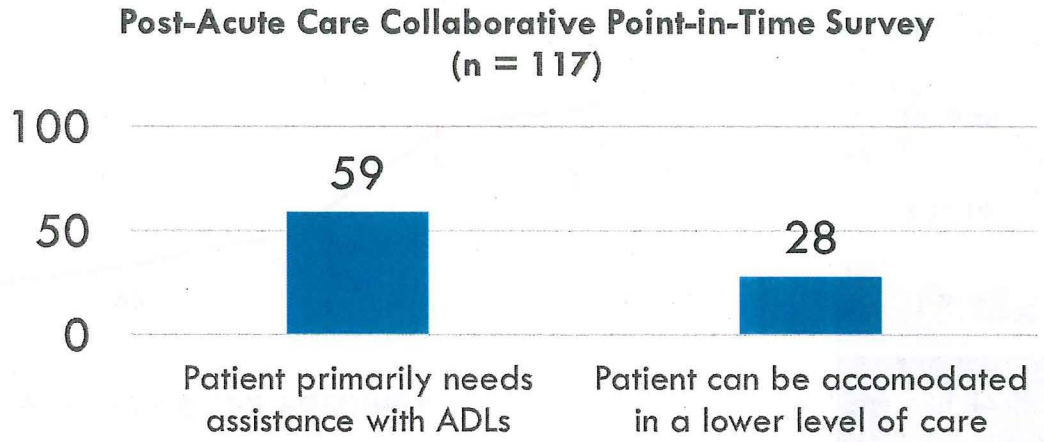
**Home care is generally provided on a part-time basis*

Most Seniors Pay Out of Pocket for Long-Term Care



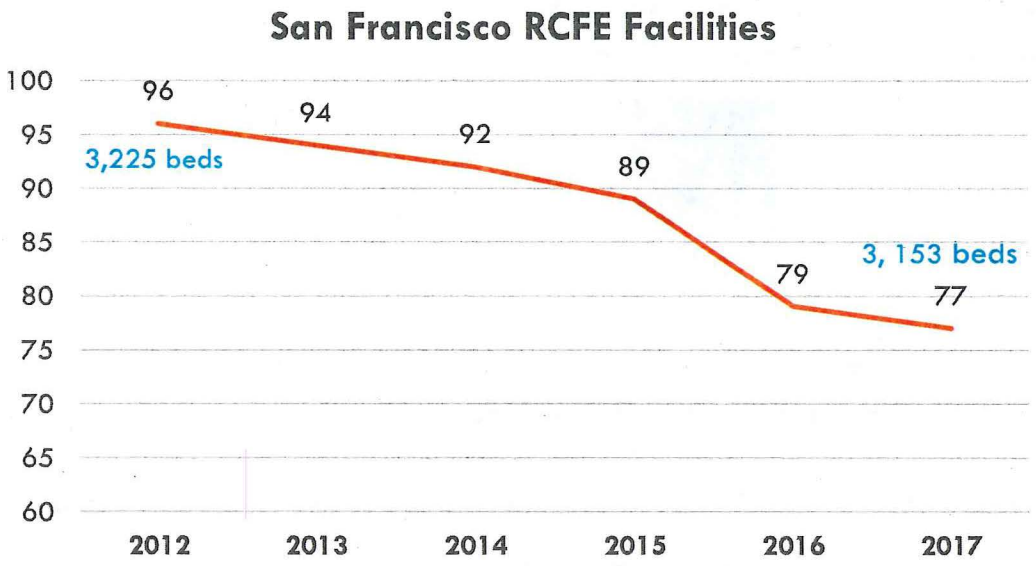
Some Patients Can Transition to Lower Levels of Care

Some patients who receive long-term care in SNFs could be supported in lower levels of care (estimated up to 25%)



Average Cost in San Francisco	SNF	RCFE
	$11,700 - $14,200/month	$4,300/month

San Francisco RCFE Supply



Bed Size	Number of Facilities	%
1 to 6	29	38%
7 to 14	18	24%
15 to 49	14	19%
50 to 99	6	8%
100+	10	13%

Access Challenges for RCFEs

Challenge	Contributing Factors
Reduction of Facilities	• Operators ready to retire • Families do not want to take over the business • Value of the land
Affordability For Low And Middle Income Residents	• As non-medical facilities, no insurance covers this level of care • Average cost is $52,000/year • Few to no facilities will accept Social Security • Growth of higher cost facilities/beds
Limited Facilities Accept Patients with Behavioral or Cognitive Challenges	• Cost of doing business (i.e. higher staffing levels) • Requires specialized staff

Home- and Community-Based Care

The Department of Aging and Adult Services supports programs that bridge the gap between acute and community-based care settings through programs that include:

- Home Care Services
- Case Management
- Home Delivered Meals or Groceries
- Transportation
- Caregiver Support
- **Community Living Fund**

Post-Acute Care Collaborative Solutions

1) A Standardized Post-Acute Care Assessment Tool

2) A Citywide Roving Placement Team

3) Increase Access to Residential Care Facilities for the Elderly and Independent Housing with Wraparound Services

A) provide subsidies and other support to increase access to RCFEs and independent housing with wraparound services in San Francisco, for patients who can live supported in the community;

B) advocate for expanding the supply of RCFEs in the Mayor's housing initiative.

Thank You

Seniors, Disabled People and Others Need a Full Continuum of Care

Seniors, disabled people and others need a full continuum of care, ranging from help at home, to assisted living, to residential care, to Skilled Nursing Facility (SNF) care, and for those who choose to live on life support, to sub-acute SNF care. Importantly, a shortage at any level of care in this continuum hampers other levels of care. The overarching obstacle to providing this continuum of care has been hospitals' perceived need to preserve revenues and profits as a priority over providing what the people of San Francisco need for a good quality of life in their home city as they grow older. Some facts:

1. Low and moderate income San Franciscans are not able to access adequate long-term care or support to continue to live safely in San Francisco when they need it.

2. The causes involve the massive numbers of aging people with related illness and disability, the current reimbursement system which pays mostly for acute care, the high cost of land, and the lack of citywide health planning. In this void, hospitals tend to offer only services that preserve their revenue, even though they are non-profit entities. The needs of the people of San Francisco are not the determining factor when the hospitals consider their (tax free) revenues.

3. In the draft report of the Hospital Council/Post-Acute Care Coordinating Council, December 2017, there was little mention of the fact that San Francisco hospitals have shut down SNF care, subacute SNF care, and acute psychiatric care on their campuses. This has precipitated a critical shortage of SNF subacute care and long-term SNF care in San Francisco.

4. For the hospitals, a narrow focus on short stay acute care brings in the most revenue. There is currently no SNF subacute care at all in San Francisco for new people who need it. Low and moderate income people cannot find regular long-term SNF care in San Francisco. Community SNFs are using their beds to provide short-stay post-hospital rehab, which the hospitals used to provide, because it is funded by Medicare and pays more than long-term care funded by Medi-Cal.

5. Because the hospital industry will not provide post-acute SNF care on its campuses, and because of the shortage of community long-term SNF care for low and moderate income people, there is a trend toward keeping sicker people in residential care, even though Residential Care Facilities for the Elderly (RCFEs) are non-medical facilities.

6. Residential care should only be used for frail and ill people if that care truly meets their needs. Denying SNF care to low and moderate income people who really need it is a form of medical neglect. Residential care should not be funded at the expense of SNF care.

7. Enhanced residential care for people with Alzheimer's should include services that residential care facilities usually don't have: the presence of licensed nurses at the facility, specialized training for staff, and increased staffing ratios. In the community, this type of service is called "Memory Care." It is expensive to do this well, and Medi-Cal and Medicare don't pay for it. The Hospital Council report recommends this type of care but its largest member, Sutter/CPMC,is shutting down a model of this kind of care, Swindells, on its California Campus, to preserve revenue.

8. Frail seniors and others who need care can only be safely cared for in residential facilities if there is comprehensive wrap-around care that makes medical and social services easily available to them. UCSF and hospital corporations do not like to provide the medical part of

this kind of wrap-around care for seniors because Medicare does not pay as much as does major medical insurance for younger people. So we see in San Francisco that there are urgent care clinics in every neighborhood but no source of wrap-around medical care in the same neighborhood for frail seniors. Again, these bad decisions are driven by profit.

9. A subset of those who are in residential care have progressive illness and will require timely referral to a higher level of care such as skilled nursing facilities, either long-term or for short-term rehab. If these are not adequately provided, we are looking at worsening illness, being forced to leave the county, or death for elderly or disabled San Francisco residents.

10. Staff at Residential Care facilities for the elderly must have a routine of regular training with regular updates. Their responsibility for frail residents dictates that caregivers clearly understand not only how to care for their charges physically and behaviorally but also when to call for help.

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 (a) 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 (b) 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.
    d. Enact legislative/tax/code solutions that will incentivize providers of residential care to open new facilities and maintain a high standard of staff training; optimize the use of Medi-Cal and Medicare waivers and funds from non profit organizations to make needed supports and care available to low and moderate income elderly.
    e. Work with the state to adequately fund the Ombudsman's office so there will be enough staff to monitor all SNF and residential care facilities and to advocate for the people that need these services.

December 7,2017
Testimony
Benson Nadell
Program Director
San Francisco LTC Ombudsman Program
Felton
6221 Geary Blvd
San Francisco , Cal 94121

I wish to enter the following into the Public Record.

I have been with the Ombudsman Program since 1986 and have seen unfolding trends as to availability of long term care facilities. Under Federal Law the Ombudsman , as Representative of the State Ombudsman , California Department of Aging, is to identify problems made by or on behalf of residents of facilities, resulting from actions, inaction, or decisions that may adversely affect their health. Safety, welfare or rights. In California Law the Ombudsman are also charged to respond to received reports of abuse and neglect. Ombudsmen are abuse/neglect investigators. This State Law widened to jurisdiction to include dependent adults either mentally ill or developmentally disabled, who reside in other types of licensed care facilities.

I have been a member of the following City Task Forces:

1. Discharge Planning Task Force
2. Dementia Expert Panel
3. Long Term Care Coordinating Council

Residential Care /Assisted Living:
RCFE or Residential Care Facilities for the Elderly consist of sub-types under the same State of California Title22 Regulatory System(http://www.cdss.ca.gov/Portals/9/Regs/rcfeman1.pdf?ver=2017-05-24-084325-593)

In San Francisco as of December 2017 there are 70 RCFE with 3116 Beds of that total 26 RCFE have low income resident(as defined by SSI but with a supplemental payment) with a total of 279 beds as a sub-total.They would be

called board and care or group home segment of RCFE. The remaining RCFE and beds fall within the range of private pay $3200- $12,000 per month)

RCFE /Assisted living are regulated by State of California Community Care Licensing; Federal Payment programs do not pay. RCFE are market place and each consumer pays the monthly rate. Most do not have any optional long term care insurance product. State Regulations do not require a uniform standardized assessment for all assisted living/ board and care. The regulations on provision of care do not focus on qualitative outcomes. The Licensing Agency staff do not review quality of care issues, only if needs are being met.
Persons with incidental medical needs are allowed to reside in these RCFE under certain conditions. The co-morbidities of residents have exceeded the skills of many staff: O2 is allowed, as are colostomy , catheters, stage 1 and2 pressure sores, diabetic management, along with persons with dementia. RCFE house persons where the care management is lacking and the staff are inadequate in number and in skills. CCL inspectors are not trained to review quality of care.

Summary of Complaint/Grievances Ombudsman RCFE

1. Small board and care home type
   a. Evictions for complaining
   b. Sub-standard food: slice of boloney and thin soup
   c. Medication mismanagement
   d. Diversion of personal monies for payback soda and cigarettes no receipt
   e. Accepting persons back from hospital without reviewing Discharge summaries and H&P. Man with Parkinson's treated for psychiatric illness and assumption he had parkinsonian side effects. No one reviewed paper work; not on sinimet, kept falling; died.
   f. Woman receiving psychiatric medications in board and care along with case management, dies suddenly , to everyone's dismay. In her late 70's – concern over death, lessened. Ombudsman discovered she had history of cardiac problems and this was not monitored by visiting doctor ; no follow up EKG. Smaller facilities lack skill base.
   g. During Ombudsman repeated visits, half residents always in bed, shrouded in blankets. No quality of life; on TV watching and smoking. No one wants to complain. They know nothing better.
   h. In a private pay smaller RCFE- a man develops Stage 1V Pressure sores. He has a hospital bed and own room. The staff are poorly supervised and he is not turned. He should have been hospitalized because stage 3 and 4

sores are beyond the scope per Title 22. Nor was he ever in a higher level of care. He dies.

i. An agency calls Ombudsman: a client in RCFE misses appointments. She the falls, and breaks an arm. There is no notification to MSW with that agency.

2. Larger RCFE –Assisted Living
   a. A male resident calls the Ombudsman Program : He fell beyond the reach of the call system. He is afraid to notify management, because in this RCFE room check costs an extra $ 500 per month. When the morning staff found him, they put him in bed. Without assessing him, the pain worsened. His daughter upset, called 911. He had a fractured femur.
   b. In a large CCRC-(continuing retirement community) which includes RCFE, the condominium owners in this care facility are going to pay for a wall which damaged by wind and rain as an additional capital expense. The fine print is in then Contract. This is over and above the monthly costs. Yet the residents have no shares in the business of this State wide large Corporation.
   c. At an RCFE with a memory care unit. Staffing has been reduced by the new management company after purchase of the building. One employee calls the Ombudsman Program that others still working have hit and pulled those elderly residents with memory disorders. A police report is also sent to the Ombudsman Program. Morale is low among caregivers.
   d. An elderly man is running out of money to pay the $ 7000 per month rate. He has Alzheimers Dementia. His daughter calls the Ombudsman Office. His income is actually only $ 2900 per month. His disease has progressed. Because he refuses to pay the rate, he is facing eviction. The daughter calls for a nursing home alternative. All are focused in SF on post acute. The daughter calls other RCFE ; he is unable to pay their monthly rate as well.
   e. An elderly woman with dementia returns from a hospital after a fall. New medications were order. The receiving RCFE never fills the order; nor did they review the paperwork. The RCFE blames the son, who happens to live out of state for not picking up the order at Walgreens. The Ombudsman reviews the med. Room and talks to the med-tech. That person was off for four days and missed the communication. She apologized.
   f. A 87 year old man becomes septic from sores. He is diabetic with renal failure. The Dialysis clinic calls the Ombudsman Program with a follow up mandated abuse/neglect report. He missed the last appointment. The clinic notice pressure sores. Calls to the RCFE were met with voice

messages. The RCFE calls 911 and he is taken to acute hospital. He stays in the ED for a day and half. The ED MSW calls the Ombudsman Program saying he has pressure sores and also fills out a neglect abuse mandated report. He is not admitted to acute but is sent back the following weekend, after a short IV anti-biotic course. RCFE are unable to provide IV interventions under Title 22.

g. An RCFE advertising Memory /Dementia Care has a secured section with delayed egress. It is not well staffed. In the evening at least 4 residents sun-down. The Wellness Director calls their respective MD and orders was given for Depakote and Seroquel- which are contra-indicated for elderly persons. No consent is obtained.

Sub-acute utilization of remaining SNF beds, requires 24/7 placements for those unable to self manage, or unable to qualify for IHSS or to return home. For that reason Residential Care has been considered a step down from SNF but without reimbursement systems like Medi-Cal and Medicare to provide payment. The two trends like tectonic plates converge to create challenges for the citizens of San Francisco.

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.

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.

Is policy in reaction to a problem or based on forecasting for the future?
Who is responsible for future long term policy for all those constituents in each Supervisorial District:? The hospitals and the hospital council?
: 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?

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.

Solutions:

Bricks and Mortar:

It is impossible in this real estate market to build, or purchase and refurbish existing building for new SNF or RCFE which will be accessible to the many persons aging and acquiring disabilities through illnesses, accidents, and acute medical events. Many low income and moderate income are in rent control housing. Many apartments in the private market lack elevators. Pressures for housing for newer generations of tenants makes in difficult for those aging in place to who live alone, without access to family support systems, to continue, after a hospitalization. With the homeless housing initiative becoming dominant, often the housing for those aging who require 24/7 care receive less attention.

The following are solutions predicated on the following premise: where there is a will there is a way.

Solutions:

Homes of decedents without heirs – Land Trust with leasing:

Every year individuals who live alone without beneficiaries or clear estate planning die. Real estate investors plough through death notices to see if such a property could be purchased. These houses without heirs revert to the Public Administrator for sale through Probate. In SF this is very imperative. What steep climb would it take, for the City to create a Public Trust where some of these properties could held in a holding company, after maintenance and repair, as a long term investment in smaller versions of assisted living RCFE. Eminent domain could be used for those properties without claim on them. If there is data on the number of live alone homeowners who die intestate, I do not know where they would be. Something similar was done when Agnews Developmental Center was closed, under Court Order. Brilliant Corners became the holder of some homes in San Mateo, and nurses were hired to by management caregivers.

Re-zoning with Fire Safety up-grade of abandoned commercial properties and lofts : modification of work/living zone for assisted living as long term investment.

Another idea would be to look at abandoned commercial properties, like warehouses with open interiors. Gutted and sub-divided, they could be re-zoned for mixed work-living spaces. The acquisition would be similar, through eminent domain.

To solve the bricks and mortar part of long term care, there will be have to be creative solutions that by-pass the frenetic housing market. New construction for SNF or RCFE residents who have limited incomes seems to be impossible, unless there were some cost shifting quotas in loan and construction approvals by the City.

Again affordable long term care of the assisted living type, with care packages thrown in, is higher than for new supportive housing. The average monthly cost for assisted living in SF in the market ranges from $4500- $12,000 per months plus add-ons for more care. All the larger RCFE or CCRC which include Life care plans, are recent. Most more resemble hospitality construction. Capital investment and property determine monthly costs, so that there is no dollar to dollar equivalent for care for each costumer. Some have specialized memory care for persons with degrees of dementia; some have delayed egress to prevent escaping. Not all

memory care products and services are equivalent. Neither are the monthly rates-none of which are posted on respective web-sites. So to think about brick and mortal part of RCFE is to consider value added calculations.

Solution 2. More supportive housing. Supportive housing provides support services for coordinating care by professionals either in the ground floor Housing has social workers. For those living alone, if low income, IHHS would be available but not 24/7. Most IHHS workers of the 30,000 or so recipients in SF are family caregivers who come from other locations, visit, to provide care. If no family then either IP or Homebridge.

Solution Rejected:: Protection and Advocacy which was monitoring the two Civil Rights Cases against City and County, Davis V. SF and Chambers V SF posted response to the Laguna Honda Feasiblity Study August 23, 207.This set policy for the duration of the two Settlement Agreements where an affordable low income RCFE Assisted Living would not be invested in as a resolution to housing for those discharged from LHH or any other SNF. The City missed the chance to solve this lack of RCFE. Instead the shift was to rental subsidies from the city.

http://www.disabilityrightsca.org/advocacy/LHH/PublicMemo-AssistedLiving.pdf

https://ia802309.us.archive.org/30/items/assistedlivingfa1200sanf/assistedlivingfa1200sanf.pdf

http://www.stoplhhdownsize.com/PublicCommentsOnDraftAssistedLivingProjectStudy.pdf

San Francisco Senior Demographics by Supervisorial District

Population	Supervisorial Districts											
	1	2	3	4	5	6	7	8	9	10	11	Total
All ages	77,453	64,849	76,373	73,665	80,297	60,944	71,496	69,750	83,000	74,870	84,804	817,501
60-64	4,971	3,054	5,115	5,553	3,851	3,716	5,107	4,090	4,055	4,066	5,291	48,869
65-74	5,775	4,898	6,294	5,648	4,782	4,384	5,730	4,225	4,593	4,292	6,434	57,055
75-84	3,823	3,090	5,003	3,838	3,231	2,687	4,109	2,311	3,301	2,646	4,014	38,053
85+	1,857	1,720	2,324	2,336	1,902	862	1,984	1,043	1,039	1,044	1,911	18,022
Total Senior Population 60+	16,426	12,762	18,736	17,375	13,766	11,649	16,930	11,669	12,988	12,048	17,650	161,999
Seniors as % of District	21.2%	19.7%	24.5%	23.6%	17.1%	19.1%	23.7%	16.7%	15.6%	16.1%	20.8%	19.8%
Distribution, by District, of Seniors 60+	10.1%	7.9%	11.6%	10.7%	8.5%	7.2%	10.5%	7.2%	8.0%	7.4%	10.9%	100.0%
Total Senior Population 65+	11,455	9,708	13,621	11,822	9,915	7,933	11,823	7,579	8,933	7,982	12,359	113,130
Seniors 65+ as % of District	14.8%	15.0%	17.8%	16.0%	12.3%	13.0%	16.5%	10.9%	10.8%	10.7%	14.6%	13.8%
Distribution, by District, of Seniors 65+	10.1%	8.6%	12.0%	10.4%	8.8%	7.0%	10.5%	6.7%	7.9%	7.1%	10.9%	100.0%

(Source: American Community Survey 2013 5-Year Sample, Table B01001)

Gender, Age 60+	Supervisorial Districts											
	1	2	3	4	5	6	7	8	9	10	11	Total
Male	6,965	5,511	8,740	7,863	6,337	5,579	7,694	6,439	5,937	5,597	7,048	73,710
Female	9,461	7,251	9,996	9,512	7,429	6,070	9,236	5,230	7,051	6,451	10,602	88,289
% Female	58%	57%	53%	55%	54%	52%	55%	45%	54%	54%	60%	54%

(Source: American Community Survey 2013 5-Year Sample, Table B01001)

	Supervisorial Districts											
thnicity of Senior Population, 65+	1	2	3	4	5	6	7	8	9	10	11	Total
One race	11,286	9,643	13,470	11,623	9,784	7,722	11,661	7,401	8,650	7,831	12,133	111,204
One race %	98.5%	99.3%	98.9%	98.3%	98.7%	97.3%	98.6%	97.7%	96.8%	98.1%	98.2%	98.3%
African American	284	141	263	75	1,664	459	520	251	451	2,131	1,281	7,520
African American %	2.5%	1.5%	1.9%	0.6%	16.8%	5.8%	4.4%	3.3%	5.0%	26.7%	10.4%	6.6%
Asian/Pacific Islander	6,375	1,441	8,780	6,964	3,015	4,457	3,484	1,057	3,264	3,502	5,697	48,036
Asian/Pacific Islander %	55.7%	14.8%	64.5%	58.9%	30.4%	56.2%	29.5%	13.9%	36.5%	43.9%	46.1%	42.5%
Native American/Alaskan Native	14	0	27	21	13	0	28	29	90	52	65	339
Native American/Alaskan Native %	0.1%	0.0%	0.2%	0.2%	0.1%	0.0%	0.2%	0.4%	1.0%	0.7%	0.5%	0.3%
White (Alone)	4,512	8,019	4,324	4,511	5,013	2,656	7,563	5,820	3,912	1,884	4,590	52,804
White (Alone) %	39.4%	82.6%	31.7%	38.2%	50.6%	33.5%	64.0%	76.8%	43.8%	23.6%	37.1%	46.7%
Other race	101	42	76	52	79	150	66	244	933	262	500	2,505
Other race %	0.9%	0.4%	0.6%	0.4%	0.8%	1.9%	0.6%	3.2%	10.4%	3.3%	4.0%	2.2%
more races	169	65	151	199	131	211	162	178	283	151	226	1,926
more races %	1.5%	0.7%	1.1%	1.7%	1.3%	2.7%	1.4%	2.3%	3.2%	1.9%	1.8%	1.7%
	222	473	501	554	378	350	744	866	2,833	825	2,700	10,446
	1.9%	4.9%	3.7%	4.7%	3.8%	4.4%	6.3%	11.4%	31.7%	10.3%	21.8%	9.2%
Hispanic)	4,377	7,644	4,002	4,052	4,765	2,548	7,003	5,212	2,227	1,359	2,477	45,666
ic) %	38.2%	78.7%	29.4%	34.3%	48.1%	32.1%	59.2%	68.8%	24.9%	17.0%	20.0%	40.4%
	11,455	9,708	13,621	11,822	9,915	7,933	11,823	7,579	8,933	7,982	12,359	113,130

2013 5-Year Sample, Tables B01001A to B01001I

r	1	2	3	4	5	6	7					
	11,455	9,708	13,621	11,822	9,915	7,933	11,823	7,579	8,933			
.s primary language ery well" or "Well"	7,696	8,832	6,868	7,088	7,258	3,783	10,123	6,692	5,697	5,201	7,639	76,8??
. Speaks English "Not well" or	3,759	876	6,753	4,734	2,657	4,150	1,700	887	3,236	2,781	4,720	36,253
glish, % of Seniors 65+ in District	32.8%	9.0%	49.6%	40.0%	26.8%	52.3%	14.4%	11.7%	36.2%	34.8%	38.2%	32.0%
Spanish	29	48	153	81	54	141	60	325	1,346	326	1,043	3,606
Spanish %	0.3%	0.5%	1.1%	0.7%	0.5%	1.8%	0.5%	4.3%	15.1%	4.1%	8.4%	3.2%
Indo-European Languages*	520	439	109	346	908	966	368	192	164	72	329	4,413
Indo-European %	4.5%	4.5%	0.8%	2.9%	9.2%	12.2%	3.1%	2.5%	1.8%	0.9%	2.7%	3.9%
Asian-Pacific Island Languages	3,184	389	6,461	4,225	1,685	3,021	1,257	363	1,726	2,383	3,336	28,030
API %	27.8%	4.0%	47.4%	35.7%	17.0%	38.1%	10.6%	4.8%	19.3%	29.9%	27.0%	24.8%
Other Languages^	26	0	30	82	10	22	15	7	0	0	12	204
Other %	0.2%	0.0%	0.2%	0.7%	0.1%	0.3%	0.1%	0.1%	0.0%	0.0%	0.1%	0.2%
ibution, by District, Limited English %	10.4%	2.4%	18.6%	13.1%	7.3%	11.4%	4.7%	2.4%	8.9%	7.7%	13.0%	100.0%

amples of Indo-European languages include Russian, French, German, Persian, and Hindi.

amples of Other languages include Hebrew and Arabic, as well as Native American and African languages.

ource: American Community Survey 2013 5-Year Sample, Table B16004)

	Supervisorial Districts											
enior Households	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Total Households with Persons 60+	9,543	8,830	12,683	9,191	9,622	8,372	10,159	8,190	6,948	6,145	7,295	96,978
Owner Occupied	4,995	4,904	2,663	7,028	2,894	871	7,779	4,958	4,178	3,959	5,960	50,189
Renter Occupied	4,548	3,926	10,020	2,163	6,728	7,501	2,380	3,232	2,770	2,186	1,335	46,789
Renter Occupied %	47.7%	44.5%	79.0%	23.5%	69.9%	89.6%	23.4%	39.5%	39.9%	35.6%	18.3%	48.2%
Distribution, By District, Renter Occupied	9.7%	8.4%	21.4%	4.6%	14.4%	16.0%	5.1%	6.9%	5.9%	4.7%	2.9%	100.0%

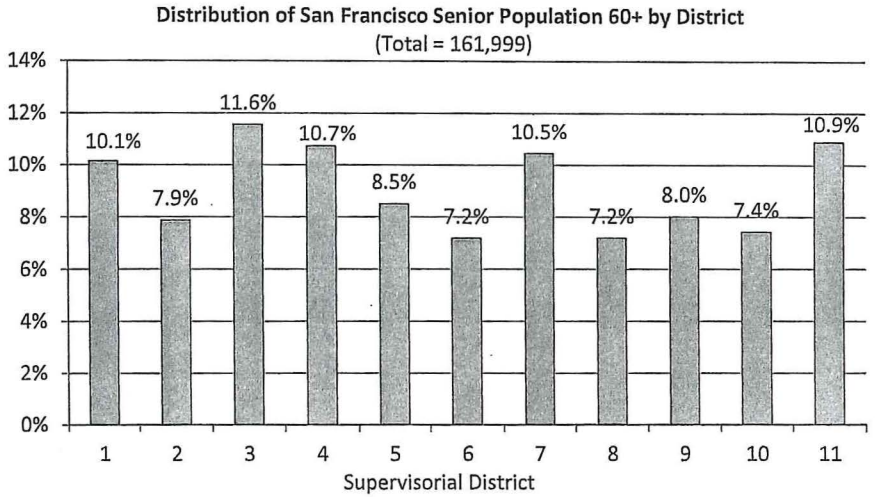
(Source: American Community Survey 2013 5-Year Sample, Table B25007)

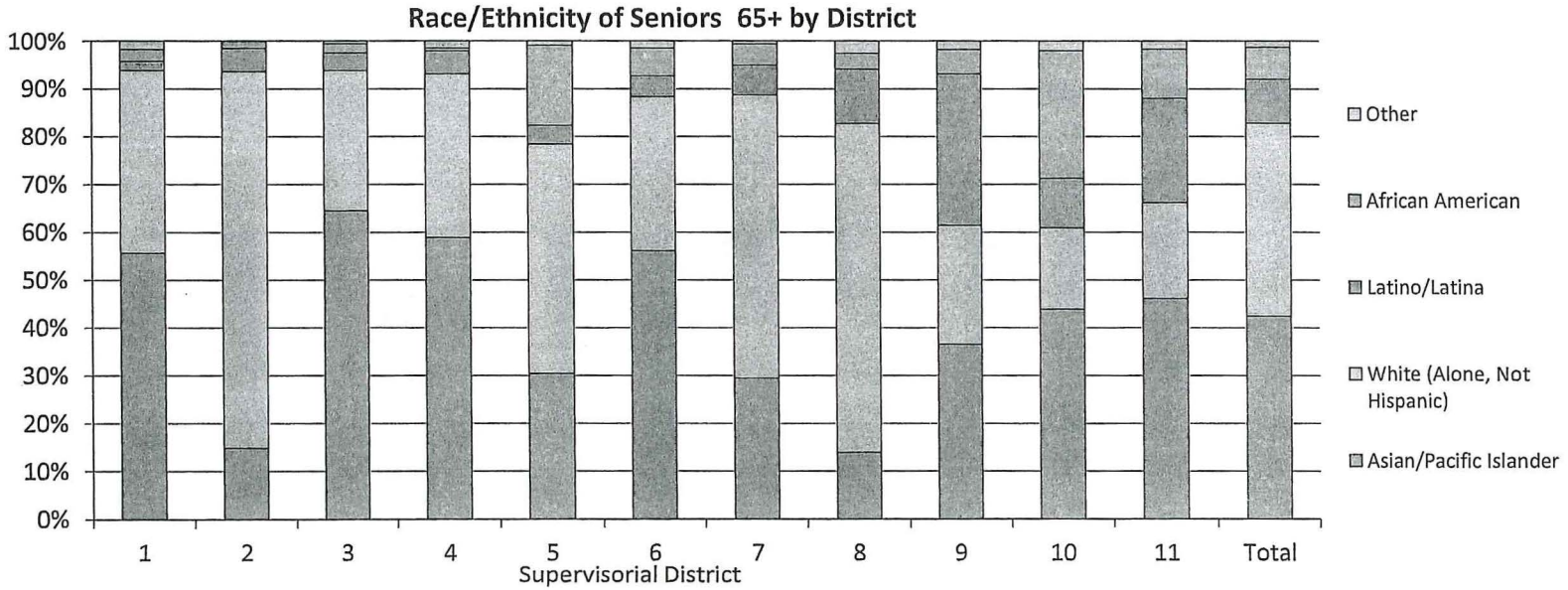
Total Households with Persons 65+	8,094	7,486	10,593	8,229	7,686	6,262	8,353	6,120	6,169	5,635	7,840	82,467
Lives Alone	3,002	4,226	5,673	2,556	4,595	3,843	3,068	3,109	2,034	1,571	1,570	35,247
Lives Alone %	37.1%	56.5%	53.6%	31.1%	59.8%	61.4%	36.7%	50.8%	33.0%	27.9%	20.0%	42.7%
Distribution, by District, Lives Alone	8.5%	12.0%	16.1%	7.3%	13.0%	10.9%	8.7%	8.8%	5.8%	4.5%	4.5%	100.0%

(Source: American Community Survey 2013 5-Year Sample, Table B11007)

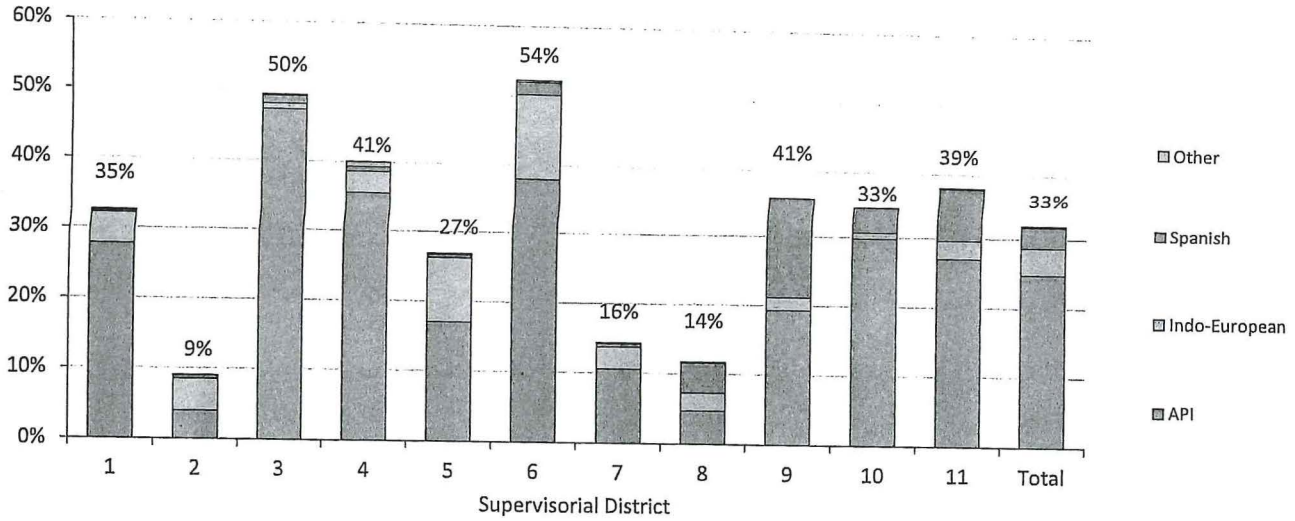
	Supervisorial Districts											
Lesbian, Gay, Bisexual, Transgender (LGBT) Population Estimate, 60+	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Senior LGBT Population	828	972	2,196	1,109	991	1,805	1,152	2,190	741	590	752	17,211
Senior LGBT Population %	5.3%	7.8%	11.7%	6.8%	7.4%	16.3%	7.2%	19.8%	5.9%	5.2%	4.7%	11.1%

Source: San Francisco City Survey 2001-2011. Note that seniors were defined as 60+ for all years except 2011, in which they were defined as 65+. The sum of the estimates for the districts do not total the estimate for the entire city; each percentage, including that for all districts, are applied independently.

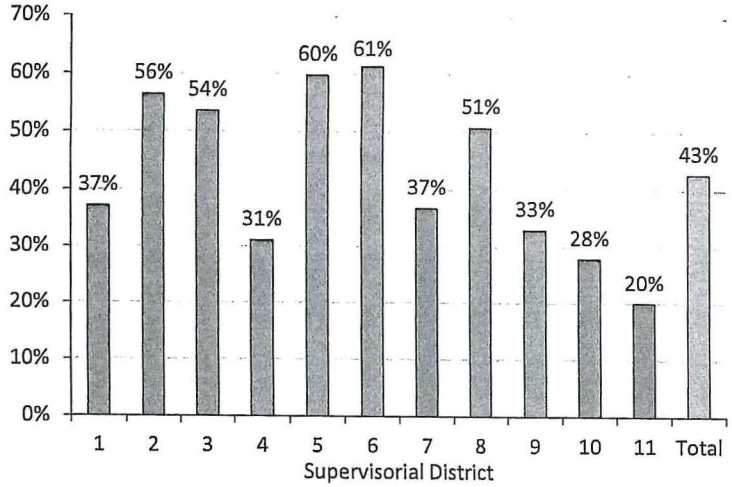

Distribution of San Francisco Senior Population 60+ by District
(Total = 161,999)
14%
12%
10%
8%
6%
4%
2%
0%
10.1%
7.9%
11.6%
10.7%
8.5%
7.2%
10.5%
7.2%
8.0%
7.4%
10.9%
1
2
3
4
5
6
7
8
9
10
11
Supervisorial District


Race/Ethnicity of Seniors 65+ by District
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
1
2
3
4
5
6
7
8
9
10
11
Total
Supervisorial District
Other
African American
Latino/Latina
White (Alone, Not Hispanic)
Asian/Pacific Islander

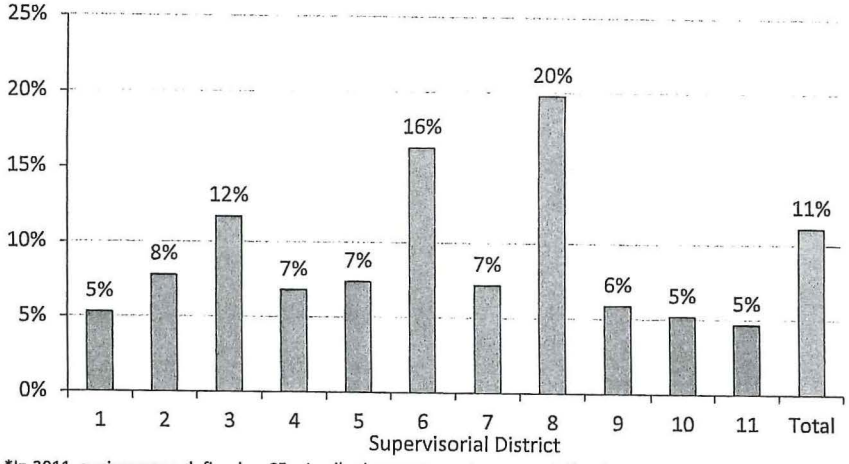
% of Seniors 65+ in District who speak English "Not well" or "Not at all" by Language Group and District



% of Seniors 65+ in District Living Alone



% of Seniors (60+)* in District who are LGBT

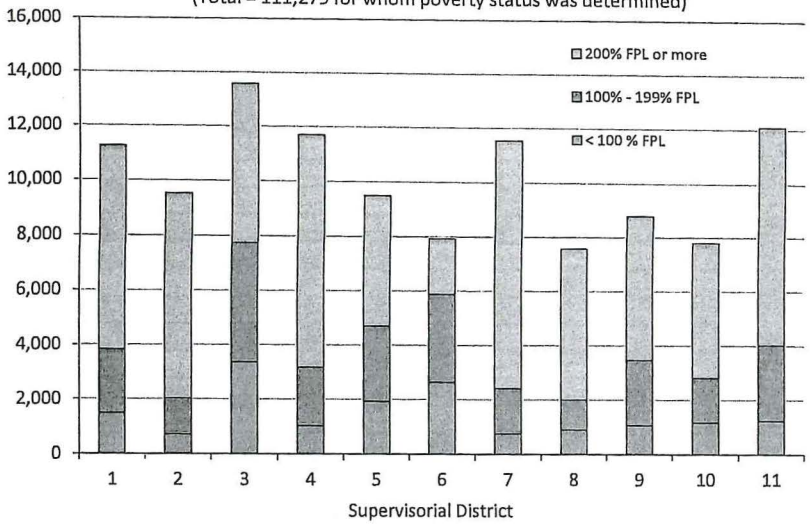


*In 2011, seniors were defined as 65+. In all other years, seniors were defined as 60+.

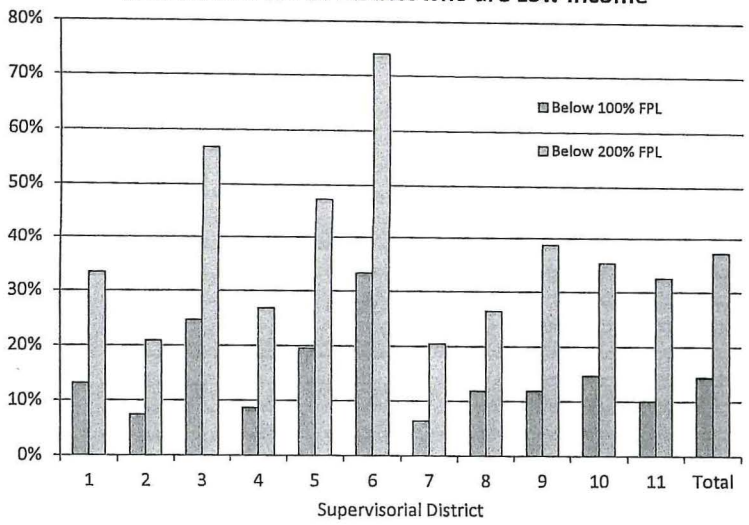
	Supervisorial Districts											
Poverty Status (Estimates Based on Poverty Threshold)	1	2	3	4	5	6	7	8	9	10	11	Total
Total Seniors 65+ <100% PT	1,505	720	3,365	1,028	1,932	2,642	755	901	1,069	1,176	1,242	16,335
Total Seniors 65+ 100%-199% PT	2,315	1,310	4,364	2,146	2,767	3,229	1,662	1,105	2,387	1,638	2,780	25,703
Total Seniors 65+ 200% PT	7,435	7,502	5,847	8,531	4,801	2,050	9,126	5,550	5,350	4,976	8,073	69,241
Seniors 65+ for whom poverty status was determined	11,255	9,532	13,576	11,705	9,500	7,921	11,543	7,556	8,806	7,790	12,095	111,279
Total Senior Population 65+	11,455	9,708	13,621	11,822	9,915	7,933	11,823	7,579	8,933	7,982	12,359	113,130
% of seniors in this district with incomes below:	1	2	3	4	5	6	7	8	9	10	11	Total
100% PT	13.1%	7.4%	24.7%	8.7%	19.5%	33.3%	6.4%	11.9%	12.0%	14.7%	10.0%	14.4%
200% PT	33.3%	20.9%	56.7%	26.8%	47.4%	74.0%	20.4%	26.5%	38.7%	35.3%	32.5%	37.2%
Distribution, by district, of seniors with incomes below:	1	2	3	4	5	6	7	8	9	10	11	Total
100% FPL	9.2%	4.4%	20.6%	6.3%	11.8%	16.2%	4.6%	5.5%	6.5%	7.2%	7.6%	100.0%
200% FPL	9.1%	4.8%	18.4%	7.6%	11.2%	14.0%	5.7%	4.8%	8.2%	6.7%	9.6%	100.0%
(Source: American Community Survey 2013 5-Year Sample, Table B17024)												
	Supervisorial Districts											
Race & Ethnicity of Seniors 65+ with Incomes below Poverty Threshold	1	2	3	4	5	6	7	8	9	10	11	Total
One race	1,471	720	3,321	1,017	1,906	2,580	747	875	990	1,154	1,195	15,976
One race %	97.7%	100.0%	98.7%	98.9%	98.7%	97.7%	98.9%	97.1%	92.6%	98.1%	96.2%	97.8%
African American	47	0	36	0	423	161	28	0	66	334	152	1,247
African American %	3.1%	0.0%	1.1%	0.0%	21.9%	6.1%	3.7%	0.0%	6.2%	28.4%	12.2%	7.6%
Asian/Pacific Islander	867	155	2735	720	628	1787	367	236	340	518	550	8,903
Asian/Pacific Islander %	57.6%	21.5%	81.3%	70.0%	32.5%	67.6%	48.6%	26.2%	31.8%	44.0%	44.3%	54.5%
Native American/Alaskan Native	0	0	13	4	0	0	0	0	23	19	0	59
Native American/Alaskan Native %	0.0%	0.0%	0.4%	0.4%	0.0%	0.0%	0.0%	0.0%	2.2%	1.6%	0.0%	0.4%
White (Alone)	538	565	481	293	841	574	352	639	418	204	451	5,356
White (Alone) %	35.7%	78.5%	14.3%	28.5%	43.5%	21.7%	46.6%	70.9%	39.1%	17.3%	36.3%	32.8%
Other race	19	0	56	0	14	58	0	0	143	79	42	411
Other race %	1.3%	0.0%	1.7%	0.0%	0.7%	2.2%	0.0%	0.0%	13.4%	6.7%	3.4%	2.5%
Two or more races	34	0	44	11	26	62	8	26	79	22	47	359
Two or more races %	2.3%	0.0%	1.3%	1.1%	1.3%	2.3%	1.1%	2.9%	7.4%	1.9%	3.8%	2.2%
Latino/Latina*	38	77	152	32	81	125	40	107	454	118	339	1,563
Latino/Latina %	2.5%	10.7%	4.5%	3.1%	4.2%	4.7%	5.3%	11.9%	42.5%	10.0%	27.3%	9.6%
White (Alone, Not Hispanic)	529	488	414	261	790	542	312	532	191	165	154	4,378
White (Alone, Not Hispanic) %	35.1%	67.8%	12.3%	25.4%	40.9%	20.5%	41.3%	59.0%	17.9%	14.0%	12.4%	26.8%
Total Senior Population 65+ in Poverty	1,505	720	3,365	1,028	1,932	2,642	755	901	1,069	1,176	1,242	16,335
(Source: American Community Survey 2013 5-Year Sample, Tables B17001A to B17001I)												
*Non-white races may include a few individuals who identify as Latino, but the total is relatively low.												

Total Senior Population 65+, by Poverty Status and District

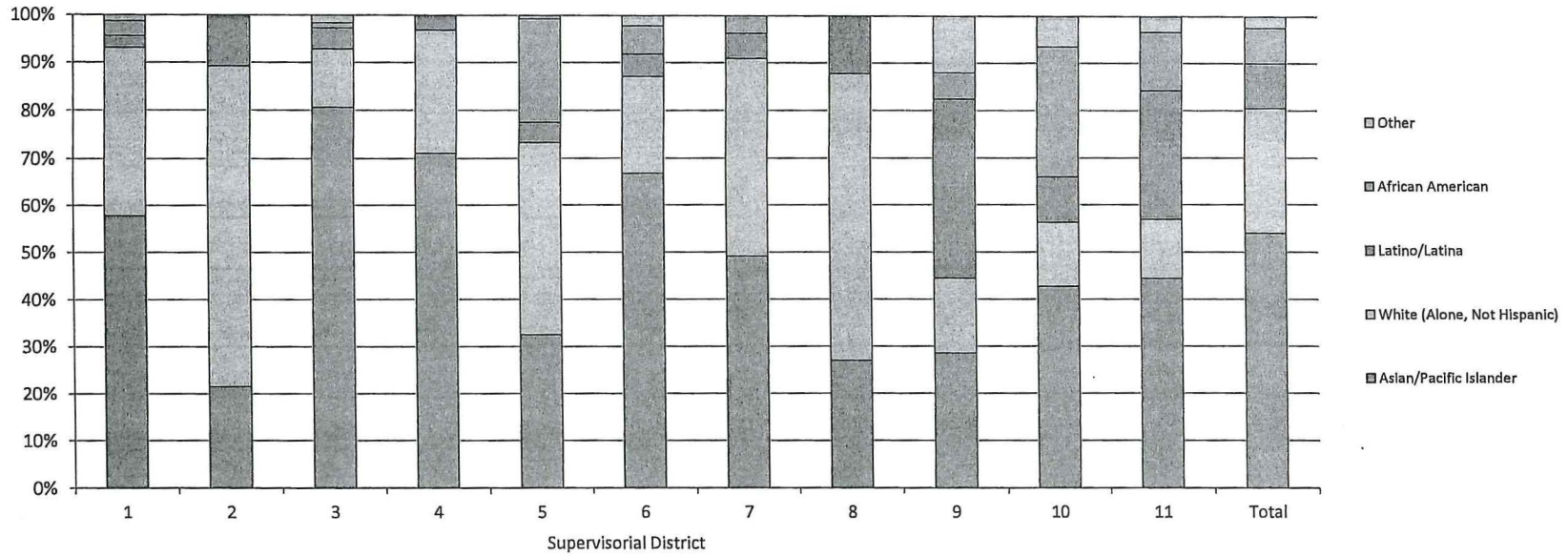
(Total = 111,279 for whom poverty status was determined)



% of Seniors 65+ in District who are Low Income



Race/Ethnicity of Seniors with Incomes <100% Poverty Threshold, by District



San Francisco Senior Demographics by Supervisorial District

	Supervisorial Districts											
Seniors Reporting Disabilities	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Total Senior Population, 65+	11,455	9,708	13,621	11,822	9,915	7,933	11,823	7,579	8,933	7,982	12,359	113,130
Seniors Reporting Disabilities	4,357	3,085	5,901	4,151	4,192	4,344	3,597	2,416	3,461	3,152	4,579	43,235
Seniors with Disabilities as % of District	38%	32%	43%	35%	42%	55%	30%	32%	39%	39%	37%	38%
Distribution, by District, of Seniors Reporting Disabilities	10%	7%	14%	10%	10%	10%	8%	6%	8%	7%	11%	100%

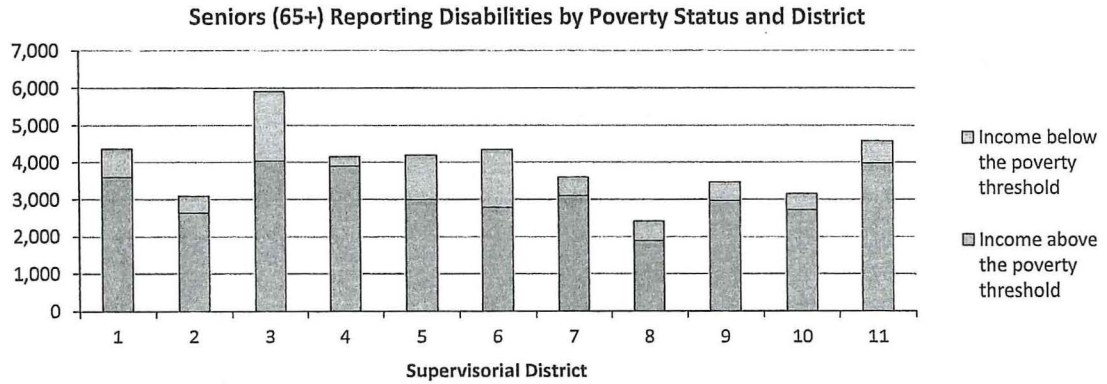
* The census disability definitions are:

- Hearing difficulty: deaf or having serious difficulty hearing.
- Vision difficulty: blind or having serious difficulty seeing, even when wearing glasses.
- Cognitive difficulty: Because of a physical, mental, or emotional problem, having difficulty remembering, concentrating, or making decisions.
- Ambulatory difficulty: Having serious difficulty walking or climbing stairs.
- Self-care difficulty: Having difficulty bathing or dressing.
- Independent living difficulty: Because of a physical, mental, or emotional problem, having difficulty doing errands alone such as visiting a doctor's office or shopping.

(Source: American Community Survey 2013 5-Year Sample, Table S18130

	Supervisorial Districts											
Seniors Reporting Disabilities with Income Below Poverty Threshold	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Total Senior Population, 65+	11,455	9,708	13,621	11,822	9,915	7,933	11,823	7,579	8,933	7,982	12,359	113,130
Seniors Reporting Disabilities	4,357	3,085	5,901	4,151	4,192	4,344	3,597	2,416	3,461	3,152	4,579	43,235
Seniors Reporting Disabilities with income below the poverty threshold	765	460	1,858	252	1,199	1,566	500	525	495	433	602	8,655
% of Seniors with Disabilities with income below the poverty threhsold	17.6%	14.9%	31.5%	6.1%	28.6%	36.0%	13.9%	21.7%	14.3%	13.7%	13.1%	20.0%
Distribution, by District, of Seniors Reporting Disabilities with income below the poverty threshold	8.8%	5.3%	21.5%	2.9%	13.9%	18.1%	5.8%	6.1%	5.7%	5.0%	7.0%	100.0%

(Source: American Community Survey 2013 5-Year Sample, Table S18130



San Francisco Adults with Disabilities Demographics
by Supervisorial District

	Supervisorial Districts											
Population	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Adult Population (18 to 64) with Disabilities	3,441	1,422	3,599	2,929	4,355	6,951	2,272	3,295	4,076	4,371	4,298	41,009
Total Adult Population (18-64)	55,606	47,460	56,979	50,464	63,208	46,671	48,096	54,677	61,027	50,704	57,671	592,563
Adult Population (18 to 64) with Disabilities %	6.2%	3.0%	6.3%	5.8%	6.9%	14.9%	4.7%	6.0%	6.7%	8.6%	7.5%	6.9%
Distribution, by District, of Adults with Disabilities	8.4%	3.5%	8.8%	7.1%	10.6%	16.9%	5.5%	8.0%	9.9%	10.7%	10.5%	100.0%
(Source: American Community Survey 2013 5-Year Sample, Table B18101)												
	Supervisorial Districts											
Gender, Adults (18 to 64) with Disabilities	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Male	1,547	802	1,944	1,559	2,207	4,903	1,194	2,287	2,403	2,019	1,935	22,800
Female	1,894	620	1,655	1,370	2,148	2,048	1,078	1,008	1,673	2,352	2,363	18,209
Female %	55%	44%	46%	47%	49%	29%	47%	31%	41%	54%	55%	44%
(Source: American Community Survey 2013 5-Year Sample, Table B18101)												
	Supervisorial Districts											
Ethnicity of Adult Population (18 to 64) with Disabilities	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
One race	3,269	1,393	3,429	2,798	4,017	6,576	2,208	3,057	3,932	4,115	4,125	38,919
One race %	95.0%	98.0%	95.3%	95.5%	92.2%	94.6%	97.2%	92.8%	96.5%	94.1%	96.0%	94.9%
African American	124	56	441	68	1,191	1,215	217	211	566	1,699	573	6,361
African American %	3.6%	3.9%	12.3%	2.3%	27.3%	17.5%	9.6%	6.4%	13.9%	38.9%	13.3%	15.5%
Asian/Pacific Islander	1,358	268	1,266	1,358	324	771	262	369	598	1,040	1,462	9,076
Asian/Pacific Islander %	39.5%	18.8%	35.2%	46.4%	7.4%	11.1%	11.5%	11.2%	14.7%	23.8%	34.0%	22.1%
Native American/Alaskan Native	72	20	11	0	60	148	14	0	118	139	0	582
Native American/Alaskan Native %	2.1%	1.4%	0.3%	0.0%	1.4%	2.1%	0.6%	0.0%	2.9%	3.2%	0.0%	1.4%
White (Alone)	1,625	1,015	1,643	1,334	2,233	3,597	1,655	2,291	2,022	940	1,460	19,815
White (Alone) %	47.2%	71.4%	45.7%	45.5%	51.3%	51.7%	72.8%	69.5%	49.6%	21.5%	34.0%	48.3%
Other race	90	34	68	38	209	845	60	186	628	297	630	3,085
Other race %	2.6%	2.4%	1.9%	1.3%	4.8%	12.2%	2.6%	5.6%	15.4%	6.8%	14.7%	7.5%
Two or more races	172	29	170	131	338	375	64	238	144	256	173	2,090
Two or more races %	5.0%	2.0%	4.7%	4.5%	7.8%	5.4%	2.8%	7.2%	3.5%	5.9%	4.0%	5.1%
Latino/Latina	261	113	170	162	454	1,538	291	607	1,598	728	1,343	7,265
Latino/Latina %	7.6%	7.9%	4.7%	5.5%	10.4%	22.1%	12.8%	18.4%	39.2%	16.7%	31.2%	17.7%
White (Alone, Not Hispanic)	1,560	936	1,543	1,246	2,020	3,011	1,438	1,894	1,201	578	757	16,184
White (Alone, Not Hispanic) %	45.3%	65.8%	42.9%	42.5%	46.4%	43.3%	63.3%	57.5%	29.5%	13.2%	17.6%	39.5%
Adult Population (18 to 64) with a Disability	3,441	1,422	3,599	2,929	4,355	6,951	2,272	3,295	4,076	4,371	4,298	41,009
(Source: American Community Survey 2013 5-Year Sample, Tables B17001A to B17001I)												

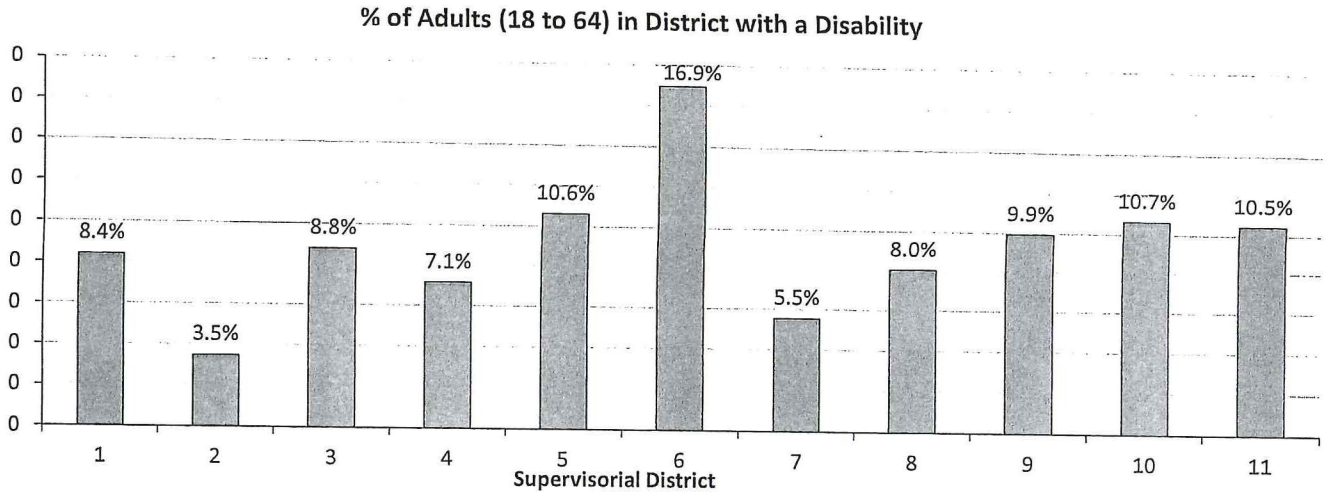
San Francisco Adults with Disabilities Demographics
by Supervisorial District

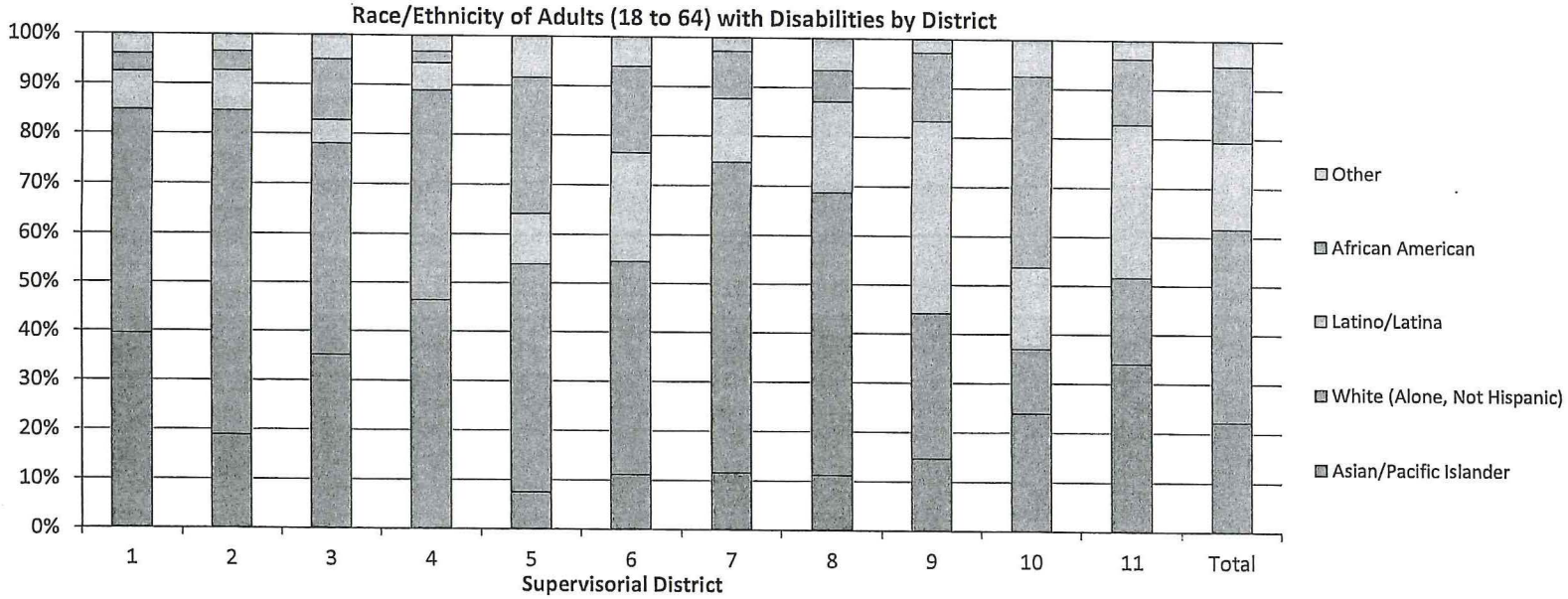
	Supervisorial Districts											
Disability Characteristics* of Adult Population (18 to 64)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Hearing difficulty	535	408	648	422	497	707	525	633	592	765	924	6,656
Hearing %	15.5%	28.7%	18.0%	14.4%	11.4%	10.2%	23.1%	19.2%	14.5%	17.5%	21.5%	16.2%
Vision difficulty	514	343	802	324	597	1,545	413	580	775	808	763	7,464
Vision %	14.9%	24.1%	22.3%	11.1%	13.7%	22.2%	18.2%	17.6%	19.0%	18.5%	17.8%	18.2%
Cognitive difficulty	1,507	580	1,922	1,480	2,280	4,322	1,135	1,596	1,632	1,923	1,916	20,293
Cognitive %	43.8%	40.8%	53.4%	50.5%	52.4%	62.2%	50.0%	48.4%	40.0%	44.0%	44.6%	49.5%
Walking (Ambulation) difficulty	1,510	529	1,589	1,381	2,153	3,356	812	1,226	2,055	2,372	1,838	18,821
Walking (Ambulation) %	43.9%	37.2%	44.2%	47.1%	49.4%	48.3%	35.7%	37.2%	50.4%	54.3%	42.8%	45.9%
Self Care difficulty	823	182	681	581	886	1,035	369	623	710	1,112	991	7,993
Self Care %	23.9%	12.8%	18.9%	19.8%	20.3%	14.9%	16.2%	18.9%	17.4%	25.4%	23.1%	19.5%
Independent Living difficulty	1,306	443	1,333	1,064	1,798	2,405	823	1,261	1,387	1,999	1,631	15,450
Independent Living %	38.0%	31.2%	37.0%	36.3%	41.3%	34.6%	36.2%	38.3%	34.0%	45.7%	37.9%	37.7%
Adult Population (18 to 64) with Disabilities	3,441	1,422	3,599	2,929	4,355	6,951	2,272	3,295	4,076	4,371	4,298	41,009
Total Adult Population (18-64)	55,606	47,460	56,979	50,464	63,208	46,671	48,096	54,677	61,027	50,704	57,671	592,563

* The census disability definitions are:
- Hearing difficulty: deaf or having serious difficulty hearing.
- Vision difficulty: blind or having serious difficulty seeing, even when wearing glasses.
- Cognitive difficulty: Because of a physical, mental, or emotional problem, having difficulty remembering, concentrating, or making decisions.
- Ambulatory difficulty: Having serious difficulty walking or climbing stairs.
- Self-care difficulty: Having difficulty bathing or dressing.
- Independent living difficulty: Because of a physical, mental, or emotional problem, having difficulty doing errands alone such as visiting a doctor's office or shopping.

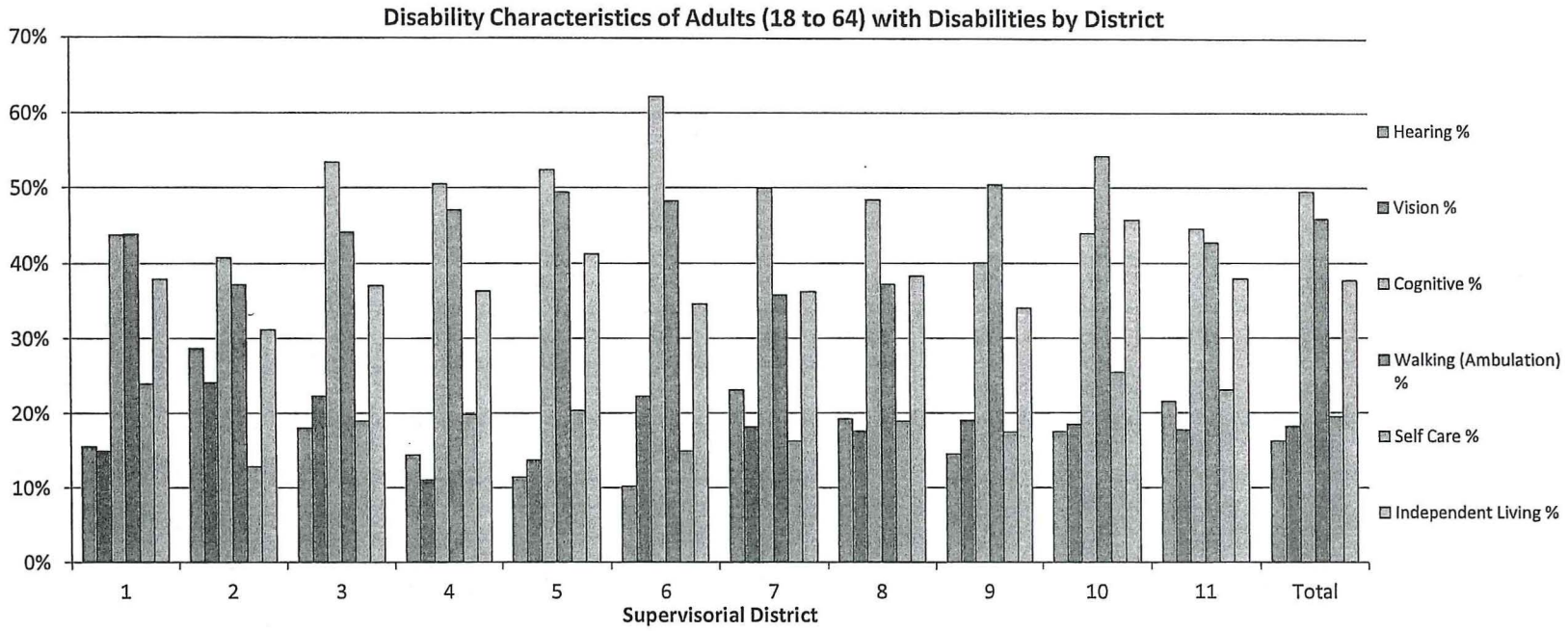
(Source: American Community Survey 2013 5-Year Sample, Table S1801

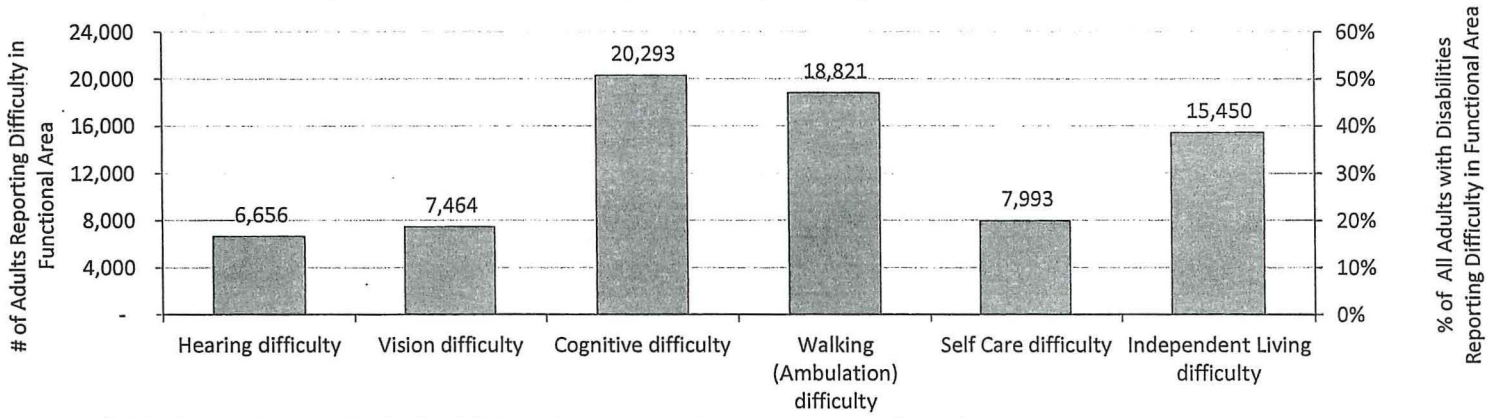
San Francisco Adults with Disabilities Demographics
by Supervisorial District





San Francisco Adults with Disabilities Demographics
by Supervisorial District





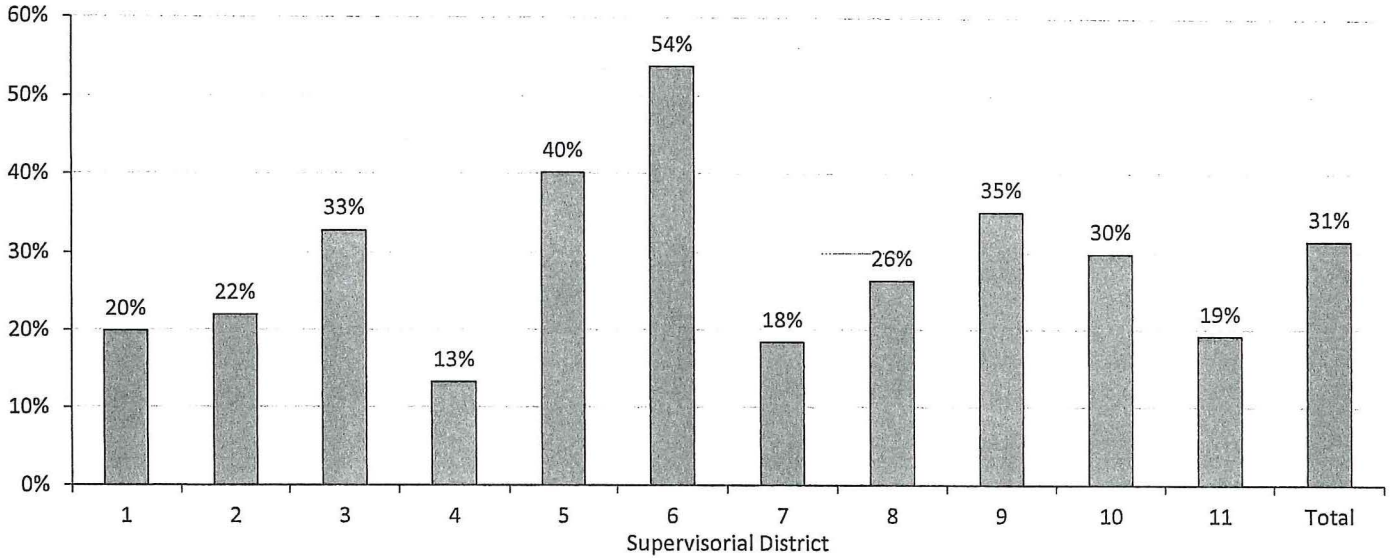
Note: Individuals may have multiple disabilities. These categories are not mutually exclusive.

San Francisco Adults with Disabilities Demographics
by Supervisorial District - Poverty Estimates

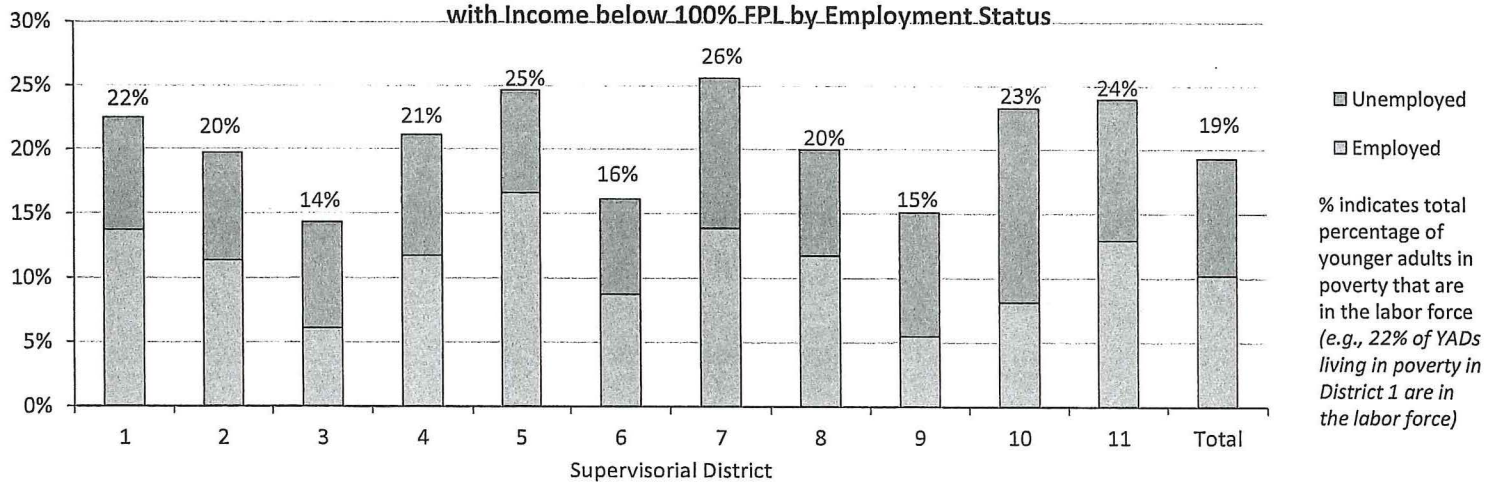
	Supervisorial Districts											
Poverty Status of Adult Population with Disabilities (Estimates Based on Poverty Threshold)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Total Adults (18 to 64) with Disabilities below the poverty threshold	685	313	1,180	389	1,749	3,735	419	870	1,431	1,304	827	12,902
Total Adults (18 to 64) with Disabilities above the poverty threshold	2,636	1,109	2,340	2,540	2,584	3,128	1,731	2,425	2,645	2,999	3,471	27,608
Total Adults (18 to 64) with Disabilities for whom poverty status is determined	3,321	1,422	3,520	2,929	4,333	6,863	2,150	3,295	4,076	4,303	4,298	40,510
Total Adults (18 to 64) with Disabilities	3,441	1,422	3,599	2,929	4,355	6,951	2,272	3,295	4,076	4,371	4,298	41,009
% of Adults (18 to 64) with Disabilities in district with incomes below 100% PT	19.9%	22.0%	32.8%	13.3%	40.2%	53.7%	18.4%	26.4%	35.1%	29.8%	19.2%	31.5%
Distribution, by district, of Adults (18 to 64) with Disabilities <100% PT	5.3%	2.4%	9.1%	3.0%	13.6%	28.9%	3.2%	6.7%	11.1%	10.1%	6.4%	100.0%
(Source: American Community Survey 2013 5-Year Sample, Table B18130)												

	Supervisorial Districts											
Employment Status of Adults (20-64) with Disabilities in Poverty	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Employed	94	34	75	45	289	326	58	102	77	103	107	1,310
Employed %	14%	11%	6%	12%	17%	9%	14%	12%	5%	8%	13%	10%
Unemployed	60	25	101	36	139	275	49	72	135	192	91	1,175
Unemployed %	9%	8%	8%	9%	8%	7%	12%	8%	10%	15%	11%	9%
Not in labor force	531	240	1,004	302	1,308	3,123	311	696	1,191	972	629	10,307
Not in labor force %	78%	80%	82%	79%	75%	84%	74%	80%	85%	77%	76%	80%
Total Adults (20 to 64) with disabilities <100% FPL	685	299	1,228	383	1,736	3,724	418	870	1,403	1,267	827	12,840
Total Adults (20 to 64) with poverty status determined	3,291	1,408	3,560	2,904	4,243	6,852	2,149	3,270	3,998	4,236	4,284	40,195
% of Adults (20 to 64) with disabilities in this district with incomes below 100% PT	20.8%	21.2%	34.5%	13.2%	40.9%	54.3%	19.5%	26.6%	35.1%	29.9%	19.3%	31.9%
Distribution, by district, of Adults (20 to 64) with disabilities <100% PT	5.3%	2.3%	9.6%	3.0%	13.5%	29.0%	3.3%	6.8%	10.9%	9.9%	6.4%	100.0%
(Source: American Community Survey 2013 5-Year Sample, Table B23024)												

% of Adults (18 to 64) with Disabilities in District with Income below 100% FPL



% of Adults (18 to 64) with Disabilities in District with Income below 100% FPL by Employment Status



% indicates total percentage of younger adults in poverty that are in the labor force *(e.g., 22% of YADs living in poverty in District 1 are in the labor force)*

San Francisco RCFEs

Facility Name	Capacity	Address	Zip Code	Phone Number	Administrator
9th Avenue Community Care Home	6	1730 9th Ave	94122	(415) 759-5825	Dimayuga, A & Valenciano
Agesong University	74	350 University St.	94134	(415) 337-1587	Champaneri, Ami
Alma Via of San Francisco	175	One Thomas More Way	94132	(415) 337-1339	Dunakin, Katherine Castro
Araville Residential Care Home	15	1506 Florida St.	94110	(415) 285-6497	Paniza, Dorie C.
Autumn Glow	15	654 Grove St.	94102	(415) 934-1622	Wong, James
Belen's Residential Care Home for the Elderly	22	565 Grove St.	94102	(415) 621-8505	Gomez, A. & Encarnacion, W.
Bestudio's Care Home for the Elderly	6	51 De Long St.	94112	(650) 755-1498	Bestudio, Gorgonio
Buena Vista Manor House	87	399 Buena Vista East	94117	(415) 863-1721	Wall, David
Byxbee Home	4	383 Byxbee St.	94132	(415) 586-4663	Atendido, Nemia
Care and Care Residence I	14	940 Haight St.	94117	(415) 829-2775	Nevarez, Jose
Care and Care Residence II	6	901 Grafton Ave	94112	(415) 715-8400	Navaraz, Jose
Carlise, The	130	1450 Post St.	94123	(415) 929-0200	Palermo, Tricia
Cayco's Care Home	6	1855 35th Ave	94112	(415) 310-0539	Gonzales, Rogelio & Prospe
Corinthian Gardens Residential Care Home	6	170 Aptos Ave	94127	(415) 841-0311	Encarnacion, William S.
Coventry Place *	210	1550 Sutter St.	94109	(415) 921-1552	Fox, Alan
CPMC Irene Swindells Alzheimer's Residential	25	3698 California St., Ste. 371	94118	(415) 600-6392	Sarison, Robert
Cypress at Golden Gate *	138	1601 19th Ave	94122	(415) 664-6264	Raukhman, Katherine
Damenik's Home	12	331 30th Ave	94121	(415) 379-9051	Montilla, Danilo F.

Facility Name	Capacity	Address	Zip Code	Phone Number	Administrator
Fook Hong SF Care Home, Inc.	40	5735 Mission St.	94112	(415) 533-0541	Leewong, Sau Ting Josephin
Golden Care Senior Residence	5	59 Winding Way	94112	(415) 568-0581	Tong, Sharon Pei-Yi
Golden Residential Care Home	6	166 Foote Ave	94112	(415) 587-2507	Magtibay, Antonina M.
Golden Sunset Care Home	6	1219 32nd Ave	94112	(415) 731-0965	Hernandez, Salome
Gonzales Home	6	2237 Noriega St.	94112	(415) 242-0848	Gonzales, Rogelio & Prospe
Guirola Resident Care	6	618 Holloway Ave	94112	(415) 334-6498	Guirola, Jose & Teodora
Heritage on the Marina	104	3400 Laguna St.	94123	(415) 202-0300	Hastings, Marla Long
Ida's Rest Home, LLC	11	612 39th Ave	94121	(415) 751-1029	Yee, Margaret
Janet's Residential Facility for the Elderly	8	2970 25th Ave	94132	(415) 759-8137	Spires, Janet
Julie's Care Home	14	1363 5th Ave	94122	(415) 566-4527	Chae, Julie
Kimochi Home	20	1531 Sutter St.	94109	(415) 922-9972	Chan, Linda Ishii
Kokoro Assisted Living	61	1881 Bush St.	94109	(415) 776- 8066	Miyake, Kirk
Lady of Perpetual Help RFE #1	15	476 Fair Oaks St.	94110	(415) 648-9533	Grepo, Ceasar
Lina's Rest Home 1	6	393 Silver Ave	94112	(415) 586-8171	Bautista, Aquilina E.
Marian's Care Home 1	6	1450 24th Ave	94122	(415) 269-1500	Cua, Marian Torres
Maulino Board and Care Services	6	370 Richland Ave	94110	(415) 826-9234	Maulino, Carmelita C.
Merced Girard Residential Care Facility	42	129 Girard St.	94134	(415) 467-8900	Wu, James D.
Merced Reisdential Care Facility	14	259 Broad St.	94112	(415) 585-6112	Wu, James D.
Merced Three Residential Care Facility	33	1420 Hampshire St.	94110	(415) 285-7600	Wu, James D.

Facility Name	Capacity	Address	Zip Code	Phone Number	Administrator
Merced Two Residential Care Facility	14	257 Broad St.	94112	(415) 585-6112	Wu, James D.
Morning Star Residence # 1	15	658 Shotwell St.	94110	(415) 285-1368	Mateo, Ruben
Morning Star Residence #2	14	666 Shotwell St.	94110	(415) 285-1368	Mateo, Ruben
Nobis Care Home	9	110 Vale Ave	94132	(415) 753-3216	Nobis, Patrick and Carole
Palarca Rest Home	10	1241 26th Ave	94122	(415) 681-1550	Palarca, Carmen
Parkside Care Home	6	2360 33rd Ave	94116	(415) 681-5312	Bondoc, Grace
Parkside Retirement Home	6	2447 19th Ave	94116	(415) 661-6679	Stemberga Aldo and Ana
Providence Place	34	2456 Geary Blvd.	94115	(415) 359-9700	Knop, Galina
Quality Care Homes, LLC 1	11	801 38th Ave	94121	(415) 751-6028	Farol, Fernand
Quality Care Homes, LLC 2	6	757 44th Ave	94121	(415) 751-5469	Farol, Fernand & Verano, M.
Quality Care Homes, LLC 3	12	2277 33rd Ave	94116	(415) 661-3477	Ares, Cesar
Quality Care Homes, LLC 4	10	457 Eucalyptus Dr.	94132	(415) 564-6318	Farol, Ferdand
Rhoda Goldman Plaza	195	2180 Post St.	94115	(415) 345-5060	Koster, Susan
RJ Starlight Home Corporation	12	2680 Bryant St.	94110	(415) 648-2280	Jomok, Teresita
Sagebook Senior Living at San Francisco *	86	2750 Geary Blvd.	94118	(415) 346-0246	Gibson, Laura
San Francisco RCFE	59	887 Potrero Ave	94110	(415) 206-6300	Morales, Adela
San Francisco Towers	350	1661 Pine St.	94109	(415) 776-0500	Mitchell, Melody
Santiago Home Care	6	152 Harold St.	94112	(415) 333-8964	Santiago, Marilyn
Sequoias San Francisco, The	400	1400 Geary Blvd.	94109	(415) 922-9700	Dougherty, Michael

Facility Name	Capacity	Address	Zip Code	Phone Number	Administrator
SFAL - The Avenue	145	1035 Van Ness Ave	94109	(415) 776-1800	Wong, Teresa
St. Anne's Home for the Aged	41	300 Lake St.	94118	(415) 751-6510	Sister Clotilde Jardim, NHA
St. Catherine Home	6	389 Guttenberg St.	94112	(415) 586-7250	Masangkay, Caridad
St. Francis Manor I	12	1450 Portola Dr.	94127	(415) 564-8794	Elmoraly, Amal
Stella's Care Home 1	12	616 39th Ave	94121	(415) 752-8652	Chang, Stella
Sunset Care Home	15	1434 7th Ave	94122	(415) 516-9368	Zhang, Alice Feng
Sunset Care Home 2	6	1367 39th Ave	94122	(415) 516-9368	Zhang, Alice Feng
Sunset Gardens	11	1338 27th Ave	94122	(415) 219-9645	Eiseman, Katie
Sutro Heights Residential Care	14	659 45th Ave	94121	(415) 752-3429	Shvartser, Anna
Taraval Residential Care Home	6	3721 Taraval St.	94116	(415) 681-0294	Aureus, Leonora
Tiffany's Care Home, Inc.	6	50 Tiffany Ave	94110	(415) 285-2112	Mateo, Cherry G.
Victorian Manor	124	1444 McAllister St.	94115	(415) 921-7550	Pacheco, Ana
Village at Hayes Valley, The *	47	601 Laguna St.	94102	(415) 252-1128	Holland, Cherese
Village at Hayes Valley, The *	56	624 Laguna St.	94102	(415) 318-8670	Holland, Cherese
Total of 70 Facilities	3116				

*** = License Pending**

Updated Dec.7, 2017

Carroll, John (BOS)

From: Carroll, John (BOS)
Sent: Thursday, December 07, 2017 12:33 PM
To: 'gordon@jwjsf.org'; Ronen, Hillary; Sheehy, Jeff (BOS); Fewer, Sandra (BOS); Yee, Norman (BOS); Safai, Ahsha (BOS)
Cc: Board of Supervisors, (BOS); 'Calvillo, Angela (angela.calvillo@sfgov.org)'; Somera, Alisa (BOS)
Subject: FW: Written comments for NSPS Hearing #170788 on Institutional Housing for Seniors
Attachments: SFHHJJ Statement for BOS Committee Hearing 120717.pdf

Categories: 170788, 2017.12.07 - PSNS

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

PSNS members and guests expected for today's meeting: the attached is commentary for today's agenda item number two.

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

Board of Supervisors File No. 170788

John Carroll
Assistant Clerk
Board of Supervisors
San Francisco City Hall, Room 244
San Francisco, CA 94102
(415)554-4445 - Direct | (415)554-5163 - Fax
john.carroll@sfgov.org | bos.legislation@sfgov.org

Click here to complete a Board of Supervisors Customer Service Satisfaction form.

The Legislative Research Center provides 24-hour access to Board of Supervisors legislation and archived matters since August 1998.

From: Gordon Mar [mailto:gordon@jwjsf.org]
Sent: Thursday, December 07, 2017 11:26 AM
To: Carroll, John (BOS) <john.carroll@sfgov.org>
Subject: Written comments for NSPS Hearing #170788 on Institutional Housing for Seniors

Dear Mr. Carroll,

I would like to submit the following statement as written comments for the hearing #170788 on Dec. 7, 2017, in the Neighborhood Services and Public Safety Committee on Institutional Housing for Seniors.

Gordon Mar
San Franciscans for Healthcare, Housing, Jobs and Justice

Seniors, disabled people and others need a full continuum of care, ranging from help at home, to assisted living, to residential care, to Skilled Nursing Facility (SNF) care, and for those who choose to live on life support, to sub-acute SNF care. Importantly, a shortage at any level of care in this continuum hampers other levels of care. The overarching obstacle to providing this continuum of care has been hospitals' perceived need to preserve revenues and profits as a priority over providing what the people of San Francisco need for a good quality of life in their home city as they grow older. Some facts:

1. Low and moderate income San Franciscans are not able to access adequate long-term care or support to continue to live safely in San Francisco when they need it.

2. The causes involve the massive numbers of aging people with related illness and disability, the current reimbursement system which pays mostly for acute care, the high cost of land, and the lack of citywide health planning. In this void, hospitals tend to offer only services that preserve their revenue, even though they are non-profit entities. The needs of the people of San Francisco are not the determining factor when the hospitals consider their (tax free) revenues.

3. In the draft report of the Hospital Council/Post-Acute Care Coordinating Council, December 2017, there was little mention of the fact that San Francisco hospitals have shut down SNF care, sub-acute SNF care, and acute psychiatric care on their campuses. This has precipitated a critical shortage of SNF sub-acute care and long-term SNF care in San Francisco.

4. For the hospitals, a narrow focus on short stay acute care brings in the most revenue. There is currently no SNF sub-acute care at all in San Francisco for new people who need it. Low and moderate income people cannot find regular long-term SNF care in San Francisco. Community SNFs are using their beds to provide short-stay post-hospital rehab, which the hospitals used to provide, because it is funded by Medicare and pays more than long-term care funded by Medi-Cal.

5. Because the hospital industry will not provide post-acute SNF care on its campuses, and because of the shortage of community long-term SNF care for low and moderate income people, there is a trend toward keeping sicker people in residential care, even though Residential Care Facilities for the Elderly (RCFEs) are non-medical facilities.

6. Residential care should only be used for frail and ill people if that care truly meets their needs. Denying SNF care to low and moderate income people who really need it is a form of medical neglect. Residential care should not be funded at the expense of SNF care.

7. Enhanced residential care for people with Alzheimer's should include services that residential care facilities usually don't have: the presence of licensed nurses at the facility, specialized training for staff, and increased staffing ratios. In the community, this type of service is called "Memory Care." It is expensive to do this well, and Medi-Cal and Medicare don't pay for it. The Hospital Council report recommends this type of care, but its largest member, Sutter/CPMC, is shutting down a model of this kind of care, Swindells, on its California Campus, to preserve revenue.

8. Frail seniors and others who need care can only be safely cared for in residential facilities if there is comprehensive wrap-around care that makes medical and social services easily

available to them. UCSF and hospital corporations do not like to provide the medical part of this kind of wrap-around care for seniors because Medicare does not pay as much as does major medical insurance for younger people. So we see in San Francisco that there are urgent care clinics in every neighborhood but no source of wrap-around medical care in the same neighborhood for frail seniors. Again, these bad decisions are driven by profit.

9. A subset of those who are in residential care have progressive illness and will require timely referral to a higher level of care such as skilled nursing facilities, either long-term or for short-term rehab. If these are not adequately provided, we are looking at worsening illness, being forced to leave the county, or death for elderly or disabled San Francisco residents.

10. Staff at Residential Care facilities for the elderly must have a routine of regular training with regular updates. Their responsibility for frail residents dictates that caregivers clearly understand not only how to care for their charges physically and behaviorally but also when to call for help.

Our broad-based coalition of community, labor and patient advocate organizations, proposes the following actions by Board of Supervisors regarding the loss and demise of post-acute care beds in San Francisco:

1. Issue a resolution that Sutter/CPMC (a) 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 (b) 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) 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) 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;

d) Enactment of legislative/tax/code solutions that incentivize providers of residential care to open new facilities and maintain a high standard of staff training and that optimize the use of Medi-Cal and Medicare waivers and funds from non-profit organizations to make needed supports and care available to low and moderate income elderly;

e) Work with the state to adequately fund the San Francisco Ombudsman's office so there will be enough staff to monitor all SNF and residential care facilities and to advocate for the people that need these services.

--
Gordon Mar
Executive Director
Jobs with Justice San Francisco
209 Golden Gate Avenue
San Francisco, CA 94102
Phone: (415) 840-7420
Email: gordon@jwjsf.org
Web: www.jwjsf.org

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

December 7, 2017

Seniors, Disabled People and Others Need a Full Continuum of Care

Seniors, disabled people and others need a full continuum of care, ranging from help at home, to assisted living, to residential care, to Skilled Nursing Facility (SNF) care, and for those who choose to live on life support, to sub-acute SNF care. Importantly, a shortage at any level of care in this continuum hampers other levels of care. The overarching obstacle to providing this continuum of care has been hospitals' perceived need to preserve revenues and profits as a priority over providing what the people of San Francisco need for a good quality of life in their home city as they grow older. Some facts:

1. Low and moderate income San Franciscans are not able to access adequate long-term care or support to continue to live safely in San Francisco when they need it.

2. The causes involve the massive numbers of aging people with related illness and disability, the current reimbursement system which pays mostly for acute care, the high cost of land, and the lack of citywide health planning. In this void, hospitals tend to offer only services that preserve their revenue, even though they are non-profit entities. The needs of the people of San Francisco are not the determining factor when the hospitals consider their (tax free) revenues.

3. In the draft report of the Hospital Council/Post-Acute Care Coordinating Council, December 2017, there was little mention of the fact that San Francisco hospitals have shut down SNF care, sub-acute SNF care, and acute psychiatric care on their campuses. This has precipitated a critical shortage of SNF sub-acute care and long-term SNF care in San Francisco.

4. For the hospitals, a narrow focus on short stay acute care brings in the most revenue. There is currently no SNF sub-acute care at all in San Francisco for new people who need it. Low and moderate income people cannot find regular long-term SNF care in San Francisco. Community SNFs are using their beds to provide short-stay post-hospital rehab, which the hospitals used to provide, because it is funded by Medicare and pays more than long-term care funded by Medi-Cal.

5. Because the hospital industry will not provide post-acute SNF care on its campuses, and because of the shortage of community long-term SNF care for low and moderate income people, there is a trend toward keeping sicker people in residential care, even though Residential Care Facilities for the Elderly (RCFEs) are non-medical facilities.

6. Residential care should only be used for frail and ill people if that care truly meets their needs. Denying SNF care to low and moderate income people who really need it is a form of medical neglect. Residential care should not be funded at the expense of SNF care.

7. Enhanced residential care for people with Alzheimer's should include services that residential care facilities usually don't have: the presence of licensed nurses at the facility, specialized training for staff, and increased staffing ratios. In the community, this type of service is called "Memory Care." It is expensive to do this well, and Medi-Cal and Medicare don't pay for it. The Hospital Council report recommends this type of care, but its largest member, Sutter/CPMC, is

shutting down a model of this kind of care, Swindells, on its California Campus, to preserve revenue.

8. Frail seniors and others who need care can only be safely cared for in residential facilities if there is comprehensive wrap-around care that makes medical and social services easily available to them. UCSF and hospital corporations do not like to provide the medical part of this kind of wrap-around care for seniors because Medicare does not pay as much as does major medical insurance for younger people. So we see in San Francisco that there are urgent care clinics in every neighborhood but no source of wrap-around medical care in the same neighborhood for frail seniors. Again, these bad decisions are driven by profit.

9. A subset of those who are in residential care have progressive illness and will require timely referral to a higher level of care such as skilled nursing facilities, either long-term or for short-term rehab. If these are not adequately provided, we are looking at worsening illness, being forced to leave the county, or death for elderly or disabled San Francisco residents.

10. Staff at Residential Care facilities for the elderly must have a routine of regular training with regular updates. Their responsibility for frail residents dictates that caregivers clearly understand not only how to care for their charges physically and behaviorally but also when to call for help.

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

December 7, 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 (a) 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 (b) 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) 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) 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;
d) Enactment of legislative/tax/code solutions that incentivize providers of residential care to open new facilities and maintain a high standard of staff training and that optimize the use of Medi-Cal and Medicare waivers and funds from non-profit organizations to make needed supports and care available to low and moderate income elderly;
e) Work with the state to adequately fund the San Francisco Ombudsman's office so there will be enough staff to monitor all SNF and residential care facilities and to advocate for the people that need these services.

Carroll, John (BOS)

From: Carroll, John (BOS)
Sent: Thursday, December 07, 2017 12:28 PM
To: 'pmonette-shaw@earthlink.net'
Cc: Board of Supervisors, (BOS)
Subject: RE: Public Safety and Neighborhood Services Committee December 7 Testimony — RCFEs, Ombudsman Testimony, and SNFs

Categories: 2017.12.07 - PSNS, 170788

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 link below:

Board of Supervisors File No. 170788

John Carroll
Assistant Clerk
Board of Supervisors
San Francisco City Hall, Room 244
San Francisco, CA 94102
(415)554-4445 - Direct | (415)554-5163 - Fax
john.carroll@sfgov.org | bos.legislation@sfgov.org

Click here to complete a Board of Supervisors Customer Service Satisfaction form.

The Legislative Research Center provides 24-hour access to Board of Supervisors legislation and archived matters since August 1998.

From: pmonette-shaw [mailto:pmonette-shaw@earthlink.net]
Sent: Wednesday, December 06, 2017 7:57 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 December 7 Testimony — RCFEs, Ombudsman Testimony, and SNFs

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

December 7, 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: **Institutional Housing for Seniors**

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

You need to read Long-Term Care Ombudsman Benson Nadell's testimony he submitted for today's hearing. And then you need to re-read it.

Attached is my testimony for the Public Safety Committee's December 7 hearing.

Supervisor Ronen: Since the November 29 hearing was continued to the "Call of the Chair," I respectfully request that you schedule a third hearing on the lack of SNF facilities in San Francisco.

Until that shortage is addressed, there will continue to be a shortage in sub-acute and residential care beds in-county in San Francisco.

Respectfully submitted,

Patrick Monette-Shaw
Columnist
Westside Observer Newspaper

Patrick Monette-Shaw

975 Sutter Street, Apt. 6
San Francisco, CA 94109
Phone: (415) 292-6969 • e-mail: pmonette-shaw@eartlink.net

December 7, 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: **Hearing on Residential Care Facilities for the Elderly (RCFE) and Community Housing**

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

Please read senior Ombudsman Benson Nadell's extended written testimony submitted for today's hearing, which is heartbreaking.

Then re-read it again. It suggests to me a greater need for SNF facilities. And it suggests that another hearing by this Committee on the separate need for expanded SNF facilities in San Francisco must be scheduled, quickly.

1. **Supervisor Safai:** This Committee's November 29 hearing was supposed to have included discussion of the closure of both SNF-beds and sub-acute beds at St. Luke's Hospital, but grandstanding, Supervisor Safai hijacked the November 29 hearing by limiting discussion only on sub-acute care beds, which are admittedly important. Obviously, a city of nearly one million people MUST have a sub-acute facility located in-county.

   DPH indicated November 29 that just 0.5% of post-acute discharges are to sub-acute beds. By contrast, 9% of patients discharged from hospitals were discharged to SNF facilities. There must be an extended discussion about the lack of SNF facilities in San Francisco.

   After all, the PACCs draft final report noted that in a second point-in-time survey conducted on October 5, 2017, that 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. This Committee cannot ignore that many patients prefer SNF placement, probably in-county, and that issue deserves to have another hearing at this Committee.

   Safai's staff claimed last week that today's hearing would manage to work in discussion of SNF-level of care, in addition to Supervisor Yee's focus on the shortage of residential care beds.

2. **Supervisor Yee**: There are too many acute-hospital discharges to RCFEs, clogging RCFE facilities, while at the same time RCFE patients cannot get admitted to SNF facilities. These patients are both getting discharged to inappropriate locations where they may not receive the appropriate level of care. San Francisco is NOT going to solve the lack of RCFE facilities until you address the lack of in-county SNF Facilities.

3. **Supervisor Ronen:** Because the November 29 hearing was continued to the "Call of the Chair," I respectfully ask that you quickly schedule another hearing to focus solely on the lack of SNF facilities citywide, above and beyond the lack of sub-acute, and the lack of residential care beds. This is a triad, and San Franciscans deserve a third hearing that you should schedule quickly to address the full continuum of care by focusing on the SNF bed shortage crisis.

Ombudsman Nadell's testimony submitted for today's hearing is but one reason another hearing is required.

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: Thursday, December 07, 2017 12:27 PM
To: 'bnadell@sanfranciscoltcombudsman.org'; Ronen, Hillary; Sheehy, Jeff (BOS); Fewer, Sandra (BOS); Yee, Norman (BOS); Safai, Ahsha (BOS)
Cc: Board of Supervisors, (BOS); 'Calvillo, Angela (angela.calvillo@sfgov.org)'; Somera, Alisa (BOS)
Subject: FW: Ombudsman electronic file-12-7-17BOS-Yee-RCFE
Attachments: December 7-bosTest-draft3.docx

Categories: 170788, 2017.12.07 - PSNS

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

PSNS members and guests expected for today's meeting: the attached is commentary for today's agenda item number two.

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

Board of Supervisors File No. 170788

John Carroll
Assistant Clerk
Board of Supervisors
San Francisco City Hall, Room 244
San Francisco, CA 94102
(415)554-4445 - Direct | (415)554-5163 - Fax
john.carroll@sfgov.org | bos.legislation@sfgov.org


Click here to complete a Board of Supervisors Customer Service Satisfaction form.

The Legislative Research Center provides 24-hour access to Board of Supervisors legislation and archived matters since August 1998.

From: bnadell@sanfranciscoltcombudsman.org [mailto:bnadell@sanfranciscoltcombudsman.org]
Sent: Wednesday, December 06, 2017 4:25 PM
To: Carroll, John (BOS) <john.carroll@sfgov.org>
Subject: Ombudsman electronic file-12-7-17BOS-Yee-RCFE

Hello

John

I will be attending the BOS Committee Hearing Neighborhood and Safety. I would like to add my written testimony for file 170788 pertaining to Supervisor Yee review of Residential Care and Assisted Living. As the SF Long Term Care Ombudsman Program Director for the last three decades I have a longitudinal view of trends pertaining to skilled nursing home beds and residential care bed.

Please find enclosed written testimony, from which I will excerpt for two of three minutes in front of the microphone per Jarmon's instructions.

Sincerely

Benson Nadell
Program Director
San Francisco Long Term Care Ombudsman
Felton

6221 Geary Blvd.
San Francisco, Ca. 94121

December 7,2017
Testimony
Benson Nadell
Program Director
San Francisco LTC Ombudsman Program
Felton
6221 Geary Blvd
San Francisco , Cal 94121

I wish to enter the following into the Public Record.

I have been with the Ombudsman Program since 1986 and have seen unfolding trends as to availability of long term care facilities. Under Federal Law the Ombudsman , as Representative of the State Ombudsman , California Department of Aging, is to identify problems made by or on behalf of residents of facilities, resulting from actions, inaction, or decisions that may adversely affect their health. Safety, welfare or rights. In California Law the Ombudsman are also charged to respond to received reports of abuse and neglect. Ombudsmen are abuse/neglect investigators. This State Law widened to jurisdiction to include dependent adults either mentally ill or developmentally disabled, who reside in other types of licensed care facilities.

I have been a member of the following City Task Forces:

1. Discharge Planning Task Force
2. Dementia Expert Panel
3. Long Term Care Coordinating Council

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.

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.

Is policy in reaction to a problem or based on forecasting for the future?
Who is responsible for future long term policy for all those constituents in each Supervisorial District:? The hospitals and the hospital council?
: 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?

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.

RCFE /Assisted living are regulated by State of California Community Care Licensing; Federal Payment programs do not pay. RCFE are market place and each consumer pays the monthly rate. Most do not have any optional long term care insurance product. State Regulations do not require a uniform standardized assessment for all assisted living/ board and care. The regulations on provision of care do not focus on qualitative outcomes. The Licensing Agency staff do not review quality of care issues, only if needs are being met.
Persons with incidental medical needs are allowed to reside in these RCFE under certain conditions. The co-morbidities of residents have exceeded the skills of many staff: O2 is allowed, as are colostomy , catheters, stage 1 and2 pressure sores, diabetic management, along with persons with dementia. RCFE house persons where the care management is lacking and the staff are inadequate in number and in skills. CCL inspectors are not trained to review quality of care.

Summary of Complaint/Grievances Ombudsman RCFE

1. Small board and care home type
   a. Evictions for complaining
   b. Sub-standard food: slice of boloney and thin soup
   c. Medication mismanagement
   d. Diversion of personal monies for payback soda and cigarettes no receipt
   e. Accepting persons back from hospital without reviewing Discharge summaries and H&P. Man with Parkinson's treated for psychiatric illness and assumption he had parkinsonian side effects. No one reviewed paper work; not on sinimet, kept falling; died.
   f. Woman receiving psychiatric medications in board and care along with case management, dies suddenly , to everyone's dismay. In her late 70's – concern over death, lessened. Ombudsman discovered she had history of cardiac problems and this was not monitored by visiting doctor ; no follow up EKG. Smaller facilities lack skill base.
   g. During Ombudsman repeated visits, half residents always in bed, shrouded in blankets. No quality of life; on TV watching and smoking. No one wants to complain. They know nothing better.
   h. In a private pay smaller RCFE- a man develops Stage 1V Pressure sores. He has a hospital bed and own room. The staff are poorly supervised and he is not turned. He should have been hospitalized because stage 3 and 4 sores are beyond the scope per Title 22. Nor was he ever in a higher level of care. He dies.
   i. An agency calls Ombudsman: a client in RCFE misses appointments. She the falls, and breaks an arm. There is no notification to MSW with that agency.
2. Larger RCFE –Assisted Living
   a. A male resident calls the Ombudsman Program : He fell beyond the reach of the call system. He is afraid to notify management, because in this RCFE room check costs an extra $ 500 per month. When the morning staff found him, they put him in bed. Without assessing him, the pain worsened. His daughter upset, called 911. He had a fractured femur.
   b. In a large CCRC-(continuing retirement community) which includes RCFE, the condominium owners in this care facility are going to pay for a wall which damaged by wind and rain as an additional capital expense. The fine print is in then Contract. This is over and above the monthly costs. Yet the residents have no shares in the business of this State wide large Corporation.

c. At an RCFE with a memory care unit. Staffing has been reduced by the new management company after purchase of the building. One employee calls the Ombudsman Program that others still working have hit and pulled those elderly residents with memory disorders. A police report is also sent to the Ombudsman Program. Morale is low among caregivers.
d. An elderly man is running out of money to pay the $ 7000 per month rate. He has Alzheimers Dementia. His daughter calls the Ombudsman Office. His income is actually only $ 2900 per month. His disease has progressed. Because he refuses to pay the rate, he is facing eviction. The daughter calls for a nursing home alternative. All are focused in SF on post acute. The daughter calls other RCFE ; he is unable to pay their monthly rate as well.
e. An elderly woman with dementia returns from a hospital after a fall. New medications were order. The receiving RCFE never fills the order; nor did they review the paperwork. The RCFE blames the son, who happens to live out of state for not picking up the order at Walgreens. The Ombudsman reviews the med. Room and talks to the med-tech. That person was off for four days and missed the communication. She apologized.
f. A 87 year old man becomes septic from sores. He is diabetic with renal failure. The Dialysis clinic calls the Ombudsman Program with a follow up mandated abuse/neglect report. He missed the last appointment. The clinic notice pressure sores. Calls to the RCFE were met with voice messages. The RCFE calls 911 and he is taken to acute hospital. He stays in the ED for a day and half. The ED MSW calls the Ombudsman Program saying he has pressure sores and also fills out a neglect abuse mandated report. He is not admitted to acute but is sent back the following weekend, after a short IV anti-biotic course. RCFE are unable to provide IV interventions under Title 22.
g. An RCFE advertising Memory /Dementia Care has a secured section with delayed egress. It is not well staffed. In the evening at least 4 residents sun-down. The Wellness Director calls their respective MD and orders was given for Depakote and Seroquel- which are contra-indicated for elderly persons. No consent is obtained.

Solutions:

Bricks and Mortar:

It is impossible in this real estate market to build, or purchase and refurbish existing building for new SNF or RCFE which will be accessible to the many persons aging and acquiring disabilities through illnesses, accidents, and acute medical events. Many low income and moderate income are in rent control housing. Many apartments in the private market lack elevators. Pressures for housing for newer generations of tenants makes in difficult for those aging in place to who live alone, without access to family support systems, to continue, after a hospitalization. With the homeless housing initiative becoming dominant, often the housing for those aging who require 24/7 care receive less attention.

The following are solutions predicated on the following premise: where there is a will there is a way.

Solutions:

Homes of decedents without heirs – Land Trust with leasing:

Every year individuals who live alone without beneficiaries or clear estate planning die. Real estate investors plough through death notices to see if such a property could be purchased. These houses without heirs revert to the Public Administrator for sale through Probate. In SF this is very imperative. What steep climb would it take, for the City to create a Public Trust where some of these properties could held in a holding company, after maintenance and repair, as a long term investment in smaller versions of assisted living RCFE. Eminent domain could be used for those properties without claim on them. If there is data on the number of live alone homeowners who die intestate, I do not know where they would be. Something similar was done when Agnews Developmental Center was closed, under Court Order. Brilliant Corners became the holder of some homes in San Mateo, and nurses were hired to by management caregivers.

Re-zoning with Fire Safety up-grade of abandoned commercial properties and lofts : modification of work/living zone for assisted living as long term investment.

Another idea would be to look at abandoned commercial properties, like warehouses with open interiors. Gutted and sub-divided, they could be re-zoned for mixed work-living spaces. The acquisition would be similar, through eminent domain.

To solve the bricks and mortar part of long term care, there will be have to be creative solutions that by-pass the frenetic housing market. New construction for SNF or RCFE residents who have limited incomes seems to be impossible, unless there were some cost shifting quotas in loan and construction approvals by the City.

Again affordable long term care of the assisted living type, with care packages thrown in, is higher than for new supportive housing. The average monthly cost for assisted living in SF in the market ranges from $4500- $12,000 per months plus add-ons for more care. All the larger RCFE or CCRC which include Life care plans, are recent. Most more resemble hospitality construction. Capital investment and property determine monthly costs, so that there is no dollar to dollar equivalent for care for each costumer. Some have specialized memory care for persons with degrees of dementia; some have delayed egress to prevent escaping. Not all memory care products and services are equivalent. Neither are the monthly rates- none of which are posted on respective web-sites. So to think about brick and mortal part of RCFE is to consider value added calculations.

Solution 2. More supportive housing. Supportive housing provides support services for coordinating care by professionals either in the ground floor Housing has social workers. For those living alone, if low income, IHHS would be available but not 24/7. Most IHHS workers of the 30,000 or so recipients in SF are family caregivers who come from other locations, visit, to provide care. If no family then either IP or Homebridge.

Solution Rejected:: Protection and Advocacy which was monitoring the two Civil Rights Cases against City and County, Davis V. SF and Chambers V SF posted response to the Laguna Honda Feasiblity Study August 23, 207.This set policy for the duration of the two Settlement Agreements where an affordable low income RCFE Assisted Living would not be invested in as a resolution to housing for those discharged from LHH or any other SNF. The City missed the chance to solve this lack of RCFE. Instead the shift was to rental subsidies from the city.

http://www.disabilityrightsca.org/advocacy/LHH/PublicMemo-AssistedLiving.pdf

https://ia802309.us.archive.org/30/items/assistedlivingfa1200sanf/assistedlivingfa1200sanf.pdf

http://www.stoplhhdownsize.com/PublicCommentsOnDraftAssistedLivingProjectStudy.pdf

Carroll, John (BOS)

From: Carroll, John (BOS)
Sent: Thursday, December 07, 2017 12:24 PM
To: 'Ann Ludwig'; Ronen, Hillary; Sheehy, Jeff (BOS); Fewer, Sandra (BOS); Safai, Ahsha (BOS); Yee, Norman (BOS)
Cc: Board of Supervisors, (BOS); 'Calvillo, Angela (angela.calvillo@sfgov.org)'; Somera, Alisa (BOS)
Subject: RE: NSPS Hearing #170788 on Institutional Housing for Seniors
Attachments: SWINDELLS STATEMENT.docx

Categories: 2017.12.07 - PSNS, 170788

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

PSNS members and guests expected for today's meeting: the attached is commentary for today's agenda item number two.

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

Board of Supervisors File No. 170788

-----Original Message-----
From: Ann Ludwig [mailto:anacanasta@aol.com]
Sent: Wednesday, December 06, 2017 3:47 PM
To: Carroll, John (BOS) <john.carroll@sfgov.org>
Subject: NSPS Hearing #170788 on Institutional Housing for Seniors

Dear Mr. Carroll:
Please enter my comments, attached, in the legislative record for the hearing tomorrow, December 7, 2017. Thank you.
Ann Ludwig
1121 Greenwich St.
94109

Comments from Ann Ludwig, Swindells Family Council
TO Public Safety, etc. Committee Meeting of December 7, 2017

Good afternoon. My name is Ann Ludwig and I am a member of the Family Council of Swindells Alzheimer's Residence. I am the wife of a 79-year-old former marathon runner, a victim of advanced Alzheimer's, now unable to walk, speak, or feed himself. What can families in this stair-intensive city do when this disaster occurs? When three years ago this progressive disease made it impossible for Karl to live and be cared for at home, we were fortunate to be able to move him to Swindells, part of the CPMC/Sutter California Street campus.

Swindells provides the residential care dementia patients require, specialized training and staffing, and in this case, extraordinary loving and expert caregivers, many of whom have worked there most of the twenty years of its existence. They are our family now.

The Hospital Council report recommends this type of care, but its largest member, CPMC/Sutter is shutting down Swindells, a model facility that should be expanded to meet a growing need.
Some of us were told Swindells would be moved to another campus when the current building is sold and demolished. But Medicare and Medi-Cal don't pay for this kind of care and CPMC/Sutter has decided we aren't profitable enough. They are letting Swindells wither by attrition, affecting morale and quality of care until shutting us down sometime next year.

We of the Family Council protest this decision, which is wrong for our loved ones and wrong for the city, as was the similar action CPMC took about the St. Luke's Sub-Acute. We have decided as a group that we aren't moving.

Some other members of our group will tell you about how Swindells provides exactly the kind of memory care our city needs and why it must not be closed but expanded. You will also hear from some Swindells staff members. Thank you.