File No. 190725 **Committee Item No.** 5
Board Item No. _____

COMMITTEE/BOARD OF SUPERVISORS

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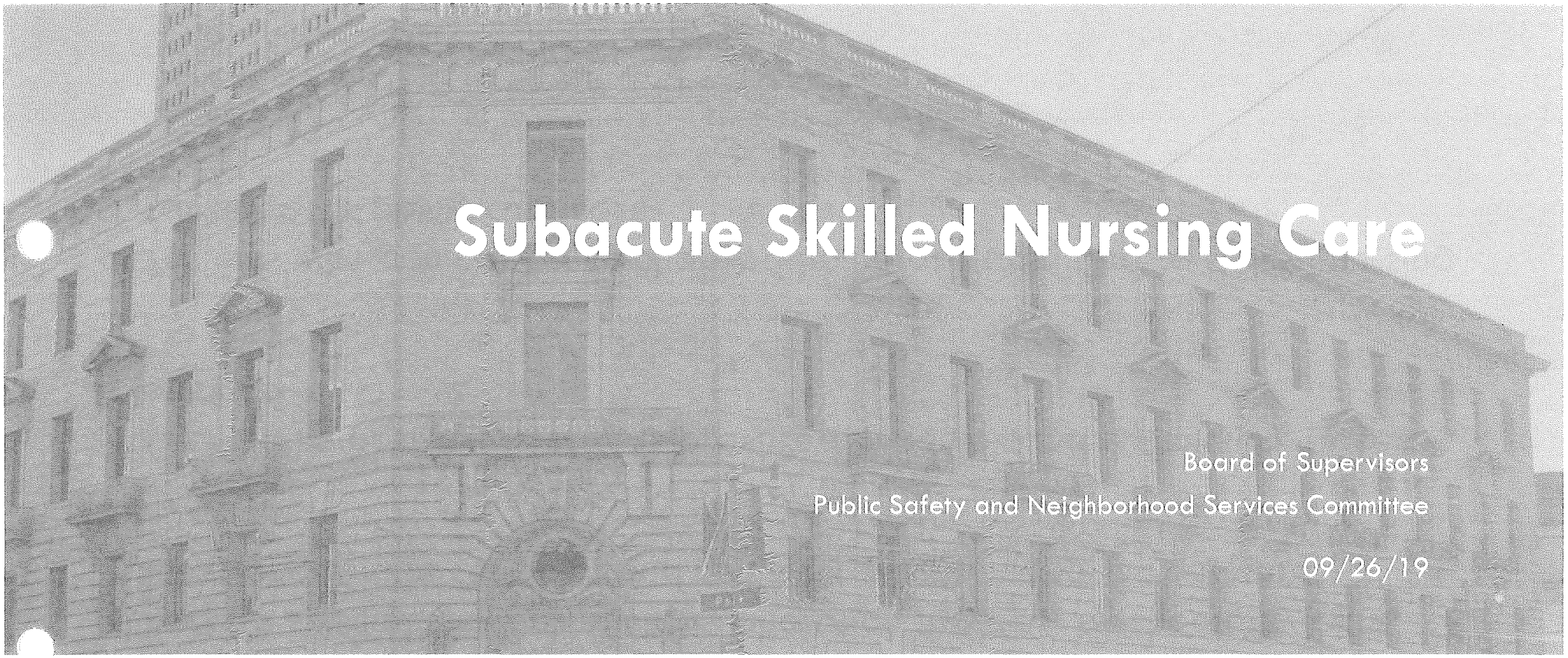
Prepared by: John Carroll **Date:** January 17, 2020
Prepared by: John Carroll **Date:** _____



Subacute Skilled Nursing Care

Board of Supervisors

Public Safety and Neighborhood Services Committee

09/26/19

Kelly Hiramoto, LCSW

SFDPH Project Manager

Subacute Skilled Nursing Care

- Subacute skilled nursing care is provided to medically fragile and require special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care

- Optimally, post-acute care is provided in home- and community-based settings

- Patients who can not be discharged home are admitted to skilled nursing facilities for post-acute care

Subacute Care

- In 2018 CPMC transferred 17 St. Luke's subacute patients to Davies Campus

- In Fall 2018 DPH began the process to identify a consultant to conduct an environmental scan, manage project selection and implementation to bring new subacute skilled nursing beds online

- Milliman, Inc., was selected in June 2019

Subacute Care Capacity in San Francisco

Current Needs and Opportunities to Develop Capacity

Preliminary Findings

Susan Philip, MPP
Senior Healthcare Management Consultant

SEPTEMBER 26, 2019

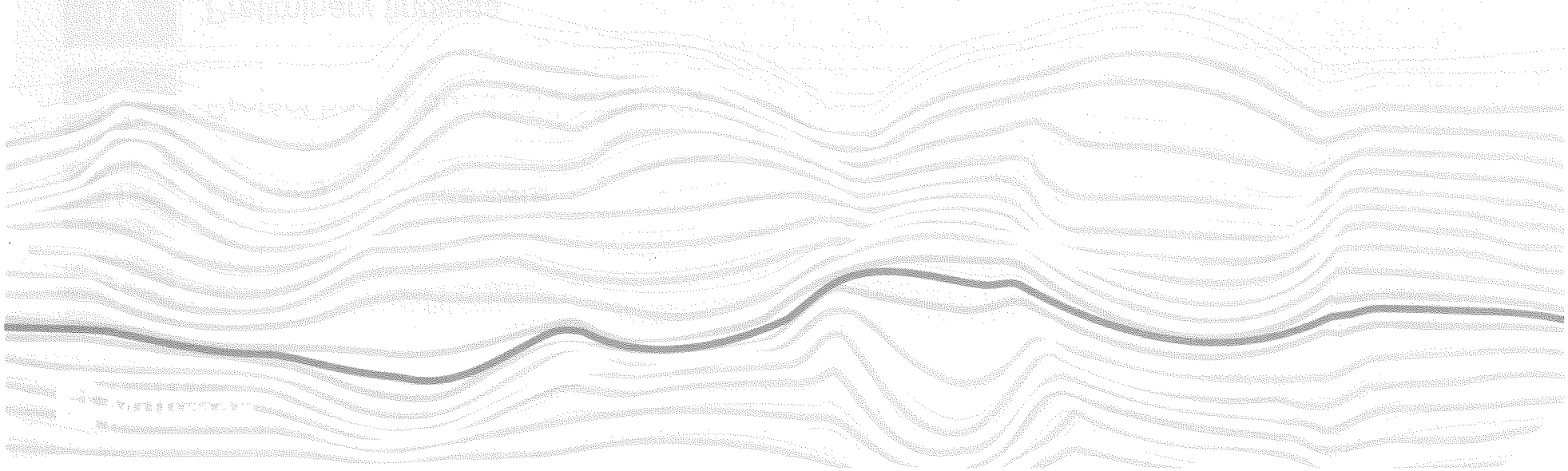
Milliman

Outline

I	Introduction and purpose
II	Defining subacute care
III	Project background and progress
IV	Preliminary findings
V	Next steps

Milliman's Mission

To serve our clients to protect
the health and financial
well-being of people everywhere.



Introduction

Actuarial and financial consulting firm founded in 1947

- Extensive public sector experience
- Depth and breadth of benefits expertise
- Unparalleled data and industry-leading analytics
- Practical expertise in project implementation

Purpose of presentation is to provide a project status update

- Provide a status update of the Department of Public Health's engagement with Milliman to identify strategies for expanding subacute care bed capacity
- Begin to define the subacute care needs of the Medi-Cal and indigent population of San Francisco
- Present preliminary options for addressing needs
- Outline next steps to further explore and generate additional options
- Obtain comments and feedback

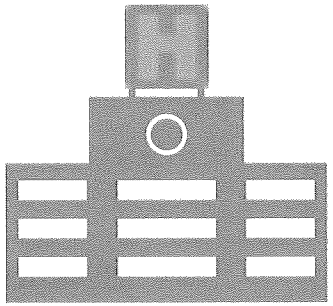
Outline

Subacute care is facility-based, medical and skilled nursing care provided following hospitalization for medically fragile patients

- **Subacute patients** are medically fragile and require special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care.
- **Adult subacute care** is a level of care that is defined as comprehensive inpatient care designed for someone who has an acute illness, injury or exacerbation of a disease process.
- **Pediatric subacute care** is a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.
- **CDPH License/ Medi-Cal Designation:**
  - **General SNF Services:** In California, SNFs are required to provide a minimum of 3.2 hours of nursing care per resident per day. Skilled nursing facility services include 24/7 supervision, physical, occupational and speech therapy, wound care, intravenous therapy, injections, monitoring of vital signs, and assistance with Activities of Daily Living (ADLs) - i.e. bathing, eating, dressing, feeding, transferring, toilet hygiene. SNFs are also responsible for creating an individualized care plan for each resident that determines what services are provided based on patient needs.
  - **Subacute SNF Care**: Some SNFs have a Medi-Cal designation which allows them to provide specialized skilled nursing care, called subacute care, to complex patients. Subacute SNFs provide care for adults with higher levels of need such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management.

1. DHCS. Subacute Care Contracting Unit. https://www.dhcs.ca.gov/provgovpart/Pages/SubacuteCare.aspx.
2. San Francisco Department of Public Health, Office of Policy and Planning. (September 1, 2017). Memorandum, RE: Proposition Q – CPMC St. Luke's Skilled Nursing Facility Unit Closure.

Subacute care is a type of post-acute care

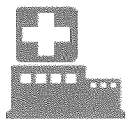


Acute care Short-term, acute care provided by hospitals.

Higher intensity

Lower intensity

Subacute Care



Long Term Acute Care

Inpatient Rehabilitation

Skilled Nursing Care

Outpatient Rehabilitation

Home Health

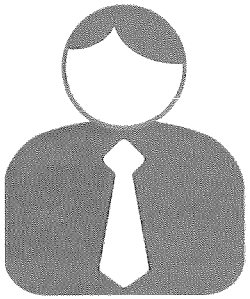
Level of care for general SNF versus Subacute

Category	Characteristic	General SNF	Subacute
Capacity	Licensed beds in San Francisco, 2018	2,227*	8**
Supervision	24/7	✓	✓
Services	Physical therapy, occupational therapy, speech therapy	✓	✓
	Wound care, intravenous therapy, injections, monitoring of vital signs	✓	✓
	Assistance with activities of daily living, e.g., bathing, eating, dressing, feeding, transferring, toilet hygiene	✓	✓
	Ventilator care, complex wound management, intravenous tube feeding		✓

* Includes free-standing facility bed counts

** Current patient bed census at CPMC Davies

Subacute care: patient illustrations



- 75 years of age, male
- Experiences falls and has traumatic brain injury and spinal injury
- Also has acute and chronic respiratory failure and requires a tracheostomy with ventilatory support
- Does not qualify for acute rehabilitation and is in need of partial ventilatory support
- Does not have any family members who are able to serve as caregivers

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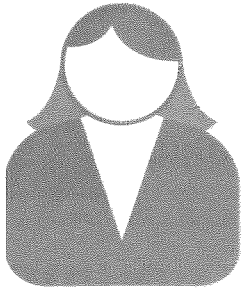


- 45 year of age, female
- Has postoperative infections which results in sepsis, acute respiratory distress syndrome and anoxic brain damage
- Requires tracheostomy and ventilatory support
- Is otherwise stable and is in need of long-term subacute care

Outline

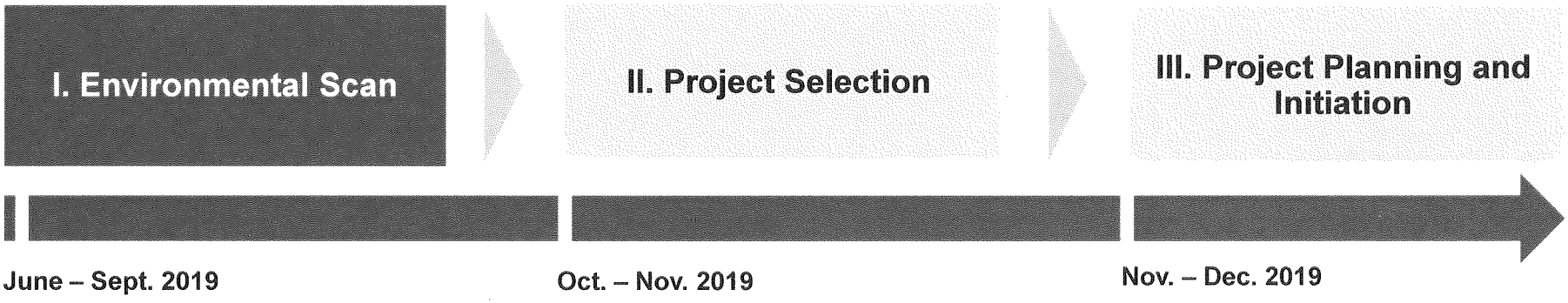
Project objectives

To support the Department of Public Health plan for and implement expansion of San Francisco's capacity for subacute care beds for Medi-Cal beneficiaries and vulnerable members of San Francisco.

Our approach

Take a comprehensive view of subacute care needs and identify options to address those needs

- The current phase is focused on interviewing and gathering data points from San Francisco health systems to understand needs for subacute care in the area, current and future institutional capacity, and stakeholder perspective on partnering to address these care needs



Current status

San Francisco hospital-based facilities interviewed

Facility	Interviewed	Provided data
Kaiser Permanente San Francisco	✓	
Chinese Hospital	✓	✓
Dignity Health (St. Mary's & St. Francis)	✓	✓
Vibra Health (Kentfield Hospital)	✓	✓
California Pacific Medical Center (all campuses, including Davies, Mission Bernal, and St. Luke's)	✓	✓
University of California San Francisco Medical Center	✓	✓
Zuckerberg San Francisco General Hospital	✓	✓

Outline

I Introductions and purpose

II Defining subacute care

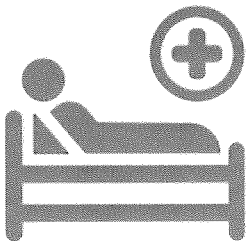
III Project background and progress

IV Preliminary findings

- Current state of subacute care needs
- Projected needs

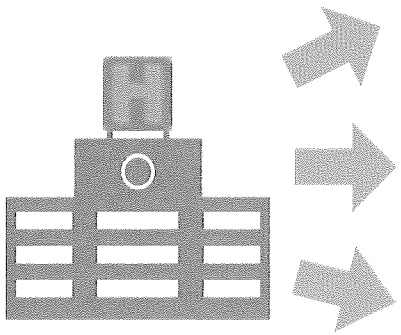
V Next steps

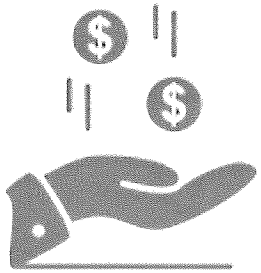
Current state of subacute care bed capacity



- CPMC transferred 17 subacute care patients from St. Luke's to Davies Campus in 2018. Those beds will revert to SNF beds
- Shortage of subacute care beds in Northern California as a whole
- Patients that are ventilator dependent **and** in need of dialysis have no subacute care options in Northern California and must go to Southern California or outside of the State

Challenges to placing subacute care patients





- **Post-acute care placement challenges as a whole**
  - Need to improve acute care discharge planning patients to support placement in the "right place at the right time."
  - Capacity limits for custodial SNF beds, room & board exacerbate challenges
- **Family / caregiver preferences**
  - Primary consideration for discharge placement as family is a key part of the caregiver team, and integral to the well-being of the patient
- **Payer sources and payment rates**
  - Medi-cal is the typical payer for long-term subacute care services. Medi-Cal's per-diem payment rates for subacute care are reportedly too low to cover the costs in San Francisco
- **Regulatory hurdles and impact on bed supply**
  - Meeting regulatory and licensing rules may reported pose a barrier to quickly increasing supply

Subacute care needs, 2018

Wait times for placement

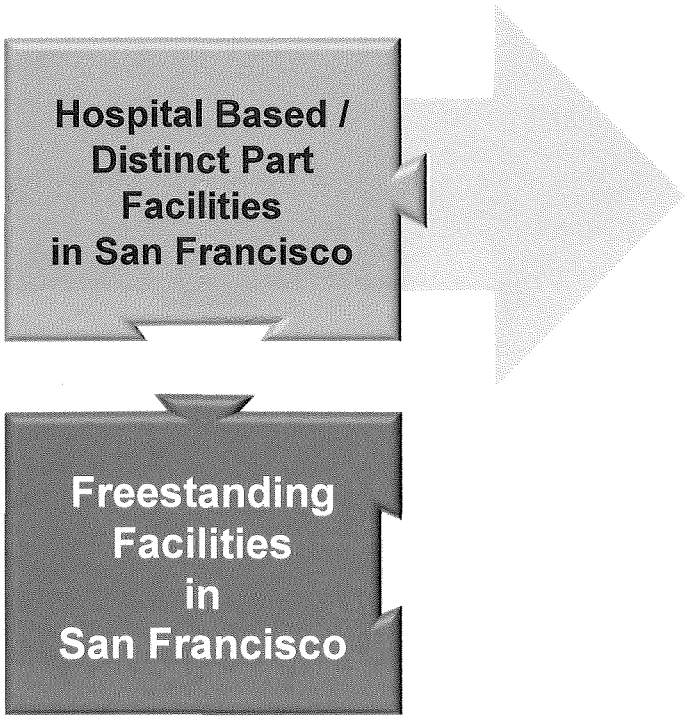
- Ranges of wait times vary widely, given the small number of individuals and barriers to placement.
- Generally average wait time for placement may vary from 30-45 days with extreme cases, such a 500+ days wait times
- While most interviewees indicated they did not track this data or it was difficult to separate for SNF or LTAC placements, they were able to provide a snapshot of current patients waiting for placement
- 2 of 6 hospitals reported they have not been able to successfully place **any** subacute care patients in the last year

Discharges

- Estimated discharges to subacute care are about 49 discharges in 2018. This is based on:
  - 5 of 7 hospitals' responses
  - Available data on (1) actual discharges to out-of-county subacute care in 2018 and (2) those who would have had a subacute care placement in 2018 had there been beds available
- Discharges to subacute care are less than 1% of all discharges. This is expected given there are a small number of such patients that require subacute level of care
- **Estimates are likely deflated as respondents pursue alternate options**

Outline

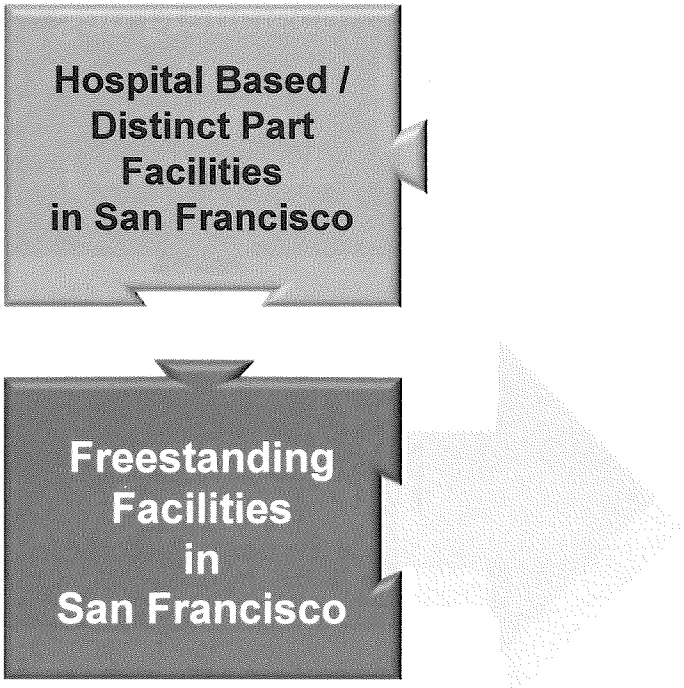
Potential subacute care options



Explore opportunities with hospital-based options with available space

- Chinese Hospital: 23 available beds
- DPH in discussion with Dignity Health
- Kentfield (Vibra) as an operator with experience in running SNF/subacute/LTACH facilities and operations are willing partners

Explore alternative options



Next steps

- Conduct interviews with free standing nursing home operators
  - San Francisco Health Care
  - Aspen Skilled Healthcare
  - Providence Group
  - Generations Healthcare
- Consider supplemental services and arrangement necessary to support capacity (e.g., critical care transport)
- Assess current capacity, readiness to partner, barriers
- Work with DPH to obtain proposals

Milliman

Caveats and limitations

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Susan Philip
Susan.Philip@Milliman.com

September 26, 2019

BOS Testimony

September 24, 2019

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

Dear Supervisors

I wish to enter the following into the public record:

1. Hospitals and their increasing costs and mergers have held hostage long term care options for the aging population in San Francisco. What does this mean? I have been an Ombudsman for the aging and disabled population in San Francisco since 1987. That is a long time and my memory is good and knows of the trends despite comings and goings generations of elected officials.
2. Since 1983 Medicare had attempted to control hospital billing by setting up a prospective billing system based on diagnoses. That policy , developed at Yale University is called the DRG system. Payments were limited to a number of days based on a diagnostic related category Hospital had to scurry. The net effect that in the 1980s sicker persons were discharged to skilled nursing facilities. That period could be considered the base line for hospital decisions affecting skilled nursing facilities. Persons were discharged for recovery. And the acuity in nursing homes shifted from an ADL-assistance model to increased demands to coordinate co-morbities for a much sicker population. Yet the nursing home staffing never was adjusted upward to provide good quality of care and

quality of life. (here I wish to city a NYT article , by Elizabeth Rosenthal, September 1,2019 about the costs of hospitals driving up costs throughout the health care system.) The main point is that hospitals drive long term care policy and yet no data on discharges by sickness and supports is demanded by any politicians in San Francisco. Where do patients go? To what destination? What supports are provided? Where is data on destination and discharge services by acuity from the remaining Post-Acute SNF?

3. Fast forward to 2010 , Sutter took over the CPMC hospital system. Decisions were made. All the in hospital SNF units on California Street were shuttered. Patients would be discharged to community based SNF. At the same time Sutter had to build a new glass hospital to weather earthquakes. The Planning Commission made an agreement with Sutter. Part of the agreement was to give $ 8 million to various nonprofits through a Foundation to build capacity for community based LTSS. And to subsidize supportive housing construction.. SFDPH worked out the arrangement. Part of the arrangement was to address the sub-acute SNF unit at St Luke's.
4. When Sutter took over the CPMC hospital system, St Luke's serving three major neighborhoods in San Francisco-Bayview, Mission, Excelsior- was on the chopping block. But the City prevailed, and there is a new Bernal Heights Hospital , adjacent to the old St Luke's but following in the spirit of a profitable bottom line, the SNF was phased out. This included the Sub-acute unit. Sutter has already closed admissions from other hospital systems to this sub-acute specialty unit. As part of the phase-out family members were given lists of SNF throughout California- the list did not differentiate post- acute from sub-acute. If the patients in the sub-acute unit were to be dispersed throughout California, visits and monitoring by involved family would have been impossible. Sutter did not care. But the families and advocates pushed back. SFDPH Commission held a Prop Q meeting. Their policy analyst reviewed bed data and determined taking any SNF beds off line would adversely affect citizens of San Francisco.
5. A minor victory for families and advocates resulted in moving the remaining 17 sub-acute units to the Davies Campus SNF. Visits could continue; and there was proximity to an ICU if needed.
6. From 2018 through September 2019 9 patients remain. Difficult to prove, but had these 17 remained at St Luke's the attrition would not have been so precipitous.
7. Reasons why include – lack of staff continuity. Between 2017-2019 a Nurse Manager has left. The nurse manager who knew the patients at St Luke's and who became an MDS coordinator left and is working elsewhere; lack of training in providing care for sub-acute patients, specifically each person in that cohort. Staff at Davies have had turn-over rates. A recent visit by family member reported registry persons working. This sub-acute SNF was merged with post-acute SNF. Although numbers of staffing are posted in both sections, the knowledge of these post-acute patients is not. Supports of sub-acute patients requires constant monitoring and suctioning, and getting persons out of bed when possible. The Activity person at SF Luke's provided support to family and knew all the patients. She was not carried over through the ensuing years.
8. Post-Acute: Sutter's power in San Francisco cannot be underestimated. The Hospital Council with SFDPH and its post Laguna Honda class actions on institutionalizing the

disabled, merged into a Post-Acute Care Collaborative. Now, with the closure of all hospital based SNF, community- based SNF , as Community Partners, would step into the role of post-acute care. The Community Based SNF were eager to seize this opportunity of billing Medicare for elderly patients once discharged.

9. The SFDPH policy analyst conducted a data analysis as to how many SNF beds there are in San Francisco, with this shift to short term stay in these community SNF. What remained as long term care beds was reduced to 1588. The rest were allocated for persons, often very sick, or recovering post- op for short term stays in these SNF
10. The Ombudsman Program has received constant complaints about persons too sick to return home and who could be Medi-Medi.It is against the law to discharge someone too sick to return home safely; and it is against the law to discriminate against persons on Medical. From the Ombudsman Perspective this is clearly a collision between hospital driven policies and the needs and rights of San Franciscans who do need 24/7 care with nursing involvement.
11. Since 1987 San Francisco has lost 6 skilled nursing facilities or 1000 beds. This includes the loss of 440 beds with the completion of the new Laguna Honda.
12. " Patient flow" and " transitions " are buzz words within and without San Francisco Department of Public Health. These terms have their antecents in the two law suits against Laguna Honda City and County, Olmstead Supreme Court Decision, and much earlier Deinstutionalization of state hospitals and acute psychiatric settings.
13. Return to community ideal for those with acquired disabilities. But persons come out of the hospital with illnesses, especially complex medical illnesses, which require 24/7 care. The most dependent are those who need sub-acute care. The sub-acute service was originally focused on children and adults with severe disabling conditions. End of life discussions which focus on aging persons included palliative and hospice care. But for the disabled community and many with ALS and MS that end of life narrative was not acceptable. Keeping persons alive who were younger was what drove the creation of sub-acute skilled nursing care.
14. By merging the sub-acute unit with a post-acute model at Davies Campus SNF, Sutter probably knew the eventual outcome.
15. What this Ombudsman wants, even though PHI and HIPAA protected, is data on suctioning and turning for all 17 after transfer. The Ombudsman Program does not provide a forensic nursing investigative unit. We doubt that the precariousness of this population warranted any such investigation by the Medical Examiner. Death is inevitable. But were all steps taken to prevent such outcomes as had occurred at ST Luke's'
16. When the last person at this Sub-acute leaves, there will be none in San Francisco. In my opinion we have Sutter and the Planning Commission to thank.

The New York Times

That Beloved Hospital? It's Driving Up Health Care Costs

It's easy to criticize pharmaceutical and insurance companies. But we spend much more on hospitals.

By Elisabeth Rosenthal
Ms. Rosenthal, a journalist and physician, is a contributing opinion writer.

Sept. 1, 2019

As voters fume about the high cost of health care, politicians have been targeting two well-deserved villains: pharmaceutical companies, whose prices have risen more than inflation, and insurers, who pay their executives millions in salaries while raising premiums and deductibles.

But while the Democratic presidential candidates have devoted copious airtime to debating health care, many of the country's leading health policy experts have wondered why they have given a total pass to arguably a primary culprit behind runaway medical inflation: America's hospitals.

Data shows that hospitals are by far the biggest cost in our $3.5 trillion health care system, where spending is growing faster than gross domestic product, inflation and wage growth. Spending on hospitals represents 44 percent of personal expenses for the privately insured, according to Rand.

A report this year from researchers at Yale and other universities found that hospital prices increased a whopping 42 percent from 2007 to 2014 for inpatient care and 25 percent for outpatient care, compared with 18 percent and 6 percent for physicians.

So why have politicians on both the left and right let hospitals off scot-free? Because a web of ties binds politicians to the health care system.

Every senator, virtually every congressman and every mayor of every large city has a powerful hospital system in his or her district. And those hospitals are as politically untouchable as soybean growers in Iowa or oil producers in Texas.

As hospitals and hospital systems have consolidated, they have become the biggest employers in numerous cities and states. They have replaced manufacturing as the hometown industry in a number of rust-belt cities, including Cleveland and Pittsburgh.

Can Kamala Harris ignore the requests of Sutter Health, Kaiser Permanente, U.C.L.A. or any of the big health care systems in California? Can Elizabeth Warren ignore the needs of Partners HealthCare, Boston's behemoth? (Bernie Sanders may be somewhat different on this front because Vermont doesn't have any nationally ranked hospitals.)

Beyond that, hospitals are often beloved by constituents. It's easy to get voters riled up about a drug maker in Silicon Valley or an insurer in Hartford. It's much riskier to try to direct their venom at the place where their children were born; that employed their parents as nurses, doctors and orderlies; that sponsored local Little League teams; that was associated with their Catholic Church.

And, of course, there's election money. Hospital trade groups, medical centers and their employees are major political donors, contributing to whichever party holds power — and often to the out-of-power party as well. In 2018, PACs associated with the Greater New York Hospital Association, and individuals linked to it, gave $4.5 million to the Democrats' Senate Majority PAC and $1 million to their House Majority PAC. Its chief lobbyist personally gave nearly a quarter of a million dollars to dozens of campaigns last year.

Senator Sanders has called on his competitors for the Democratic nomination to follow his lead and reject contributions from pharma and insurance. Can any candidate do the same for hospitals? The campaign committees of all 10 candidates participating in the upcoming Democratic debate have plentiful donations linked to the hospital and health care industry, according to Open Secrets.

But the symbiosis between hospitals and politicians operates most insidiously in the subtle fueling of each other's interests. Zack Cooper, a health economist at Yale, and his colleagues looked at this life cycle of influence by analyzing how members of Congress voted for a Medicare provision that allowed hospitals to apply to have their government payments increased. Hospitals in districts of members who voted yea got more money than hospitals whose representatives voted nay, to the collective tune of $100 million. They used that money to hire more staff and increase payroll. They also spent millions lobbying to extend the program.

Members who voted yea in turn received a 25 percent increase in total campaign contributions and a 65 percent increase in contributions from individuals working in the health care industry in their home states. It was a win-win for both sides.

To defend their high prices, medical centers assert that they couldn't afford to operate on Medicare payments, which are generally lower than what private insurers pay. But the argument isn't convincing.

The cost of a hospital stay in the United States averaged $5,220 a day in 2015 — and could be as high as over $17,000, compared with $765 in Australia. In a Rand study published earlier this year, researchers calculated that hospitals treating patients with private health insurance were paid, overall, 2.4 times the Medicare rates in 2017, and nearly three times the rate for outpatient care. If the plans had paid according to Medicare's formula, their spending would be reduced by over half.

Most economists think hospitals could do just fine with far less than they get today from private insurance.

While on paper many hospitals operate on the thinnest of margins, that is in part a choice, resulting from extravagance.

It would be unseemly for these nonprofit medical centers to make barrels of money. So when their operations generate huge surpluses — as many big medical centers do — they plow the money back into the system. They build another cancer clinic, increase C.E.O. pay, buy the newest scanner (whether it is needed or not) or install spas and Zen gardens.

Some rural hospitals are genuinely struggling. But many American hospitals have been spending capital "like water," said Kevin Schulman a physician-economist at Stanford. The high cost of hospitals today, he said, is often a function of the cost of new infrastructure or poor management decisions. "Medicare is supposed to pay the cost of an efficient hospital," he said. "If they've made bad decisions, why should we keep paying for that?"

If hospitals were paid less via regulation or genuine competition, they would look different, and they'd make different purchasing decisions about technology. But would that matter to medical results? Compared with their European counterparts, some American hospitals resemble seven-star hotels. And yet, on average, the United States doesn't have better outcomes than other wealthy nations. By some measures — such as life expectancy and infant mortality — it scores worse than average.

As attorney general in California, Kamala Harris in 2012 initiated an antitrust investigation into hospitals' high charges. But as a senator and presidential candidate, she has been largely silent on the issue — as have all the other candidates.

As Uwe Reinhardt, the revered Princeton health economist who died in 2017, told me, "If you want to save money, you have to pay less." That means taking on hospital pricing.

So fine, go after drug makers and insurers. And for good measure, attack the device makers who profit from huge markups, and the pharmacy benefit managers — the middlemen who negotiate drug prices down for insurers, then keep the difference for themselves.

But with Congress returning to Washington in the coming days and a new Democratic debate less than two weeks away, our elected officials need to address the elephant in the room and tell us how they plan to rein in hospital excesses.

Elisabeth Rosenthal, a former New York Times correspondent, is the editor in chief of Kaiser Health News, the author of "An American Sickness: How Healthcare Became Big Business and How You Can Take It Back" and a contributing opinion writer.

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A version of this article appears in print on Sept. 1, 2019, Section A, Page 25 of the New York edition with the headline: Time to Rein in Hospital Excesses

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September 25, 2019

San Francisco Board of Supervisors
San Francisco City Hall
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San Francisco, California 94102

Members of the Board Of Supervisors

I am writing to you today because I feel it is critical that my voice not go unheard in these proceedings. As a licensed physician with 40 years of experience and 22 years as a primary care provider for subacute patients, I thought it important to share my unique perspective on this issue.

As many of you are aware, this is not the first time I have been vocal on the topic of subacute care. I am an independent physician and staff clinician at several facilities in the Bay Area, and I was the previous Medical Director of St. Luke's subacute unit. When CPMC announced their plans to close down the unit at St. Luke's and relocate patients out of the county, I was openly critical of that decision as an advocate for my patients.

CPMC did the right thing in keeping the subacute unit open for those patients and I speak once again as an advocate – not just for my patients, but this time also *for* CPMC – and the high-quality, compassionate care they are providing patients in the subacute unit.

I currently serve patients in my capacity as a primary care physician with Bay West Family Health Care, and have privileges at CPMC. I am well aware of the clinical decisions impacting the patients in the subacute unit, and I have no concerns – ethical or clinical – about the care, staffing, or conditions at the Davies Campus. I have heard allegations from family members and caregivers regarding the quality of care and incidence of death in the unit, and I can say with confidence that they are without merit. While it is heartbreaking for families and their care providers, the passing of patients requiring subacute care is an unfortunate but not unexpected outcome of their clinical condition. In fact due to the excellent care provided by the nursing and ancillary staffs at both the St Luke's and Davies unit these patients survived far longer than similar patients in other subacute units.

In the decades I have served post-acute patients, I have witnessed firsthand the challenges presented by the citywide lack of skilled nursing facilities. I feel strongly about the need for a comprehensive solution that leads to increased high-quality skilled nursing facility beds including subacute beds, and offer to lend my expertise to continuing conversations on this issue.

Thank you for your service to the City of San Francisco, and your consideration.

Respectfully,

Gary Birnbaum, M.D.
Bay West Family Health Care

Carroll, John (BOS)

From:	Teresa Palmer <teresapalmer2014@gmail.com>
Sent:	Saturday, September 21, 2019 11:41 AM
To:	Carroll, John (BOS)
Cc:	Mandelman, Rafael (BOS); Walton, Shamann (BOS); Stefani, Catherine (BOS); Safai, Ahsha (BOS); Ronen, Hillary; Kung Feng
Subject:	File # 190725; Please add to information packet for Sept 26 PS & NS Comm Hearing
Attachments:	SFHHJJ Final Subacute Care Position Paper 061119.pdf
Categories:	190725, 2019.09.26 - PSNS

File # 190725; Please add the attached to information for Sept 26 PS & NS Comm Hearing (subacute SNF Care)

Mr. Carroll: On behalf of San Franciscans for Housing, Healthcare, Jobs and Justice, please place the attached in the informational file for this hearing. Please call me or email me if there is any problem with this.

Thank you, Teresa Palmer M.D. email teresapalmer2014@gmail.com; phone 4152608446
On behalf of:

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

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

June 18, 2019

A Crisis in San Francisco Subacute Skilled Nursing Care: First steps to repairing all levels of care to SF residents

Background

Since at least 2016, any San Francisco resident who newly requires Subacute Skilled Nursing Facility (Subacute SNF) care has to leave the county. Subacute SNF care is an intensive form of long-term care for people who require ventilators and/or other forms of complex nursing care to survive. It is best done in a hospital setting, as those who need this care can get critically ill quickly and then need to go straight to an intensive care unit.

Subacute SNF beds are not the only category of long-term care that has been lost due to "shifts in the market" in San Francisco; ***but it is the only level of care that is absolutely not available in-county to new patients***. To be forced to leave your family and community to get this type of care is not only morally and ethically wrong, it leads to psychological trauma and social isolation that impairs survival.

In 2017, Sutter/CPMC proposed to shut down the last Subacute SNF in San Francisco. By late 2016, it already had stopped admitting new patients to its 40-bed unit at St. Luke's. Despite earlier promises, the Sutter/CPMC corporate team stated that the Development Agreement with San Francisco, which provided for major changes in development plans and substantial community benefits as conditions for approving Sutter/CPMC's construction of two new hospitals, did not require Subacute SNF beds. The Development Agreement, in actuality, was silent on this matter. Sutter/CPMC fabricated a false basis for stepping away from its responsibilities and past promises regarding the provision of subacute care.

Sutter/CPMC instead pressured existing patients at the St. Luke's Subacute SNF to leave the county. However, due to family and community public advocacy, Sutter/CPMC agreed in late 2017 to care for the remaining patients in the St. Luke's Subacute Unit (23 patients at the time of CPMC's decision), until they died or otherwise left. With the closing of St. Luke's Hospital, the patients were relocated in August 2018 to the Sutter/CPMC Davies Campus. As of this writing (June 2019), 11 of these patients remain at the Davies Campus.

Hospital revenues are maximized by competing for profitable short-term acute hospitals stays. Because of the expense, most long-term patients in Subacute SNF units are on Medi-Cal. Most hospitals and other providers view Medi-Cal reimbursements as too low and serving Medi-Cal patients as a financial negative. The shortfall between what hospitals set as their fee rates for specific services (which are much higher than private health insurance reimbursement rates and not the same as the actual costs of services) and what Medi-Cal reimburses for its beneficiaries is a large part of what hospitals count as their contributions to charity care broadly defined.

Since the implementation of the Affordable Care Act, the costs of providing traditional charity care, which covers patients who get fee reductions and are not Medi-Cal beneficiaries, have gone down. Generally speaking, this decline corresponds with increases in the numbers of individuals with private insurance through California exchanges or with Medi-Cal coverage. (*See* the May 2019 draft of the 2017 *San Francisco Hospital Charity Care Report*, Figures 18 & 19 at pp. 22 & 23.) Notably, one major result is that reported Medi-Cal dollar shortfall amounts for most San Francisco hospitals have gone up, 2 to 3 times for some. (*Id.*, Figure 20, at p. 24.) Strikingly, the exceptions all involve Sutter/CPMC hospitals. Sutter/CPMC expenditures on traditional charity are at an all-time recent low, approximately 1/3 less in 2017 compared to 2013, but Medi-Cal shortfall amounts are also down. (*Id.*, Figures 18-20, at pp. 22-24.) Sutter/CPMC reported for its Pacific, California and Davies campuses a combined Medi-Cal shortfall of $63.5 million in 2013 and $62.8 million in 2017 and for its St. Luke's campus a drop almost in half from $26.0 million in 2013 to $13.4 million in 2017.

The indisputable conclusion is that Sutter/CPMC did much less in dollar terms in 2017 than in 2013 to meet the healthcare and hospital needs of low-income San Franciscans. Part of the drop in reported Medi-Cal shortfall amounts is very likely due to its cutting back in the number of patients in the St. Luke's Subacute Care SNF Unit. But this cutback is almost certainly not the only service reduction contributing to Sutter/CPMC's dramatically opposite Medi-Cal shortfall trend-lines as compared to other San Francisco hospitals.

For example, one area that needs to be closely examined is potential changes in the types and costs of services being provided by Sutter/CPMC to Medi-Cal beneficiaries since the 2013 Development Agreement (DA). The DA requires Sutter/CPMC to meet and exceed certain baseline numbers in serving unduplicated Medi-Cal patients. San Francisco administrators have allowed Sutter/CPMC to count a one-off diagnostic service, on referral from Zuckerberg San Francisco General Hospital, as meeting DA requirements for serving an unduplicated patient. Providing a single diagnostic service to a Medi-Cal beneficiary in all likelihood accounts for much less in an overall Medi-Cal shortfall amount than providing a full array of emergency room, outpatient, or inpatient services. The DA's focus on unduplicated patients provides an incomplete and probably false impression of the extent to which Sutter/CPMC now serves Medi-Cal beneficiaries.

While Sutter/CPMC is not the only entity that has to step-up to meet the need for subacute care in San Francisco, it is the largest, most profitable, private, fee-for-service hospital group in San Francisco. As is all too evident in its sorry recent record of shutting down services and obfuscating other cutbacks, Sutter/CPMC will not do its fair share in serving subacute care patients and other low-income San Francisco residents unless politically constrained or legally compelled to do so.

Barbara Garcia, Director of DPH in 2018, noted that beds exist at St. Mary's and Chinese Hospital that could serve as Subacute SNF beds. St. Francis Hospital may also have suitable beds. Since Director Grant Colfax took over, there has been no further public expression of Health Department efforts to address this egregious situation. Former Director Garcia had determined, as a rough estimate, that San Francisco needs a minimum of 70 Subacute SNF beds.

Sutter/CPMC's refusal to accept any new patients in its Subacute SNF unit now on the Davies Campus means that every San Francisco hospital indiscriminately discharges patients in need of subacute care to out-of-county facilities, some as far away as Fresno and Los Angeles.

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

Proposals for Action

SFHHJJ urges the Health Commission to do the following:

1. Direct the Department of Public Health as part of its pending revision of the Health Care Services Master Plan to address comprehensively the need for and availability of post-acute care services in San Francisco taking into account the entire continuum of such services, especially Subacute SNF care;

2. Direct the Department of Public Health to prepare within two months a report identifying all beds in San Francisco hospitals that are licensed or could be re-licensed for use by Subacute SNF patients;

3. Direct the Department of Public Health to collect to the maximum extent feasible from all acute care hospitals and SNF facilities located within San Francisco comprehensive and specific data and information, for the past three years and prospectively, about all San Francisco residents who have been discharged to out-of-county facilities to receive SNF, Subacute SNF care, or RCFE care; to support the enactment of legislation by the Board of Supervisors to mandate all acute care hospitals and SNF facilities in San Francisco to provide such data and information; to prepare and publicly publish, within four months, a written report covering all such data and information collected along with specific reasons for not having or having only incomplete data and information from each individual hospital and healthcare facility; and to prepare and publish a similar report annually from now on; and

4. Direct the Department of Public Health, in immediate consultation with labor and grassroots community groups as well as healthcare providers and associations, to analyze and develop solutions to the absence of Subacute SNF beds in San Francisco, including the following proposals—

    a. Co-operation agreements among private and public hospitals to jointly operate and fund Subacute SNF beds within 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 licensed and staffed bed elsewhere within San Francisco so that there is not a decrease in such beds in San Francisco, and
    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 San Francisco must create and maintain.

Carroll, John (BOS)

From:	pmonette-shaw <pmonette-shaw@earthlink.net>
Sent:	Wednesday, September 25, 2019 12:49 PM
To:	Carroll, John (BOS)
Subject:	Please Post On-Line — Fwd: Testimony for September 26 Hearing: Sub-Acute Care Solutions
Attachments:	Printer-Friendly Testimony on Delay of Sub-Acute Care Solutions.pdf
Categories:	190725, 2019.09.26 - PSNS

Hi Mr. Carroll,

Can you please post the attached PDF file on the PSNS agenda page fro tomorrow on a "Public Correspondence" tab on the background information page?

Thanks,
Patrick Monette-Shaw

-------- Forwarded Message --------
Subject: Testimony for September 26 Hearing: Sub-Acute Care Solutions
Date: Tue, 24 Sep 2019 22:21:59 -0700
From:pmonette-shaw <pmonette-shaw@earthlink.net>
Reply-To:pmonette-shaw@earthlink.net
To: Catherine.Stefani@sfgov.org, Rafael.Mandelman@sfgov.org, Shamann.Walton@sfgov.org, Ahsha.Safai@sfgov.org
CC: Norman.Yee@sfgov.org, Sandra.Fewer@sfgov.org, Aaron.Peskin@sfgov.org, Gordon.Mar@sfgov.org, Vallie.Brown@sfgov.org, Matt.Haney@sfgov.org, Hillary.Ronen@sfgov.org, angela.calvillo@sfgov.org, lee.hepner@sfgov.org, sunny.angulo@sfgov.org, tim.h.ho@sfgov.org, suhagey.sandoval@sfgov.org, ian.fregosi@sfgov.org, angelina.yu@sfgov.org, percy.burch@sfgov.org, daisy.quan@sfgov.org, alan.wong1@sfgov.org, edward.w.wright@sfgov.org, juancarlos.cancino@sfgov.org, derek.remski@sfgov.org, tom.temprano@sfgov.org, courtney.mcdonald@sfgov.org, ivy.lee@sfgov.org, erica.maybaum@sfgov.org, jen.low@sfgov.org

Patrick Monette-Shaw

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September 24 , 2019

Public Safety and Neighborhood Services Committee, Board of Supervisors
The Honorable Rafael Mandelman, Chair
The Honorable Catherine Stefani, Member
The Honorable Shamann Walton, Member
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

Re: **Shameful Delay on Sub-Acute Care Solutions in San Francisco**

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

When I submitted testimony to PSNS Committee then-members Supervisors Ronen, Sheehy and Fewer on November 28, 2017 the number of then-known out-of-county discharges stood at just 1,381 people. Out-of-county discharges of San Francisco residents now stand at a minimum of 1,659 — but the data is incomplete and is likely far higher. I testified in November 2017:

> "This Public Safety Committee must ascertain just how many out-of-county discharges of San Franciscans there have been from all private-sector and public-sector hospitals in San Francisco, dating back to July 1, 2006. As previous Civil Grand Juries have noted — and I reminded this Committee in July 2017 — '***You can't fix what you don't measure***'."

This Committee, and the full Board of Supervisors, have done nothing in the past two years to introduce legislation requiring that all private sector hospitals submit basic out-of-county discharge data to the Department of Public Health. Th delay creating such legislation is shameful!

The Health Commission and the Board of Supervisors should have known that seven years ago in 2012 CPMC — a Sutter Health affiliate — stopped admitting patients to its St. Luke's sub-acute unit from any other non-Sutter hospital in the City. The Board and Health Department must have known that there were no other sub-acute units anywhere else in the City.

CPMC then stopped new admissions to its St. Luke's sub-acute unit in FY 16—17, even from its own Sutter affiliates.

Table 1 shows that CPMC has admitted to DPH that it discharged 312 people out-of-county between 2016 and 2017. How many more San Franciscans CPMC has discharged out-of-county since 2017 isn't known, in part because the Board of Supervisors has failed to enact legislation requiring that out-of-county patient discharges be reported to the City.

Since 2012, people who need sub-acute unit level of care have faced being dumped into out-of-county facilities, which this Board should also have known. In the past seven years, the City failed to address this crisis, despite knowing about it.

Then, when CPMC notified the City in June 2017 that it planned to close its sub-acute and skilled nursing units at CPMCs St. Luke's campus at the end of October 2017, the Health Commission held a "Prop. Q" hearing on the closure on September 5, 2017. The Health Commission adopted its Resolution 17-7 finding that the closure of St. Luke's sub-acute and SNF units ***would*** in fact have a detrimental effect on San Franciscans' healthcare.

Table 1: Public Hospital's Out-of-County Discharges, FY 2006–2013 — FY 2018–2019

	Fiscal Year	Laguna Honda Hospital	SFGH[1]	Private-Sector Hospitals	Total
1	FY 06–07	35		?	35
2	FY 07–08	36		?	36
3	FY 08–09	14		?	14
4	FY 09–10	18	27	?	45
5	FY 10–11	6	54	?	60
6	FY 11–12	19	41	?	60
7	FY 12–13	26	30	39	95
8	FY 13–14	28	42	2	72
9	FY 14–15	25	68	25	118
10	FY 15–16	20	56	261	337
11	FY 16–17	20	40	449[2]	509
12	FY 17–18	25	57	?	82
13	FY 18–19	14	182	?	196
	Total[3]	286	597	776	1,659

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

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

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

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

Source: San Francisco Department of Public Health responses to records requests. Updated: July 18, 2019

After the Health Commission ruled against CPMC, then-Director of Public Health Barbara Garcia began working in 2017 on identifying where 70-bed sub-acute beds could be created in existing spaces in the City's private-sector hospitals. Garcia had made some progress working with St. Mary's to host some of the beds.

The Board of Supervisors stepped in on September 12, 2017 and held a "Committee of the Whole" (CoW) hearing on St. Luke's at the urging of Supervisors Ahsha Safai and Hillary Ronen, rather than waiting for several weeks to hold a second hearing before the Supervisors Public Safety and Neighborhood Services Committee, as it first had on July 26.

But on August 21, 2018 Director Garcia was forced out due to a contract-steering scandal, and her efforts came to a screeching halt. It's unknown whether the new Director of Public Health, Grant Colfax, has lifted a finger to pick up where Garcia left off trying to open sub-acute beds quickly, or whether the issue is even on his radar screen.

On September 3, 2018 I specifically asked now Board President Norman Yee to introduce legislation ***requiring*** each and every private-sector and public-sector hospitals in the City, and also RCFE facilities, to submit out-of-county discharge information, including a limited amount of demographic data, to DPH annually on a Fiscal Year basis going forward.

I also recommended that such legislation should also require all hospitals report annually their out-of-county discharges to the types of long-term care facilities (including RCFE's and SNF's) facilities listed in the table in Appendix E, Summary o San Francisco LTC Residential Facilities, in HMA's report (starting on page 77 in the PDF file), and additionally require

them to report the number of out-of-county discharges to other acute-care hospitals and to sub-acute care facilities. Supervisor Yee has failed to sponsor such legislation.

Labor leader Kim Tavaglione has reportedly been working with the Board of Supervisors to craft legislation to require out-of-county discharge reporting, but she may have overstepped wanting the public- and private-sector hospital to report burdensome details about each discharge, rather than seeking basic data reporting. Why hasn't that legislation been submitted and enacted? What's the delay?

It is incumbent on the Board of Supervisors to require that all of the private-sector hospitals — including St. Francis, St. Mary's, and Kaiser — provide data on all out-of-county discharges of San Francisco residents in order to gain an historical context of just how severe this problem has been back to FY 2006—2007 from all hospitals in the City.

The PSNS Committee should quickly develop legislation to:

1. Direct the Department of Public Health issue an RFP within six months to develop a public-private partnership entity to identify and open 70 sub-acute beds in the City within the next years. Negative patient outcomes, and out-of-county patient dumping has simply got to stop!

2. Move along, and finalize, legislation requiring all hospitals in the City to report basic-level out-of-county discharge information to the Department of Public Health, including retroactive data.

This issue has languished for at least two years, if not longer. Lives are at stake! It's long past time for the Board of Supervisors to act, meaningfully.

Respectfully submitted,

Patrick Monette-Shaw

Columnist, Westside Observer Newspaper

cc: The Honorable Sandra Lee Fewer, Supervisor, District 1
The Honorable Aaron Peskin, Supervisor, District 3
The Honorable Gordon Mar, Supervisor, District 4
The Honorable Vallie Brown, Supervisor, District 5
The Honorable Matt Haney, Supervisor, District 6
The Honorable Norman Yee, Supervisor, District 7
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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

Patrick Monette-Shaw

975 Sutter Street, Apt. 6
San Francisco, CA 94109
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September 24 , 2019

Public Safety and Neighborhood Services Committee, Board of Supervisors
The Honorable Rafael Mandelman, Chair
The Honorable Catherine Stefani, Member
The Honorable Shamann Walton, Member
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

Re: **Shameful Delay on Sub-Acute Care Solutions in San Francisco**

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> "This Public Safety Committee must ascertain just how many out-of-county discharges of San Franciscans there have been from all private-sector and public-sector hospitals in San Francisco, dating back to July 1, 2006. As previous Civil Grand Juries have noted — and I reminded this Committee in July 2017 — '***You can't fix what you don't measure***'."

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Respectfully submitted,

Patrick Monette-Shaw
Columnist, Westside Observer Newspaper

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The Honorable Aaron Peskin, Supervisor, District 3
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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

BOARD of SUPERVISORS

City Hall
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco 94102-4689
Tel. No. 554-5184
Fax No. 554-5163
TDD/TTY No. 554-5227

MEMORANDUM

TO: Dr. Grant Colfax, Director, Department of Public Health

FROM: John Carroll, Assistant Clerk,
Public Safety and Neighborhood Services Committee

DATE: June 26, 2019

SUBJECT: HEARING MATTER INTRODUCED

The Board of Supervisors' Public Safety and Neighborhood Services Committee has received the following hearing request, introduced by Supervisor Safaí on June 18, 2019:

File No. 190725

Hearing to discuss the status of sub-acute care in San Francisco and plans to care for this vulnerable population to prevent unnecessary deaths; and requesting the Department of Public Health to report.

If you have any comments or reports to be included with the file, please forward them to me at the Board of Supervisors, City Hall, Room 244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102.

c: Greg Wagner, Department of Public Health
Dr. Naveena Bobba, Department of Public Health
Sneha Patil, Department of Public Health

Print Form

Introduction Form

By a Member of the Board of Supervisors or Mayor

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BOARD OF SUPERVISORS
SAN FRANCISCO
2019 JUN 18 PM 2:19
BY

Time stamp
or meeting date

I hereby submit the following item for introduction (select only one):

- ☐ 1. For reference to Committee. (An Ordinance, Resolution, Motion or Charter Amendment).
- ☐ 2. Request for next printed agenda Without Reference to Committee.
- ☑ 3. Request for hearing on a subject matter at Committee.
- ☐ 4. Request for letter beginning :"Supervisor [ ] inquiries"
- ☐ 5. City Attorney Request.
- ☐ 6. Call File No. [ ] from Committee.
- ☐ 7. Budget Analyst request (attached written motion).
- ☐ 8. Substitute Legislation File No. [ ]
- ☐ 9. Reactivate File No. [ ]
- ☐ 10. Topic submitted for Mayoral Appearance before the BOS on [ ]

Please check the appropriate boxes. The proposed legislation should be forwarded to the following:

☐ Small Business Commission ☐ Youth Commission ☐ Ethics Commission

☐ Planning Commission ☐ Building Inspection Commission

Note: For the Imperative Agenda (a resolution not on the printed agenda), use the Imperative Form.

Sponsor(s):

Safai

Subject:

Hearing re: Sub-Acute Care in San Francisco

The text is listed:

Hearing to discuss the status of sub-acute care in San Francisco and plans by the Department of Public Health, and private hospitals, to care for this vulnerable population to prevent unnecessary deaths.

Signature of Sponsoring Supervisor:

For Clerk's Use Only