From:	pmonette-shaw
To:	Mar, Gordon (BOS); Stefani, Catherine (BOS); Haney, Matt (BOS)
Cc:	Calvillo, Angela (BOS); Carroll, John (BOS); Ronen, Hillary; Safai, Ahsha (BOS); Chan, Connie (BOS); Melgar, Myrna (BOS); Peskin, Aaron (BOS); Preston, Dean (BOS); Mandelman, Rafael (BOS); Walton, Shamann (BOS); Quan, Daisy (BOS); Wong, Alan (BOS); Wright, Edward (BOS); Lovett, Li (BOS); Hepner, Lee (BOS)
Subject:	Testimony for PSNS Committee 9/9/2021 Hearing on Sub-Acute Care
Date:	Tuesday, September 7, 2021 2:15:29 PM
Attachments:	Testimony to Public Safety and Neighborhood Services Sub-Acute Care 21-09-09.pdf

September 7, 2021

Public Safety and Neighborhood Services Committee, Board of Supervisors
The Honorable Gordon Mar, Chair
The Honorable Catherine Stefani, Member
The Honorable Matt Haney, Member
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102 Re: **Testimony for 9/9/2021 Agenda Item #3, Sub-acute SNF Care in San Francisco**

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

Attached is my additional testimony for the PSNS Committee on both the issue of opening a Sub-acute SNF Unit at Chinese Hospital, and the related issue of Board f Supervisors legislation requiring all public- and private-sector hospitals operating in San Francisco to submit out-of-county discharge data annually to San Francisco's Department of Public Health.

After all, in this day and age, all hospitals have robust Electronic Health Records (EHR) database systems that must be able to track whether a patient is discharged to a City other than to San Francisco, which makes them by definition out-of-county discharges. Many hospitals either use the Epic EHR system, or have links to it using Epic's "Care Everywhere" platform. Epic's Media Relations Department has informed me it's "Patient Flow" module in its basic enterprise database product does, indeed, have structured database fields that include the name of the facility patients are discharged to, what type of facility it is they are discharged to, and for what level of medical care they require, contrary to the misinformation SFGH and SFDPH have claimed that its $167.4 million Epic system can't track out-of-county discharges.

Thank you.

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

September 9, 2021

Public Safety and Neighborhood Services Committee, Board of Supervisors
The Honorable Gordon Mar, Chair
The Honorable Catherine Stefani, Member
The Honorable Matt Haney, Member
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

Re: **Repatriate Ken Zhao to San Francisco**
Agenda Item #3: Sub-Acute SNF Care in San Francisco

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

Along with other healthcare advocates in San Francisco, I have previously submitted testimony multiple times to the Public Safety and Neighborhood Services (PSNS) Committee during the four years between 2017 and May 2021 regarding the dire shortage of skilled nursing facility beds in San Francisco and the problem the City faces in having zero sub-acute SNF beds in-county. Both problems have resulted in a glut of patient discharges to out-of-county facilities.

This Committee must surely remember that I've begged this Committee multiple times since 2018 to develop and pass legislation by the Board of Supervisors to require that all public- and private-sector acute care hospitals and other healthcare facilities report to San Francisco's Department of Public Health their aggregate number of out-of-county discharges. As I've said repeatedly, "***You can't fix what you don't measure***."

Chinese Hospital Has Agreed to Host a Sub-Acute SNF

On May 5, 2021 I requested that Chair Gordon Mar call the Sub-Acute SNF matter from the PSNS Committee's *Call of the Chair* docket. It's regrettable it took four months for this hearing.

> **"During the week of January 31, 2020 Chinese Hospital's Board agreed to continue to explore a partnership with DPH for a subacute unit at Chinese Hospital. Now 20 months after Chinese Hospital indicated its willingness to open a sub-acute SNF, what's the delay now?"**

During this year's Board of Supervisors processes developing the City's FY 2021–2022 and FY 2022–2023 two-year budget, I also repeatedly urged the Board to provide funding to SFDPH to open a sub-acute SNF at Chinese hospital. My impression is that the two-year budget eventually adopted did ***not*** include additional funding for SFDPH to open a sub-acute SNF quickly.

On April 13, 2021 I placed a public records request to DPH seeking 1) All correspondence between DPH and any private-sector hospitals regarding progress on opening a replacement sub-acute SNF following Barbara Garcia's departure from DPH in August 2018, 2) All documents exchanged between the Department of Public Health and San Francisco's Board of Supervisors since August 2018 regarding DPH's progress in identifying opening a replacement sub-acute SNF, and 3) All documents in DPH's possession since August 2018 analyzing options to open an in-county sub-acute SNF in San Francisco and the expected date on which a sub-acute SNF will eventually be opened in-county.

It took SFDPH nearly three months before it responded to my April 13 records request on July 9. Among the dozens of stand-alone e-mails and documents DPH provided, one e-mail (see Enclosure 1, attached) from Chinese Hospital dated **January 31, 2020** to DPH's Kelly Hiramoto revealed that Chinese Hospital's Board of Directors had agreed to host a sub-acute SNF 18 months ago.

As Enclosure 1 shows, Paul Ziegele, Chinese Hospital's then-Interim Chief Financial Officer indicated Chinese Hospital's Board of Directors had met during the week of January 31, 2020 and the Board agreed to continue to explore a partnership with DPH for a subacute unit at Chinese Hospital. Ziegele indicated the basic terms its Board had endorsed included, 1) The sub-acute unit would be separately licensed and operated by an independent subacute provider, 2) Chinese Hospital would lease space to the subacute provider, and 3) Chinese Hospital would need an annual payment of $1.7 million, in addition to services provided in item #2.

$1.7 million of DPH's $1 billion dollar budget is less than two tenths of one percent of its budget (actually, 0.17%). Here we are now 20 months after Chinese Hospital indicated its willingness to, and agreed to, open a sub-acute SNF at its hospital. How much more money DPH would need to pony up to Chinese Hospital beyond the initial $1.7 million annual payment was not disclosed. What's the delay, now?

Surely, that expenditure should have been added by the Board of Supervisors to SFDPH's FY 2021–2022 and FY 2022–2023 two-year budget. During today's hearing, the PSNS Committee should drill down and get SFDPH to provide an update on progress towards opening a sub-acute SNF at Chinese Hospital and why there has now been an almost two-year delay since Chinese Hospital's Board agreed to lease the space for a sub-acute SNF.

After all, Ken Zhao should be returned from his out-of-county discharge to Seton Hospital in Daly City. **Ken should be the first person quickly repatriated to an in-county sub-acute SNF, and he should be given a priority certificate of preference to facilitate his return to living in our City**.

Legislation Requiring Reporting of Out-of-County Discharges

I have repeatedly informed the PSNS Committee that on September 3, 2018 I had specifically asked then-Board President Norman Yee to introduce legislation ***requiring*** each and every private-sector and public-sector hospital in the City to submit out-of-county discharge information by the various types of long-term care facilities they are discharged to. No action has been taken since 2018 to develop, introduce, and pass legislation requiring all hospitals in the City to submit out-of-county discharge data to DPH. **Why has it taken this Board of Supervisors three years without such legislation being introduced and passed?**

As I reported four years ago in December 2017, I began my quest for out-of-county discharge data after badgering the Laguna Honda Hospital Joint Conference Committee (LHH-JCC) for months during 2012 and 2013 to release public records on the number of LHH patients discharged out-of-county, which patient dumping had begun in earnest in 2009 and 2010 when 420 SNF beds were eliminated from the LHH replacement rebuild due to cost overruns.

The then-chairperson of the LHH-JCC (a subcommittee of the Health Commission) was Health Commissioner David Sanchez (now deceased), who finally agreed during the LHH-JCC's November 21, 2013 meeting that LHH would begin reporting out-of-county discharge data beginning in January 2014, mid-year into FY 13-14. The first trickle of data I obtained was for 28 LHH patients discharged out of county during FY 13-14. DPH subsequently provided additional OOC data dating back to FY 06–07.

As of November 27, 2017 public records I had obtained from SFDPH since January 2014 documented there were a minimum of 1,381 San Franciscans discharged out-of-county. Fast forward to May 2021: **The number of known out-of-county discharges has jumped to 1,746**.

However, notice in Table 1 that the blue shading indicates not only that SFGH has suddenly refused to provide out-of-county discharge data **since the onset of COVID-19 in January 2020** after years of having done so, we also don't know how many out-of-county discharges there have been from private-sector hospitals since July 1, 2017.

This is ridiculous! Every one of these hospitals have Electronic Health Record (EHR) database systems that should be able to provide aggregate data on out-of-county discharges based on the name of the City each patient had been discharged to.

Table 1: Out-of-County Discharges

	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	49[3]	131
13	FY 18–19	14	182	?	196
14	FY 19–20 7/1/2019 – 12/31/2019	8	20	?	28
15	FY 19–20 1/1/2020 – 6/30/2020	6	?	?	6
16	FY 20–21 7/1/20 – 4/31/21	4	?	?	4
	Total[4]	**304**	**617**	**825**	**1,746**

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

[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] On September 29, 2019 DPH and its consultant, Milliman, reported to the Board of Supervisors Public Safety and Neighborhood Services Committee that 49 patients had been discharged by 5 of 7 private sector hospitals to out-of-county sub-acute or post-acute facilities as part of Milliman's contractual sub-acute provider capacity analysis. DPH creatively claimed no breakdown of the data had been ***officially*** "*supplied to the City and County of San Francisco by Milliman* ," and so the records request was simply closed. It's not known when in 2018 the discharges were made, or which private-sector hospital-based facilities were involved. It's also not known whether the 49 patients were all San Francisco residents, or if some were residents of other counties sent back to their originating jurisdictions.

[4] 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: **May 19, 2021**

I believe the PSNS Committee must prioritize writing legislation requiring out-of-county discharge data reporting to SFDPH, and making this legislation a priority.

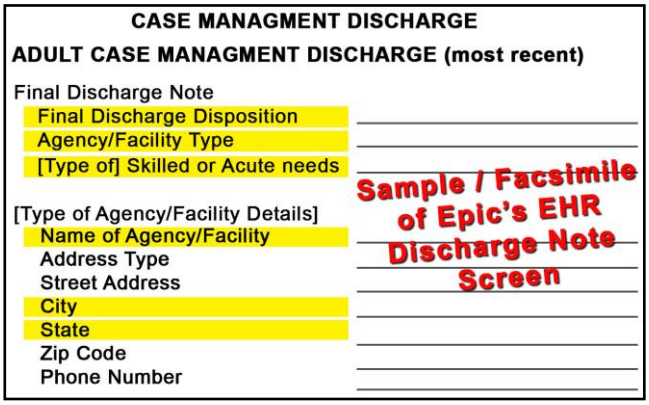
New Protracted Dispute With SFDPH Out-of-County Discharge Records Request

I placed a records request to SFDPH on July 6, 2020 (#20-2673) seeking out-of-county (OOC) discharge data from both SFGH and Laguna Honda Hospital between January 1, 2020 and June 30, 2020, and I had placed a separate records request on May 4, 2021 (#21-2189) seeking OOC discharge data for two additional periods — 7/1/2020 to 12/31/2020 and 1/1/2021 to 4/303/2021.

> **"Epic's own Media Relations Department informed me that Epic's standard configuration (i.e., its 'base' enterprise package) includes discharge destinations/ dispositions including the name of the *City* a patient is discharged to in an Epic module named 'Patient Flow'."**

For both records requests, DPH creatively claimed it's new Electronic Health Records (EHR) system — Epic — does not contain structured database fields to identify OOC discharges. **This is patently ridiculous, and is probably a lie**. **What good is the Epic database that will initially cost DPH $167.4 million to roll out and implement if it can't track OOC discharges?**

First, that Epic's own Media Relations Department informed me that Epic's standard configuration (i.e., its "base" enterprise package) includes discharge destinations/ dispositions including the name of the ***City*** a patient is discharged to in an Epic module named "Patient Flow." After consulting with its in-house subject-matter experts, Epic's Media Relations Department confirmed that the Patient Flow module includes database fields for Discharge Disposition — the broad category of where a patient is discharged to, e.g., returned to home *vs*. discharged to a skilled nursing facility, a Long-Term Care Acute Hospital (LTCAH), or perhaps a Residential Care Facility for the Elderly (RCFE) — and the actual discharge location (including the name, address and City, phone number, and type of facility).



Second, healthcare clinicians have confirmed discharge disposition data ***is*** available in Epic's core enterprise package, in apparent structured database fields . A clinician who enters into Epic can type in a patient's name and then use Epic's "*Search Chart*" feature by typing in "Discharge" to locate Epic case management notes indicating where a patient was discharged to the type of a facility it was.

A sample of those database fields is shown above. Since Epic's Media Relations staff also indicated that in addition to standard reporting tools, information systems computer professionals can write their own custom, facility-specific, *ad hoc* database queries into Epic's various components, including its Patient Flow module.

Since San Francisco is the only ***city*** in the **County** of San Francisco, a relatively easy database query to extract data from Epic is simple: *If a patient is **not** discharged to the **City** of San Francisco, then ergo, the patient was discharged OOC*.

I filed a Sunshine complaint with the Sunshine Ordinance Task Force on May 4, 2021 over DPH's false claim Epic is unable to determine whether Epic can track OOC discharges; my complaint may finally be heard by the full Task Force on October 6, 2021 — fully five months ***after*** I filed my complaint in May.

Just as CPMC stopped admitting non-CPMC patients to its sub-acute SNF unit at St. Luke's Hospital in 2012, LHH is now only admitting patients from SFGH. Non-SFGH patients needing SNF level of care are dumped out of county.

Proposed Features of Legislation Requiring Reporting of Out-of-County Discharges

I recommend that this PSNS Committee develop legislation requiring out-of-county discharge data be reported to SFDPH to address the following high-level issues:

- All public- and private sector acute-care hospitals and hospital-based SNF's must report the aggregate number of **only San Francisco residents** discharged to each type of out-of-county healthcare facilities.

- In order to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), reports submitted by the acute-care hospitals must **not** include any protected health information (PHI) patient data (e.g., patient medical diagnoses, patient age, prognosis, etc.) other than the types of out-of-county facilities patients are discharged to.

- Reports must include: 1) Aggregate data on the **types of facilities patients are discharged to** [including to other acute care facilities, long-term care acute hospitals, skilled nursing facilities (SNF), sub-acute skilled nursing units (sub-acute SNF), Residential Care Facilities for the elderly (RCFE's), other types of assisted living facilities, etc.]; 2) Aggregate data on the **type and level of care to be provided** (acute care vs. skilled nursing care, etc.); 3) Aggregate data on the **number of patients discharged to each named facility** (including enumerating the name of each facility); and 4) Aggregate data on the **name of the out-of-county City** patients were discharged to for each city.

  Requiring hospitals to stratify and report both the number of OOC discharges by the types of facilities patients are discharged to, and the level of care these patients need (nursing vs. custodial vs. sub-acute care), will help identify the shortages of various types of in-county facilities available in San Francisco and what types of additional facilities are needed.

- Quarterly and annual reporting of out-of-county discharge data from all acute-care hospitals to the SF Department of Public Health.

- Annual hearings must be held by both the Public Safety and Neighborhood Services Committee and the full Board of Supervisors to review the out-of-county discharge data and possible solutions to the lack of in-county facilities.

- Provide retrospective out-of-county discharge data for past three fiscal years (July 1, 2018 to June 30, 2019, July 1, 2019 to June 30, 2020, and July 1, 2020 to June 30, 2021) to assist with historical trends and context analyses.

"Requiring hospitals stratify and report both the number of OOC discharges by the types of facilities patients are discharged to, and the level of care these patients need, will help identify the shortages of various types of in-county facilities available in San Francisco."

- Create a Certificates of Preference program to expatriate San Francisco residents discharged out-of-county so they have preference for being returned to San Francisco as additional facility capacity becomes available. **Think Ken Zhao!**

I've been urging the Board of Supervisors to write this legislation and get it passed for the past three to four years. You must do something NOW to make sure this legislation comes to fruition!

Respectfully submitted,

Patrick Monette-Shaw
Columnist
Westside Observer Newspaper

cc: The Honorable Connie Chan, Supervisor, District 1
The Honorable Aaron Peskin, Supervisor, District 3
The Honorable Dean Preston, Supervisor, District 5
The Honorable Myrna Melgar, Supervisor, District 7
The Honorable Rafael Mandelman, Supervisor, District 8
The Honorable Hillary Ronen, Supervisor, District 9
The Honorable Shamann Walton, Supervisor, District 10
The Honorable Ahsha Safai, Supervisor, District 11
Angela Calvillo, Clerk of the Board
John Carroll, Clerk of the Public Safety and Neighborhood Services Committee
Daisy Quan, Legislative Aide to Supervisor Gordon Mar
Edward Wright, Legislative Aide to Supervisor Gordon Mar
Li Miao Lovett, Legislative Aide to Supervisor Gordon Mar
Alan Wong, Administrative Aide to Supervisor Gordon Mar
Lee Hepner, Legislative Aide to Supervisor Aaron Peskin

Enclosure 1: E-Mail From Chinese Hospital to Kelly Hiramoto at SFDPH, January 31, 2020

From: Paul Ziegele <paulz@chasf.org>
Sent: Friday, January 31, 2020 12:53 PM
To: Hiramoto, Kelly (DPH) <kelly.hiramoto@sfdph.org>
Cc: Jian Zhang <JianZ@chasf.org>; Antonia Lendaris <antonial@chasf.org>
Subject: Good News, Next Steps RE: Subacute Unit

Kelly,

Great news, **our board met this week and they are in agreement that we should continue to explore a partnership for a subacute unit at Chinese Hospital**. The board has expressed a strong desire for Chinese Hospital to NOT operate the unit itself, which means we could only participate when we've found a suitable partner that could wholly run the unit. The basic terms that the board endorsed include:

[1] **Subacute unit would be separately licensed and operated by an independent subacute provider**.

[2] **Chinese Hospital would lease space to the subacute provider**, and are willing to further subcontract with the provider for support and clinical/ancillary services as mutually agreeable.

[3] Due to the constraints of our agreements with Cal Mortgage, **Chinese Hospital would need an annual payment of $1.7m in addition to services provided above in #2** since we had anticipated a productive use of the 2nd floor space.

From here what are the next steps to continue discussions and begin negotiations about the structure of how a deal would proceed? What role will you and the supervisors have, and who are the principals we should be in contact with for this discussion?

And if you have recommendations for which subacute providers are more likely to be favored by the community that would be helpful since I'm a relative newcomer here.

Looking forward to advancing the needs of our community together!

--Paul

Paul Ziegele, CHFP, MBA
Interim Chief Financial Officer
Office: 415/677-2496
Mobile:
paulz@chasf.org
www.ChineseHospital-SF.org

From:	VIVIAN IMPERIALE
To:	Mar, Gordon (BOS); Carroll, John (BOS)
Subject:	Written public testimony for 9/9 Public Safety & Neighborhood Services Committee
Date:	Monday, September 6, 2021 4:50:41 PM
Attachments:	Imperiale testimony re- no sub-acute beds in SF.txt

Hello:

Attached please find my testimony urging the return of sub-acute beds to San Francisco.

Thank you in advance for taking the time to read it and take into consideration the information I provided.

Best regards,

Vivian Imperiale, M.A.
Board President
Mental Health Association of San Francisco

September 6, 2021

To: Supervisor Gordon Mar,
Committee Chair

Re: Public Testimony for Sept. 9
Public Safety and Neighborhood Services Committee
Hearing - Sub-acute care in San Francisco

There is a definite need for sub-acute beds in San Francisco. It is traumatic enough for a person to be in a situation where they need this level of care. Sending them away to another county adds to the trauma at a time when they need to feel the support of their own community and see familiar faces.

As an example, one of my closest friends was placed at Crestwood's Idylwood Care Center in Sunnyvale. His psych medications now are working and he is bright, articulate and well-tempered while receiving post-surgery OT and PT. But for months he has been geographically and socially isolated:

1. He is misplaced, surrounded by residents decades older and unable to communicate due to dementia. He has nobody with whom to converse.

2. There is no phone in his room. Whether or not he is brought a phone -- only for limited time use -- is at the sole discretion of staff on duty. There have been times they turned
down his request.

3. He is hours away on public transportation from San Francisco, the city he has has called home for decades and where his friends live and will find that commute to see him
overbearing.

4. There is no resident library. Imagine having nothing to read.

5. There is no resident computer. He is missing out on email, social media, music, entertainment, information-searching and education.

6. He would like to buy an iPad but staff told him there is no wi-fi. This is obviously not true as he can see staff down the hall busy on their computers.

7. Because they do not support his getting his own phone or computer, he is unable to seek remote employment.

8. Although the facility has on-site OT and PT, he is making few gains toward post-surgery independence.

Behavioral Health sent him there. Now he is a San Franciscan alone and missing his city. No conversations. Nothing to read. No computer. No reliable access to a phone.

No technology to pursue job prospects or expand his horizons. These isolating practices may be categorized as abuse, yet the city maintains no oversight.

It is very alarming that San Francisco dumped him there and forgot about him. Not only are his social worker and conservator not checking in with him, they are not returning his calls. They chose to work in "helping professions" yet are providing no help.That is totally unacceptable.

This is far from an isolated case. During my time as former board president of both NAMI SF (National Alliance on Mental Illness) and NAMI California, I heard many stories like this. It is painful for people to be so far away and not be able to travel the distance to visit their friend or family member.

As someone who has been a mental health advocate for over 40 years, including working in the field for 20, I beseech you to provide needed beds here in the city. Also, as the current board president of the Mental Health Association of San Francisco, I add their voice that people in our community should receive services in our community.

From:	Teresa Palmer
To:	Mar, Gordon (BOS); Lovett, Li (BOS); Safai, Ahsha (BOS); Haney, Matt (BOS); Stefani, Catherine (BOS); Ronen, Hillary; Carroll, John (BOS); Board of Supervisors, (BOS)
Subject:	Article about subacute SNF care for: Sept 9 ps & ns comm hearing BOS file 190725
Date:	Sunday, August 29, 2021 3:20:19 PM
Attachments:	2021, April 27-Shameful Lack of Subacute SNF Care in San Francisco-article.pdf

PublicSafetyandNeighborhoodServicesCommittee
Board of Supervisors
The Honorable GordonMar, Chair
The Honorable CatherineStefani, Member
The Honorable MattHaney, Member

From:

Teresa Palmer M.D.
Family Medicine/Geriatrics
1845 Hayes St.
San Francisco, California 94117
Phone:415-260-8446
Fax: 415-292-7738
Email: Teresapalmer2014@gmail.com
Date: August 29 2021

Here is an article I wrote online for the Westside Observer about the lack of subacute care in SF.

Can you get this into the online file or advise me how to do so?

Attached is PDF

Public Safety and Neighborhood Service Committee meeting on Sept. 9th; BOS file 190725

Dr. Teresa Palmer, Geriatrician

SF's Shameful Healthcare Gap

Exile from San Francisco for Subacute SNF Patients — a Continuing Reality

April 27, 2021 Westside Observer

Photographs can be viewed in the publication link:
https://westsideobserver.com/news/longTermCare.html#apr21

---

by Teresa Palmer M.D.

What happened to Ken Zhao is heartbreaking. At 39 he is alert, and understands what is going on around him, but he is paralyzed and dependent on a ventilator via a tracheostomy. He can understand English and Cantonese, but he cannot speak. He is, in essence, "locked in." And now he has to leave San Francisco, and his loving elderly parents, in order to survive. He needs a "subacute skilled nursing facility (SNF)."

California Pacific Medical Center/Sutter (CPMC)announced the shut down of the only subacute SNF in San Francisco (at St. Luke's hospital) in 2017. Families, patients and advocates organized to protest. Supervisor Ahsha Safai held hearings via the Public Safety and Neighborhood Services Committee, of which Supervisor Hilary Ronen was chair.

In 2018, at a hearing in front of the full Board of Supervisors, CPMC/Sutter, shamed by the publicity, agreed to keep the remaining St. Luke's subacute SNF patients in county. CPMC would transfer those patients left in the 40-bed unit at St. Lukes to the SNF at CPMC Davies until they died.

The Zhaos are afraid that if they are not able to visit Ken very frequently to oversee his care and emotional health, that Ken will deteriorate again and potentially die. He is very vulnerable."

CPMC's Profit Motivation
The CPMC Davies 38 bed SNF unit, which until then had not served subacute level patients, was retrofitted for the 17 remaining patients. Of course this displaced other patients who needed post-hospital SNF/rehab care. Also, to the horror of families and advocates, after transfer away from their stable team at St. Lukes in 2018, many subacute patients died in a short time. And no subacute SNF beds were left available in San Francisco for new admissions.

Ken's situation illustrates how cruel and dangerous the absence of any sub-acute Skilled Nursing Facility (SNF) beds in San Francisco is. No progress has been made on this, despite a number of meetings with the Board of Supervisors, the Health Commission, and efforts by SFDPH, advocates and families between 2017 and January 2020.

Subacute Skilled Nursing Facility Care is a specialized and labor intensive form of long term care for those who require ventilators, tracheostomies with frequent suction, or other complex forms of care to stay alive. (This is an entirely different entity than subacute psychiatric care.) It is reimbursed, for those who are not able to pay, by "Medicaid" (Medi-Cal in California). This type of care is best done on a hospital campus with access to an Intensive Care Unit (ICU), as these patients can rapidly deteriorate and must then be cared for in an ICU. For the hospital, it does not generate as much revenue as short stay acute care.

Revenue driven decision making, not what the people of Northern California really need, has driven the Sutter empire to massive financial success. In San Francisco, the losers have been, among other services, post-acute hospital based SNF rehab, hospital based subacute SNF care, and acute inpatient psychiatric services. All have been cut o the SF-CPMC campuses.

St. Luke's, historically a safety net hospital for the Mission and Excelsior, has been the recipient of one divestment of needed services after another, despite its rebuild and renaming as "Mission-Bernal." Sutter did not want to rebuild or continue St. Luke's, but the community insisted.

A regular nursing home (SNF), including Laguna Honda, offers post-hospital rehab (SNF) care, but does not have the capacity to offer subacute SNF care.

Kentifield Social Worker tells Mrs. Zhao by phone she may be liable for $2400 a day if Ken does not leave Kentfield hospital. The Zhaos had already exhausted their savings and legally Kentfield had no right to bill them-so Kentfield backed down once advocates got involved.

Those San Franciscans who must live on life support long-term deserve a chance to live in their own city, near those who love them. CPMC/Sutter's closure of San Francisco's only sub-acute SNF at St. Luke's Hospital has made this impossible.

Ken Zhao's Story

In 2016, at 34, Ken had a sudden stroke that led to a coma. He was hospitalized at San Francisco General Hospital. After he emerged from a coma, Ken was quadriplegic, breathing through a tracheostomy, and could not speak. He was alert but "locked in." An event like this could happen suddenly to any of us.

After he stabilized and could breathe without a ventilator, Ken was transferred to Laguna Honda Hospital (LHH) for skilled nursing care. At that point he was quadriplegic, and had a tracheostomy (opening in the neck to his airway). His elderly parents began to visit almost daily and assisted with exercise and suction of secretions from his mouth. He gained strength, developed some ability to move one arm, and the tracheostomy healed over.

Ken is an only child. His parents are 70 years old. He was the only English speaker, and the only member of the family who could drive.

The Zhao family

His father, Ru Sen Zhao, is retired. Mr. and Mrs. Zhao only speak Cantonese. They are very low-income, and dependent on public transportation. Ken's parents report that he was doing fine and even improving for years at LHH while his family came in to assist with care-giving and to cheer him on. Along came Covid-19, and in March 2020 all family visitation was shut down at LHH.

According to Ken's parents, he deteriorated within half a year of Covid lockdown due to deficits in care. In addition to family being excluded, there were undoubtedly staff shortages from the ravages of Covid-and with no family to give early warning of a change in condition, things did not go well. This is a story that has been repeated in nursing homes all over the country during the pandemic, resulting in death rates that are not explained by Covid alone.

After eight months of family lockout, on November 15, 2020, Ken was transferred from Laguna Honda to UCSF Medical Center by ambulance. He had hypoxemic respiratory failure (not enough oxygen in his blood), urosepsis (sepsis caused by urinary tract infections), and pneumonia.

As he improved from this episode, it became clear, that Ken's ability to breathe without a tracheostomy/oxygen/ventilator was now dangerously poor. He indicated that he didn't want a tracheostomy or ventilator, but that he did want to receive on-going life prolonging care.

On January 3, 2021 following his nearly two month hospitalization at UCSF Medical Center, Ken was discharged to Kentfield Hospital on St. Mary's San Francisco campus. A long-term acute care hospital (LTACH), Kentfield is a specialty facility designed to accommodate extended hospital needs of patients having complex medical issues, including patients with chronic respiratory failure.

While at Kentfield, Ken did agree to a tracheostomy and is now ventilator-dependent. He is alert, and communicates to a limited extent, using a letter board or gestures indicating "yes" or "no." He needs a level of care that is only available at a facility like Kentfield, or for the long term, only at a sub-acute SNF.

Those San Franciscans who must live on life support long-term deserve a chance to live in their own city, near those who love them. CPMC/Sutter's closure of San Francisco's only sub-acute SNF at St. Luke's Hospital has made this impossible."

Ken and his parents had wanted him to return LHH where his parents could continue visiting, but they now understand his current needs will necessitate long-term placement in a sub-acute SNF.The Zhaos are afraid that if they are not able to visit Ken very frequently to oversee his care and emotional health, that Ken will deteriorate again and potentially die. He is very vulnerable.

Kentfield Puts the Squeeze on the Zhao Family

Kentfield informed the Zhao family, after 3 months, on April 9, 2021 that it wanted to quickly discharge Ken, now 39, to available sub-acute facilities in Sacramento or in Hayward. Ken's parents would be unable to visit frequently or take care of Ken in Sacramento. Alternatively, although Hayward is accessible by BART, it would pose a long, costly ride and then walk for Ken's elderly parents.

Mr. Zhao's former employer reached out to a host of advocates for assistance on behalf of Ken. Unfortunately, the Zhao family's first appeal to Medicare Quality Improvement of Ken's impending discharge was denied. On April 13, the Zhao family's second appeal was also denied. A Kentfield Social worker told Ken's mother by phone after this (through a family friend who was translating,) that the Zhao parents could be liable for $2400 dollars a day if they did not agree to quick discharge.

The Zhaos had, by then been informed by their own advocates that they have the right to refuse inappropriate discharge placement. Also, they were informed that Ken's continued stay at Kentfield, even once he had truly maximized the benefit of being there, would be covered by insurance during the wait for an appropriate SNF placement. Appropriate would mean that Ken would be near enough to allow frequent visits from his parents.

By April 15, a lawyer from California Advocates for Nursing Home Reform, a member of Pelosi's staff, Supervisor Gordon Mar, and Adult Protective Services helped to advocate for keeping Ken at Kentfield until an appropriate sub-acute SNF could be found. On April 16, Kentfield agreed to honor Ken's rights, and to delay discharge.

Daly City Beds Wait for Staffing

Seton Hospital (Daly City) sub-acute SNF, the closest to San Francisco, appears to have beds available, but it is closed to new admissions until Seton hires more staff. Supervisor Mar had attempted discussion in the past with San Francisco's Department of Public Health about contracting for beds there for San Franciscans, at least until beds could be funded in San Francisco. Supervisor Mar has again been asked by Ken's family to explore whether SFDPH could assist in admitting Ken to Seton's sub-acute SNF.
However, in-county sub-acute SNF beds are really needed for San Franciscans. And even Seton would pose a longer public transportation commute for Ken's elderly parents than an in-county facility.

Previous SFDPH director Barbara Garcia made efforts in 2017 and 2018 to look at available space at Chinese Hospital or St. Mary's Hospital for some of San Francisco's needed sub-acute beds. SFDPH made an estimate that

70 Subacute SNF beds are needed for all the city hospitals. Given that all hospitals would use these beds, all hospitals should assist in funding them. In June 2019 SFDPH hired consulting firm Milliman to manage the process of bringing new subacute SNF beds on line.

The last I have heard of the effort to re-institute subacute SNF beds in San Francisco was at a Public Services and Neighborhood Safety Committee in January 2020. There were no definitive commitments, and then Covid 19 hit.

In the face of a respiratory pandemic, it sure would be nice to have the extra ventilator capacity that an in-county sub-acute unit offers. The hospitals know how many folks they have sent out of county for sub-acute SNF care. Undoubtedly there were quite a number due to Covid 19. But the public has not been informed.

If these beds were in place now, Ken would have been able to move from Kentfield on St. Mary's campus to either St. Mary's or Chinese hospital for his long-term care.

Intense involvement from family, friends and advocates has now prevented Ken from being immediately transferred out-of-county. He can stay at his specialized acute facility in San Francisco, for now, but not for long.

Dr. Teresa Palmer is a geriatrician/family physician who has worked in San Francisco for over 30 years, including at St. Luke's Hospital, Laguna Honda Hospital, UCSF, and at On Lok, a program of all inclusive care for the elderly.
April 27, 2021

From:	pmonette-shaw
To:	Mar, Gordon (BOS); Stefani, Catherine (BOS); Haney, Matt (BOS)
Cc:	Calvillo, Angela (BOS); Carroll, John (BOS); Ronen, Hillary; Safai, Ahsha (BOS); Chan, Connie (BOS); Melgar, Myrna (BOS); Peskin, Aaron (BOS); Preston, Dean (BOS); Mandelman, Rafael (BOS); Walton, Shamann (BOS); Quan, Daisy (BOS); Wong, Alan (BOS); Wright, Edward (BOS); Lovett, Li (BOS); Hepner, Lee (BOS)
Subject:	Request for Public Safety and Neighborhood Services Committee Hearing on Sub-Acute Care
Date:	Wednesday, May 5, 2021 4:25:13 PM
Attachments:	Request for Public Safety and Neighborhood Services Committee Hearing on Sub-Acute Care 21-05-05.pdf

May 5, 2021

Public Safety and Neighborhood Services Committee, Board of Supervisors
The Honorable Gordon Mar, Chair
The Honorable Catherine Stefani, Member
The Honorable Matt Haney, Member
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

Re: **Request for PSNS Hearing on Sub-Acute Care Facilities**

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

Attached is a request for the PSNS Committee to schedule and hold a follow-up hearing on sub-acute skilled nursing facilities as quickly as possible.

Thank you.

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

May 5, 2021

Public Safety and Neighborhood Services Committee, Board of Supervisors
The Honorable Gordon Mar, Chair
The Honorable Catherine Stefani, Member
The Honorable Matt Haney, Member
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102 Re: **Request for PSNS Hearing on Sub-Acute Care Facilities**

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

As you probably know, following a stroke that left him in a coma at SFGH, Ken Zhao was transferred to Laguna Honda Hospital in 2016 where his parents were able to visit him for four years. But then Ken declined at LHH, was transferred by ambulance on November 15, 2020 to UCSF, which then discharged him to Kentfield Hospital for long-term acute care. Unfortunately, Kentfield initially tried to discharge Ken out-of-county for sub-acute level of care in Sacramento or Hayward because there are no sub-acute skilled nursing facilities (sub-acute SNF) anywhere in San Francisco.

As you also likely know, all people needing sub-acute level of care face being summarily discharged out-of-county, away from their caregivers, families, and friends, and face the further possibility of transfer trauma exacerbating their already fragile compromised health.

The Department of Public Health and the Board of Supervisors have known that the City has not had a sub-acute SNF facility since CPMC stopped admitting non-CPMC patients to St. Luke's sub-acute SNF damn near a decade ago in 2012. The PSNS Committee held a hearing on July 26, 2017 about the lack of sub-acute facilities in the City, which was continued to the call of the chair of the PSNS Committee.

The sub-acute SNF issue was pulled from the PSNS Committee when the full Board of Supervisors held a "*Committee of the Whole*" (CoW) hearing on September 12, 2017. Supervisor Safai clarified that the September 12 hearing was specifically to be about "***in-county, in-hospital*** [sub-acute] *solutions for San Francisco*."

Subsequently, the PSNS Committee held another hearing on September 26, 2019 on sub-acute facility care. I submitted testimony for the September 2019 hearing, and I noted that on September 3, 2018 I had specifically asked then-Board President Norman Yee to introduce legislation ***requiring*** each and every private-sector and public-sector hospitals in the City to submit out-of-county discharge information by various types of long-term facilities. No action has been taken since 2018 to develop, introduce, and pass legislation requiring all hospitals in the City to submit out-of-county discharge data to DPH.

The last time the PSNS Committee held a hearing on sub-acute SNF care was on January 23, 2020, during which DPH's Kelly Hiramoto reported progress on the possibility of Chinese Hospital opening 23 sub-acute SNF beds had essentially stalled. Hiramoto appears to have informed the PSNS Committee in January 2020 that San Francisco hospitals may have discharged between 49 to potentially 90 patients out-of-county for sub-acute care, and that in 2018 the discharge count was closer to 70. To his credit, Supervisor Safai rightly noted on January 23, 2020 that the City's preference was for [in-county] **hospital-based sub-acute care beds** — not potential beds in a freestanding regular skilled nursing facility (San Francisco Health Care and Rehabilitation on Grove Street) — to eliminate the need for immediate transfer to an ICU if a sub-acute patient faced an emergency decline in their health requiring transfer by ambulance to an ICU in a hospital.

John Carroll, clerk of the PSNS Committee, kindly responded today to my public records request for the forward calendar(s) of upcoming scheduled meetings of the PSNS Committee.

I note with interest that there are no planned upcoming PSNS Committee hearings on the ongoing problem of no sub-acute SNF facilities in San Francisco. I also note that the PSNS Committee could potentially schedule a hearing on the sub-acute SNF issue for it's meetings on May 27, June 10, or July 8, 2021 (with respective deadlines for developing meeting agenda's on May 20, June 3, or July 1, respectively).

I am specifically asking that Supervisor Mar — in his capacity as Chairperson of the PSNS Committee — call this item from the Call of the Chair and hold a PSNS hearing on this issue as quickly as possible.

In addition, a long-overdue good start would be to finally introduce and pass legislation requiring that every hospital in the City — both public- and private-sector — submit out-of-county discharge data to SFDPH annually, and to require retroactive submission of out-of-county discharge data back to June 1, 2006!

Respectfully submitted,

Patrick Monette-Shaw
Columnist
Westside Observer Newspaper

cc: The Honorable Connie Chan, Supervisor, District 1
The Honorable Aaron Peskin, Supervisor, District 3
The Honorable Gordon Mar, Supervisor, District 4
The Honorable Dean Preston, Supervisor, District 5
The Honorable Myrna Melgar, Supervisor, District 7
The Honorable Hillary Ronen, Supervisor, District 9
The Honorable Shamann Walton, Supervisor, District 10
The Honorable Ahsha Safai, Supervisor, District 11
Angela Calvillo, Clerk of the Board
John Carroll, Clerk of the Public Safety and Neighborhood Services Committee
Daisy Quan, Legislative Aide to Supervisor Gordon Mar
Edward Wright, Legislative Aide to Supervisor Gordon Mar
Li Miao Lovett, Legislative Aide to Supervisor Gordon Mar
Alan Wong, Administrative Aide to Supervisor Gordon Mar
Lee Hepner, Legislative Aide to Supervisor Aaron Peskin

- ***The legacy of St Luke's SNF.***

Testimony from Benson Nadell; Program Director

San Francisco Long Term Care Ombudsman Program

Felton Institute

6221 Geary Blvd

San Francisco, Ca 94121

415 751 8788

- It is difficult to gauge the effects of closure on the citizens of San Francisco of Sutter closing its SNF . The 17 resident in the sub-acute part of the SNF were moved to Davies SNF campus . Victory is measured by the fact that none were dispersed over great distances throughout California. Families were given lists of skilled nursing facilities they were to call . Most were post -acute skilled nursing facilities.
- The effects of closure of this hospital based SNF can be gauged by the uptick of admission for rehabilitation from hospitals to the remaining community based Skilled nursing facilities.

- When Sutter closed the hospital based SNF on California Street. The data supporting those closures indicated low census. Sutter was cooking the books , in the sense that all patients from the CPMC hospitals were being sent to what was known during that period the Kindred facilities.
- Sutter did the same thing to demonstrate there was no demand for sub-acute beds at ST Lukes. That unit denied admission of sub-acute patients from other hospital systems. What drove the point home was that none were keeping data on sub-acute patients vs post acute

patients coming out of various hospitals. No data collected was intentional Where do patients go once discharge from all the remaining hospitals in SF? Who knows. No one is asking. Hospitals do not share such monthly discharge data.

In 2017 17 patients were transferred to Davies skilled nursing in a segmented area for sub=acute patients. Core staff were training in this higher level of care. A few staff came over from St Lukes to provide continuity. Staffing in skilled nursing facilities is by the numbers . Those numbers are posted by the elevators. All the contact people where were working at Davies and who served as reassuring contact for the families the next year moved away from Davies. The command structure was decapitated somewhat. This Ombudsman with a few families has met with new leadership and they appeared concerned and accountable to the families.

Commented [BN3R1]:

Commented [BN6R4]:

This is the micro view: why in two years has move than % 50 of sub-acute patients moved from St Luke's Sub Acute to Davies skilled nursing died? If this is a performance measure of the Davies SNF what is being measured?

Quality of life: At St Luke's Sub acute there was a very engaged activity person who knew all residents. She was not allowed to transfer with the patients to Davies. Instead, the residents shared whatever activities was available for the other residents at Davies SNF. It takes special approaches for sub-acute patients. These 17 lived longer at St Lukes because of a stability of activities and staff. The Activity person worked at sub-acute unit at St Lukes from its beginning. In many ways she was the linchpin in the sense of community for all residents. Enter Sutter..By their business decisions, these sub acute patients were treated not as persons but as persons. When each person died at Davies, that was one more bed dedicated to these St Lukes patients removed from the list.

Macro: The sub-acute idea originated with pediatrics, when small children born with a disability were kept alive. One could argue the bioethics of this and the decades progressed. The choice was up to parents. The politics were complicated.

In San Francisco if we take an aerial view: there are these hospital systems. Let's name them: UCSF Med Center; CPMC Sutter; Kaiser; Chinese Hospital; Dignity Health St Francis and St Mary's; Zuckerberg SFGH , run by SF City and County. Over the last three decades these hospitals have changed in terms of ownership and management. Some mergers were short lived: eg UCSF and Stanford; Mt Zion was absorbed by UCSF; Franklin and Childrens and Presbyterian were absorbed by CPMC, which in turn was taken over by Sutter.

These hospitals would send patients to home, nursing home and some other care facility depending on the finances of the patient. Hospitals had to rebuild in response to state seismic law . There was a lot of construction. Fancy new hospitals , same patient flow. The duration of stay over decades was shortened. CMS controlling Medicare days for elderly and disabled, was forced to reduce days, sending sicker persons to nursing homes. That was in the decades of the 80s nineties; etc.

The acuity of patients based on co-morbidities who were admitted to nursing homes increased. Post acute rehabilitation and recovery occurred in step down hospital units, called extended care or distinct part skilled nursing.

In the decade of 2010 all there extended care units were closed: St Mary's closed its SNF. St Francis Closed its SNF. Sutter joined in and closed their in hospital SNF at the California Street and St Lukes. Davies SNF. Convergent forces led to these closures: new hospital construction; specialization of acute services; the eagerness of

community based SNF to capture the higher daily reimbursement rate.

The squeeze: Since 1990, SF has lost 7 SNF which had admitted patietns long term care from hospitals. They closed. The new Laguna Honda opened in 2010, had 440 beds. Since 1990 SF has lost over 1000 long term care beds – all of which were paid for by Medi-Cal.

According to the Post Acute Care Collaborative the community SNF will accept post acute patients. These patients were supposed to stay for short term, and then go home. With the elderly patient it turned out that discharge planning was not going well. Too many were too sick to go home. These receiving SNF did not want any more Medi-Cal reimbursed patients. They were told to go elsewhere.

The quality of doctoring changed. At hospital based SNF doctors were present more frequently . At the community based SNF an older pattern was followed: doctors did not know their patients but relied on nurses to report out. That disconnect between patient and doctor never benefited the patient.

The Ombudsman Office investigates cases where health safety welfare or rights are affected by actions inactions or decisions by providers. The Ombudsmen in the field react to demands for advocacy. Most of the cases have been from residents who do not want to be discharged. They are too sick; unable to get out of bed; have lost functionality . The Ombudsman Program has been able to instruct some of these SNF social workers to leverage such city services as the Community Living Fund etc.

There is finally a patient who needs round the clock care and may be taken to ICU – this is the sub-acute population of patients. These persons are not candidates for rehabilitation. They are the most vulnerable. Where will hospitals send them?

Teresa Palmer M.D.
Family Medicine/Geriatrics
1845 Hayes St.
San Francisco, California 94117
Phone:415-260-8446
Fax: call for fax #
Date: 1/23/2020

TO;
Neighborhood Safety and Public Services Committee:
Subacute SNF Care, and issues about hospital based post acute care in San Francisco:

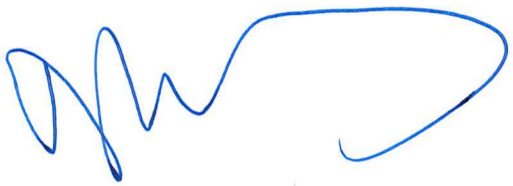
Good studies show that for elderly folks with multisystem illness, neurologic illness and for chronic severe respiratory illness—that post acute care in a hospital based skilled nursing facility is superior to a free standing facility.

This is even more so for those who need long term care at a Subacute SNF level.

The shut down of hospital based care for those who are complex and need skilled rehab or those who need long term Subacute care is not based on what is best for the health of the people---it is based on the ongoing need of public and private hospital corporations to generate revenue from fast turnover, short term, acute hospital care.

The incredible shortage of hospital based skilled nursing care (which feeds the shortage of long term nursing home care) and the absolute absence now in San Francisco of subacute SNF care is an insult to the people of San Francisco that must be remedied: we are literally dumping our grandparents and parents out of town to help organiztions like CPMC /Sutter generate revenue for a self-dealing empire.

We must collect data on who gets dumped out of town, and we must push our hospital organizations to do what we need them to do: take care of us, and not their bottom line.



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.

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

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.

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

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, January 22, 2020 9:34 PM
To: Carroll, John (BOS)
Subject: Post-On-Line? — Fwd: Public Testimony: Board of Supervisors Public Safety Committee Hearing on Sub-Acute Care Facility Solutions — "Analysis Paralysis" ? (Where's K. Tavaglione ?)
Attachments: Testimony to Public Safety and Neighborhood Services Sub-Acute Care 20-01-23.pdf

Categories: 190725, 2020.01.23 - PSNS

Hi Mr. Carroll,

Pleas add this to the public information file for tomorrow's PSNS hearing. If you can add an active on-line hyperlink to this testimony, I'd appreciate it!

Best,
Patrick

-------- Forwarded Message --------
Subject: Public Testimony: Board of Supervisors Public Safety Committee Hearing on Sub-Acute Care Facility Solutions — "Analysis Paralysis" ? (Where's K. Tavaglione ?)
Date: Wed, 22 Jan 2020 21:31:09 -0800
From: pmonette-shaw <pmonette-shaw@earthlink.net>
Reply-To: pmonette-shaw@earthlink.net
To: Catherine.Stefani@sfgov.org, Rafael.Mandelman@sfgov.org
CC: Norman.Yee@sfgov.org, Sandra.Fewer@sfgov.org, Aaron.Peskin@sfgov.org, Gordon.Mar@sfgov.org, dean.preston@sfgov.org, Matt.Haney@sfgov.org, Hillary.Ronen@sfgov.org, Shamann.Walton@sfgov.org, Ahsha.Safai@sfgov.org, 'Angela Calvillo' <Angela.Calvillo@sfgov.org>, Angelina.Yu@sfgov.org, Ian.Fregosi@sfgov.org, Chelsea.Boilard@sfgov.org, Daniel.Herzstein@sfgov.org, Samuel.Bennett@sfgov.org, Andrew.Mullan@sfgov.org, Frankie.Falzon@sfgov.org, Sunny.Angulo@sfgov.org, Lee.Hepner@sfgov.org, Calvin.Yan@sfgov.org, Daisy.Quan@sfgov.org, Alan.Wong1@sfgov.org, Edward.W.Wright@sfgov.org, Jenny.Huang1@sfgov.org, Abigail.Rivamontemesa@sfgov.org, Courtney.McDonald@sfgov.org, Honey.Mahogany@sfgov.org, Han.Zou@sfgov.org, Jen.Low@sfgov.org, Erica.Maybaum@sfgov.org, Ivy.Lee@sfgov.org, Caitlin.Vejby@sfgov.org, Kyle.Smeallie@sfgov.org, Tom.Temprano@sfgov.org, Erin.Mundy@sfgov.org, Joe.Adkins@sfgov.org, Carolyn.Goossen@sfgov.org, Paul.Monge@sfgov.org, Amy.Beinart@sfgov.org, Jennifer.Li-D9@sfgov.org, Percy.Burch@sfgov.org, Tracy.Gallardo@sfgov.org, Natalie.Gee@sfgov.org, Abe.Evans@sfgov.org, Suhagey.Sandoval@sfgov.org, Tim.H.Ho@sfgov.org, Monica.Chinchilla@sfgov.org, Dean.Preston@sfgov.org, john.carroll@sfgov.org

Patrick Monette-Shaw

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

January 22, 2020

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 Public Testimony: **Board of Supervisors Public Safety Committee Hearing on Sub-Acute Care Solutions — "*Analysis Paralysis*" ?**

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

This is testimony for the Public Safety and Neighborhood Services (PSNS) Committee meeting on January 23, 2019.

Four or more years have passed, while the Board of Supervisors have failed to address multiple shortages of post-acute car facilities in San Francisco. The shortage of post-acute care options is an urgent healthcare crisis. What's taking so long to develop reasonable solutions? It seems as if the Board of Supervisors and the Department of Public Health are hamstrung with *analysis paralysis* or *decision fatigue*, paralyzing the outcome of quickly creating sub-acute care facilities in county.

It's been almost four years since the Health Commission received a report in February 2016 — *Framing San Francisco's Post-Acute Care Challenge* — that noted private-sector hospitals cite out-of-county placement as necessary to transfer patients from acute care to lower levels of care. All acute care hospitals — now including CPMC — transfer sub-acute patients out-of-county. The number of private-sector out-of-county discharges weren't fully reported in 2016 and haven't been by now.

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.

After the Health Commission ruled against CPMC, then-Director of Public Health Barbara Garcia began working in ***2017*** to identify 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, but that work came to a screeching halt when Garcia was forced out over a contract steered to her partner's employer. Why has it taken over two years to identify potential existing spaces in hospitals that could be pressed into service for sub-acute SNF care?

Unanswered Questions Raised During September 26, 2019 PSNS Hearing

A number of issues were raised during your September 26, 2019 PSNS hearing, which remain unanswered.

1. **San Francisco's Long-Term are Ombudsman, 9/26/2019:** Benson Nadell, submitted written testimony on Septembe 24 for your September 26 hearing. He pointedly noted that hospitals drive long-term care policies, but have failed to report data on discharges by sickness or needed supports.

   He asked "*Where do patients go (upon hospital discharge)? To what destinations? What [services] and supports are provided? Where is data on destination and discharges services by acuity from the remaining Post-Acute SNF's?*"

   Without putting words in his mouth, Nadell appeared to essentially be asking the Board of Supervisors to request data from all hospitals regarding what types of facilities patients are discharged to (e.g., board and cares, skilled nursing facilities, sub-acute facilities, RCFE's, etc.), and whether the discharge locations are to in-county, or out-of-county facilities elsewhere in the State. And it was clear that Nadell was asking for the data based on the acuity level of the patients involved, particularly for those patients with complex medical illnesses.

What has this Committee, the Board of Supervisors, or the Department of Public Health done in the intervening months collect and analyze this data?

2. **Milliman Presentation, 9/26/2019:** DPH's Kelly Hiramoto claimed on September 26, 2019 that DPH began a proces in Fall 2018 to identify a consultant to conduct an environmental scan, manage project selection and implementation bring new subacute skilled nursing beds online. Hiramoto should have known that, in reality, Director Garcia had star that process a year earlier in 2017. Milliam Inc. was chosen in June 2019 as the lead consultant for the project.

   It should not have taken over two years starting in June 2017 to have eventually chosen Milliman or any other consultant!

   Milliman informed the PSNS Committee during your September 26, 2019 hearing that patients who are both ventilato dependent ***and*** need dialysis have no sub-acute care options in Northern California and must go to Southern Californi or outside of the state, to obtain a bed in a sub-acute care facility.

   Milliman also reported that it had interviewed seven hospital-based facilities, but only six of them had provided data f analysis. Two of the six hospitals reported they had been unable to successfully place (discharge) any sub-acute care patients *"in the past year"* (2018). Milliman estimated from the five hospitals that provided data there were *"about"* patient discharges to sub-acute care facilities in 2018. Obviously those 49 discharges had to have been out-of-county, CPMC stopped accepting non-CPMC patients to its sub-acute beds as far back as 2012, and even stopped new admissions from its own affiliate Sutter facilities to its St. Luke's sub-acute unit in FY 2016–2017.

   Milliman also reported that its data was likely *"deflated"* — under-estimated — since the hospitals surveyed had been somehow pursuing *alternate placement options*. What alternate placement options weren't discussed.

   I reported to the PSNS Committee on September 26, 2019 that there have been a minimum of 1,659 patients discharg to out-of-county facilities since 2006, a figure that is probably far higher because of the missing data from San Francisco's private-sector hospitals for at least ten years (FY 2006–2007 through FY 2011–2012, plus FY 2017–2018 through FY 2019–2020), and SFGH has failed to provide data for three years (FY 2006–2007 through FY 2008–2009) claiming the records were in off-site storage and were too burdensome to retrieve and count.

   Since Milliman didn't report how many of the 49 discharges in 2018 came from which hospital and how many were fr SFGH, it's not clear if all 49 discharges should be added to the 1,659 — pushing known out-of-county discharges to ov 1,708 — which is probably far higher, because no data has been reported yet for all of 2019.

3. **Kim Tavaglione, 9/26/2019:** On September 26, 2019 I advised the PSNS Committee that labor leader Kim Tavaglion had reportedly been working with the Board of Supervisors to craft legislation to require out-of-county discharge reporting from all San Francisco hospitals. I've advised Tavaglione that she may be overstepped by wanting all public- and private-sector hospitals in the City to report overly-burdensome details about each patient discharge, rather than seeking basic data reporting. Why hasn't the Board of Supervisors developed that legislation, and how long is it going take to submit and enact it? What's the delay? Has Ms. Tavaglione also been stricken by analysis paralysis?

Short History of How We Got Here

A short history of how we have gotten here is notable.

The Hospital Council of Northern and Central California formed and launched a Post-Acute Care Collaborative (PACC) in March 2017, nearly three years ago, to explore creating a public-private partnership model using existing health care facilities in San Francisco to provide subacute care. The project sought to utilize unused space in hospitals, medical office and/or freestanding skilled nursing facilities to create a new subacute unit managed by freestanding SNF providers.

On June 6, 2017 CMPC announced its plan to close the Skilled Nursing Facility (SNF) and sub-acute unit at its former St. Luke's Hospital campus, which was the only sub-acute SNF in the entire City.

I first asked this Public Safety and Neighborhood Services on July 23, 2017 in written testimony about the proposed closur of the St. Luke's SNF to work with the Department of Public Health to introduce legislation to require that **all** private-sect hospitals obtain and report all out-of-county patient discharges of San Francisco citizens from private-sector hospitals sinc July 1, 2006.

San Francisco's Health Commission ruled on September 5, 2017 that CPMC's planned closure of St. Luke's Hospital's skilled nursing and sub-acute units ***would*** have a detrimental impact on San Franciscans' healthcare. In response, Supervisors Hillary Ronen and Ahsha Safai introduced a request to hold a hearing on the shortage of skilled nursing and su acute facilities in the City.

A week after the Health Commission's ruling, the Board of Supervisors held a Committee of the Whole hearing on September 12, 2017 regarding the severe shortage of SNF and sub-acute level of care facilities in-county. During opening remarks on September 12, Supervisor Noeman Yee threw a wrench in the proceedings, claiming he had asked in June 201 for a hearing "on these issues." In fact, he had not. Instead, Yee had requested that June to have a hearing to *"understand the efforts of City departments regarding institutional housing, particularly assisted living, residential care facilities, and small beds for seniors in San Francisco."* Those are separate issues from the issues of sub-acute and SNF level of care.

Yee essentially high-jacked the discussion, because the September 12 hearing had been convened to address the acute shortage of hospital-based and free-standing skilled nursing facilities, and sub-acute facilities.

Since 2017, all we have heard has been Supervisor Yee's pitch for independent housing for seniors, and next to nothing about his overall plan to increase Residential Care Facilities for the Elderly (RCFE), while the PSNS hasn't been able to mo the needle very far on solving the sub-acute care facility vacuum, and while there has been virtually no public hearings or addressing the very shortage of skilled nursing facilities that is driving the out-of-county patient dumping.

I've said this repeatedly: *You can't fix what you don't measure*. Until you start requiring that out-of-county discharge data from all public- and private-sector hospitals and other community-based healthcare providers be reported to the Departmer of Public Health, you are never going to be able to fix the problem of out-of-county patient dumping due to shortages of in county sub-acute care, skilled nursing care, and RCFE-level of care. ***What you don't measure, you can't fix.***

This issue should not languish for any more years. Act, meaningfully, now!

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 Dean Preston, Supervisor, District 5
The Honorable Matt Haney, Supervisor, District 6
The Honorable Norman Yee, Supervisor, District 7
The Honorable Hillary Ronen, Supervisor, District 9
The Honorable Ahsha Safai, Supervisor, District 11
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
Phone: (415) 292-6969 • e-mail: pmonette-shaw@eartlink.net

January 22, 2020

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: **Board of Supervisors Sub-Acute Care Solutions "*Analysis Paralysis*"**

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

This is testimony for the Public Safety and Neighborhood Services (PSNS) Committee meeting on January 23, 2019.

Four or more years have passed, while the Board of Supervisors have failed to address multiple shortages of post-acute care facilities in San Francisco. The shortage of post-acute care options is an urgent healthcare crisis. What's taking so long to develop reasonable solutions? It seems as if the Board of Supervisors and the Department of Public Health are hamstrung with *analysis paralysis* or *decision fatigue*, paralyzing the outcome of quickly creating sub-acute care facilities in county.

It's been almost four years since the Health Commission received a report in February 2016 — *Framing San Francisco's Post-Acute Care Challenge* — that noted private-sector hospitals cite out-of-county placement as necessary to transfer patients from acute care to lower levels of care. All acute care hospitals — now including CPMC — transfer sub-acute patients out-of-county. The number of private-sector out-of-county discharges weren't fully reported in 2016 and haven't been by now.

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.

After the Health Commission ruled against CPMC, then-Director of Public Health Barbara Garcia began working in ***2017*** to identify 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, but that work came to a screeching halt when Garcia was forced out over a contract steered to her partner's employer. Why has it taken over two years to identify potential existing spaces in hospitals that could be pressed into service for sub-acute SNF care?

Unanswered Questions Raised During September 26, 2019 PSNS Hearing

A number of issues were raised during your September 26, 2019 PSNS hearing, which remain unanswered.

1. **San Francisco's Long-Term are Ombudsman, 9/26/2019:** Benson Nadell, submitted written testimony on September 24 for your September 26 hearing. He pointedly noted that hospitals drive long-term care policies, but have failed to report data on discharges by sickness or needed supports.

   He asked "*Where do patients go (upon hospital discharge)? To what destinations? What [services] and supports are provided? Where is data on destination and discharges services by acuity from the remaining Post-Acute SNF's?*"

   Without putting words in his mouth, Nadell appeared to essentially be asking the Board of Supervisors to request data from all hospitals regarding what types of facilities patients are discharged to (e.g., board and cares, skilled nursing facilities, sub-acute facilities, RCFE's, etc.), and whether the discharge locations are to in-county, or out-of-county facilities elsewhere in the State. And it was clear that Nadell was asking for the data based on the acuity level of the patients involved, particularly for those patients with complex medical illnesses.

   What has this Committee, the Board of Supervisors, or the Department of Public Health done in the intervening months to collect and analyze this data?

2. **Milliman Presentation, 9/26/2019:** DPH's Kelly Hiramoto claimed on September 26, 2019 that DPH began a process in Fall 2018 to identify a consultant to conduct an environmental scan, manage project selection and implementation to bring new subacute skilled nursing beds online. Hiramoto should have known that, in reality, Director Garcia had started that process a year earlier in 2017. Milliam Inc. was chosen in June 2019 as the lead consultant for the project.

It should not have taken over two years starting in June 2017 to have eventually chosen Milliman or any other consultant!

Milliman informed the PSNS Committee during your September 26, 2019 hearing that patients who are both ventilator dependent ***and*** need dialysis have no sub-acute care options in Northern California and must go to Southern California, or outside of the state, to obtain a bed in a sub-acute care facility.

Milliman also reported that it had interviewed seven hospital-based facilities, but only six of them had provided data for analysis. Two of the six hospitals reported they had been unable to successfully place (discharge) any sub-acute care patients "*in the past year*" (2018). Milliman estimated from the five hospitals that provided data there were "*about*" 49 patient discharges to sub-acute care facilities in 2018. Obviously those 49 discharges had to have been out-of-county, as CPMC stopped accepting non-CPMC patients to its sub-acute beds as far back as 2012, and even stopped new admissions from its own affiliate Sutter facilities to its St. Luke's sub-acute unit in FY 2016–2017.

Milliman also reported that its data was likely "*deflated*" — under-estimated — since the hospitals surveyed had been somehow pursuing *alternate placement options*. What alternate placement options weren't discussed.

I reported to the PSNS Committee on September 26, 2019 that there have been a minimum of 1,659 patients discharged to out-of-county facilities since 2006, a figure that is probably far higher because of the missing data from San Francisco's private-sector hospitals for at least ten years (FY 2006–2007 through FY 2011–2012, plus FY 2017–2018 through FY 2019–2020), and SFGH has failed to provide data for three years (FY 2006–2007 through FY 2008–2009) claiming the records were in off-site storage and were too burdensome to retrieve and count.

Since Milliman didn't report how many of the 49 discharges in 2018 came from which hospital and how many were from SFGH, it's not clear if all 49 discharges should be added to the 1,659 — pushing known out-of-county discharges to over 1,708 — which is probably far higher, because no data has been reported yet for all of 2019.

3. **Kim Tavaglione, 9/26/2019:** On September 26, 2019 I advised the PSNS Committee that labor leader Kim Tavaglione had reportedly been working with the Board of Supervisors to craft legislation to require out-of-county discharge reporting from all San Francisco hospitals. I've advised Tavaglione that she may be overstepped by wanting all public- and private-sector hospitals in the City to report overly-burdensome details about each patient discharge, rather than seeking basic data reporting. Why hasn't the Board of Supervisors developed that legislation, and how long is it going to take to submit and enact it? What's the delay? Has Ms. Tavaglione also been stricken by analysis paralysis?

Short History of How We Got Here

A short history of how we have gotten here is notable.

The Hospital Council of Northern and Central California formed and launched a Post-Acute Care Collaborative (PACC) in March 2017, nearly three years ago, to explore creating a public-private partnership model using existing health care facilities in San Francisco to provide subacute care. The project sought to utilize unused space in hospitals, medical offices, and/or freestanding skilled nursing facilities to create a new subacute unit managed by freestanding SNF providers.

On June 6, 2017 CMPC announced its plan to close the Skilled Nursing Facility (SNF) and sub-acute unit at its former St. Luke's Hospital campus, which was the only sub-acute SNF in the entire City.

I first asked this Public Safety and Neighborhood Services on July 23, 2017 in written testimony about the proposed closure of the St. Luke's SNF to work with the Department of Public Health to introduce legislation to require that **all** private-sector hospitals obtain and report all out-of-county patient discharges of San Francisco citizens from private-sector hospitals since July 1, 2006.

San Francisco's Health Commission ruled on September 5, 2017 that CPMC's planned closure of St. Luke's Hospital's skilled nursing and sub-acute units ***would*** have a detrimental impact on San Franciscans' healthcare. In response, Supervisors Hillary Ronen and Ahsha Safai introduced a request to hold a hearing on the shortage of skilled nursing and sub-acute facilities in the City.

A week after the Health Commission's ruling, the Board of Supervisors held a Committee of the Whole hearing on September 12, 2017 regarding the severe shortage of SNF and sub-acute level of care facilities in-county. During opening remarks on September 12, Supervisor Noeman Yee threw a wrench in the proceedings, claiming he had asked in June 2017 for a hearing "on these issues." In fact, he had not. Instead, Yee had requested that June to have a hearing to "*understand the efforts of City departments regarding institutional housing, particularly assisted living, residential care facilities, and small beds for seniors in San Francisco.*" Those are separate issues from the issues of sub-acute and SNF level of care.

Yee essentially high-jacked the discussion, because the September 12 hearing had been convened to address the acute shortage of hospital-based and free-standing skilled nursing facilities, and sub-acute facilities.

Since 2017, all we have heard has been Supervisor Yee's pitch for independent housing for seniors, and next to nothing about his overall plan to increase Residential Care Facilities for the Elderly (RCFE), while the PSNS hasn't been able to move the needle very far on solving the sub-acute care facility vacuum, and while there has been virtually no public hearings on addressing the very shortage of skilled nursing facilities that is driving the out-of-county patient dumping.

I've said this repeatedly: *You can't fix what you don't measure*. Until you start requiring that out-of-county discharge data from all public- and private-sector hospitals and other community-based healthcare providers be reported to the Department of Public Health, you are never going to be able to fix the problem of out-of-county patient dumping due to shortages of in-county sub-acute care, skilled nursing care, and RCFE-level of care. ***What you don't measure, you can't fix.***

This issue should not languish for any more years. Act, meaningfully, now!

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 Dean Preston, Supervisor, District 5
The Honorable Matt Haney, Supervisor, District 6
The Honorable Norman Yee, Supervisor, District 7
The Honorable Hillary Ronen, Supervisor, District 9
The Honorable Ahsha Safai, Supervisor, District 11
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

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.

The Times is committed to publishing a diversity of letters to the editor. We'd like to hear what you think about this or any of our articles. Here are some tips. And here's our email: letters@nytimes.com.

Follow The New York Times Opinion section on Facebook, Twitter (@NYTopinion) and Instagram.

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

BAY WEST
family health care 1580 Valencia Street, Suite 201 San Francisco, California 94110 Phone: 415.550.0811 Fax: 415.550.0877

September 25, 2019

San Francisco Board of Supervisors
San Francisco City Hall
1 Carlton B. Goodlett Place
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

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

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. Tl 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.

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

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.

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
The Honorable Hillary Ronen, Supervisor, District 9
The Honorable Ahsha Safai, Supervisor, District 11
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
Phone: (415) 292-6969 • e-mail: pmonette-shaw@eartlink.net

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. The 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.

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**

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.

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 of 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
The Honorable Hillary Ronen, Supervisor, District 9
The Honorable Ahsha Safai, Supervisor, District 11
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