City and County of San Francisco
Edwin M. Lee
Mayor

San Francisco Department of Public Health
Barbara A. Garcia, MPA
Director of Health

MEMORANDUM

DATE: July 10, 2014

TO: Dr. Edward Chow, Health Commission President, and Members of the Health Commission

THROUGH: Barbara A. Garcia, MPA, Director of Health

FROM: Colleen Chawla, Deputy Director of Health and Director of Policy & Planning

RE: July 15, 2014 Proposition Q Hearing on the Reduction of Skilled Nursing Facility Beds at California Pacific Medical Center

This memo is a follow-up to the Health Commission's first Proposition Q hearing on June 17 on the reduction of skilled nursing facility (SNF) beds at California Pacific Medical Center (CPMC). The Health Commission requested additional information both from CPMC and from San Francisco Department of Public Health (SFDPH) staff.

Additional Information Requested of CPMC

On July 10, CPMC submitted a memorandum, included as Attachment A, responsive to the Health Commission's request for additional information. The Health Commission requested information on CPMC's proposed changes to licensed SNF beds at CPMC. This information appears in Table 1 below.

Table 1: CPMC's Current and 2014 SNF Bed Inventory

Campus	Licensed SNF Beds			Staffed SNF Beds		
	Current	2014 Plan	Change	Current	2014 Plan	Change
California	95	0	**-95**	46	0	**-46**
Davies	38	38	**0**	34	38	**+3**
Pacific	0	0	**0**	0	0	**0**
St. Luke's	79	79 (19 designated SNF; 40 designated subacute)	**0**	59 (19 designated SNF; 40 designated subacute)	77 (37 designated SNF; 40 designated subacute)	**+18**
TOTAL	**212**	**117**	**-95**	**139**	**115**	**-24**

The Health Commission also requested information on the staffing changes that would result from the realignment of its SNF beds. While impact has not yet been finalized, CPMC believes that 4 licensed vocational nurses would be displaced by this reduction.

Additional Information Requested of SFDPH

Health Care Services Master Plan

Information on current inventory and projected need from the Health Care Services Master Plan was included in the previous memo to the Health Commission on this topic and is included here again as Attachment B for ease of reference. Following are the key findings regarding SNF beds from the Health Care Services Master Plan:

- Although San Francisco's population is older than California overall, the rate of long-term care beds is lower than the state's;
- The rate of SNF beds per 1,000 population aged 24 and over is 4.1 in San Francisco, compared to 5.1 in California; and
- Given current available information, San Francisco is likely to be 702 SNF beds short of its projected need by 2050.

The Lewin Report

Attachment C to this memo is SFDPH's review of CPMC's 2009 Institutional Master Plan, which was prepared by The Lewin Group. CPMC's Institutional Master Plan outlines the proposed changes to each of the hospital campuses. The Lewin report analyzes the impact of the rebuilds that CPMC originally proposed. While CPMC's original rebuild plans were amended pursuant to its Development Agreement with the City, resulting in a larger St. Luke's Hospital and a smaller Cathedral Hill Hospital, The Lewin Group's analysis of SNF beds remains relevant, as no changes to CPMC's SNF bed plans have been announced. Table 2 below shows CPMC's current licensed SNF beds and the planned number of licensed SNF beds after completion of construction at CPMC's Cathedral Hill and St. Luke's campuses.

*Table 2: CPMC's Current and Post-Construction Skilled Nursing Bed Inventory**

Campus	Licensed SNF Beds		
	Current	Post-Construction	Change
California	95	N/A	**-95**
Davies	38	38	**0**
Pacific	0	N/A	**0**
St. Luke's	79	0	**-79**
TOTAL	**212**	**38**	**-174**

*Though close, the data in The Lewin Report, do not exactly match the most current data available from the Office of Statewide Health Planning and Development and may reflect additional changes made since The Lewin Report was drafted.

Following are the key findings regarding SNF beds from the Lewin report:

- The need for SNF beds by San Franciscans over age 65 are projected to be 115% of capacity beginning in 2015 and 130% of capacity in 2020;
- Gradual reductions in staffed SNF beds contributed to the declining rate of utilization of these services; between 2004 and 2008, CPMC's staffed SNF beds declined by 96.
- The CPMC plan to eliminate SNF beds does not support the potential city-wide need for skilled nursing services;
- Hospital-based SNF service availability has been declining not only in San Francisco, but also throughout the US; and
- Given the extent of potential need, a broader, city-wide plan will likely be needed to appropriately address the shortage.

ATTACHMENT A
July 10, 2014 Memorandum from CPMC

MEMORANDUM

To: Barbara Garcia, Director, San Francisco Department of Public Health
San Francisco Health Commission
From: Craig Vercruysse, Chief Operating Officer, CPMC
Re: Proposition Q Hearing Follow-Up Items
Date: July 10, 2014

Please find follow-up information requested during the June 17th, 2014 hearing on CPMC's proposed reduction in Skilled Nursing Facility (SNF) beds below.

Proposed Changes in Licensed and Staffed SNF Beds

CPMC SNF beds are operated to provide short term focused nursing care or rehabilitation support for patients discharged from CPMC care units who need more intensive continuing services than those provided in home care or outpatient.

Campus	Current Licensed Beds	Current Staffed Beds	2014 Licensed Bed Consolidation Plan	2014 Staffed Bed Consolidation Plan
California	95	46	0	0
Davies	38	34	38	38
St. Luke's SNF	19	19	39	37
Total SNF	*152*	*99*	*77*	*75*
St. Luke's SNF/ Sub-Acute Designated	60	40	40	40
Total SNF and Sub-Acute	*212*	*139*	*117*	*115*

Staffing Impact of Proposed Reduction in SNF Beds

CPMC is in the process of working with our employees and union representatives to determine the impact of the proposed reduction in SNF beds on staffing. At this time we believe 4 LVN positions will be displaced by the reduction in SNF beds. We are working with our union representatives and believe all other staff will be offered positions at other campuses and/or different shifts.

ATTACHMENT B
Excerpt from the 2013 Health Care Services Master Plan

Exhibit 53. Emergency room visits for ambulatory care sensitive dental conditions, all ages (2007)

Dental ambulatory care sensitive ER visits per 100,000	San Francisco	California
Without hospitalization	149	215
Total	158	222

Source: "Emergency Department Visits for Preventable Dental Conditions in CA," California HealthCare Foundation

Long-Term and Residential Care for Seniors and Persons with Disabilities

Seniors Between 75 and 94 Represent Highest Users of Long-Term Care Services in San Francisco

According to OSHPD, there were 18 licensed long-term care facilities operating in San Francisco in 2010. (Please note that there may be other long-term care providers that are not licensed as long-term care facilities and therefore do not report as such to OSHPD. For example, Laguna Honda Hospital and Jewish Home are the two largest providers of long-term care in San Francisco, though they are licensed as acute care hospitals and are not included in these exhibits.) Of the OSHPD-reporting long-term care facilities, 17 were licensed as skilled nursing facilities and one was licensed as a congregate living health facility. There were 1,279 beds available at these facilities. In 2010, there were 3,760 admissions, 3,779 discharges and 423,018 patient days. At the time of the annual census, two-thirds of the occupants were female and **the largest proportion of occupants was between the ages of 75 and 94**. These data appear below.

By 2030, it is estimated that 55 percent of the population will be over the age of 45.

Exhibit 54. Long-term care facility occupants in San Francisco by sex and age* (2010)

	Female		Male	
Age Group	Number	Percent	Number	Percent
Under 45	4	.52	1	.27
Ages 45-64	33	4.3	26	6.9
Ages 65-74	66	8.5	69	18.3
Ages 75-94	564	73.1	261	69.2
Ages 95+	105	13.6	20	5.3
TOTAL	772	--	377	--
Percent of All Patients	67.2		32.8	

* Occupants of 18 licensed long-term care facilities that report to OSHPD.
Source: OSHPD, 2010, LTC Census taken on 12/31/2010

San Francisco's LTC Occupancy Rate Exceeds that of State Despite Fewer Available Beds per Population

In addition to OSHPD-reporting long-term care (LTC) facilities, Laguna Honda Hospital operated 780 long-term care beds in 2010, and Jewish Home operated 478 long-term care beds. When combined with OSHPD long-term care facility data, the **number of long-term care beds per 1,000 adults age 24 and older in San Francisco was 4.1 compared to 5.1 statewide in 2010.**[152] (Please see exhibit below.) The LTC occupancy rate in San Francisco was higher than that of California at 91.8 percent compared to 86.1 percent, meaning that the ability of existing providers to expand in the event of increased need is limited; this finding complements existing data suggesting that San Francisco patients use 13 times more skilled nursing facility bed days per year than the state as a whole.[153] This is important to note since San Francisco's population trends show that San Francisco residents are older than California residents overall and that the population over 75 is expected to increase by almost two-thirds over the next two decades.

Exhibit 55. Long-term care beds and licensed bed occupancy rates (2010)

	San Francisco	California
Beds per 1,000 adults age 24+	4.1	5.1
Occupancy rate (percent)*	91.8**	86.1

Source: OSHPD and OSCAR (Online Survey, Certification and Reporting)
** Occupancy Rate = (Patient Bed Days)/(Licensed Bed Days) x 100%*
*** NOTE: OSHPD does not distinguish between long-term care and rehabilitation beds in long-term care facilities. Rehabilitation beds, for which there are often vacancies, may be deflating the true occupancy rate for long-term care beds, for which there is often a wait list in San Francisco.*

Results from the San Francisco Human Services Agency – Department of Aging 2012 needs assessment affirms concern regarding San Francisco's ability to meet the long-term care needs of seniors and adults with disabilities.[154] According to the report, the number of Medi-Cal-funded beds in the city's Skilled Nursing Facilities (SNFs) has dropped dramatically. As a result, many seniors and persons with disabilities who require long-term care are forced to move outside the city, away from family and friends, becoming socially and culturally isolated in the later years of their lives.

2,321

Projected number of SNF beds needed to meet San Francisco's needs by 2050. After the current wave of hospital seismic safety rebuilds (projected completion 2015), analysts project that San Francisco will have only 1,619 SNF beds (702 SNF bed gap).

Source: Resource Development Associates, Chinese Hospital Association of San Francisco, Institutional Master Plan Update Analysis,2011

SNFs have also converted beds from long-term care to short-term rehabilitation, shifting their funding from Medi-Cal to Medicare, which is more lucrative. These facilities are under financial pressure to complete the course of rehabilitation and discharge patients within prescribed time frames. They may tend to emphasize rehabilitative activities at the expense of custodial care, or they may hurry discharge without the needed supports in place for the patient to transition home safely. In addition to complaints about poor care (feeding assistance, unanswered call bells, etc.) in rehabilitation facilities, the San Francisco Ombudsman Program, which

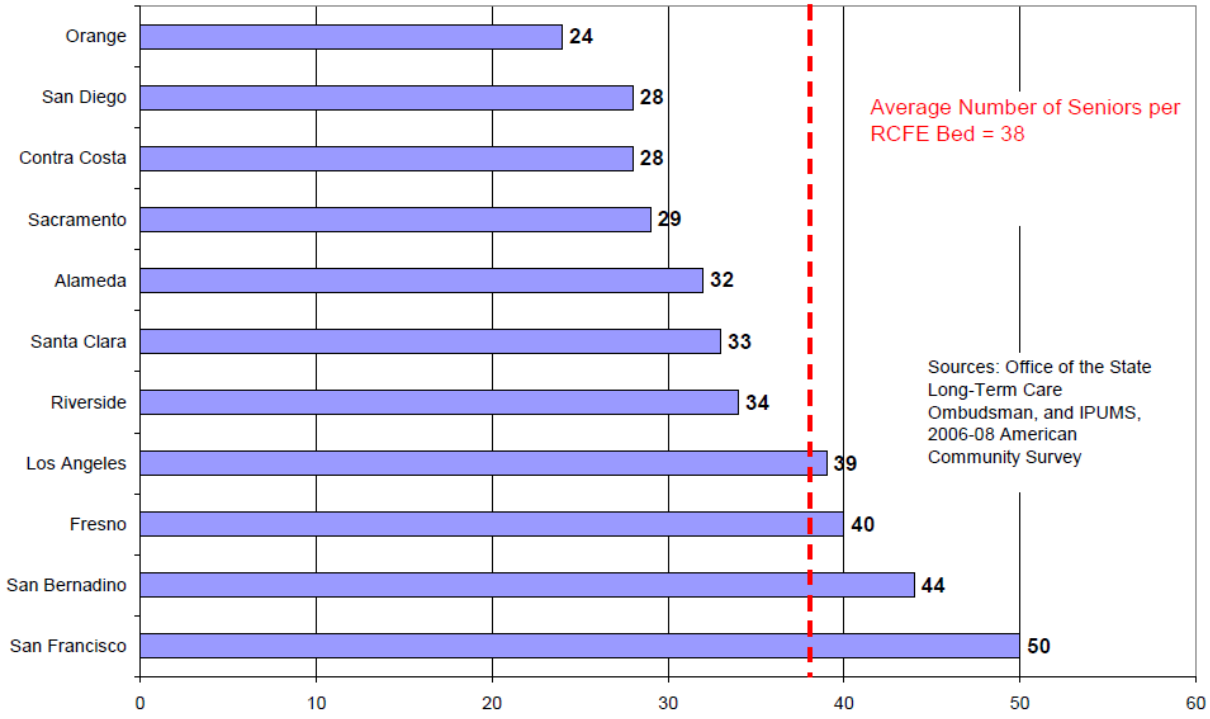
Although San Francisco's population is older than California overall, the rate of long-term care beds is slightly lower than the state's, while the San Francisco occupancy rate is higher.

investigates complaints of seniors in care, frequently responds to complaints about rights related to discharge planning.

San Francisco Lacks Sufficient Community-Based Care Options for Growing Senior Population

Despite increasing demand for community-based – rather than institutional – services for seniors and persons with disabilities, long-term residential care facilities for the elderly are also scarce. San Francisco currently has only 93 residential care facilities for the elderly, with 3,100 beds.[155] Only 24 accept persons receiving Supplemental Security Income (SSI), none of which can serve non-ambulatory residents. These facilities are largely filled with younger persons who have psychiatric disabilities. Meanwhile, newer assisted living facilities for seniors are very expensive.[156] The following exhibit illustrates the comparative shortage of San Francisco's residential care facilities for the elderly.[157]

Exhibit 56. Ratio of seniors (age 60+) to Residential Care Facility for the Elderly beds in California's 10 largest counties and San Francisco, 2006-2008



Behavioral Health Service Availability and Use in San Francisco

While State Estimates of the Prevalence of Mental Illness in San Francisco Appear Lower than that of Other Bay Area Counties and the State, Service Utilization Indicates that Prevalence is Underestimated in San Francisco

The exhibit below highlights the prevalence of serious mental illness in California and in the nine Bay Area counties. **These estimates from the California Department of Mental Health indicate that the prevalence of serious mental illness in San Francisco is lower than most other Bay Area counties and lower than the state overall.**

ATTACHMENT C
The Lewin Group CPMC Institutional Master Plan Review

California Pacific Medical Center

Institutional Master Plan Review

Prepared for: The San Francisco Department of Public Health

Submitted by: The Lewin Group

Date: June 26, 2009

Table of Contents

INTRODUCTION

This report by The Lewin Group has been prepared for the San Francisco Department of Public Health (SFDPH) to meet the requirements of an Institutional Master Plan (IMP) review per Section 304.5 of the City and County of San Francisco Municipal Code Planning Code and Section 97 of the San Francisco Administrative Code. The following report analyzes changes to inpatient services proposed by California Pacific Medical Center (CPMC) within the context of citywide health needs, including emergency department capacity, transitional care, urgent care services, and behavioral health services.

EXECUTIVE SUMMARY

CPMC is proposing several major changes to the existing four-campus health system:

- Build an entirely new 3.85 acre campus with a 555-bed acute care hospital as its centerpiece (Cathedral Hill) by 2015. The campus will include a Women's and Children's Center of Excellence.
- Replace an existing hospital (St. Luke's) with a smaller, seismic compliant facility on the existing campus.
    - In 2014, a new St. Luke's Hospital will have 86 staffed acute care beds.
    - The new campus will continue to provide general acute care services, including maternity and emergency services, as well as a senior health Center of Excellence.
    - Discontinue skilled nursing (SNF) services (eliminate 86 SNF beds).
- Convert an existing full service medical center (Pacific Campus) to an ambulatory care center, relocating 298 staffed acute care beds as well as emergency services to the new Cathedral Hill campus by 2019. Inpatient psychiatric services (18 beds) will remain on the campus as a distinct part unit.
- Eliminate all but imaging services and medical offices from what is now a 242 staffed bed, full service medical center (California Campus) by 2019. The remaining parcel of land would be sold.
- Consolidate neuroscience care, including acute rehabilitation, into a single Center of Excellence on the Davies Campus (2010/2012). The elimination of 20 psychiatry beds will be offset by 16 additional rehabilitation beds.

All inpatient bed relocation is contingent on the development of the Cathedral Hill campus and would not begin until the Cathedral Hill campus is complete. Additionally, medical office buildings, parking facilities and other facilities will be built, renovated or demolished on each of the remaining campuses. A detailed listing of all proposed projects is provided in Appendix A.

Based on a review of the IMP details, an assessment of city-wide healthcare needs, interviews with community leaders, and discussions with CPMC stakeholders, we view the plans proposed in the CPMC IMP as a proactive measure to ensure the long-term availability of health care services in the City and County of San Francisco. The CPMC IMP does not address a potential city-wide shortage of transitional and skilled nursing service capacity, nor does it aim to improve access to mental health services, however, it does propose the following key tenets:

- All CPMC inpatient facilities will meet SB 1953 standards by or around 2015, ensuring access to care in the event of a major earthquake
- St. Luke's Hospital will continue to serve as one of only two acute care hospitals located south of Market Street and will do so in a new, SB 1953 compliant facility.
- Funding for the construction and renovation program, currently estimated at $2.3 billion dollars will be almost completely funded through reserves, philanthropy, and operations. No public financing or private placement debt is being planned as a source of project funding. Many providers throughout the US have had to curtail or cancel badly needed capital improvements because debt financing for projects became either too expensive, or was rescinded due to limited demand for municipal bond issues.
- There is an evidence base that supports higher quality outcomes result from the consolidation of tertiary and quaternary services. Hospitals, physicians, and care teams that perform a high volume of procedures are likely to realize better outcomes than lower volume counterparts.
- The plan expands access to staffed acute care beds, ambulatory care services, and emergency services without significantly altering patient access patterns.

The remainder of this report details our findings and analyses.

OVERVIEW OF THE ORGANIZATION

California Pacific Medical Center (CPMC) was formed in 1991 through the merger of Pacific Presbyterian Medical Center and Children's Hospital of San Francisco. Ralph K. Davies Medical Center became the third campus in 1998, and in 2007, St. Luke's Hospital became the fourth campus.[1] Currently CPMC consists of four existing medical centers, or campuses:

1) Pacific Campus, a 313 licensed inpatient bed hospital located at 2333 Buchanan Street
2) California Campus, a 400 licensed inpatient bed hospital located at 3700 California Street
3) Davies Campus, a 311 licensed inpatient bed hospital located at 38 Castro Street
4) St. Luke's Campus, a 229 licensed inpatient bed hospital located at 3555 Cesar Chavez Street

CPMC has been affiliated with Sutter Health, a not-for-profit network of community-based health care providers since 1996. CPMC is currently in the process of a legal and organizational restructuring as part of Sutter Health's regional strategy. CPMC's Chief Executive Officer, Martin Brotman, MD, has become the first President of the newly established West Bay Region, which adds three hospitals north of San Francisco to the CPMC system. The governing Board of the West Bay Region is anticipated to function in January, 2010, with participation and leadership by current CPMC Board members. In addition, the regional management team includes representation from CPMC.

Utilization and Financial Performance

CMPC California, Pacific, and Davies (CPD) campuses draw patients from every corner of the city, as well as from localities outside of the San Francisco city limits. As shown in Figure 1, four localities located outside of the City and County limits are part of the primary service area and over 30% of all patients discharged from the CPD campuses originated from outside the City and County of San Francisco.

Table and Figure I illustrate the CPMC - CPD service area, defined as those zip codes which account for more than 1% of total inpatient admissions (greater than 300 admissions).

[1] California Pacific Medical Center. 2008 Institutional Master Plan.

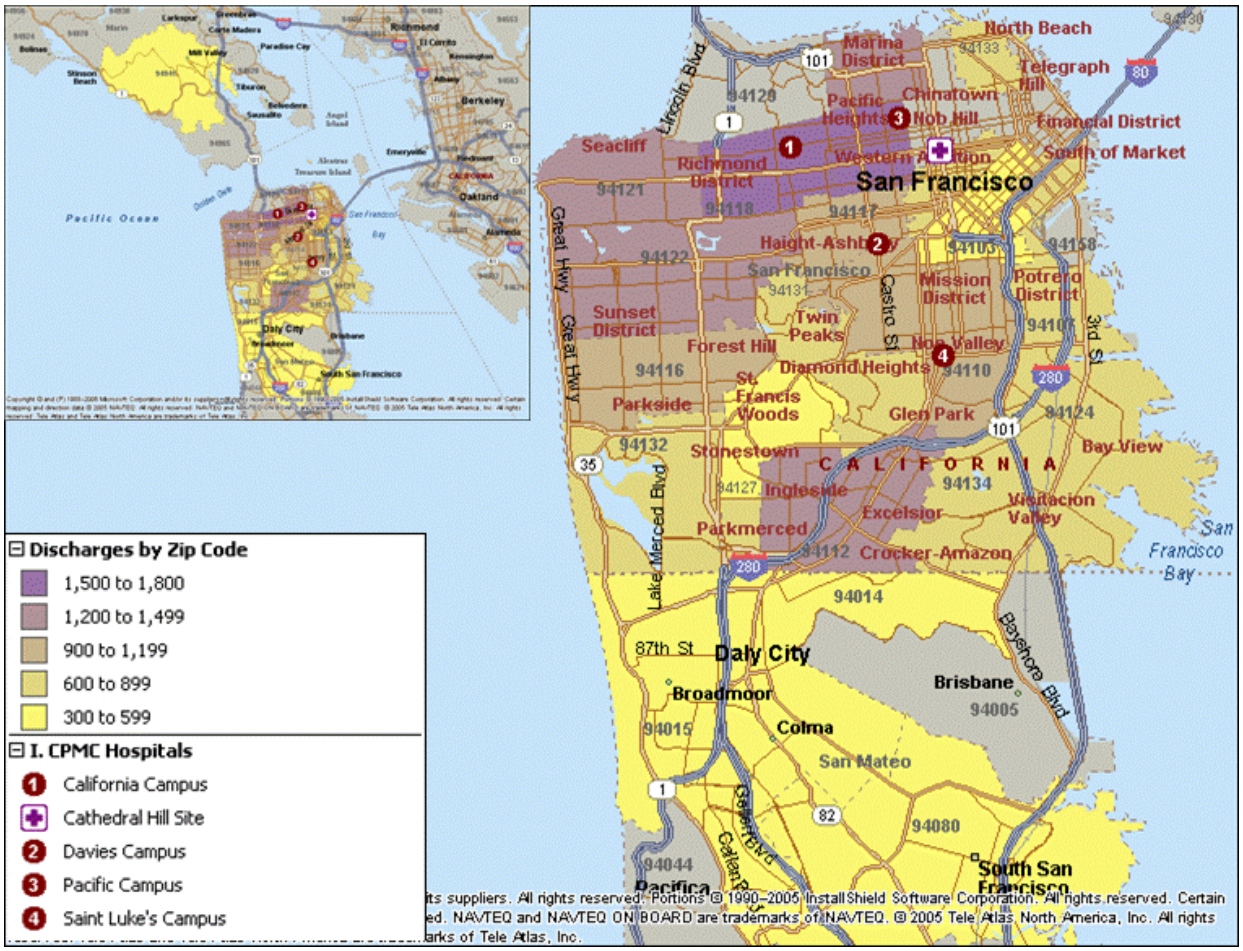
Table I - 2007 CPMC - CPD Discharges by Locality

Zip Code	Neighborhood	Discharges	Percent of Total Discharges	Cumulative Percentage
94109	Nob Hill/Russian Hill	1,895	5.6%	5.6%
94115	Pacific Heights/Western Addition/Japantown	1,662	4.9%	10.4%
94118	Inner Richmond	1,505	4.4%	14.8%
94112	Ingelside-Excelsior	1,441	4.2%	19.1%
94121	Outer Richmond	1,397	4.1%	23.2%
94122	Inner Sunset	1,312	3.8%	27.0%
94123	Marina District	1,207	3.5%	30.5%
94114	Castro, Noe Valley	1,177	3.5%	34.0%
94110	Mission District/Bernal Heights	1,172	3.4%	37.4%
94116	Outer Sunset	1,085	3.2%	40.6%
94117	Haight-Ashbury/Cole Valley	949	2.8%	43.4%
94131	Twin Peaks, Glen Park	822	2.4%	45.8%
94134	Visitacion Valley	795	2.3%	48.1%
94133	North Beach/Telegraph Hill	733	2.1%	50.3%
94102	Hayes Valley/Tenderloin	710	2.1%	52.4%
94107	Potero Hill	674	2.0%	54.3%
94132	Lake Merced	627	1.8%	56.2%
94124	Bayview	607	1.8%	58.0%
94103	SOMA	502	1.5%	59.4%
94127	St. Francis Wood/West Portal	594	1.7%	61.2%
94015	Daly City (San Mateo County)	595	1.7%	62.9%
94941	Mill Valley (Marin County)	495	1.5%	64.4%
94080	South San Francisco (San Mateo County)	395	1.2%	65.5%
94014	Colma (San Mateo County)	386	1.1%	66.7%
n/a	Other San Francisco	994	2.9%	69.6%
	Sub-Total	23,731	69.6%	
Other San Mateo County		1,706	5.0%	74.6%
Alameda County		1,646	4.8%	79.4%
Other Marin County		1,518	4.5%	83.9%
Sonoma County		554	1.6%	85.5%
Other California		4,090	12.0%	97.5%
Other U.S. / Unknown		862	2.5%	100.0%
	Sub-Total	10,376	30.4%	
	Total	34,107		

Source: Office of Statewide Health Planning and Development 2007. Other San Francisco includes patients using a P.O. Box, having no fixed address or living in a San Francisco zip code that does not account for more than 1% of total discharges.

CPMC's position as a regional referral center is confirmed by the significant patient volume originating in San Mateo, Alameda, Marin and Sonoma counties. Moreover, residents from three zip codes in San Mateo County and one zip code in Marin County each accounted for at least 1% of total CPMC-CPD discharges. The largest percentages of San Francisco resident admissions are concentrated in the northern tier of the city, from areas such as Nob Hill, Russian Hill, Pacific Heights, and Richmond. Two CPMC campuses (California and Pacific) are located in these neighborhoods.

Figure I: CPMC - CPD Patient Origin Map



Source: Office of Statewide Health Planning and Development 2007

The CMPC St. Luke's campus (SLC) draws the majority of its patients from an approximate 3.5 mile radius around the campus, made up primarily of nine zip code defined neighborhoods.

Table and Figure II illustrate the CPMC - SLC service area, defined as those zip codes which account for more than 1% of total inpatient admissions. In 2007, more than 80% of CPMC–SLC patients originated in the City and County of San Francisco.

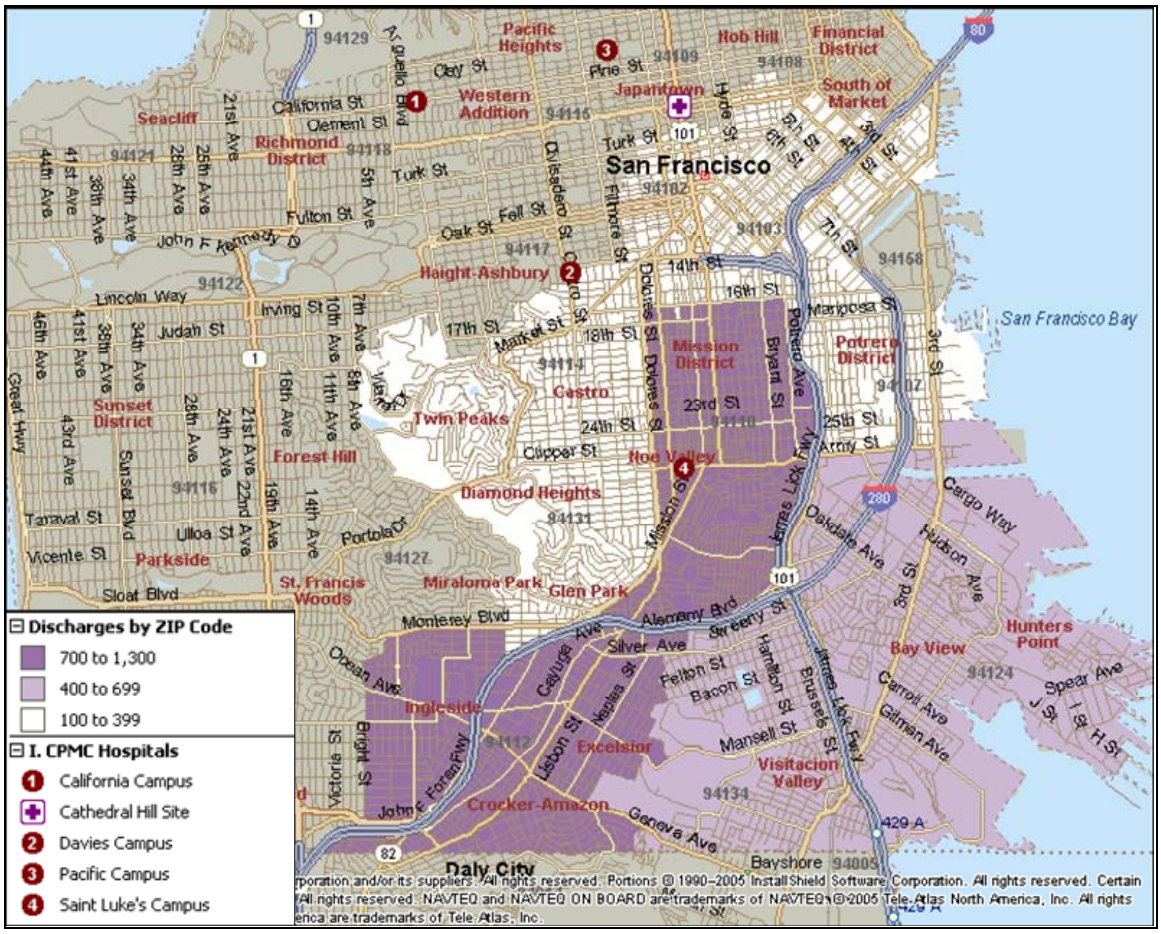
Table II - 2007 CPMC - St. Luke's Campus Discharges by Locality

Zip Code	Neighborhood	Discharges	Percent of Total Discharges	Cumulative Percentage
94110	Mission District/Bernal Heights	1,262	20.8%	20.8%
94112	Ingelside-Excelsior	1,038	17.1%	37.9%
94124	Bayview	638	10.5%	48.4%
94134	Visitacion Valley	487	8.0%	56.4%
94103	SOMA	214	3.5%	60.0%
94102	Hayes Valley/Tenderloin	195	3.2%	63.2%
94131	Twin Peaks, Glen Park	172	2.8%	66.0%
94107	Potero Hill	146	2.4%	68.4%
94114	Castro, Noe Valley	104	1.7%	70.1%
n/a	Other San Francisco	637	10.5%	80.6%
	Sub-Total	4,893	80.6%	
Alameda County		110	1.8%	82.4%
San Mateo County		798	13.2%	95.6%
Other California		167	2.8%	98.4%
Other U.S. / Unknown		100	1.6%	100.0%
	Sub-Total	1,175	19.4%	
	Total	6,068		

Source: Office of Statewide Health Planning and Development, 2007. Other San Francisco includes patients using a P.O. Box, having no fixed address or living in a San Francisco zip code that does not account for more than 1% of total discharges.

Nearly half of all CPMC–SLC patients originated from the Mission District/Bernal Heights, Ingelside-Excelsior, and Bayview. The 2000 Census identified these areas as having above average deprivation based on income levels; however, 2010 Census data is anticipated to show some improvement based on increased residential migration and commercial development south of Market Street.

Figure II: CPMC - St. Luke's Campus Patient Origin Map



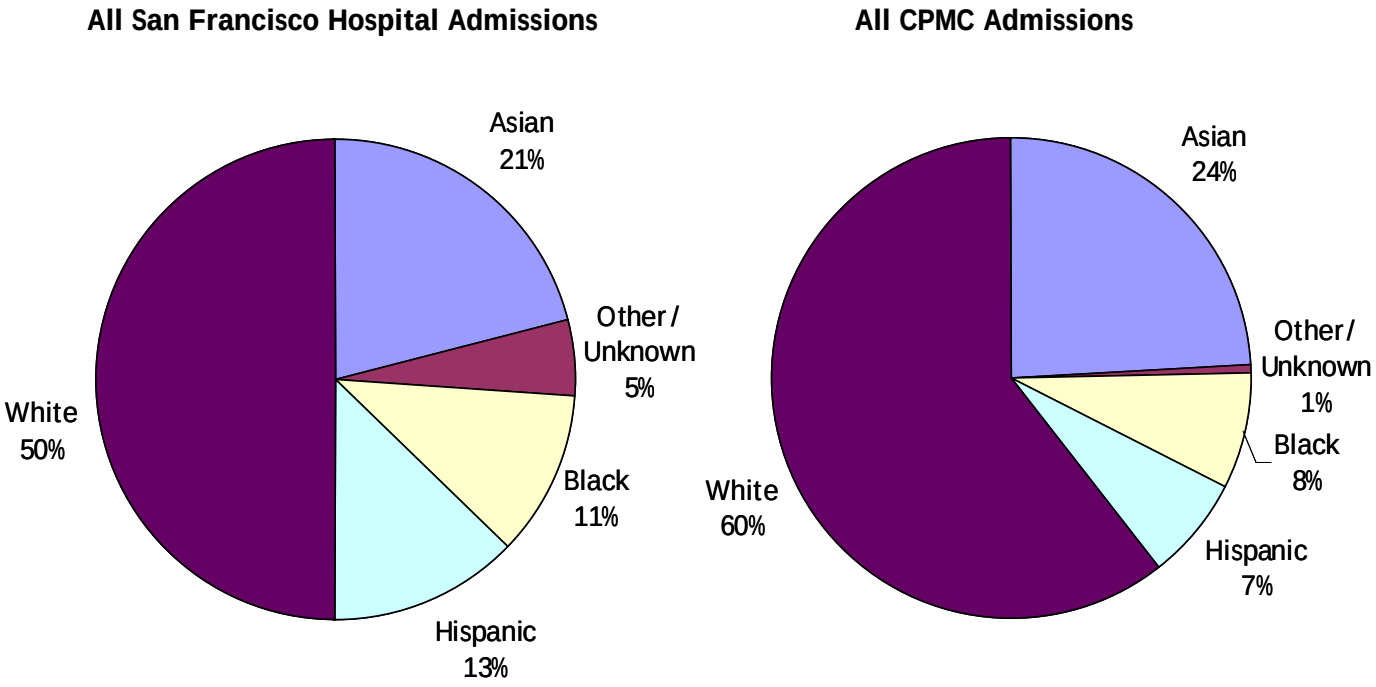
Ethnic Profile

Per the Office of Statewide Health Planning and Development (OSHPD), Figure III shows that non-Hispanic whites accounted for 60% of patients admitted to CPMC in 2007. Based on 2000 Census data, the population of San Francisco was approximately 44% non-Hispanic white, 8% black, and 14% Hispanic.

When compared to all of San Francisco hospital admissions, Figure III shows that a higher proportion of non-Hispanic white and Asian patients are seeking care at CPMC, with a lower share of blacks and Hispanics compared to the aggregate city-wide admission totals.

However, a broad range of variables such as referring physician preference, proximity from home or work, and prior experiences with the hospital contribute to how and where specific populations choose to access healthcare services.

Figure III: 2007 Inpatient Ethnic Profile Comparison



Source: Office of Statewide Health Planning and Development 2007 (latest available).

Utilization Trends

CPMC has posted declining inpatient activity for the past three years, with skilled nursing and psychiatric care discharges decreasing at the greatest rate. Only outpatient visits have demonstrated a notable increase, driven both by a broadening range of services that can be performed in an ambulatory setting, as well as greater utilization of the emergency department by Bay Area residents. Table III provides a snapshot of key utilization indicators.

Table III – CPMC Key Utilization Indicators

	2006	2007	2008	% Change 2006-2008	2008 Est. Staffed Bed Occupancy %
CPMC-CPD					
Discharges					
Medical/Surgical/Obstetrics	25,749	25,420	25,986	0.9%	61.8%
Rehabilitation	383	381	392	2.3%	62.1%
Skilled Nursing	1,973	1,729	1,660	-15.9%	81.8%
Psychiatric	979	941	757	-22.7%	55.3%
Outpatient Visits	491,080	517,241	520,787	6.0%	
CPMC-SLC					
Discharges					
Medical/Surgical/Obstetrics	5,451	4,604	4,182	-23.3%	83.2%
Skilled Nursing	472	364	419	-11.2%	85.0%
Outpatient Visits	107,588	105,590	92,985	-13.6%	

Source: Office of Statewide Health Planning and Development, preliminary 2008 dataset. Excludes newborns.

Gradual reductions in staffed psychiatric and SNF beds contributed to the declining rate of utilization of these services. Between 2004 and 2008, CPMC's staffed psychiatric and SNF beds declined by 45 and 96 respectively. City-wide inpatient utilization and occupancy data is discussed in the Market Summary section that begins on page 16.

Community Benefit Planning

In 2007, CPMC provided more than $7M in charity care, the most of any private, not-for-profit hospital in San Francisco. However, as a percentage of net patient revenue, Catholic Healthcare West hospitals (St. Mary's Medical Center and St. Francis Memorial Hospital) provided significantly higher levels of charity care (see Table XI for all hospital comparison).

The California Pacific Medical Center Foundation (CPMC Foundation), a separate, incorporated not-for-profit organization, raised over $26.7 million in 2007, exceeding its goal by nearly $4 million. The money raised will be used to fund programs at the new Cathedral Hill Campus, the rebuilt St. Luke's Hospital and other projects described in the IMP.[2] In addition, CPMC agreed in September 2008 to provide inpatient services to over 6,000 Healthy San Francisco (HSF) participants who have North East Medical Services (NEMS) as their primary care medical home. This population is estimated to constitute approximately 14% of all HSF enrollees. In 2008, the support amount was capped by CPMC at $1 million.

According to the 2008 CPMC Community Benefit Plan Report, the total quantifiable community benefit provided by CPMC, including the unpaid cost of Medi-Cal and Medicare, was $210,937 million[3]. However, although the CPMC Community Benefit Plan report references "*A Guide for Planning & Reporting Community Benefit1 from the Catholic Health Association (CHA)*", Medicare shortfall estimates are not an allowable measure of community

[2] California Pacific Medical Center 2008 Institutional Master Plan
[3] California Pacific Medical Center 2008 Community Benefit Plan Report

benefit per CHA guidelines. The 2008, CPMC Medicare shortfall was estimated at $82.2 million.

PROPOSED CHANGES TO THE FACILITIES

In 2001, in response to SB 1953, all of California's acute care hospitals were assigned seismic ratings in a report prepared for the Office of Statewide Health Planning and Development by the California Acute Care Hospitals. The ratings were as follows:

1) SPC-1: the building poses significant risk of collapse in a strong earthquake
2) SPC-2: the building does not significantly jeopardize life in a significant earthquake, but must be repairable or functional following a strong earthquake
3) SPC-3: the building may experience structural damage that does not significantly jeopardize life and may be used to 2030 and beyond
4) SPC-4 - the building is in compliance but may experience structural damage which could inhibit the building's availability following a strong earthquake. The building will have been constructed or reconstructed under a building permit obtained through OSHPD. It may be used to 2030 and beyond.
5) SPC-5 – the building is in compliance and is reasonably capable of providing services to the public following strong ground motion

Buildings rated SPC-1 and SPC-2 had to be brought into compliance by 2008 in order to operate until 2030, at which point they will again be evaluated. Many hospitals, including CPMC, received an extension on the 2008 deadline to 2013.

CPMC consists of four campuses, of which all require SB 1953 compliance. The California Campus, The Davies Campus, the Pacific Campus, and the St. Luke's Campus all contain acute care hospital facilities that are seismically inadequate and require retrofitting or replacement to comply with SB 1953.

Per discussions with the leadership team, CPMC considered retrofitting the hospital facilities at the California and Pacific Campuses, but ultimately concluded that transferring services to a brand new campus at Van Ness Avenue and Geary Boulevard was the most viable and cost effective plan for the organization. CMPC also plans to rebuild the St. Luke's Campus by 2014 to meet SB 1953 standards. The North Tower at the Davies Campus has been retrofitted and will be available to provide inpatient care until 2030.

The IMP describes a plan in which CPMC will bring all inpatient acute care services into compliance by 2015, through the following major initiatives:

1) Building Cathedral Hill Hospital to SPC-5 compliance, and
2) Rebuilding St. Luke's Hospital to SPC-5 compliance

In addition to these major milestones, CPMC plans to renovate, rebuild or eliminate numerous other facilities, such as medical office buildings and parking garages, by 2030. A detailed listing of all proposed changes is provided in Appendix A.

Acute Care Services

The CPMC IMP calls for a significant alteration of the delivery of acute care services by CPMC in San Francisco. The following details the planned changes to the delivery of acute care services at each CPMC campus:

- *Cathedral Hill Campus* - CMPC plans on constructing the new 3.85 acre Cathedral Hill Campus with a 555-bed acute care hospital by 2015.
- *Pacific Campus* - Contingent on the completion of the Cathedral Hill Campus, CPMC will eliminate 298 staffed acute care beds as well as an emergency room at the Pacific Campus and transfer acute care and emergency services to the Cathedral Hill Campus. The remaining medical center will then be converted an ambulatory care center.
- *California Campus* - Acute care services at the California Campus will be transferred to the Cathedral Hill Campus upon its completion (estimated by 2015).
- *Davies Campus* – CPMC will consolidate neuroscience care, including acute rehabilitation, into a single Center of Excellence on the Davies Campus by 2012.
- *St. Luke's Campus* – CPMC will replace the existing hospital with a seismic compliant 86-bed facility on the existing campus. The new campus will continue to provide general acute care services, including maternity and emergency services, as well as a senior health Center of Excellence.

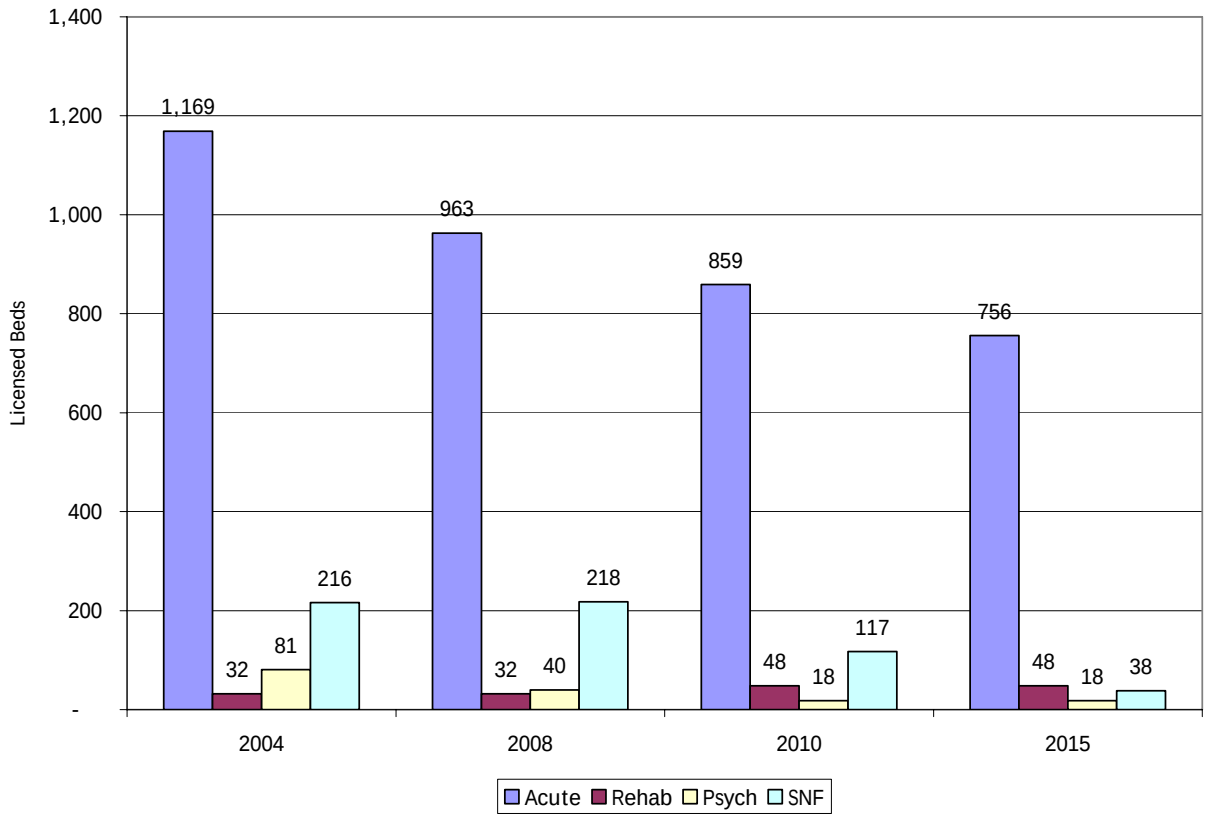
CPMC Inpatient Services

The plan proposed by CPMC will consolidate most inpatient services from four existing facilities into two new facilities and one existing facility, upgraded to meet SB 1953 standards. In addition, an 18-bed psychiatric unit will be maintained on the Davies Campus, operated as a distinct part psychiatric unit[4]. The following tables outline CPMC's proposed changes to inpatient services.

The IMP calls for a gradual licensed bed reduction through 2015, or the maximum number of beds for which a hospital holds a license to operate. Figure IV below illustrates the reduction and reallocation of total licensed beds from 1,498 in 2004 to 842 in 2015.

[4] A distinct part psychiatric unit is a Medicare designation that allows for a hospital or health system to operate psychiatric inpatient services in a stand-alone facility.

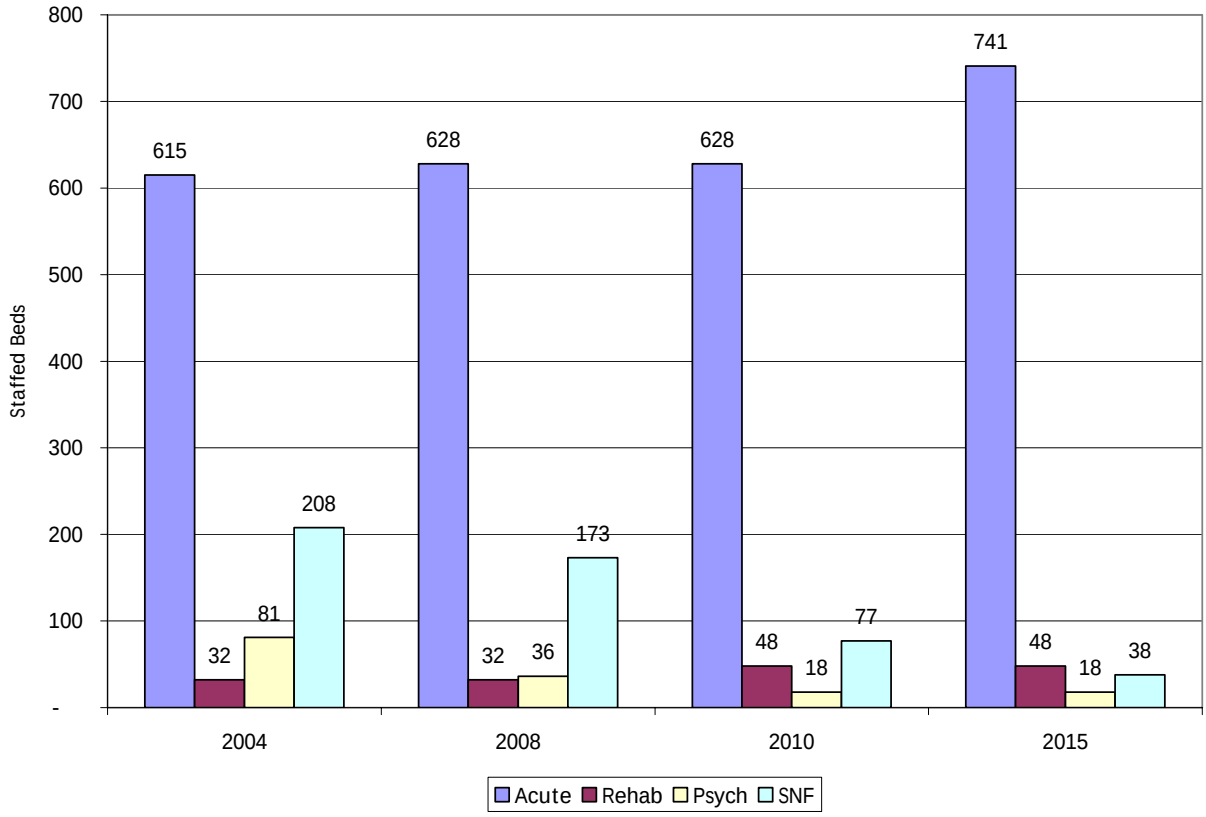
Figure IV – Summary of Changes Proposed in Licensed CPMC Beds



Source: CPMC Environmental Evaluation Application, Filed December 4, 2008.

Staffed beds, or beds that are available for patient care, will increase by a total of 74. 113 additional acute care beds will be added, and 16 additional rehabilitation beds while 18 psychiatric beds and 135 skilled nursing beds will be eliminated. Upon completion of the project, all licensed beds will be available for patient care. Figure V illustrates the progression of staffed or available beds from 2004 through 2015.

Figure V – Summary of Changes Proposed in Staffed/Available CPMC Beds



Source: CPMC Environmental Evaluation Application, Filed December 4, 2008.

Skilled Nursing Facility Beds

The total number of licensed skilled nursing beds in San Francisco County will decline from 3,179 currently to 2,813 in 2015. Contributing to the decline in licensed SNF beds is the elimination of 180 licensed SNF beds at CPMC through 2015. Only the Davies Campus will continue to operate SNF beds, maintaining 38 licensed SNF beds through 2015.

Psychiatric Beds

The number of licensed psychiatric beds is projected to decrease by 50% in 2010, from 36 to 18 beds. An 18–bed distinct part psychiatric unit will continue to operate at the Pacific Campus.

Rehabilitation Beds

CPMC will increase the number of rehabilitation beds from 32 in 2008 to 48 by 2015. All rehabilitation beds will be located on the Davies Campus to support the Neurosciences Center of Excellence.

Emergency Services

While two existing emergency services locations will be closed (Children's Emergency Department (ED) at the California Campus and the Pacific Campus ED), planned ED square footage will increase by more than 8,000 square feet. Diagnostic and Treatment (D&T) capabilities, a key component of outpatient and emergency care, are also planned to expand by nearly 100,000 square feet. The following table provides a summary of planned changes in emergency and D&T services.

Table IV – Proposed Allotment of ED and D&T Space

	Cathedral Hill	Pacific*	California**	Davies	St. Lukes	Total
Emergency Department (Sq. Ft.)						
Current	-	12,424	3,593	3,755	7,060	26,832
Proposed	19,900	-	-	3,755	12,000	35,655
Diagnostic and Treatment (Sq. Ft.)						
Current	-	103,602	142,144	49,017	55,854	350,617
Proposed	140,527	149,036	2,400	73,017	68,000	432,980

Source: CPMC Environmental Evaluation Application, filed December 4, 2008
* The Pacific Campus ED will be renovated and used for urgent care and outpatient services.
** The California Campus recently resumed pediatric emergency services which will be transferred to the Cathedral Hill Campus.

Impact of Changes on Neighborhood and Environment

The IMP provides a detailed plan for construction and renovation at each campus. The plans address areas such as car and bicycle parking, public transit accessibility, traffic circulation, and loading/unloading. Since the Planning Commission has an environmental review process, The Lewin Group has not assessed the project from this perspective beyond noting concerns that were aired during the interview process.

COMMUNITY NEED FOR AFFECTED SERVICES

The primary goal of the IMP review is to determine how planned changes to San Francisco inpatient provider facilities may impact the availability of healthcare services, impede access to services or significantly alter the way services are currently being delivered. In order to provide an accurate assessment, we have employed both quantitative and qualitative steps to inform the recommendation.

Market Summary

There are eight private inpatient providers currently operating in the City of San Francisco (Figure VI). In addition, San Francisco General Hospital is a 598-bed public hospital operated by the Department of Public Health. The city also has three facilities primarily dedicated to inpatient psychiatric care and rehabilitation services[5] and a Veterans Administration hospital.

Figure VI: San Francisco Inpatient Providers

Source: Office of Statewide Health Planning and Development 2007

[5] Jewish Home, Laguna Honda Hospital and Rehabilitation Center and Langley Porter Psychiatric Institute

Demand for Inpatient Services and Long-Term Outlook

The 2007 Lewin Group report titled "Market Assessment and Benchmarking Project "analyzed the City's population dynamics and healthcare delivery system characteristics. The most significant findings were concentrated around population dynamics and the long-term need for additional inpatient capacity.

The report found that the population is aging and diversifying. The aging of the population is attributed to the confluence of an increase in "baby boomers" and a decrease in the number of residents less than 35 years of age. The report also projects that while the African-American population is expected to decline significantly, an increasing proportion of Hispanic and Asian-Americans will create a more diverse community. These two shifts will require the healthcare providers to develop or improve coordinated chronic care and disease management programs in a culturally competent way. The following table provides the latest population projections for the City and County of San Francisco.

Table V – California Department of Finance Population Projections[6]

AGE	2009	2010	2020	2030	CAGR 2010 - 2030
Population					
0-14	104,700	106,077	109,271	92,305	-0.7%
15-44	392,300	390,541	310,872	291,191	-1.5%
45-64	202,300	205,879	276,716	291,804	1.8%
65+	114,600	115,666	147,607	179,375	2.2%
Projected Total	*813,900*	*818,163*	*844,466*	*854,675*	*0.2%*
% of Total Population					
0-14	12.9%	13.0%	12.9%	10.8%	
15-44	48.2%	47.7%	36.8%	34.1%	
45-64	24.9%	25.2%	32.8%	34.1%	
65+	14.1%	14.1%	17.5%	21.0%	

Source: State of California, Department of Finance, Population Projections for California and Its Counties 2000-2050, Sacramento, California, July 2007.

Regarding the long-term outlook for inpatient bed availability, it was determined that given the eventual increase in demand for inpatient services, San Francisco could see a significant bed shortage occurring between 2010 and 2030.

While bed shortages are projected to occur over the long-term, Bay Area hospitals have continued to maximize existing capacity and are managing to sustain a decade long trend of

[6] A number of organizations develop and report population estimates and projections. It is likely that other studies and reports may utilize different data to develop estimated and projected population statistics. The Lewin Group utilized population projections developed by the CA Department of Finance. These projections appear understated based on recently published 2009 estimates, which estimate San Francisco's current population at approximately 845,000; however long-term population projections have not yet been recast by the CA Department of Finance.

transitioning services to the outpatient setting. Inpatient utilization in the Bay Area did not increase between 2005 and 2007, as evidenced by a real decline in number of admissions as well as a decrease in population adjusted utilization. Given the long term outlook, hospital operators will likely continue to implement programs aimed at reducing inpatient utilization until additional capacity is realized. Table VI illustrates Bay Area inpatient utilization trends between 2005 and 2007.

Table VI – Bay Area Inpatient Utilization Trends[7]

	2005		2007		
Age Cohort	Estimated Population	% of Total	Estimated Population	% of Total	% Change 2005-2007
0-14	99,000	12.6%	101,800	12.8%	2.8%
15-44	390,600	49.5%	388,700	48.7%	-0.5%
45-64	188,000	23.8%	194,600	24.4%	3.5%
65+	110,800	14.1%	112,600	14.1%	1.6%
Total Population	788,400		797,700		1.2%
S.F. Resident Acute Care Discharges	72,481		71,365		
Utilization Rate Per 1,000 Pop.	91.9		89.5		

Source: Office of Statewide Health Planning and Development 2009. State of California, Department of Finance, Population Projections for California and Its Counties 2000-2050, Sacramento, California, July 2007.

In 2007, the California Department of Finance recast its population projection figures through 2050. Although prior year projections showed an eventual decline in the San Francisco population, the updated estimates project continued modest growth through 2050.

Based on the latest available data, total acute care inpatient utilization per 1,000 population declined by 2.7% between 2005 and 2007. However, the population age 45 to 64 increased by 3.5% during the same period. While it is true that Americans are accessing inpatient care at a higher rate as they reach middle age, the availability of beds in the Bay Area appears sufficient for servicing this population over the next five to ten years. These updated projections vary slightly from the 2007 report titled "Market Assessment and Benchmarking Project" which estimated a bed need by 2010.

[7] The potential understatement of population estimates for the City and County of San Francisco would further reduce the inpatient utilization rate.

Table VII provides a comparison of licensed and staffed bed occupancy rates at Bay Area inpatient facilities. Staffed bed estimates are based on data submitted by each hospital to OSHPD as a component of their quarterly financial reporting requirement. As noted, the CPMC construction program will increase the total number of available staffed inpatient beds.

Table VII- 2008 Bay Area Hospital Occupancy Estimates

Hospital	Licensed Beds	Available Beds	Staffed Beds	Licensed Bed Occupancy	Staffed Bed Occupancy
CPMC (ex. St. Lukes)	1,024	730	730	48.0%	67.3%
St. Lukes Hospital	229	229	229	51.0%	51.0%
Chinese Hospital	54	52	52	65.0%	67.5%
Kaiser Foundation	247	247	206	79.1%	94.7%
San Francisco General Hospital	598	564	386	63.5%	98.4%
St. Francis Memorial Hospital*	362	296	210	29.2%	50.4%
St. Mary's Medical Center	403	264	220	35.9%	51.4%
UCSF (Including Mt. Zion)	706	646	646	71.5%	78.6%

Source: Office of Statewide Health Planning and Development 2008. Quarterly financial reports for the four quarters ended 12/31/2008. * St. Francis Memorial Hospital closed a 34-bed skilled nursing unit in December 2007. The closure is reflected in the total.

In 2008, 67.3% of CPMC - CPD and 51% of CPMC - SLC staffed beds were occupied. Most hospitals in the city have sufficient inpatient reserve capacity at this point in time and potential new projects at SFGH and UCSF, along with CPMC's plan, will further expand bed availability.

Occupancy rates appear lower when calculated using licensed bed totals, however many of the areas for unstaffed licensed beds have been converted to serve other purposes, such as waiting areas, supply storage and diagnostic testing areas. Other licensed beds are located in buildings that are no longer compliant with inpatient safety standards, and therefore would be costly, if not impossible to re-commission. System-wide, the CPMC IMP proposes to add 113 staffed acute care beds to the city's total bed inventory.

Hospital Performance

The operating margins of San Francisco hospitals vary considerably. Although all hospitals in San Francisco are not-for-profit entities, a positive operating margin is vital to the long term sustainability of an organization. Organizations must generate a surplus in order to appropriately manage capital improvements, physician recruitment and retention, labor shortages and other events or situations that occur outside of day to day operations. In 2008, CPMC generated a 10.6% operating margin despite a $21.6 million loss at St. Luke's Hospital. In 2008, Moody's reported that the median operating margin for acute care hospitals was 2.1%, while high performing systems designated as having an Aa rating, averaged operating margins in excess of 4%. Table VIII provides a summary of San Francisco hospital operating margins.

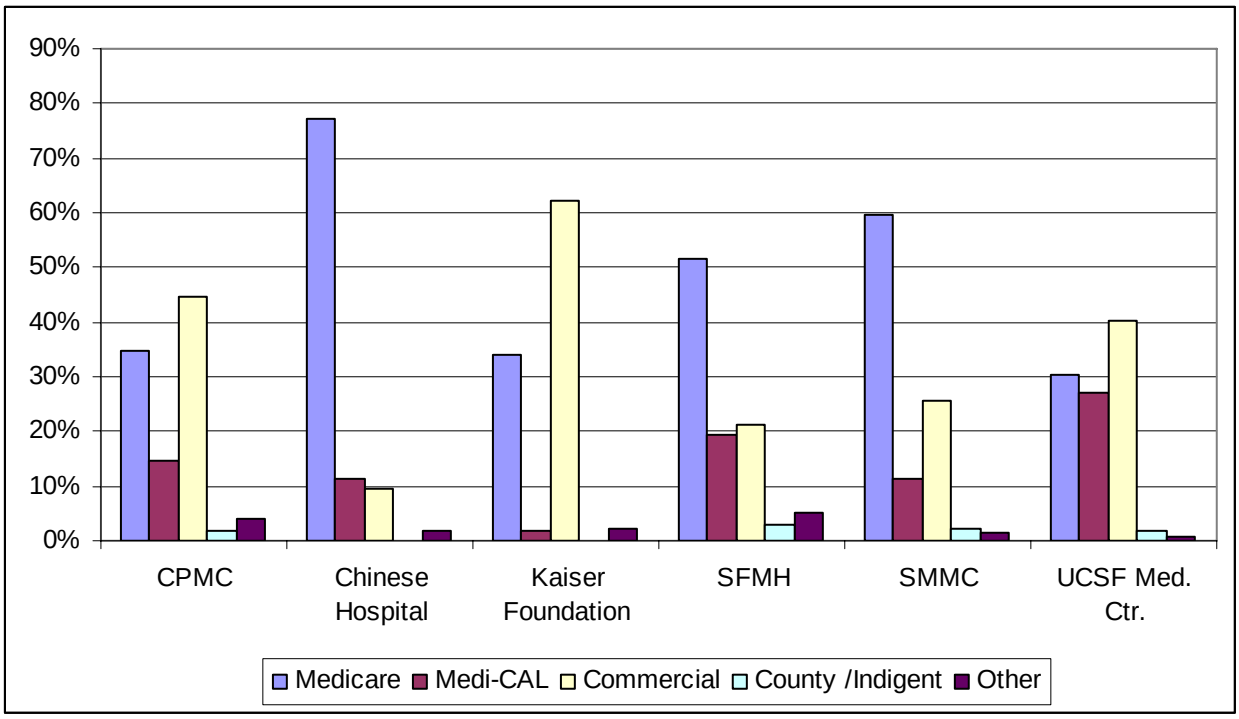
Table VIII- 2008 Bay Area Hospital Financial Performance

	Total (Net) Operating Revenue	Net Income from Operations	Operating Margin
	(000s)	*(000s)*	
CPMC - SLC	898.7	(215.8)	-24.0%
CPMC - CPD	10,742.6	1,444.5	13.5%
CPMC Sub-total	11,641.2	1,228.7	10.6%
St. Mary's Medical Center	1,933.4	28.1	1.5%
St. Francis Medical Center	1,499.1	(62.3)	-4.2%
CHW S.F. Sub-total	3,432.5	(34.2)	-1.0%
Chinese Hospital	876.3	135.0	15.4%
Kaiser Foundation Hospital	DNR	DNR	DNR
SF. General Hospital	4,015.2	(1,761.7)	-43.9%
UCSF	15,494.3	486.2	3.1%

Source: Office of Statewide Health Planning and Development 2008. Quarterly financial reports for the four quarters ended 12/31/2008

Operating margins are dependant upon a number of factors, however payor mix plays a major role in a hospital's ability to generate a positive margin. Commercial, or private payors, typically reimburse hospitals more favorably than Federal and State sponsored programs. Hospitals that care for a high percentage of Medicaid (Medi-CAL) or indigent patients will likely experience greater difficulty achieving a sustainable margin, as reimbursement rates tend to skew lower than commercial or Medicare plans. The following illustration provides a comparison of payor mix, based on total hospital discharges, for all private San Francisco hospitals.

Figure VII: 2007 Payor Mix Comparison

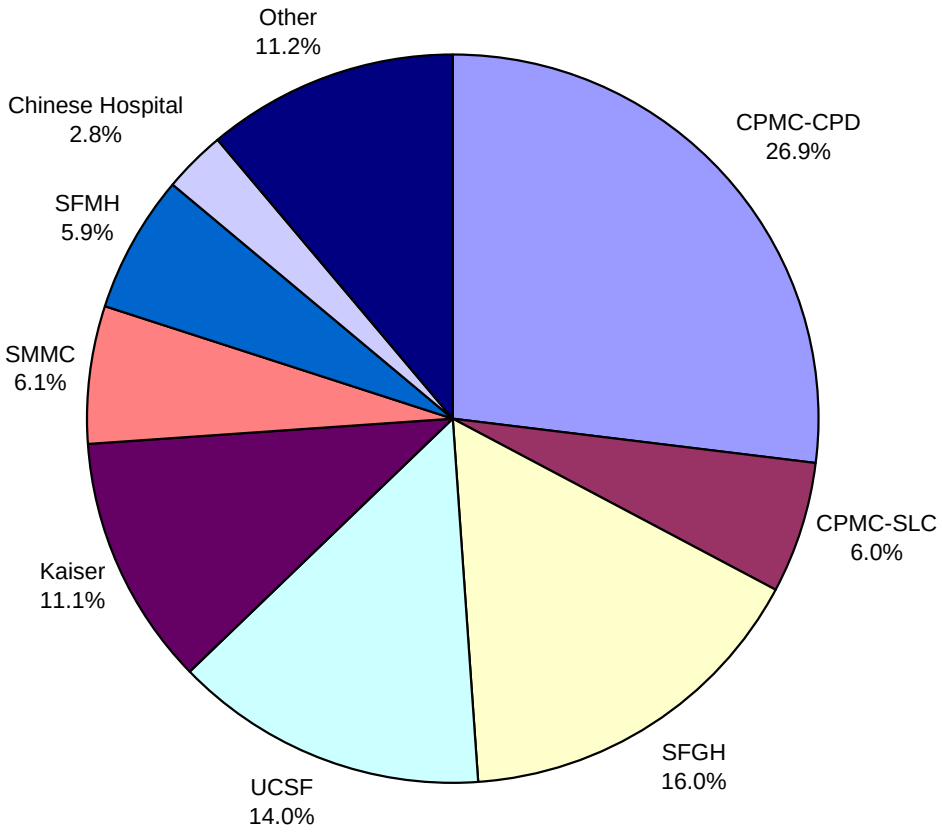


Source: Office of Statewide Health Planning and Development 2007.

Only Kaiser had a larger percentage of commercial patients, which is due to their closed model delivery system where only Kaiser insured patients utilize Kaiser facilities and services. It is unclear how the reconfiguration of service delivery as described in the CPMC IMP might impact payor mix. Since the Cathedral Hill Campus will be closer to major transportation arteries and the Tenderloin neighborhood, it is possible that CPMC could experience an increase in Medi-Cal and indigent care patients. The expansion of the emergency department may also alter existing access patterns.

Lastly, CPMC maintains a dominant market share, measured as the percentage of total San Francisco resident discharges. In 2007, CPMC had a 33% market share in the City and County of San Francisco, more than double the nearest private hospital competitor, UCSF, who posted a 14.0% market share in the same year.

Figure VIII: 2007 Market Share Comparison



Source: Office of Statewide Health Planning and Development 2007.

Skilled Nursing Facilities

From a city-wide healthcare need perspective, access to transitional care, skilled nursing, and long term elder care are of great concern. The latest California Department of Finance population estimates show that persons age 65 and older currently make up approximately 14% of San Francisco's population and by 2030 will account for more than 21% of all San Franciscans. Based on current utilization of the City's skilled and long term care facilities, assuming all patients are age 65 or older, the following table provides a hypothetical SNF utilization projection.

Table IX- Projected SNF Bed Utilization[8]

	2008	2010	2015	2020
Estimated Total Population	803,500	818,163	820,600	844,466
Estimated Population 65+	113,500	115,666	130,400	147,607
% Change 65+ Population		1.9%	12.7%	13.2%
Estimated Total Certified SNF Beds	3,179	2,813	2,774	2,774
Estimated Daily Census	2,767	2,800	3,200	3,600
Use Rate	*24.4*	*24.4*	*24.4*	*24.4*
Occupancy Rate	87.0%	99.5%	115.4%	129.8%

Source: State of California Department of Finance Population Estimates, July 2007. CMS Nursing Home Compare, Accessed 5/29/09.

The bed projection assumes that persons age 65 and older will continue to utilize inpatient skilled nursing and transitional care services at the same rate through 2020, with no change in net in-migration or out-migration[9]. The projection also adjusts for a 270 bed reduction at Laguna Honda Hospital and Rehabilitation Center and reductions at CPMC. Based on our estimate, currently 24.4 out of every 1,000 persons age 65 and older are utilizing these services. Without an alteration in how care is delivered throughout the city, a significant shortage or change in migration patterns is projected to occur.

Hospital-based SNF service availability has been declining both in San Francisco, as well as throughout the US. SNF services are reimbursed by Medicare at a lower rate than general acute care services, and are typically operated at breakeven or a loss. In California, the issue is more pronounced. Since hospitals are required to meet SB 1953 standards either through renovation or replacement, construction costs are typically two to three times the national averages, on a per bed basis. As such, hospitals are choosing not to allocate expensive facility space to a service that can be performed in a lower cost facility, where reimbursement may meet or exceed necessary operating requirements. San Francisco's high real estate values and scarcity of available space only exacerbate an already difficult situation.

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8 The potential understatement of population estimates for the City and County of San Francisco would increase the projected SNF bed occupancy rate.

9 In-migration refers to patients who reside outside of the City and County of San Francisco but seek care at a San Francisco provider. Out-migration refers to San Francisco residents who choose to seek care outside of the City and County of San Francisco.

The following table provides a comparison of hospital-based SNF licensed beds and SNF days between 2002 and 2008.

Table X – Hospital-based SNF Bed Comparison

	2002		2008		% Change 2002-2008	
Organization	Licensed SNF Beds	SNF Census Days	Licensed SNF Beds	SNF Census Days	Licensed SNF Beds	SNF Census Days
CHINESE	-	-	-	-		
CPMC-CPD	137	38,858	139	28,051	1.5%	-27.8%
CPMC-SLC*	79	n/a	79	24,523	0.0%	n/a
KAISER	-	-	-	-		
SFGH	215	58,547	89	31,644	-58.6%	-46.0%
SFMH	34	10,200	-	-	-100.0%	-100.0%
SMMC	32	9,256	32	8,037	0.0%	-13.2%
UCSF	-	-	-	-		
Grand Total	**418**	**116,861**	**339**	**92,255**	**-18.9%**	**-21.1%**
All California Acute Care Hospitals	**12,528**	**3,187,612**	**10,599**	**2,659,906**	**-15.4%**	**-16.6%**

Source: Office of Statewide Health Planning and Development, 2008. *St. Luke's was not affiliated with CPMC in 2002.

The CPMC plan to eliminate 135 SNF beds does not support the potential city-wide need for skilled nursing services. However, given the extent of potential need, a broader, city-wide plan will likely be needed to appropriately address the shortage.

Charity Care

The provision of charity care is a key issue for both the citizens and political leaders in the City and County of San Francisco. San Francisco is a progressive city that has created both a highly recognized safety net service (SFGH and its clinic network), as well as an innovative approach to expanding access to care (Healthy San Francisco). Assessing hospital participation in the safety net, however, requires awareness that charity care is one component of community benefit. Charity care does not include donations to non-profit clinics and shortfalls from payments for Medi-Cal patients, which are reported as community benefit. The following table provides an overview of each hospital's 2007 charity care contribution, and community benefit Medi-Cal payment shortfalls adjusted to reflect estimated cost.

Table XI – 2007 Charity Care Comparison Including Medi-Cal Community Benefit Shortfall*

System	Facility	Net Patient Revenue (NPR)	Charity Care Cost	Medi-Cal Shortfall Cost	Total	Percent of NPR
		(000's)				
California Pacific Medical Center (CPMC)						
Sutter Health	CPMC - CPD	$ 920,339	$ 3,988	$ 53,979	$ 57,967	6.3%
Sutter Health	CPMC - SLC	95,250	3,128	44,742	47,870	50.3%
Total CPMC		$ 1,015,589	$ 7,245	$ 98,722	$ 105,967	10.4%
Other Private Nonprofit Hospitals*						
Catholic Healthcare West (CHW)	SFMC	$ 135,886	$ 4,459	$ 17,823	$ 22,282	16.4%
Catholic Healthcare West (CHW)	SMMC	160,022	4,630	10,537	15,167	9.5%
Total CHW		$ 295,908	$ 9,089	$ 28,360	$ 37,449	12.7%
N/A	Chinese Hospital**	80,339	523	5,920	6,444	8.0%
University of California	UCSF Medical Center	1,369,432	4,127	193,655	197,782	14.4%

* Data not available for Kaiser Permanente's S.F. Hospital, which operates as part of a regional nonprofit health plan. All costs estimated as reported charges times cost to charge ratio, or the difference between total operating expenses and other operating revenue, divided by gross patient revenue.

** Chinese Hospital also operates a medical plan with $44.5 million in capitated revenue that provides subsidized care.

Hospitals also participate in the safety net by providing reduced or "sliding" fee schedules which adjust hospital charges for patients without insurance or of limited means. CPMC currently offers the most flexible income based guideline for receiving a discounted fee for service. The following table summarizes each hospital Federal Poverty Level (FPL) inflection point for accessing a sliding fee schedule.

Table XII – Sliding Fee Schedule Access Points

	Monthly Income by Federal Poverty Level				
	0 - 100%	101% to 200%	201% to 350%	351% to 400%	401% to 500%
CPMC	No Fee	No Fee	No Fee	No Fee	Reduced Fee
Chinese Hospital	No Fee	No Fee	No Fee	Full Fee	Full Fee
Kaiser Permanente	No Fee	No Fee	No Fee	Reduced Fee	Reduced Fee
S.F. General Hospital	No Fee	Reduced Fee	Reduced Fee	Reduced Fee	Reduced Fee
St. Francis Memorial Hospital	No Fee	No Fee	Reduced Fee	Reduced Fee	Reduced Fee
St. Mary's Medical Center	No Fee	No Fee	Reduced Fee	Reduced Fee	Reduced Fee
UCSF Medical Center	No Fee	No Fee	Reduced Fee	Reduced Fee	Reduced Fee

Source: San Francisco Department of Public Health

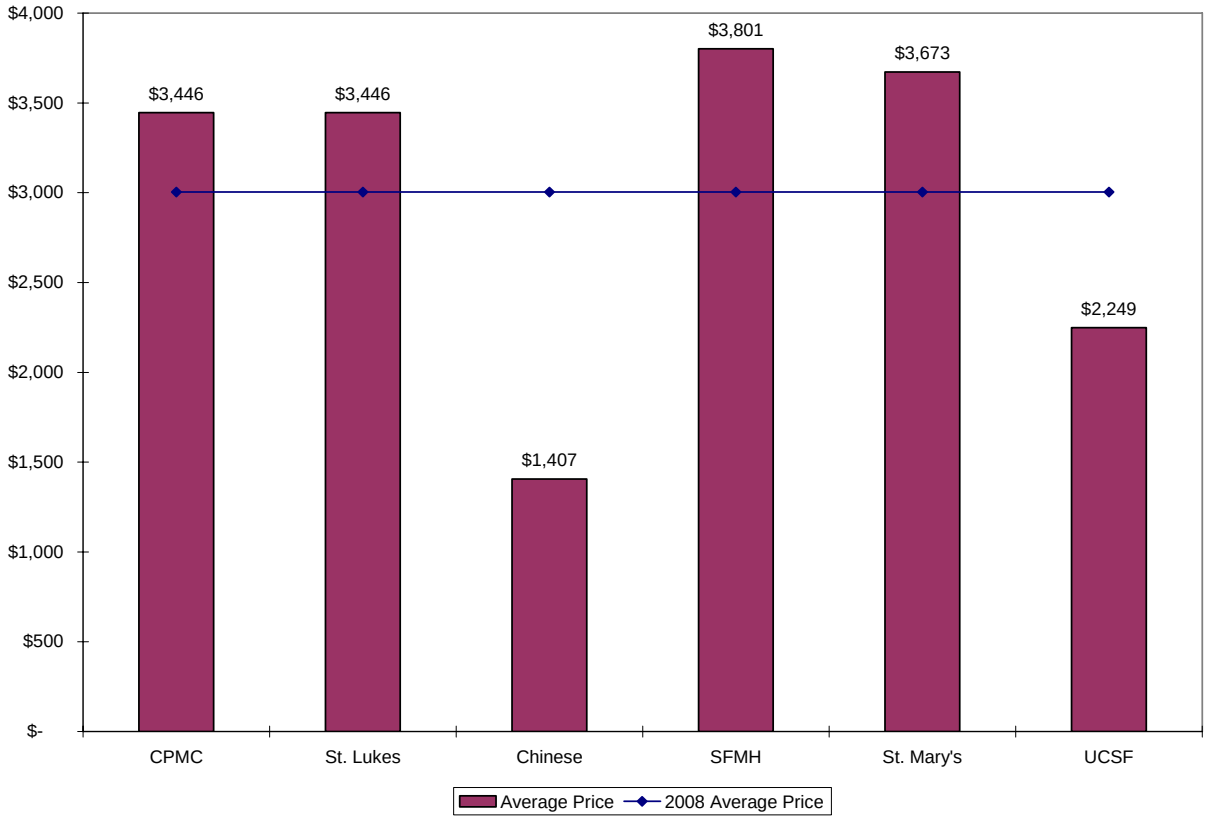
Pricing

A hospital's "charge" or the list price for a service does not necessarily reflect cost or the amount a hospital will be reimbursed by an insurer. Hospitals are reimbursed in various ways depending on the payor. For example, Medicare pays hospitals a set fee based on a fee schedule updated by the federal government on an annual basis. Commercial payors can choose to pay based on a pre-set fee schedule, a percentage of charges, or in a number of other ways. Actual prices, or charge amounts are most relevant to self-pay patients and patients with high deductible health plans, and health savings accounts (HSA), because those

persons will be directly responsible for some portion of the charge before a health plan payment is made or after a sliding fee discount is applied. Actual payments made by commercial payors to providers are highly confidential and negotiated directly between the payor and the provider. Pricing levels were evaluated utilizing three approaches:

1. Current Procedural Terminology (CPT) – CPT codes are highly standardized allowing for fairly accurate comparisons across organizations. CPT codes are primarily used to bill for physician services and outpatient procedures and visits. The following illustrate a CPT charge comparison for a CT scan of the pelvis with contrast (CPT Code 72193).

Figure IX: 2008 CPT Price Comparison for CT Pelvis w/Contrast (CPT Code 72193)



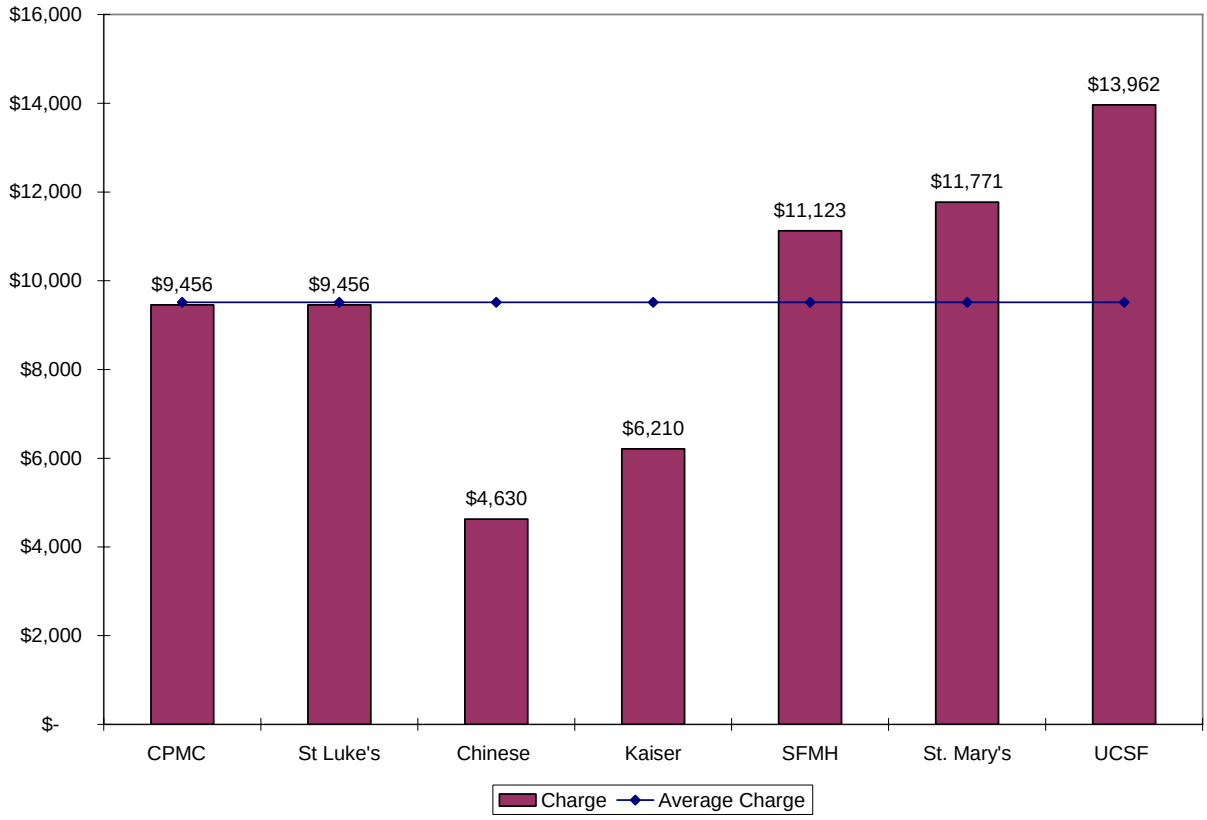
Source: Office of Statewide Health Planning and Development 2007

Pricing at Chinese Hospital is considerably below the average for hospitals reporting prices for CPT code 72193. Pricing variations at Chinese Hospital are due to a large portion of their patient population being covered by an affiliated HMO, the Chinese Community Health Plan (CCHP). CPMC pricing for CPT code 72193 is below the group average.

2. Charge Description Master (CDM) – Each hospital's CDM is a unique accumulation of all services and supplies utilized by the hospital in the course of treating patients. As a patient is treated, "charges" are attached to each service or consumable, resulting in a final bill at the time of discharge. CDMs do not have a standard format and can contain more than 10,000 items. To illustrate the difficulty in using CDM data for

charge comparisons, the following graphic contains the only room and board charge that could accurately be identified as comparable across multiple hospitals.

Figure X: 2008 CDM Price Comparison for ICU Room & Board

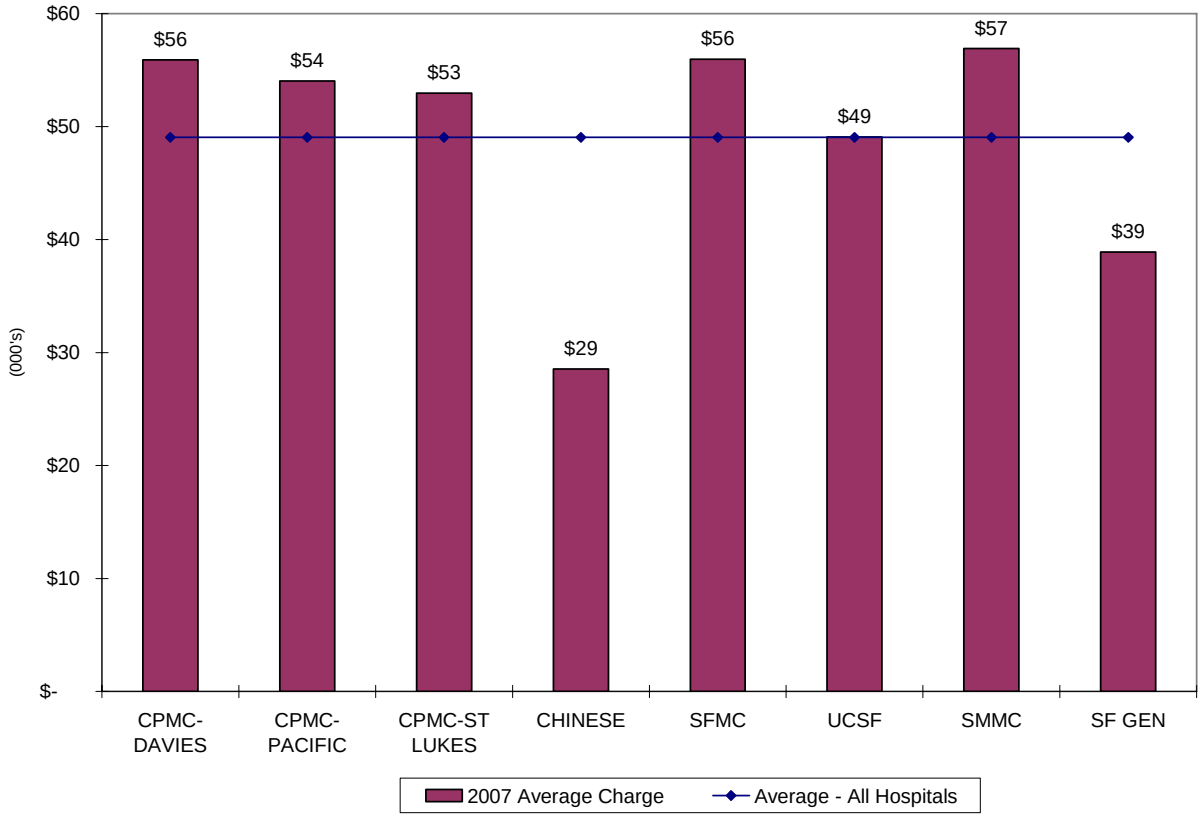


Source: Office of Statewide Health Planning and Development 2007

Since room types are structured differently at each hospital, with prices varying based on staffing, acuity and occupancy, only one comparable room type exists on all San Francisco hospital CDMs. ICU room and board charges at CPMC are below the group average.

3. Diagnosis Related Groups (DRG) – A DRG is the aggregation of individual CDM charges based on primarily on a patient's diagnosis. Medicare and some commercial payors group charges based diagnosis and make a payment based on the corresponding DRG. The average DRG charge for a specific service is a better measure of comparison for inpatient services than comparing individual CDM items.

Figure XI: 2007 DRG Price Comparison for Heart Failure (DRG 127)



Source: Medicare Provider Analysis and Review (MedPAR).

The average aggregate charge for persons with a heart failure diagnosis requiring inpatient care was approximately $49,000. CPMC hospitals charged between $53,000 and $56,000 per case. As noted earlier, the city-wide average charge per case is deflated do to pricing policies at Chinese Hospital.

Overall, the pricing analyses do not indicate that any San Francisco hospital is employing a prohibitive or excessive pricing policy.

Caregiver Training, Education and Development

Training, education and development costs are subjective in nature, in that no one comprehensive line item encompasses all financial support specifically related to these particular areas. For example, an organization may allocate costs for the use of computer equipment or space in teaching rooms and employee time spent during orientation and fire safety training to "caregiver training, education and development". In order to reasonably compare expenditures across all private hospital in the City and County of San Francisco, required under Section 97 of the City and County of San Francisco Administrative Code,

OSHPD desk audited[10] financial disclosure information from each hospital for the 2007 fiscal year was utilized to compare expenditures:

Table XIII – Education Expenditures as Reported in Annual Financial Disclosure

	CPMC	Chinese Hospital	SFMH	SMMC	UCSF
			(000's)		
Physician and Student Compensation					
Medical Postgraduate Education	7,616	-	-	709	21,466
Inservice Education - Nursing	-	-	-	-	9
Total	$ 7,616	$ -	$ -	$ 709	$ 21,475
Supplemental Trial Balance (Detail)					
Medical Postgraduate Education	2,663	88	91	5,799	7,623
Inservice Education - Nursing	3,030	191	396	735	12,731
Total	$ 5,693	$ 279	$ 487	$ 6,534	$ 20,354
Total Operating Expenses	($954,004)	($71,987)	($149,635)	($167,875)	($1,283,300)
Inservice Education - Nursing as a % of Total Operating Expenses	0.32%	0.27%	0.26%	0.44%	0.99%
Medical Postgraduate Education as a % of Total Operating Expenses	1.40%	0.39%	0.33%	4.31%	3.26%

Based on 2007 audited annual financial disclosures per OSHPD public dataset. Kaiser Foundation Hospital dataset is incomplete.

Using *Inservice Education – Nursing* to represent caregiver training, education and development, the analysis shows that proportionate to total operating expenses, St. Mary's Medical Center (SMMC) and University of California San Francisco Medical Center (UCSF) make the largest contributions to nursing education.[11] In real dollars, CPMC's expenditures are more than all other hospitals combined, excluding UCSF Medical Center.

UCSF Medical Center is a preeminent teaching hospital and SMMC sponsors a large internal medicine residency program, factors that contribute to their significant medical postgraduate education expenses.

[10] The "Audited" report contains all corrections made by the facility and OSHPD during the desk auditing process and any optional data fields calculated by OSHPD. The "Audited" report is available only after OSHPD completes its desk audit.

[11] SMMC, CPMC and Chinese each reviewed the data and agreed that without a highly standardized reporting definition for "Training, education and development," it would be difficult to develop a consistent measurement across all hospitals; therefore, using the data as presented was agreed upon as a reasonable approach, and cleared with all five private hospitals.

Interview Summary

The Lewin Group conducted interviews with stakeholders at each of the organizations listed in Table XIV to gain their perspectives on the changes proposed in the CPMC IMP. Each individual was provided with an overview of the proposed changes and an outline of the interview questions. The interview guide is provided in APPENDIX B.

Table XIV: Community Stakeholder Interviews

Asian and Pacific Islander Health Parity Coalition	San Francisco Department of Public Health (2)
Bay Area Regional Health Inequities Initiative	San Francisco Health Plan
Bayview Hunter's Point Foundation	San Francisco Interfaith Council
California Nurses Association (2)	Save St. Luke's Coalition
Chinese Hospital	Former Representative, SEIU
California Pacific Medical Center (3)	Self Help for the Elderly
Healthy San Francisco	St. Francis Memorial Hospital
Latina Breast Cancer Agency	St. Mary's Medical Center
LTC Coordinating Council	UCSF Medical Center
NICOS Chinese Health Coalition	University of California Berkeley
Peninsula Health Care District	University of California San Francisco
San Francisco Community Clinic Consortium	

Parenthesis denotes more than one person was interviewed.
A complete list of interviewees is provided in APPENDIX C.

Community and Hospital Stakeholder Interview Summary

Community and hospital stakeholders expressed varying opinions regarding the changes proposed in the CPMC IMP, but certain themes emerged during the process. There is general consensus that:

1) CPMC is a vital link in providing healthcare services to the San Francisco community. Interviewees noted the excellent quality of health care services provided at CPMC.
2) The retrofit is mandated, therefore bringing the existing facilities into SB 1953 compliance is not only necessary, but is a proactive step in ensuring that the facilities would be able to manage patients if a catastrophic event were to occur.
3) Centralizing high acuity services at the Cathedral Hill and the Davies Campus is an effective means of health care delivery, and may provide better patient outcomes.
4) The addition of acute care beds through 2015 will be beneficial to the community, as San Francisco may face a shortage of acute care beds in the over the next 10 to 20 years.[12]
5) Rebuilding St. Luke's Hospital is a key component of this plan. By ensuring access to care for residents living south of Market Street, CPMC is delivering a tangible benefit to the City's underserved populations.
6) Reducing the number of skilled nursing facility (SNF) and psychiatric beds at CPMC may have a significant impact on the San Francisco community. At peak times, patients

[12] The Lewin Group, "Market Assessment and Benchmarking Project," 2007.

requiring transitional care are being transferred out of the city because beds are not available.

7) The location of the Cathedral Hill campus would impact those currently receiving services at the California, Pacific, and Davies campuses. Many patients will have to alter their access patterns for health care services, and it is vital that CPMC properly communicate changes to residents currently utilizing these campuses.

Generally, community and hospital interviewees were receptive to the IMP proposed by CPMC. CPMC was noted for its excellence in delivering quality health care to the community of San Francisco and the majority of respondents indicated great satisfaction that St. Luke's would be rebuilt as a full service acute care hospital. The presence of a new hospital south of Market Street was seen as an essential for component of the overall project.

While interviewees identified areas such as the reduction of SNF and psychiatric beds as areas of concern, as well as the elimination of two emergency department access points, it was also recognized that CPMC is a private hospital, entitled to add or reduce beds in support of their vision for the organization. Several interviewees recommended that CPMC collaborate with the City and the other hospitals to make improvements in coordination of care and to improve availability of services to the City's underserved.

Feedback Summary – Areas of Concern

The CPMC IMP proposes to significantly alter the landscape of health care services in the San Francisco community. Community stakeholders and hospital staff identified several areas where changes resulting from the IMP would have the greatest impact. Among the areas of concern were:

1) A 78 percent reduction in the number of staffed SNF beds at the CPMC campus from 173 in 2008 to 38 in 2015. Several individuals emphasized that these reductions were not in accordance with the recommendations of the St. Luke's Blue Ribbon Panel.

2) A 50 percent reduction in the number of staffed psychiatric beds at the CPMC campus from 36 in 2008 to 18 in 2015.

3) Whether all of the campuses, particularly St. Luke's, would be completely integrated with one another, including physician privileges.

4) The ability of CPMC to complete the transfer of services from the California, Pacific and Davies campuses to the Cathedral Hill campus without interruption to service delivery.

5) The ability of CPMC to undertake the projects given the economic climate.

6) The location of the Cathedral Hill campus at a highly trafficked intersection of Van Ness and Geary.

7) The financial impact of the new Cathedral Hill campus on St. Francis Memorial Hospital and Chinese Hospital.

SNF Beds

The largest concern voiced by community and hospital staff was the potential 78 percent reduction of staffed skilled nursing facility beds from 173 in 2008 to 38 in 2015. Interviewees noted that an aging baby boomer population combined with a decrease in SNF beds may create a shortage of SNF beds in San Francisco. Combined with the loss of SNF beds at Laguna Honda Hospital and St. Francis Memorial Hospital, San Francisco may not be adequately prepared to care for its senior population. Interviewees mentioned the need for improved transitional care from acute to sub-acute to rehab facilities, with several stating that a good plan for discharge could help counter a reduction in SNF beds.

Psychiatric Beds

Another concern raised by interviewees was the potential reduction in staffed psychiatric beds from 36 in 2008 to 18 in 2015. Interviewees did note, however, that both within San Francisco and nationally, there is increasing emphasis being placed on treatment of mental health patients within outpatient and residential facilities as alternatives to inpatient psychiatric beds. The need for greater coordination between CPMC and outpatient psychiatric facilities was highlighted given the potential reduction in psychiatric beds at CPMC.

Integration of Services

Several interviewees expressed concern whether there is a serious intent by CPMC to make St. Luke's a viable part of the CPMC system. Stakeholders generally viewed the rebuild of St. Luke's as a positive concession made by CPMC to the community. However, the physical boundaries in terms of location, as well as the lack of incorporation of service lines and physician networks across hospitals led many to express concern.

Transfer of Services

Interviewees, particularly community stakeholders, expressed concern that the transfer of services to the Cathedral Hill campus would disrupt health care service delivery. Several interviewees noted that having services located within the neighborhood that patients live in is crucial for access. Often, particularly in the senior population, housing choices are dictated by proximity to health care services. Notably, the Pacific campus has a large elderly concentration which will be impacted by the transfer of services to the Cathedral Hill campus. However, interviewees also noted that due to seismic mandates, changes to service delivery are inevitable, with gradual adjustment to change a natural part of the process.

Feedback Summary – Other Suggestions

Representatives of each group did provide suggestions for CPMC that would strengthen the delivery of health care services within San Francisco. Among the suggestions were:

a) Properly integrate with outpatient long-term care (LTC) and psychiatric facilities. Improve transitional care for the senior population and address residential needs.

b) Improve organizational profile to build trust in the community.

c) Focus their efforts more broadly on the health care needs of the city and county and form a comprehensive planning perspective that incorporates the input of the SFDPH and other San Francisco hospitals.

d) Provide programs designed to address chronic disease management, as the population of San Francisco continues to age.

e) Create a Center of Excellence for Senior Health Services.

f) Fully integrate all campuses to provide a continuum of health care services across San Francisco.

The majority of the recommendations concerned more adequately caring for the senior population. Many interviewees noted the aging of the baby boomer population as a potential concern for the health care system of San Francisco, with a more devoted community-wide strategic planning of health care service provision necessary for the elderly. Some suggestions for the Center for Excellence for Senior Health Services were providing improved transportation services for the elderly, and preventing, where possible, transferring elderly patients to out-of-county to SNF beds.

Several interviewees noted that the IMP focused on hospital based services, and that a comprehensive strategic plan for health care services in San Francisco, incorporating outpatient and community services, would improve the long term viability of healthcare services in San Francisco. Further, proper integration of CPMC inpatient services with both long-term care facilities and outpatient psychiatric was consistently stressed throughout the interview process.

Lastly, based on community input, it is imperative that St. Luke's Hospital be rebuilt. There is a general concern that this component of the IMP may never actually be realized.

IMPACT OF THE CPMC IMP AND CONCLUSION

The plans outlined in the CPMC IMP will mitigate the long-term potential for an acute bed shortage in the City of San Francisco, as well as ensure that facilities are sustainable in the event of a catastrophic event. However, full execution of the IMP will further stress the system's capacity to treat and care for patients requiring transitional care, chronic condition support and inpatient mental health services. Given the findings of the St. Luke's Blue Ribbon Panel and community feedback, it will be essential to coordinate with the Long-Term Care Coordinating Council as well as psychiatric outpatient facilities to properly manage mental health and elderly patients.

Community group representatives and San Francisco hospital and clinic leadership provided generally circumspect, positive support for the CPMC IMP. Based on those interviews and our analyses, The Lewin Group finds that the plans articulated in the CPMC IMP represent a positive impact on citywide healthcare needs, based on the following key considerations:

- *Blue Ribbon Panel Recommendations and Quality*

  A blue ribbon panel convened by CPMC to provide insight and suggestions relating to the future of the St. Luke's Campus articulated approximately 26 recommendations. Based on our analysis of the plan for St. Luke's Campus, as described in the IMP, only the absence of skilled nursing beds at the replacement facility does not conform to the panels' recommendations. We strongly concur with the panel's recommendation that CPMC "engage in problem solving on the provision of beds/units for "Sub-Acute" regional patients". A complete list of the recommendations is included in Appendix B.

  From a quality perspective, it was widely acknowledged by the interviewees that CPMC provides a high level of care and offers tertiary services that are vital to the City. Additionally, the consolidation of certain services such as neuroscience, women's health, and pediatrics, is considered to be an evidence-based, quality-focused initiative.

  Lastly, CPMC has been recognized by a number of national organizations that monitor quality and performance, including:

  - Leapfrog Top Hospital Award for Quality and Safety (2008)
  - American Stroke Association's Gold Performance Achievement Award (2008)
  - U.S. News & World Report Best Hospitals for Gastrointestinal Disorders (2008)
  - National Committee for Quality Assurance (NCQA) Physician Recognition Award - Back Pain Recognition Program (2007)
  - Voluntary Hospitals of America (VHA) West Coast Performance Awards (2007)
  - American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) Special Quality Award (2007)
  - Joint Commission Primary Stroke Center Certification (2006)
  - Accreditation by the Society of Chest Pain Centers (2006)
  - UnitedHealth Premium Cardiac Specialty Designation (2006)

- *Pricing Analysis and Financing*

CPMC pricing for healthcare services appears reasonable compared to local provider medians, based on our analysis of CPT, CDM and DRG pricing data for San Francisco hospitals. CPMC's ability to finance this project without debt financing and without a request for municipal funding demonstrates solid financial stewardship. The CPMC financing plan alleviates the need to for the City and County of San Francisco to provide assurances or make contributions to a project that in part aims to ensure the availability of healthcare services in the event of a major earthquake.

- *Access and Charity Care*

While a number of interviewees suggested that CPMC should more evenly distribute new beds across all campuses, the consolidation of services at the Cathedral Hill location does not create any significant access issues from the perspective of patient orientation. Based on a transportation study commissioned by CPMC, the proposed Cathedral Hill Campus is within a two-block radius of nine San Francisco Municipal Railway lines and seven regional access points based on services provided by the Golden Gate Bridge, Highway, and Transportation District. The proposed Cathedral Hill Campus is approximately 2.2 miles from the California Campus and 0.9 miles from the Pacific Campus.

CPMC provides charity care to low income patients in San Francisco, although their support is proportionally lower than the contributions made by CHW hospitals. CPMC plays a major role in the Healthy San Francisco delivery model and the St. Luke's campus provides services to some the City's most deprived neighborhoods. It also contributes approximately $1.3 million in direct support funding for community health organizations and to the Bayview Child Health Center which opened in 2007. CPMC is an important component in the City's public health and indigent care network.

Lastly, the plan proposed in the IMP will add additional acute staffed beds, emergency department capacity, diagnostic and testing resource availability, and outpatient care access points. These additional proposed services represent a significant increase in the availability of healthcare services in San Francisco. At the same time, CPMC is recommending a substantial reduction in skilled nursing and inpatient mental health services.

Our conclusion is contingent upon CPMC providing the Long Term Care Coordinating Council with a detailed plan that addresses their role in supporting the needs of transitional care, elderly, and psychiatric patients. Consistent with the Blue Ribbon Panel recommendations, we believe that CPMC's leadership and organizational know-how can only serve to, in collaboration with public and private organizations, build a sustainable system for the delivery of sub-acute and psychiatric care to the citizens of San Francisco.

APPENDIX A
Summary of Changes Proposed in 2008 CPMC IMP

	Scope of Work	Project Schedule
Cathedral Hill Campus		
Cathedral Hill Hospital	▪ Demolish Cathedral Hill Hotel (402 room hotel), and the 1255 Post Street Office Building	▪ Demolition: 8/2010 – 6/2011
	▪ Build new 555-bed, 15-story, 925,700 square-foot acute care and women and children's hospital ▪ Build 245,000 square-foot underground parking garage	▪ Excavation, Construction: 3/2011 – 12/2014
Cathedral Hill Medical Office Building	▪ Demolish seven existing buildings	▪ Demolition: 8/2010 – 3/2011
	▪ Build new 502,000 square-foot Cathedral Hill Medical Office Building (MOB)	▪ Construction: 4/2011 – 7/2014
Van Ness Tunnel	▪ Build Van Ness Avenue Tunnel	▪ Construction: 11/2011 – 3/2014
Sutter Street Building	▪ Renovate 1375 Sutter Street Building	▪ Renovation complete by 2014
California Campus		
Sale of Campus	▪ Sell California Campus	▪ Sale completed by 2013
	▪ Transfer acute care services to Cathedral Hill Campus	▪ Completed by 2015
	▪ Transfer ambulatory services to Pacific Campus	▪ Completed by 2016
	▪ Transfer remaining services to Pacific Campus	▪ Completed by 2018
	▪ Establish free-standing outpatient imaging services on California Campus	▪ Completed by 2019
Pacific Campus		
2329 Sacramento Street	▪ Renovate or rebuild residential apartment building	▪ Begin as early as 2010; unclear of a completion date
Conversion to Ambulatory Care Center	▪ Transfer acute care and emergency departments to new Cathedral Hill Hospital ▪ Renovate 2333 Buchanan Street	▪ Begin in early 2015 and extend until the middle of 2016
Ambulatory Care Center Addition	▪ Demolish Gerbode Research Building, Stanford Building, and Annex Building	▪ Mid-2016 – 2018
	▪ Construct new Webster/Sacramento Street underground parking garage	▪ Completed by mid-2019
	▪ Construct 204,916 square-foot addition to the Ambulatory Care Center	▪ Completed by mid-2019
Additional Parking	▪ Construct North Clay Parking Garage ▪ Renovate 2018 Webster Street Parking Garage	▪ Completed by 2020
2018 Webster Street	▪ Convert 2018 Webster Street from residential to office building	▪ No Completion Date set

	Scope of Work	Project Schedule
Davies Campus		
North Tower	▪ Completed seismic upgrades to meet SB 1953 requirements	▪ Completed in 2007
Acute Rehab Services	▪ Relocate acute rehabilitation services from the South Tower to the North Tower	▪ Expected to be completed in 2010
Neuroscience Institute	▪ Consolidate neuroscience programs on the Davies Campus in a new MOB *(Project approved by SF Planning Commission but SF Board of Supervisors voted for it to be evaluated in context of seismic upgrade work).*	▪ If approved will begin in 2010 and finish in 2012
New MOB and Underground Parking	▪ Replace current parking garage with MOB with underground parking	▪ Begin in 2018 and finished in 2020
St. Luke's Campus		
New Replacement Hospital	▪ Construct new 86-bed acute care replacement hospital	▪ Constructed by 2014
Renovation of 1957 Building	▪ Renovate interior including structural and cosmetic upgrades. Move emergency department and operating rooms to new hospital.	▪ Once new hospital is built
	▪ Demolish old hospital and build new expansion building on same site, upon completion of new hospital.	▪ Once new hospital is built

APPENDIX B
The Lewin Group Interview Guide

Please note: The bed progression tables contained in the original interview guide were later amended to reflect CPMC's omission of 18 psychiatry beds in their original 2008 Environmental Evaluation Application (EEA). A revision to the EEA, which reflects continued operation of 18 licensed psychiatry beds, has been submitted by CPMC.

Also, the original interview panel was supplemented throughout the IMP review process.

LEWIN GROUP INTERVIEW GUIDE

California Pacific Medical Center Institutional Master Plan

Thank you very much for agreeing to participate in a discussion regarding the changes proposed in California Pacific Medical Center's (CPMC) Institutional Master Plan (IMP). Our firm, The Lewin Group, has been engaged by the San Francisco Department of Public Health to provide an independent assessment of the CPMC IMP. Our assessment, in compliance with section 304.5 of the San Francisco Planning Code, will focus on four key areas:

- The current and projected healthcare needs of Bay Area residents
- The potential impact of CPMC's IMP on city-wide access to healthcare services
- The potential impact of CPMC's IMP on individual constituencies, populations, and other organizations that provide healthcare services to the citizens of San Francisco
- The potential impact of CPMC's plan on the regional health economy

Attachment I provides a detailed summary of changes described in the CPMC IMP, Attachment II provides a timeline that illustrates the progression of events as proposed by CPMC, and Attachment III includes two maps that illustrate current and planned inpatient facilities in the Bay Area.

Introduction

CPMC has developed an ambitious plan that involves sweeping changes to the organization's existing footprint and an investment estimated to exceed $2.3 billion. Based on the plans outlined in the 2008 IMP, CPMC will:

- Build an entirely new 3.85 acre campus with a 555-bed acute care hospital as its centerpiece (Cathedral Hill) by 2015. The Cathedral Hill hospital will provide general acute inpatient and outpatient care, and consolidate most women's and children's services into a single Center of Excellence[13]. This component of the IMP is anticipated to be completed in 2015.
- Replace St. Luke's existing hospital with a smaller, seismic-compliant facility near the existing campus. St. Luke's is not compliant with current standards as mandated by SB 1953, and CPMC has deemed a retrofit too costly. In 2014, a new St. Luke's Hospital will have 53 fewer staffed beds, primarily due to the elimination of a skilled nursing facility (SNF). The new campus will continue to provide general acute care services, such as maternity and emergency services, as well as a senior health Center of Excellence.
- Convert the existing full service medical center at CPMC's Pacific Campus to an ambulatory care center, eliminating 298 staffed acute care beds as well as an emergency room and inpatient psychiatric services. This conversion is contingent on the development of the Cathedral Hill campus and would not begin until 2014/2015.
- Eliminate all but imaging services from what is now a full service medical center (California Campus) by 2019.

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[13] Center of Excellence typically refers to a healthcare delivery philosophy where collaborative care, research and training are delivered in a single entity by teams of specialized professionals. Official designation can be obtained from an array of organizations, such as medical societies, insurers and the federal government.

- Consolidate neuroscience care, including acute rehabilitation, into a single Center of Excellence on the Davies Campus (2010/2012).

In addition to the major events outlined above, CPMC will build or renovate medical office buildings on each of the campuses, and address parking structures, pedestrian walkways and other infrastructure. The plan, on the whole, is reportedly designed to create a more service centralized, integrated and seismically compliant health system. The changes in service delivery anticipate that more and more care will be provided in an outpatient setting, reflected most strikingly in the closure of two inpatient facilities. The following tables provide a summary of the projected changes to staffed and licensed beds across all CMPC facilities:

Table I – CPMC Staffed Bed Progression

	2004	2008	*Change 04-08*	2010	*Change 08-10*	2015	*Change 08-15*
Pacific							
Acute	282	282	*0%*	282	*0%*	0	*-100%*
Psych	30	16	*-47%*	18	*13%*	0	*-100%*
Total	312	298	*-4%*	300	*1%*	0	*-100%*
California (East)							
Acute	0	0	*n/a*	0	*n/a*	0	*n/a*
SNF	87	56	*-36%*	0	*-100%*	0	*-100%*
Total	87	56	*-36%*	0	*-100%*	0	*n/a*
California (West)							
Acute	129	186	*44%*	186	*0%*	0	*-100%*
Davies							
Acute	144	100	*-31%*	100	*0%*	100	*0%*
Rehab	32	32	*0%*	48	*50%*	48	*50%*
Psych	20	20	*0%*	0	*-100%*	0	*-100%*
SNF	42	38	*-10%*	38	*0%*	38	*0%*
Total	238	190	*-20%*	186	*-2%*	186	*-2%*
St. Luke's							
Acute	60	60	*0%*	60	*0%*	86	*43%*
Psych	31	0	*-100%*	0	*n/a*	0	*n/a*
SNF	79	79	*0%*	39	*-51%*	0	*-100%*
Total	170	139	*-18%*	99	*-29%*	86	*-38%*
Cathedral Hill							
Acute						555	
Total CPMC							
Acute	615	628	*2%*	628	*0%*	741	*18%*
Rehab	32	32	*0%*	48	*50%*	48	*50%*
Psych	81	36	*-56%*	18	*-50%*	-	*-100%*
SNF	208	173	*-17%*	77	*-55%*	38	*-78%*
Total	936	869	*-7%*	771	*-11%*	827	*-5%*

Source*: 2008 Environmental Evaluation Application submitted by CPMC, February 2008.*

Staffed beds are defined by the Office of Statewide Healthcare Planning and Development (OSHPD) as "those beds that are set-up, staffed, and in all respects, ready for use by patients remaining in the hospital overnight." Staffed beds differ from licensed beds as licensed beds do not necessarily need to be in use or even in existence.

Table II – CPMC Licensed Bed Progression

	2004	2008	*Change 04-08*	2010	*Change 08-10*	2015	*Change 08-15*
Pacific							
Acute	295	295	*0%*	295	*0%*	0	*-100%*
Psych	30	18	*-40%*	18	*0%*	0	*-100%*
	325	313	*-4%*	313	*0%*	0	*-100%*
California (East)							
Acute	95	0	*-100%*	0	*n/a*	0	*n/a*
SNF	95	101	*6%*	0	*-100%*	0	*-100%*
	190	101	*-47%*	0	*-100%*	0	
California (West)							
Acute	382	299	*-22%*	299	*0%*	0	*-100%*
Davies							
Acute	247	219	*-11%*	115	*-47%*	115	*-47%*
Rehab	32	32	*0%*	48	*50%*	48	*50%*
Psych	20	22	*10%*	0	*-100%*	0	*-100%*
SNF	42	38	*-10%*	38	*0%*	38	*0%*
	341	311	*-9%*	201	*-35%*	201	*-35%*
St. Luke's							
Acute	150	150	*0%*	150	*0%*	86	*-43%*
Psych	31	0	*-100%*	0	*n/a*	0	*n/a*
SNF	79	79	*0%*	79	*0%*	0	*-100%*
	260	229	*-12%*	229	*0%*	86	*-62%*
Cathedral Hill							
Acute						555	
Total CPMC							
Acute	1,169	963	*-18%*	859	*-11%*	756	*-21%*
Rehab	32	32	*0%*	48	*50%*	48	*50%*
Psych	81	40	*-51%*	18	*-55%*	-	*-100%*
SNF	216	218	*1%*	117	*-46%*	38	*-83%*
	1,498	1,253	*-16%*	1,042	*-17%*	842	*-33%*

Source*: 2008 Environmental Evaluation Application submitted by CPMC, February 2008.*

Both licensed and staffed beds will be eliminated during the course of the project, with the most dramatic changes occurring in the areas of psychiatry and skilled nursing.

Interview Guide

You or your organization was identified as a leader in San Francisco's health care community. A complete list of organizations contacted for this study is provided as Attachment IV. Through this interview we hope to gain additional insight on the potential impact of the changes proposed in the CPMC IMP. Your responses will remain confidential, but will be presented in a summary format as part of our final report to the DPH. While we are interested in your general insight, we have also developed the following questions to help guide our discussion. The questions have been designed to reach a broad range of individuals and organizations, including community advocates, physicians, hospitals, insurers, and labor representatives. Please feel free to focus only on those questions most important to you.

Perspective on Community Health Needs

1) What would you say are the key health care needs of people living in San Francisco today?
2) How have these changed over time? How might they differ in 5, 10, or 20 years?
3) What population or populations are likeliest to be underserved in the next four years, assuming no major healthcare reform passes? What do you see as the greatest challenges to health in San Francisco?
4) How do you see the "baby boomers" impacting the system?

Perspective on California Pacific Medical Center

5) What is your relationship with California Pacific Medical Center?
6) Are there specific health needs that CPMC hospitals address in the community about which you have expertise?
7) How would you define the role CPMC plays in addressing the health care needs of San Francisco residents?

Perspective on California Pacific Medical Center IMP

8) Prior to receiving this correspondence, were you familiar with the changes proposed in CPMC's Institutional Master Plan?
9) What are its strengths/weaknesses?
10) How might the changes impact other Bay Area providers, payors and/or social service agencies?
11) Are there any specific changes proposed in the IMP that might have a significant impact on a particular constituency or population?
12) From your perspective, how might the community benefit from the changes being proposed? How might the changes disrupt the delivery of healthcare services?

General Perspective

13) How does the economic climate influence your perspective on CPMC's plans?
14) How do you foresee local, regional or national policy decisions impacting healthcare delivery in the Bay Area?
15) If fully executed, what impact might the new CPMC "structure" have on physicians and nurses? What impact might it have on the larger healthcare workforce? What impact on patients?
16) If you were asked today to support the CPMC IMP, what would be your response?
    a. If you would support the plan, what aspects of it were most important in shaping your decision?
    b. If you would not support the plan, what variations might have changed your decision?

California Pacific Medical Center

Summary of Changes Proposed by CPMC

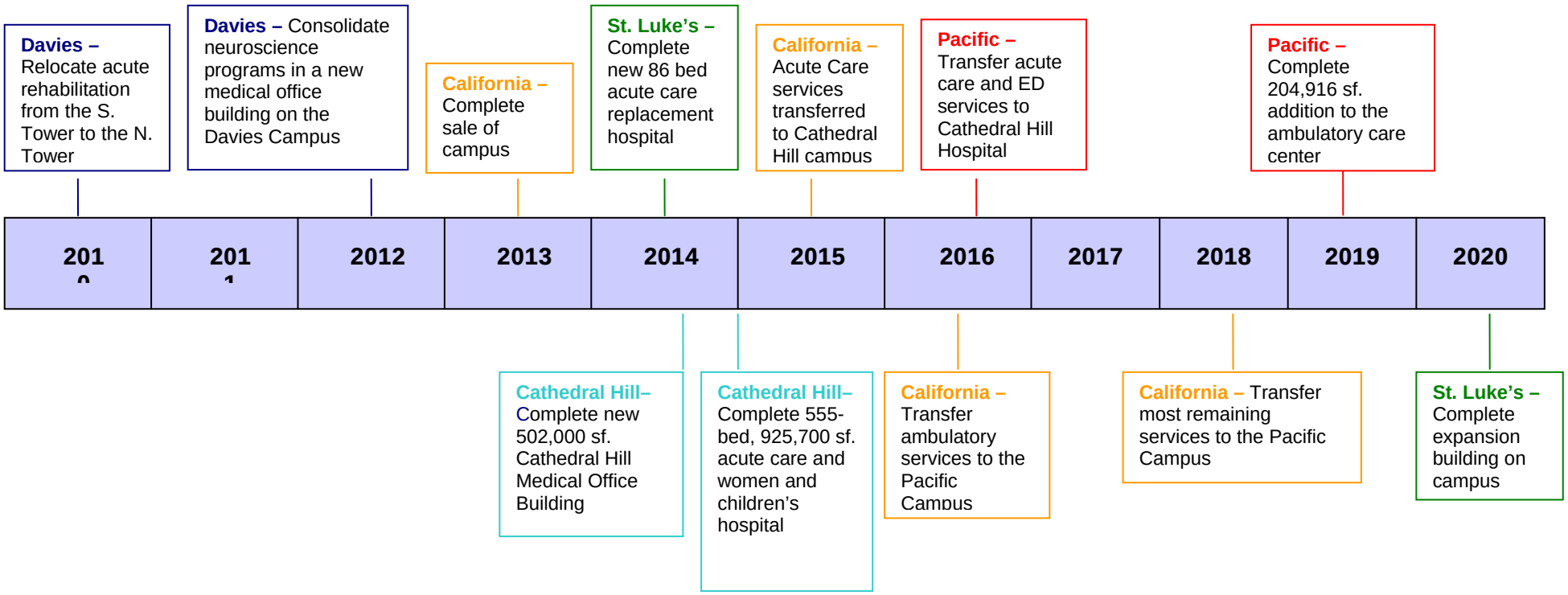
	Likelihood	Scope of Work	Project Schedule
Cathedral Hill Campus			
Cathedral Hill Hospital	Concrete	▪ Demolish Cathedral Hill Hotel (402 room hotel), and the 1255 Post Street Office Building ▪ Build new 555-bed, 15-story, 925,700 square-foot acute care and women and children's hospital ▪ Build 245,000 square-foot underground parking garage	▪ Demolition: 8/2010 – 6/2011 ▪ Excavation, Construction: 3/2011 – 12/2014
Cathedral Hill Medical Office Building	Concrete	▪ Demolish seven existing buildings ▪ Build new 502,000 square-foot Cathedral Hill Medical Office Building (MOB)	▪ Demolition: 8/2010 – 3/2011 ▪ Construction: 4/2011 – 7/2014
Van Ness Tunnel	Concrete	▪ Build Van Ness Avenue Tunnel	▪ Construction: 11/2011 – 3/2014
Sutter Street Building	Concrete	▪ Renovate 1375 Sutter Street Building	▪ Renovation complete by 2014
California Campus			
Sale of Campus	Vague	▪ Sell California Campus ▪ Transfer acute care services to Cathedral Hill Campus ▪ Transfer ambulatory services to Pacific Campus ▪ Transfer remaining services to Pacific Campus ▪ Establish free-standing outpatient imaging services on California Campus	▪ Sale completed by 2013 ▪ Completed by 2015 ▪ Completed by 2016 ▪ Completed by 2018 ▪ Completed by 2019
Pacific Campus			
2329 Sacramento Street	Vague	▪ Renovate or rebuild residential apartment building	▪ Begin as early as 2010; unclear of a completion date
Conversion to Ambulatory Care Center	Vague	▪ Transfer acute care and emergency departments to new Cathedral Hill Hospital ▪ Renovate 2333 Buchanan Street	▪ Begin in early 2015 and extend until the middle of 2016
Ambulatory Care Center Addition	Vague	▪ Demolish Gerbode Research Building, Stanford Building, and Annex Building ▪ Construct new Webster/Sacramento Street underground parking garage ▪ Construct 204,916 square-foot addition to the Ambulatory Care Center	▪ Mid-2016 – 2018 ▪ Completed by mid-2019
Additional Parking	Vague	▪ Construct North Clay Parking Garage ▪ Renovate 2018 Webster Street Parking Garage	▪ Completed by 2020
2018 Webster Street	Vague	▪ Convert 2018 Webster Street from residential to office building	▪ No Completion Date set

California Pacific Medical Center

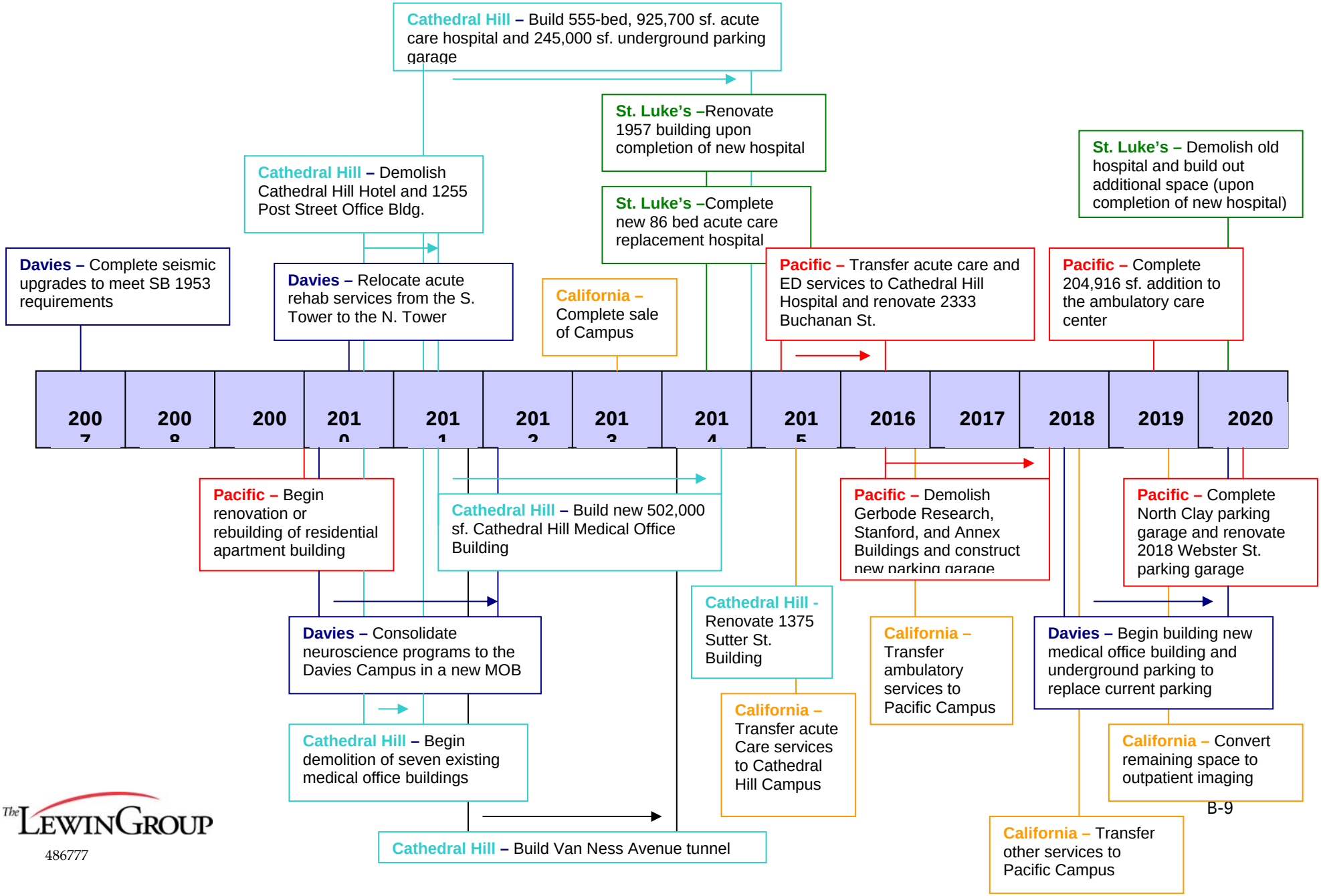
Summary of Changes Proposed by CPMC *(continued)*

	Likelihood	Scope of Work	Project Schedule
Davies Campus			
North Tower	Completed	▪ Completed seismic upgrades to meet SB 1953 requirements	▪ Completed in 2007
Acute Rehab Services	Concrete (underway)	▪ Relocate acute rehabilitation services from the South Tower to the North Tower	▪ Expected to be completed in 2010
Neuroscience Institute	Planned	▪ Consolidate neuroscience programs on the Davies Campus in a new MOB *(Project approved by SF Planning Commission but SF Board of Supervisors voted for it to be evaluated in context of seismic upgrade work).*	▪ If approved will begin in 2010 and finish in 2012
New MOB and Underground Parking	Planned	▪ Replace current parking garage with MOB with underground parking	▪ Begin in 2018 and finished in 2020
St. Luke's Campus			
New Replacement Hospital	Concrete	▪ Construct new 86-bed acute care replacement hospital	▪ Constructed by 2014
Renovation of 1957 Building	Concrete	▪ Renovate interior including structural and cosmetic upgrades. Move emergency department and operating rooms to new hospital.	▪ Once new hospital is built
Future Expansion Building	Planned	▪ Demolish old hospital and build new expansion building on same site, upon completion of new hospital.	▪ Building would be occupied around 2020

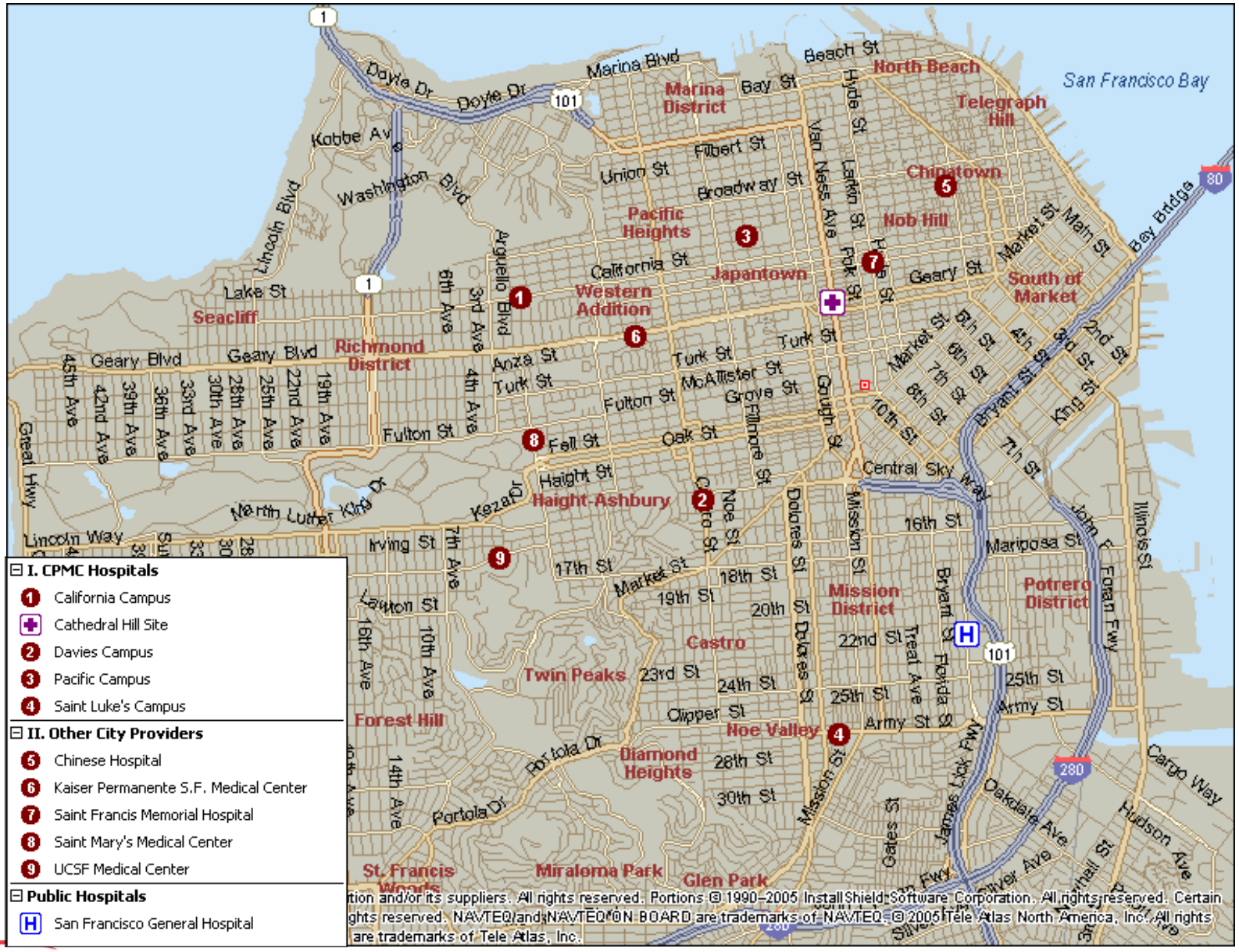
Timeline for Major Delivery Changes based on the 2008 CPMC Institutional Master Plan



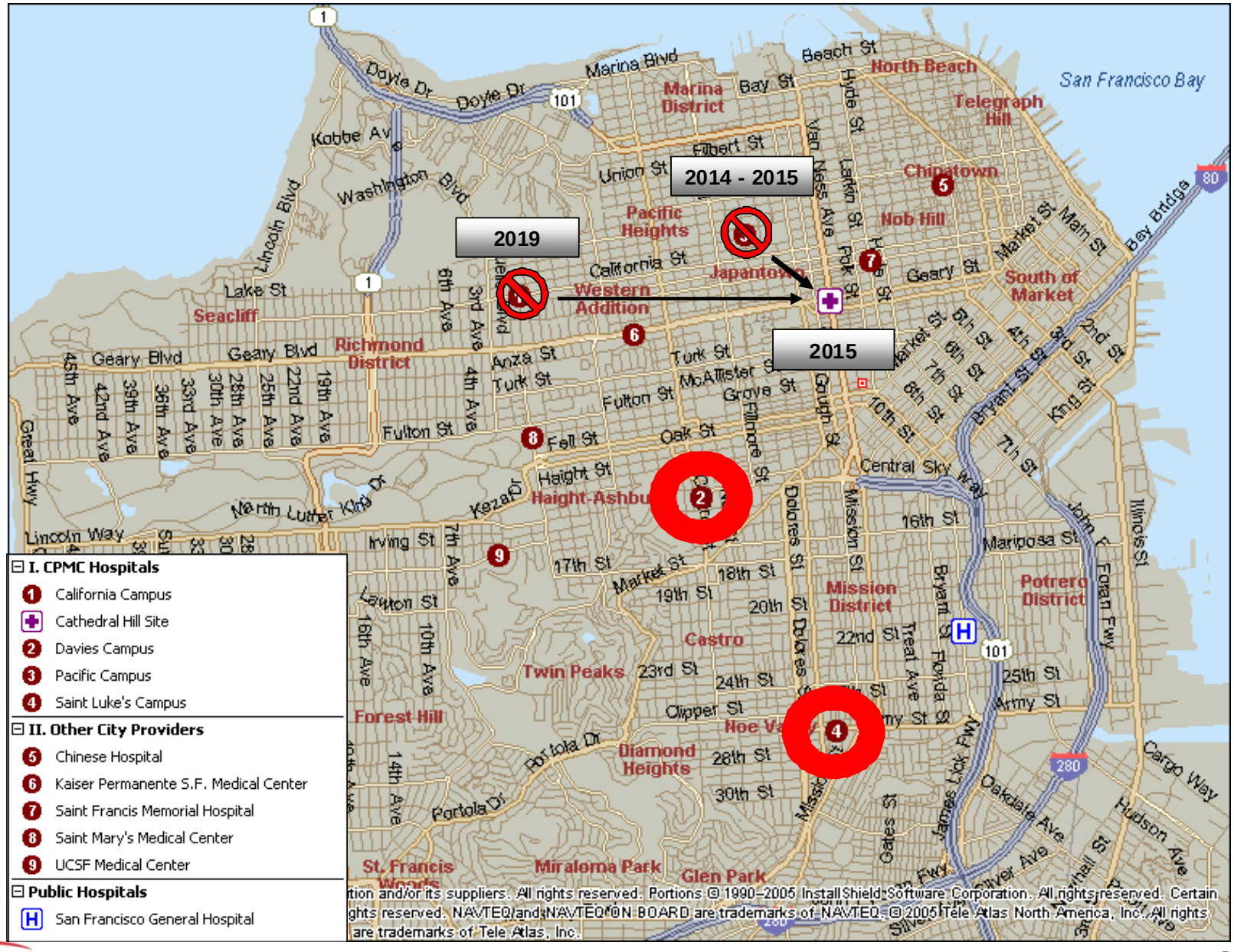
Timeline for All Proposed Changes based on the 2008 CPMC Institutional Master Plan



Current and Planned Bay Area Inpatient Facilities



2019 CPMC Bay Area Footprint



California Pacific Medical Center

Preliminary Thought Leadership Interview Panel

African-American Health Leadership Group	Perry Lang	Director of Wellness and Public Advocacy, Black Coalition on AIDS
	Jimmy Loyce	Executive Director, Black Coalition on AIDS
Arthur H. Coleman Medical Center	Pat Coleman and/or Marilyn Metz, MD	Founder, Community Foundation; Executive Director
Asian and Pacific Islander Health Parity Coalition	Doreen Der-McLeod	Executive Director, Cameron House
Bay Area Regional Health Inequities Initiative	Bob Prentice, PhD	Director
Bayview Hunter's Point Foundation	Jacob Moody, MDiv, MSW	Executive Director
Chicano/Latino/Indigena Social Justice and Health Equity Planning Group (CARECEN)	Ana Perez	Executive Director, CARECEN
Instituto Familiar de la Raza	Estela Garcia	Executive Director, Instituto Familiar de Raza
Latina Breast Cancer Agency	Olivia Fe	Executive Director
Peninsula Health Care District	Cheryl Fama	Executive Director, former CEO of St. Francis Hospital
San Francisco Community Clinic Consortium	John Gressman	President and CEO
Save St. Luke's Coalition	Kenneth Barnes, MD	MD
Self Help for the Elderly	Anni Chung, MSW	President and CEO
Westside Community Services	Donald Frazier	Deputy Executive Director
LTC Coordinating Council	Bill Haskell	Facilitator
NICOS Chinese Health Coalition	Kent Woo	Executive Director
Mission Neighborhood Health Center	Brenda Storey	Executive Director
Calvary Hill Community Church	Joseph Bryant Jr.	Reverend
Metropolitan Baptist Church	Shad Riddick	Reverend
San Francisco Interfaith Council	Michael Pappas	Executive Director

APPENDIX C
Interview Schedule

Organization	First Name	Last Name	Title	Status
Asian and Pacific Islander Health Parity Coalition	Doreen	Der-McLeod	Executive Director - Cameron House	Interview: Thursday, 4/30 @ 1 PM EST
Bay Area Regional Health Inequities Initiative	Bob	Prentice	Director	Interview: Monday, 4/20 @ 6 PM EST
Bayview Hunter's Point Foundation	Jacob	Moody	Executive Director	Interview: Tuesday, 4/21 @ 5 PM EST
California Nurses Association	Nato	Green	Labor Representative	Interview: Thursday, 5/7 @ 12:30 PM EST
California Nurses Association	Michael	Lighty	Director of Public Policy	Interview: Tuesday, 5/19 at 9:30 AM PST
Chinese Hospital	Yee	Brenda	CEO	Interview: Thursday , 5/7 @ 5 PM EST
CPMC	Judy	Li	Vice President, Health System Innovation and Community Benefit	Discussion: Friday, 5/8 @ 12:30 PM EST; Mary Lanier to join.
CPMC	Massehian	Vahram	Sr. Project Manager	Discussion: Tuesday, 4/28 @ 1:30 PM EST; Judy Lee & Jeffrey Nelson to join.
CPMC	Brotman	Martin	CEO	Interview: Monday, 5/18 @ 1 PM EST; Dr. Brotman and Dr. Browner
CPMC	Browner	Warren	Incoming CEO (Replacing Martin Brotman)	Interview: Monday, 5/18 @ 1 PM EST; Dr. Brotman and Dr. Browner
Latina Breast Cancer Agency	Olivia	Fe	Executive Director	Interview: Tuesday, 4/28 @ 2 PM EST
LTC Coordinating Council	Bill	Haskell	Facilitator	Interview: Tuesday, 4/28 @ 3 PM EST
NICOS Chinese Health Coalition	Kent	Woo	Executive Director	Interview: Tuesday, 4/28 @ 4 PM EST
Peninsula Health Care District, former CEO of St. Francis Hospital	Cheryl	Fama	Executive Director	Interview: Wednesday, 4/29 @ 1 PM EST
San Francisco Community Clinic Consortium	John	Gressman	President and CEO	Interview: Friday, 5/15 @ 12:45 PM EST
San Francisco Department of Public Health	Tangerine M.	Brigham	Deputy Director of Health & Director of Healthy San Francisco	Interview: Thursday, 5/28 @ 12 PM PST
San Francisco Department of Public Health	Mitch	Katz	Director of Health	Interview: Wednesday, 5/27 @ 10 AM PST
San Francisco Health Plan	John	Grgurina	CEO	Interview: Friday, 5/15 @ 12 PM EST
San Francisco Interfaith Council	Michael	Pappas		Interview: Friday, 4/24 @ 4 PM EST
Save St. Luke's Coalition (www.savestlukes.org)	Kenneth	Barnes		Interview: Friday, 4/24 @ 6:30 PM EST
Self Help for the Elderly	Anni	Chung	President & CEO	Interview: Tuesday, 5/5 @ 12 PM EST
St. Francis Memorial Hospital	Hennessy	Tom	CEO	Interview: Wednesday, 5/19 @ 10 PM EST
St. Mary's Medical Center	Chung	Anna	CEO	Interview: Thursday, 5/14 @ 12 PM EST
UCSF	Laret	Mark	CEO	Interview: Wednesday, 4/29 @ 3 PM EST; Jay Harris, Director of Strategic Planning will join.
United Health Workers (formerly with SEIU)	Paul	Kumar	Administrative Vice President	Interview: Wednesday, 6/3 @ 8:45 PM EST
University of California Berkeley	Stephen	Shortell	Dean, School of Public Health	Interview: Wednesday, 5/6 @ 2:35 PM EST