City and County of San Francisco
Edwin M. Lee
Mayor

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

Office of Policy and Planning

MEMORANDUM

DATE: August 11, 2017

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

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

THROUGH: Colleen Chawla, Deputy Director of Health/Director of Policy & Planning

FROM: Sneha Patil, Senior Health Program Planner, Office of Policy & Planning
Krishna Patel, Health Program Planner, Office of Policy & Planning

RE: Proposition Q – CPMC St. Luke's Skilled Nursing Facility Unit Closure

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In accordance with the Community Health Care Planning Ordinance (Proposition Q, 1988), Warren Browner, MD, MPH, Chief Executive Officer of California Pacific Medical Center (CPMC), notified the Secretary of the Health Commission, in a letter dated June 6, 2017 (copy attached), of CPMC's plans to close its Skilled Nursing Facility (SNF) and subacute unit at the St. Luke's campus on October 31, 2017. This memo provides background regarding this planned closure for the Health Commission's Proposition Q hearings that will take place on August 15, 2017 and September 5, 2017. Specifically, this memo covers:

I. An overview of the Proposition Q process generally and also as it relates to recent SNF closures;
II. An overview of the definition skilled nursing care, including subacute skilled nursing care;
III. Details on the closure of St. Luke's SNF and subacute unit;
IV. The need for and capacity of subacute care (specialized skilled nursing care) in San Francisco;
V. The need for and capacity of general skilled nursing care in San Francisco; and
VI. Additional considerations and ongoing efforts related to skilled nursing care in San Francisco.

I. PROPOSITION Q

Proposition Q, passed by San Francisco voters in November 1988, requires private hospitals in San Francisco to provide public notice prior to closing a hospital inpatient or outpatient facility, eliminating or reducing the level of services provided, or prior to the leasing, selling or transfer of management. Upon such notice, the Health Commission is required to hold a public hearing during which the hospital shall be afforded an opportunity to present any information relating to its proposed action and to respond to matters raised by any other persons during that hearing. At the conclusion of the public hearing the Health Commission shall make findings based on evidence and testimony from the public hearings and any submitted written

material that the proposed action will or will not have a detrimental impact on health care services in the community.

In recent years, the Health Commission has reviewed two Proposition Q closures/reductions related to SNFs in San Francisco. 1) In 2014, CPMC closed 101 of its licensed SNF beds at its California campus, as it realigned SNF services to the St. Luke's campus, resulting in an overall reduction of 24 staffed SNF beds across the CPMC system. The Health Commission determined that the reduction would have a detrimental impact on the community. [1] 2) Dignity Health - St. Mary's Medical Center closed its SNF unit in 2015. In its resolution related to this closure, the Health Commission recommended that the Department work with hospitals, other city agencies, and community partners to research the need for skilled nursing care in San Francisco.[2] In response to this request, the Post-Acute Care Project launched in Fall of 2015 and presented findings and recommendations to the Health Commission in 2016.[3]

II. SKILLED NURSING CARE DEFINITIONS

CPMC St. Luke's Hospital Skilled Nursing Unit provides two levels of care: general skilled nursing care and subacute skilled nursing care. Skilled nursing facilities (SNF) can be characterized by the level of care provided, the care setting, and the patient's length of stay.

A. Skilled Nursing Facilities Are Characterized by the Level of Care Provided, Setting, and Patient Length of Stay

1. Level of Care
    a. **General SNF Services:** In California, SNFs are required to provide a minimum of 3.2 hours of nursing care per resident per day. Skilled nursing facility services include 24/7 supervision, physical, occupational and speech therapy, wound care, intravenous therapy, injections, monitoring of vital signs, and assistance with Activities of Daily Living (ADLs) - i.e. bathing, eating, dressing, feeding, transferring, toilet hygiene. SNFs are also responsible for creating an individualized care plan for each resident that determines what services are provided based on patient needs.

    b. **Subacute SNF Care:** Some SNFs have a Medi-Cal designation which allows them to provide specialized skilled nursing care, called subacute care, to complex patients. Subacute SNFs provide care for adults with higher levels of need such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management.

Exhibit 1 shows the current inventory of SNF services in San Francisco by level of skilled nursing care provided and shows the services associated with each level.

[1] Resolution 14-8 https://www.sfdph.org/dph/files/hc/HCRes/Resolutions/2014/HC%20Resolution%20re%20CPMC%20SNF%20Reductionsfinal.pdf
[2] Resolution 15-8 https://www.sfdph.org/dph/files/hc/HCRes/Resolutions/2015/158F.pdf
[3] Post-Acute Care Project Report: https://www.sfdph.org/dph/files/pac/PAC-Final-Report-February2016.pdf

Exhibit 1. Skilled Nursing Facility Services

CATEGORY	CHARACTERISTIC	TYPE OF SKILLED NURSING CARE	
		GENERAL	SUBACUTE*
CAPACITY	Licensed beds in San Francisco	2,502	40
SUPERVISION	24/7	✓	✓
SERVICES	Physical therapy, occupational therapy, speech therapy	✓	✓
	Wound care, intravenous therapy, injections, monitoring of vital signs	✓	✓
	Assistance with Activities of Daily Living, e.g., bathing, eating, dressing, feeding, transferring, toilet hygiene	✓	✓
	Ventilator care, complex wound management, intravenous tube feeding		✓

**Subacute patients are medically fragile and require more intensive care*

2. Setting
    a. **Hospital-based SNF:** also called a distinct part skilled nursing facility, operated within a designated unit (or distinct part) of an acute care hospital.

    b. **Freestanding SNF**: a facility outside of a hospital commonly referred to as a nursing home.

3. Patient Length of Stay
    a. **Short-Term Patients:**
        i. *General SNF:* Patients who stay in skilled nursing facilities for short-term care and/or rehabilitation may receive physical, occupational, and speech therapy. Other common services include wound care, intravenous (IV) therapy, injections, and monitoring of vital signs and medical equipment.
        ii. *Subacute SNF:* Patients who stay in subacute facilities for short-term care are those that need a higher level of service for a limited time, for example patients who are need assistance breathing after illness or injury but can be weaned off of a ventilator and then be transferred to a lower level of care or home.
        iii. *Payer Source:* Patients who have short-term stays in a SNF are likely covered by Medicare, Medi-Cal Managed Care, or private insurance. Medicare covers a stay in a SNF for up to 100 days. Medi-Cal Managed Care covers the month of admission and up to another 30 days, with a total maximum benefit of 60 days. Private insurance coverage varies by plan.

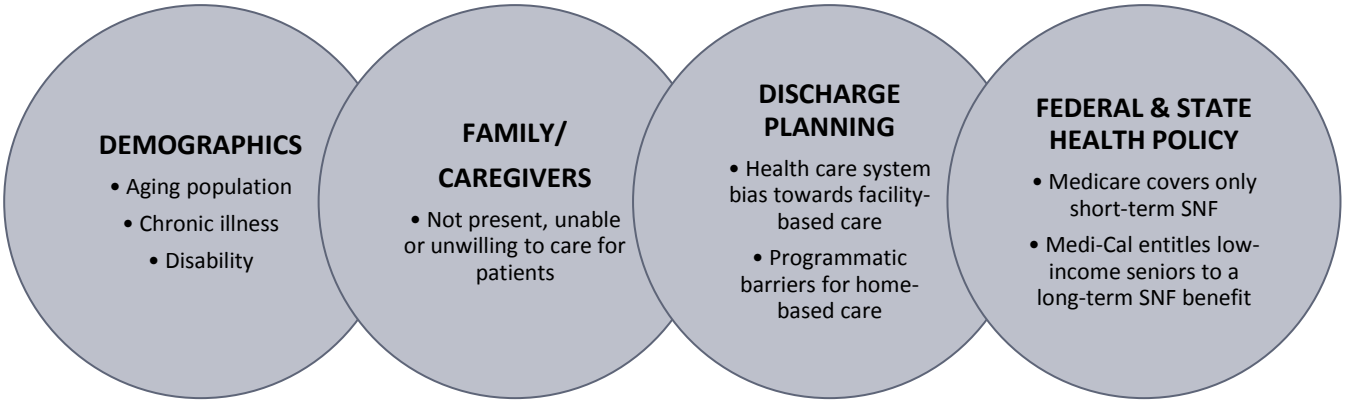
    b. **Long-Term Patients:**
        i. *General SNF:* Patients who stay in skilled nursing facilities long-term may consider the facility their home and are often referred to as custodial patients. In addition to the skilled nursing services provided to short-term patients, long-term patients need ongoing 24/7 supervision and assistance with activities of daily living, like bathing, eating, dressing, feeding transferring, and toilet hygiene.

ii. *Subacute SNF:* Long-term subacute SNF patients are those that need a higher level of service for a long period of time, for example patients who cannot be weaned off a ventilator or discharged to a lower level of care because of the complexity of their medical conditions and care needs.
iii. *Payer Source:* Patients who reside in a SNF long-term (typically greater than 100 days) are either covered by Medi-Cal Fee-for-Service (FFS) or self-pay.

B. Several Factors Influence the Need for and Utilization of General Skilled Nursing Care

There are several factors that may influence the need for and utilization of general skilled nursing facility care. Population demographics, the presence of family or caregivers, discharge planning, and federal and state health policy often affect if someone is discharged to a skilled nursing facility and how long the individual resides in the facility (Exhibit 2). While the information below is not an exhaustive list of all of the factors influencing the need for SNF care, it does illustrate some of the key issues impacting skilled nursing utilization in San Francisco and across the nation.

Exhibit 2. Factors Influencing the Need for and Utilization of General Skilled Nursing Care



Demographics: Older adults (65 years and older) are the fastest growing population segment in San Francisco and the US. According to the 2015 American Community Survey, San Francisco's population age 65 and older comprises 14.6 percent of the City's population, compared to the 13.3 percent of California's total population. Projections indicate that the population age 65 and older will rise from 14.6 percent to make up one-fifth of all residents in 2030. In contrast, the proportion of residents aged 25-64 years are expected to shrink by 6.3 percentage points over those same years. As residents age, they are likely to develop chronic conditions and experience illness or injury, which increases the probability of needing skilled nursing care.

Family/Caregivers: Family and/or caregivers play a crucial role in patient recovery and often assist patients with Activities of Daily Living when they are transitioned home. The presence of family and/or caregivers, and their ability to provide varying levels of care, may impact whether a patient can transition home after an acute hospital stay and whether a patient can transition home after a SNF stay.

Discharge Planning: Discharge planning is another important factor that influences whether someone is admitted to a skilled nursing facility. When creating a discharge plan, hospital staff consider a patient's diagnosis (or diagnoses), post-acute care medical needs, length of need, any accompanying behavioral health needs, the safety and appropriateness of the patient's proposed discharge situation (e.g., if home, team evaluates the safety and stability of the setting, and availability of social support), financial resources, and health insurance status. There is an institutional bias in the underlying structure of the health care system, which may result in greater reliance on skilled nursing facilities for the following reasons:

1) SNF's offer lower-levels of skilled care (nursing, rehabilitation) for post-acute care patients with ongoing medical needs. SNFs also provide 24/7 supervision for patients which may not be readily available in a home environment.
2) Patients with publicly-funded health insurance receive skilled nursing facility benefits - Medicare covers short SNF stays and Medi-Cal FFS covers long SNF stays.
3) Home and community based services may have programmatic and coverage limits and barriers. For example, home health care services for homebound patients are time-limited (maximum benefit of 8 hours a day under Medicare) and focus primarily on intermittent skilled nursing care and therapy. In addition, there can be a lengthy application and process period before patients can begin receiving services.

Federal and State Policy: Medicare and Medi-Cal are the two primary payers for facility-based skilled nursing care. The reimbursement policies of these payers can influence a SNFs service model and affect the sustainability of services. Medicare reimburses at a higher level than Medi-Cal but reimburses only for stays of less than 100 days. While Medi-Cal rates are low, it is the most common payer for long-term SNF care. Other types of facilities that also provide assistance with Activities of Daily Living, such as Residential Care Facilities for the Elderly, are not covered by insurance at all and residents must pay out of pocket.

III. CPMC ST. LUKE'S SKILLED NURSING FACILITY CLOSURE

CPMC is currently licensed for 117 SNF beds across two campuses, Davies and St. Luke's (Exhibit 3). The St. Luke's SNF and subacute unit is licensed for 79 SNF beds, 40 of which are designated for subacute patients while the 39 general SNF beds at CPMC's St. Luke's campus are primarily for short-term stays. The closure of the St. Luke's SNF and subacute unit represents a 68 percent reduction in the number of SNF beds at CPMC. It is important to note that this unit typically accepts only patients in the Sutter Health system. CPMC's hospital beds account for approximately 31 percent of all acute care beds in San Francisco and CPMC hospitals account for 29 percent of all patient discharges in the city.

Exhibit 3: SNF Beds Across CPMC's Four Campuses

Campus	Current Licensed Beds	Licensed Beds after St. Luke's SNF closure
California	0	0
Davies	38	38
Pacific	0	0
St. Luke's	79 (40 subacute)	0
TOTAL	**117**	**38**

Source: OSHPD Long Term Care Annual Utilization Data, 2015; California Pacific Medical Center 2017

CPMC plans to close the St. Luke's SNF and subacute unit effective October 31, 2017. The closure of the unit was originally anticipated to occur as part of the transition to the new St. Luke's Hospital facility in 2019. The construction of the new St. Luke's Hospital is ahead of schedule and now scheduled to open in the second quarter of 2018.

A. St. Luke's 40 Bed Subacute Unit Has 24 Patients Who Are Awaiting Placement in Other Facilities

The census of the subacute unit in June 2017, prior to the notice of closure, was 30 patients. Information about these patients is provided in Exhibit 4 and shows that 53 percent had resided in the unit for more than 2 years, and most patients reside in San Francisco. At least 76 percent of all patients use a ventilator, 40 percent are over the age of the 65 and 96 percent are over the age of 40. For 2017, 70 percent of residents were covered by Medicare, 27 percent were covered by Medi-Cal, and less than one percent were covered by other insurance. CPMC has reported that most subacute patients are dually eligible for Medicare and Medi-Cal.

At the closure announcement in June 2017, CPMC reported 28 patients in subacute SNF beds. Since the announcement, 1 patient was transferred to Kaiser, 1 passed away, 1 patient was weaned off a ventilator and discharged home, and 1 transferred to O'Connor Hospital Subacute Unit in San Jose, CA. The current census is 24 patients.

The public notice that CPMC provided regarding the unit's closure listed the closest three comparable subacute service providers (listed below). Families were also provided a list of facilities within a 25-mile radius. CPMC has reported that CPMC social workers are working with patients and families to find appropriate placement in other facilities.

Bay Area Health Care Center
1833 10th Ave
Oakland, CA 94606
510-536-6512

Alameda Hospital – Sub Acute Unit
2070 Clinton Ave
Alameda, CA 94501
510-814-4339

Alameda Healthcare and Wellness Center/Core Healthcare Centers
430 Willow St.
Alameda, CA 94501
510-914-1671

Exhibit 4. CPMC St. Luke's Subacute Patient 2017 Point-in-Time Census (N=30)

PATIENT RESIDENCE	N	%
San Francisco	24	80%
Outside City	6	20%
GENDER		
Female	19	63%
Male	11	37%
AGE		
Age 65 and under	18	60%
Age 65+	12	40%

PAYOR	N	%
Medicare	21	70%
Medi-Cal	8	27%
Other	1	<1%
LENGTH OF STAY		
3 months or less	0	0%
3 months to 1 year	6	20%
1 year to 2 years	8	27%
2 years to 5 years	7	23%
5 years to 8 years	5	17%
8+ years	4	13%

Source: California Pacific Medical Center, 2017

B. St. Luke's 39 Bed General SNF Unit Provides Short-Term Skilled Nursing Services to Patients

CPMC reported 15 patients in the unit's 39 general SNF beds at the closure announcement in June 2017. The general SNF beds at CPMC's St. Luke's campus are primarily for short-term stays, with an average length of stay of two to four weeks. Most patients in this unit are recovering from a surgery, wound, or condition that required an acute care stay but are not yet able to go home. Occasionally, patients may stay longer than four weeks if there is a clinical need.

Since the closure announcement, 10 patients were discharged to home leaving the current census at 5 patients. CPMC reported that each patient has a discharge plan or that the care team is working with the patient and family on an individualized transfer based on clinical needs and bed availability. There are three San Francisco facilities referred in the CPMC/St. Luke's Public Notice for continuing skilled nursing needs:

Sheffield Convalescent Hospital
1133 South Van Ness Avenue
San Francisco, CA 94110

The Jewish Home
302 Silver Ave
San Francisco, CA 94112

California Pacific Medical Center
Davies Campus Hospital – SNF
601 Duboce Street
San Francisco, CA 94117

C. St. Luke's Hospital Employees Are Affected by the Closure of the SNF and Subacute Unit

CPMC has reported that 113 employees are expected to be affected by the closure of the SNF unit at St. Luke's. This includes: 39 California Nurses Association (CNA) registered nurses, 72 Services Employee International Union (SEIU) staff, and 2 non-union staff. CPMC has reported that they are working with labor partners on options that include job training, identifying new or vacant positions at CPMC and other Sutter Health affiliates in the Bay Area, or an enhanced severance package.

D. The CPMC Development Agreement is Silent on the Provision of SNF beds

Following discussions in 2009 and 2010 related to CPMC's Institutional Master Plan, the Health Commission passed resolution 02-10 (Appendix B), which memorialized an agreement between CPMC and the Health Commission. Among the agreements made at that time was CPMC's commitment to provide a total of 100 skilled nursing beds, retaining 38 beds located at Davies Campus and adding 62 new SNF beds. Noting the shortage of SNF beds in the community, the resolution noted that the parties agreed that no existing community-beds would be utilized. Regarding subacute care, the resolution noted that CPMC agreed to place all St. Luke's subacute patients in its other hospital campuses, or in community facilities when the inpatient tower was decommissioned and that CPMC would work with the San Francisco Hospital Council to develop concrete solutions for providing subacute beds in the community.

The commitments in this resolution became the basis for the early drafts of CPMC's Development Agreement with the City. The version of the Development Agreement that was ultimately agreed upon by all parties did not include any provisions related to SNF beds. The Development Agreement does include an obligation related to subacute care requiring CPMC to work with DPH and other hospitals to develop proposals for providing subacute care services in San Francisco, and present these proposals to the Health Commission. CPMC completed this obligation under the Development Agreement as of February 2016,

when the Post-Acute Care Project Report with short- and long-term recommendations was presented to the Health Commission.

IV. SUBACUTE CARE CAPACITY

A. Initial Reports Indicate that a Relatively Small Number of Patients Need Subacute Care and Many Are Referred to Intermediate Care at a Long-Term Acute Care Hospital

Informal interviews with hospital discharge planners at Zuckerberg San Francisco General Hospital (ZSFG), University of California - San Francisco, and Dignity Health indicate that of the 52,694 patients that their hospitals collectively discharge annually, an estimated 20-30 need subacute level of care upon discharge. Most of these patients are referred to Long-Term Acute Care Hospitals (LTACs) in San Francisco and in neighboring counties. In the last fiscal year, for example, ZSFG discharged 12 patients needing subacute care to LTACs, five in San Francisco, six in neighboring counties, and one to Central Valley (due to family preference).

Long-Term Acute Care Hospitals are an important short-term care facility for patients who have chronic respiratory failure, use a ventilator and/or have a tracheostomy. LTACs are certified as acute care hospitals and focus on patients who may have more than one serious condition, but who may improve with time. LTAC patients are often transferred from an intensive or critical care unit and stay on average between 25-30 days. LTACs generally provide services like respiratory therapy, head trauma treatment, and pain management. After a stay in a LTAC, patients are discharged to lower levels of care including subacute facilities, regular skilled nursing facilities, acute care rehabilitation, or home.

Kentfield operates the one LTAC in San Francisco, a 40-bed facility located at St. Mary's Hospital. On August 8, 2017, Kentfield San Francisco reported 300 admissions and discharges per year and an average occupancy rate of 90 percent. Kentfield indicated that approximately half of the patients they admit are referred from San Francisco hospitals and approximately 20 percent of their patients are discharged to subacute facilities.

B. Approximately 11 percent of California's Subacute Beds Are Located in the Bay Area and All Are Currently Operating at or Near Capacity

In California, there are 125 subacute facilities which provide 4,752 beds statewide. A large number of subacute beds are located in Los Angeles County (46 percent) while only 11 percent are located in the Bay Area (Exhibit 5). Approximately 36 percent of California's subacute beds are located in a hospital while the remaining are located in freestanding facilities. Subacute beds that are located in hospitals primarily only serve patients within the hospital network and are typically unavailable as a discharge location for outside hospitals and networks.

Exhibit 5. California Subacute Facilities, 2017

County	Number of Beds	Number of Facilities
Los Angeles	2,193	56
Orange	532	16
San Diego	423	11
San Bernardino	384	8
Santa Clara	223	5
Alameda	149	5
Riverside	139	4
Ventura	114	3
Fresno	83	2
San Joaquin	72	2
Tulare	67	2
Contra Costa	83	2
Sacramento	52	2
Kern	51	1
San Mateo	44	1
Yolo	44	1
San Francisco*	40	1
Monterey	32	1
Sonoma	17	1
Glenn	10	1
TOTAL	**4,752**	**125**

Source: California Department of Health Care Services Medi-Cal Subacute Provider List, December 2016

In the Bay Area there are 550 subacute beds across 15 facilities. Excluding hospital-based subacute beds, there are 334 adult subacute beds that are potentially accessible to residents. Results from a phone survey of Bay Area subacute facilities conducted on August 2, 2017 show that these facilities have an average occupancy rate of 88 percent (Exhibit 6).

Exhibit 6. Bay Area Subacute Facilities, 2017

Bay Area County	Facility Name	Hospital-based or Freestanding	Subacute Beds	Occupancy Rate (August 2017)
Alameda	Alameda County Medical Center-Fairmont Campus	hospital-based	6	83%
Alameda	Alameda Healthcare & Wellness Center, LLC	freestanding	30	73%
Alameda	Alameda Hospital	hospital-based	35	97%
Alameda	All Saints Subacute and Rehabilitation Center	freestanding	47	91%
Alameda	Bay Area Healthcare Center	freestanding	31	87%
Contra Costa	Kindred Transitional Care & Rehab. -Walnut Creek	freestanding	56	86%
Contra Costa	Windsor Rosewood Care Center	freestanding	27	100%
Monterey	Windsor Gardens Rehabilitation Center of Salinas	freestanding	32	88%
San Mateo	Seton Medical Center	hospital-based	44	100%
Santa Clara	A Grace Sub Acute & Skilled Care	freestanding	77	84%
Santa Clara	Amberwood Gardens	freestanding	59	95%
Santa Clara	Children's Recovery Center of Northern California *(pediatric)*	hospital-based	27	96%
Santa Clara	O'Connor Hospital	hospital-based	24	96%
Santa Clara	Subacute Saratoga *(pediatric)*	freestanding	38	95%
Sonoma	Healdsburg District Hospital	hospital-based	17	76%
		TOTAL	**550 beds**	**88% average occupancy rate**

Source: California Department of Health Care Services Medi-Cal Subacute Provider List, December 2016; SFDPH Office of Policy & Planning

V. CAPACITY FOR GENERAL SNF CARE IN SAN FRANCISCO

A. Consistent with National Trends, Hospital-Based SNF Beds in San Francisco Have Declined While Freestanding SNF Beds Have Remained Relatively Stable

Currently, there are 1,319 hospital-based SNF beds in San Francisco (Exhibit 7). This will decrease to 1,263 beds after the closure of St. Luke's SNF unit.

Exhibit 7. San Francisco Hospital-Based Skilled Nursing Facilities

Hospital-based SNF Beds	Licensed Beds 2015
CPMC St. Luke's	79
CPMC Davies	38
Zuckerberg San Francisco General Hospital	30
Jewish Home	403
Laguna Honda Hospital	769
TOTAL	**1,319**

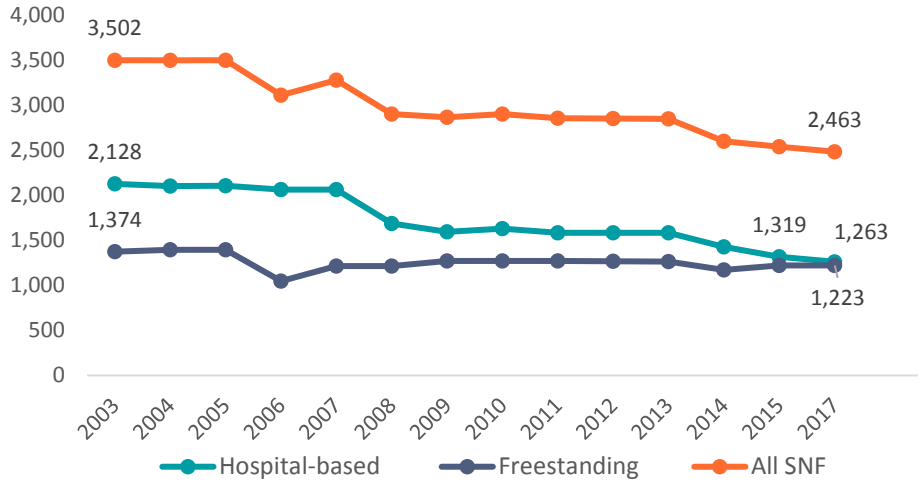
Source: OSHPD Long Term Care Annual Utilization Data, 2015

Exhibit 8 below indicates the number of licensed skilled nursing beds in San Francisco from 2003 to 2017. Since 2003, there has been a 30 percent decline in SNF beds in San Francisco, primarily due to the decline in hospital-based SNF beds. The biggest decline occurred in 2007 with the rebuild of Laguna Honda Hospital.

In recent years, this was due to the closure of hospital-based SNFs at CPMC's California campus and St. Mary's Hospital.

When acute care hospitals close their SNF units, hospital patients are discharged to outside facilities, potentially creating a strain on the remaining supply of freestanding SNF beds and limiting patient options for skilled nursing care in-county. The supply of freestanding SNF beds in San Francisco has remained relatively constant, with 1,374 beds in 2003 and 1,223 today (an 11 percent decline). This flat rate of beds suggests that there will be no growth of freestanding SNFs, likely to do to the high cost of doing business in San Francisco and health insurance reimbursement policies. Additionally, recent changes in the market may threaten access to skilled nursing facilities even further. Additional information is provided in Section V.C. below.

Exhibit 8. San Francisco Skilled Nursing Facility Beds 2003-2017



Source: OSHPD Long Term Care Annual Utilization Data, 2003 - 2015

The decline of hospital-based SNFs is a national trend likely influenced by changing reimbursement policies and a higher operating cost compared to freestanding facilities. Nationally, the number of hospital-based SNFs has declined by 63 percent between 1999 and 2013. Of the 14,978 SNFs that provided care in 2013 in the United States, only 5 percent of SNFs were located in hospitals while 95 percent of SNFs were freestanding. While the number of hospital-based SNFs has fallen by 63 percent since 1999 the number of freestanding SNFs has increased by roughly 10 percent (from 12,886 in 1999 to 14,229 facilities in 2013) leaving the total supply of SNFs relatively unchanged.

B. Payer Data Suggest That Most SNF Beds are Occupied by Long-Term Patients, and Facilities are Shifting Skilled Nursing Facility Practice Toward Short-Term Stays

Skilled nursing facilities in California report annual utilization data to the Office of Statewide Health Planning and Development (OSHPD). OSHPD, a department within the California Health and Human Services Agency, collects data and disseminates reports about more than 5,000 licensed healthcare facilities.

Skilled nursing facilities do not report data that indicates whether their beds are designated for short- or long-term patients. However, health insurance data for freestanding SNF patients can be used as a proxy to estimate patients who are long-term. Medi-Cal Fee for Service (FFS) is the primary payer for long-term skilled nursing care in California, so it is possible to estimate the number of long-term care patients by

looking at the number of patients covered by Medi-Cal FFS. In 2015 most freestanding SNF residents (59 percent) were covered by Medi-Cal Fee-For-Service. Please note that the number of short- and long-term patients in any given facility likely fluctuates throughout the year and many facilities see multiple short-term patients through the year.

Using health insurance status as a proxy for freestanding facilities, there are an estimated 1,588 long-term care SNF beds in San Francisco (Exhibit 9). This is approximately 65 percent of the total number of licensed SNF beds in the city after excluding CPMC St. Luke's Hospital.

Exhibit 9. Short & Long-Term SNF Bed Estimates

Facility	Short-Term Estimate	Long-term Bed Estimate
Hospital-based SNFs *(ZSFG, CPMC Davies)*	68	0
Freestanding Facilities (16)	583	640*
Jewish Home	100	279**
Laguna Honda Hospital	100	669**
Total	**851**	**1,588**

*The number of reported Medi-Cal Fee for Service patients in freestanding SNFs on December 31st, 2015.
** As reported by the facility in 2017. The Jewish Home is planning to reduce the number of long-term beds by 20 and increase the number of short-term beds by 20 in the next year.

OSHPD data from previous years suggest that the percentage of patients covered by Medi-Cal in San Francisco freestanding skilled nursing facilities has remained consistent around 60 percent. San Francisco's percent of Medicare patients, however, has steadily increased in recent years (from 11.9 percent in 2011 to 14.3 in 2016) also indicating that SNF beds are increasingly being utilized for short-term patients, likely due to higher reimbursement rates.

C. Market and Practice Changes for Freestanding SNFs May Decrease the Supply of Beds and Limit Access for Medi-Cal Patients in the Future

According to 2015 OSHPD data, San Francisco has 16 freestanding SNF facilities which are licensed for 1,223 beds. However, not all freestanding SNFs in San Francisco accept Medi-Cal. Of the 16 freestanding facilities, only 10 are certified to accept Medi-Cal patients (Exhibit 10). Additionally, San Francisco's freestanding SNFs typically operate close to capacity with two-thirds having occupancy rates over 80 percent (occupancy rates are calculated using OSHPD reported patient and licensed bed days). Occupancy rates are also typically higher at Medi-Cal certified facilities, suggesting limited access for new long-term Medi-Cal patients.

Further complicating the SNF landscape in San Francisco, in July 2017, Blue Mountain Capital Management LLC acquired Kindred HealthCare Inc.'s skilled nursing facilities across the United States. Kindred HealthCare provides the largest number of freestanding SNF beds in San Francisco (589 beds). At this time, it is unknown what impact the change of ownerships will have for Medi-Cal patients.

Exhibit 10. San Francisco Freestanding Skilled Nursing Facilities, 2015

	Facility	2015 Licensed SNF Beds	Patients Covered by Medi-Cal	Occupancy Rate
Medi-Cal Certified	Kindred Nursing And Rehabilitation - Golden Gate	120	105	98%
	Kindred Nursing And Healthcare-Victorian	90	80	99%
	Kindred Nursing And Rehabilitation-Nineteenth Avenue	140	135	97%
	Kindred Transitional Care And Rehabilitation- Tunnell Center	180	67	92%
	St. Anne's Home	46	46	99%
	Hayes Convalescent Hospital	34	3	83%
	Providence (San Francisco Nursing Center)	53	39	95%
	San Francisco Health Care	168	99	81%
	Central Gardens	92	66	81%
	Kindred Transitional Care And Rehabilitation – Lawton	68	0	77%
	Subtotal	***991***	***640***	
Medicare/Private Insurance/Self Pay	Laurel Heights Community Care	32	0	79%
	San Francisco Towers	55	0	53%
	Sequoias San Francisco Convalescent Hospital	50	0	86%
	Sheffield Convalescent Hospital	34	0	86%
	California Convalescent Hospital - San Francisco	29	0	66%
	The Heritage	32	0	81%
	Sub-total	***232***	***0***	--
	TOTAL	**1,223**	**640**	**--**

Source: OSHPD Long Term Care Annual Utilization Data, 2015

D. San Francisco's Skilled Nursing Facility Bed Rate Will Decline as the City's Population Ages

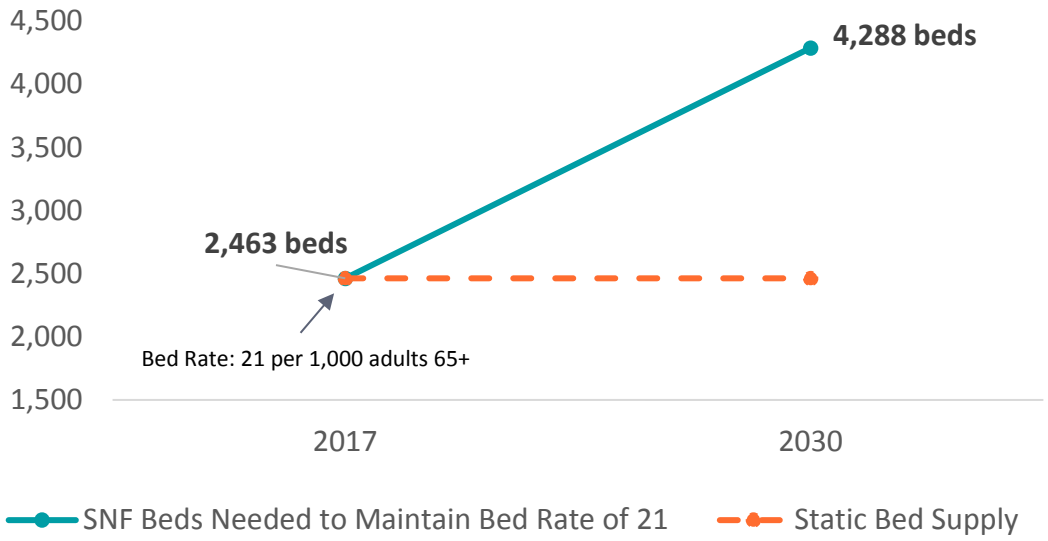
As previously discussed, San Francisco's population is aging. Based on SNF bed and population data, San Francisco has approximately 21 SNF beds per 1,000 adults age 65 and older (note: 92 percent of freestanding SNF residents are 65 and older). San Francisco's bed rate is similar to some Bay Area counties (Exhibit 11) but lower than California's rate. Other Bay Area counties bed rates range from 15 to 28 beds per 1,000 adults 65+. San Francisco's bed rate falls in the middle however, six out of eight Bay Area counties have bed rates that are similar to or below San Francisco's bed rate. Some San Francisco patients are already being placed out of county due to limited capacity in-county, and it is likely that the capacity of facilities in other Bay Area counties is also strained.

Exhibit 11. Bay Area and California Skilled Nursing Bed Rate per 1,000 Adults 65+

County	Number of Facilities	SNF Capacity	% Population 65+	Beds Per 1,000 65+ Population
Alameda	68	5,352	12%	**28**
Santa Clara	52	5,148	12%	**23**
Marin	14	1,038	19%	**21**
San Francisco	**21**	**2,463**	**14%**	**21**
Sonoma	20	1,660	16%	**21**
Contra Costa	32	3,000	14%	**20**
Napa	4	368	16%	**16**
Solano	9	846	13%	**15**
San Mateo	13	1,582	14%	**15**
California	**>1,888**	**107,172**	**12%**	**22**

If San Francisco's bed supply remains constant in the next 13 years, and the city ages as projected, San Francisco's bed rate would decrease to 12 SNF beds per 1,000 adults 65 and older. If San Francisco were to maintain its current bed rate as the population ages, by 2030 the city would need 4,288 licensed SNF beds—an increase of 1,825 beds over the current supply (Exhibit 12).

Exhibit 12. SNF Bed Supply and Bed Rate as San Francisco's Population Ages



Source: OSHPD Long Term Care Annual Utilization Data, 2015; OSHPD Hospital Utilization Data, 2015; California Department of Finance Population Projections, 2016

VI. ADDITIONAL CONSIDERATIONS & ONGOING EFFORTS

A. San Francisco's Long-Term Care Ombudsman Serves as an Advocate for Skilled Nursing Residents' Health, Rights, Safety, and Welfare.

The San Francisco Long Term Care (LTC) Ombudsman Program has been meeting with CPMC St. Luke's patients and families on an ongoing basis to discuss patients' concerns and options. When a facility provides notice that it will cease to operate, patients have a right to an appeal hearing related to involuntary discharge.

The LTC Ombudsman Program is responsible for identifying and responding to complaints/issues, resulting from action, inaction, or decisions, which may adversely affect health, safety, welfare, or rights of patients living in long term care facilities. Additionally, LTC ombudsmen roles include: testifying, recommending policy or legislative changes, and assisting in the formation of resident associations and family councils. Also, Ombudsman Representatives receive mandated reports of abuse and neglect from mandated reporters, if the victim resides in licensed long term care facilities. Ombudsman jurisdiction includes skilled nursing facilities, residential care facilities for the elderly (board and care and assisted living facilities), social rehabilitation facilities, adult residential care facilities etc. - all of which are regulated care settings. The LTC Ombudsman Program is required by federal and state laws.

B. Palliative Care Is an Important Resource of Patients with Serious and Life-Threatening Illness

Many patients who require subacute care have experienced a major traumatic event such as an injury or a stroke. In an acute care setting, a patient's prognosis for recovery may be unknown and families may feel that additional time with supportive medical treatment is necessary before making significant decisions regarding their overall care. Palliative care has the potential to greatly benefit the care of patients and families by continuing to re-assess patient goals of care on an ongoing basis.

Palliative medicine is specialized medical care for people with serious illnesses and focuses on providing relief from the pain, symptoms and distress of serious illness. It is a team-based approach to care involving specialty-trained doctors, nurses, social workers and other specialists focused on improving quality of life. By determining patients' goals of care through skilled communication, treating distressing symptoms and coordinating care, and recognizing and supporting the psychosocial and spiritual distress that often accompanies serious illness, palliative care teams meet patients' and their loved one's needs and help them align medical care with their values and possibly avoid unwanted and expensive crisis care.[4] Palliative care programs are growing across the country and are more readily accessible in hospital inpatient settings compared to community settings.

In acute care hospitals, palliative care providers help families assess whether a patient's current conditions and prognosis would support ongoing and supportive interventions, when patients cannot improve further, and whether removing life sustaining care is an option to allow patients to pass naturally and comfortably. Palliative care providers also can provide symptom management at any stage of illness, and support family members in all domains impacted by serious illness including the grieving process and other psychosocial and spiritual issues that often arise.

[4] America's Care of Serious Illness: https://reportcard.capc.org/

If a patient has completed an Advanced Care Directive, this can be helpful in the event of a traumatic event or serious illness. Standard Advance Care Directives, however, often ask about patient preferences if they are in an irreversible coma or persistent vegetative state, for example. Oftentimes, a patient's medical situation may not always align with specific information in these documents. Thus, ongoing conversations about goals of care are critical for patients with serious and life-threatening illness.

C. The San Francisco Post-Acute Care Collaborative Is Developing Solutions for High Risk Individuals Needing Post-Acute Care and Will Make Recommendations Regarding Subacute Care

In 2016, the Post-Acute Care Project Report highlighted three challenges for providing skilled nursing care in San Francisco: 1) San Francisco is at risk for an inadequate supply of skilled nursing beds in the future, 2) Medi-Cal beneficiaries with skilled nursing needs have limited options in San Francisco, and 3) post-acute care placements for some vulnerable populations are difficult to find in San Francisco.

A key recommendation of the Post-Acute Care Project was to develop a collaborative to further develop and implement strategies to address the need for skilled nursing care in San Francisco's. In 2017, the San Francisco Section of the Hospital Council of Northern and Central California launched the San Francisco Post-Acute Care Collaborative (PACC). The PACC's mission is to identify implementable, financially sustainable solutions for high-risk individuals in the City and County of San Francisco (high-risk individuals defined as non-benefited, under-benefited and/or hard to transition). In June 2017, PACC members identified two consensus high-risk populations and created two workgroups with the goal of developing implementable, financially viable solutions: 1) cognitively impaired post-acute care patients requiring 24/7 supervision, and 2) behaviorally challenged post-acute care patients—any diagnosis. Workgroups will begin developing solutions addressing the need for post-acute acute care for these populations in the next several months.

The Post-Acute Care Collaborative leadership will meet later in August to discuss recommendations and strategies to address access to subacute care for residents of San Francisco. Information from this meeting will be provided to the Health Commission at its meeting on September 5th, 2017.

The PACC includes key leaders from private non-profit hospitals, the San Francisco Department of Public Health (DPH) and San Francisco Department of Aging and Adult Services (DAAS), the Jewish Home, and others. Kelly Hiramoto, Director, Transitions Program, DPH and Daniel Ruth, President and Chief Executive Officer, Jewish Home, are PACC Co-Chairs. The ten-month project, March – December 2017, includes monthly meetings with PACC members.

D. The Health Care Services Master Plan Update Will Highlight the Need for Skilled Nursing Care and Explore Related Land Use Policy Recommendations

The Health Care Services Master Plan (HCSMP) is a long-range policy document intended to improve access to healthcare, particularly for San Francisco's low-income and vulnerable populations. The purpose of the plan is to identify current and projected needs, and locations of, for health care services in San Francisco and make recommendations about how to achieve and maintain appropriate and equitable access to health care services.

The Department of Public Health and the Planning Department are currently developing an updated HCSMP, for anticipated adoption in late fall 2017 or early 2018. The need for skilled nursing and long-term care will be highlighted in this update. As part of the update, DPH and Planning will be examining an array of supporting policy recommendations that may help meet the growing demand for skilled nursing care in

San Francisco. This includes potential modifications to current zoning requirements that would permit the development of skilled nursing facilities in more locations. The overall goals of the 2017 update are to:

- Provide the most current and available local and state data describing health care service capacity, utilization, and distribution of healthcare services
- Highlight health inequity and critical healthcare and development issues that have emerged since 2013, including the need for skilled nursing care.
- Conduct an updated assessment of land use controls and trends in medical use development
- Suggest additional policy recommendations to improve access to high quality healthcare, including suggested land use policy and process improvements

The draft HCSMP will be heard at the Health and Planning Commission in late fall of 2017 or early 2018.

E. The Department of Public Health Has Initiated Regional Conversations Regarding Post-Acute Care

DPH has initiated conversations with Health Directors in neighboring counties, beginning with San Mateo, to discuss the shared need for lower level of care options. DPH and regional partners will be assessing their joint needs and exploring local and state policy options to address this issue. These efforts may lead to additional recommendations and a regional strategy to ensure access to lower levels of care.

VII. CONCLUSION

This memo highlights the following findings related to subacute and general skilled nursing care in San Francisco:

1) Initial reports indicate that a relatively small number of patients need subacute care and many are referred to intermediate care at a long-term acute care hospital
2) Approximately 11 percent of California's subacute beds are located in the Bay Area and all are currently operating at or near capacity
3) Consistent with national trends, hospital-based SNF beds in San Francisco have declined while freestanding SNF beds have remained relatively stable
4) Payer data suggest that most SNF beds are occupied by long-term patients, and facilities are shifting skilled nursing facility practice toward short-term stays
5) Market and practice changes for freestanding SNF may decrease the supply of beds and limit access for Medi-Cal patients in the future
6) San Francisco's skilled nursing facility bed rate will decline as the city's population ages
7) San Francisco's Long-Term Care Ombudsman serves as an advocate for skilled nursing residents' health, rights, safety, and welfare
8) Palliative Care is an important resource of patients with serious and life-threatening illness
9) The San Francisco Post-Acute Care Collaborative is developing solutions for high risk individuals needing post-acute care and will make recommendations regarding subacute care
10) The Health Care Services Master Plan update will highlight the need for skilled nursing care and explore related land use policy recommendations
11) The Department of Public Health has initiated regional conversations regarding post-acute care

Based on the above findings, the Department of Public Health recommends to the Health Commission that the closure of the SNF and subacute unit at CPMC St. Luke's will have a detrimental impact on the health care services in the community. With an aging population, declining SNF beds, and no subacute SNF beds in San Francisco after the closure of St. Luke's SNF and subacute unit, San Francisco will continue facing challenges in caring for the older adult population in the future. Though the decline of hospital-based skilled nursing care is a trend nationally and locally, any reduction of skilled nursing care services will have a detrimental impact for the residents of San Francisco by limiting access to this level of care. Access to skilled nursing care, including subacute care, is a citywide and regional challenge. A draft resolution is attached for your consideration.

APPENDIX A: CPMC ST. LUKE'S SNF UNIT NOTICE OF CLOSURE

June 6, 2017

Secretary to the Health Commission
San Francisco Health Commission
101 Grove Street, Room 311
San Francisco, California 94102

Re: *Community Health Care Planning Ordinance Notice St. Luke's Hospital Skilled Nursing Facility and Sub-Acute Unit*.

Dear Secretary to the Health Commission:

In accordance with the Community Health Care Planning Ordinance (Proposition Q, 1988), I enclose a copy of a public notice announcing that CPMC- St. Luke's Campus proposes to close its Skilled Nursing Facility (SNF) and Sub-Acute Units. In total, the SNF unit is licensed for 79-beds (which includes 40 Sub-Acute beds). CPMC's new hospital, which is being built on the St. Luke's Campus, is on schedule to open in the third quarter of 2018. With 120 acute care beds, the new hospital will be a vital community resource. However, the new facility will not include any SNF or Sub-Acute beds; thus, the current SNF and Sub-Acute units at the St. Luke's Campus will be closed.

In planning for this shift in services, CPMC has worked with the Blue Ribbon Panel, the Long Term Care Coordinating Council, the City and County of San Francisco and your Commission through the Development Agreement. CPMC also conducted a Post Acute Care Assessment in partnership with SFDPH and other hospitals and presented the recommendations to your commission in February of 2016. Subsequently we helped convene a Post Acute Care Task Force to implement recommendations from the assessment.

Our clinical team will work with patients, their families, and our community partners to ensure that all SNF and Sub-Acute patients remaining at CPMC's St. Luke's Campus receive appropriate placement by October 31, 2017.

Very truly yours,

Warren Browner, M.D., M.P.H
CEO, California Pacific Medical Center

cc: Office of the Mayor of SF
Members, SF Board of Supervisors
SF Office of Economic and Workforce Development
SF Department of Public Health

Enclosure: Copy of Public Notice

Public Notice

In accordance with the San Francisco Community Health Care Planning Ordinance (Proposition Q, 1988), St. Luke's Hospital announces that it proposes to close its Skilled Nursing Facility (SNF) and Sub-Acute Unit on October 31, 2017.

Expected number of patients to be affected by the closure: 53
Expected number of employees to be affected by the closure: 122

The Health Commission will hold a hearing on this proposed change; for information as to date, time, and place, call the Health Commission at (415) 554-2666.

Posted _____, 2017

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APPENDIX B: HEALTH COMMISION RESOLUTION 2-10

HEALTH COMMISSION
RESOLUTION 02-10
RESOLUTION MEMORIALIZING THE AGREEMENTS REACHED
BY THE HEALTH COMMISSION AND THE CALIFORNIA PACIFIC MEDICAL CENTER
REGARDING ITS INSTITUTIONAL MASTER PLAN

WHEREAS, the Institutional Master Plan (IMP) process provides the City and its policy bodies, including the Health Commission and the Planning Commission, with an opportunity to ensure that proposed changes related to health care institutions are reviewed to ensure the protection of public health and consideration of neighborhood and environmental integrity; and,

WHEREAS, City and County of San Francisco Ordinance 0279-07 amending the IMP process calls for, "the Department of Public Health (DPH) to analyze the relationship between the city's long-term health care needs and facility planning for medical institutions...to provide the Planning Department with an important perspective for review of medical institutions' master plans. Such analysis will help prevent loss of services and inefficient or redundant development of healthcare services in San Francisco"; and,

WHEREAS, California Pacific Medical Center's (CPMC) IMP was presented to the Health Commission in May 2009 and at its July 21, 2009 hearing, the Health Commission adopted Resolution 10-09 supporting CPMC's plans to rebuild facilities to meet the State's current seismic requirements; and,

WHEREAS, to ensure the CPMC IMP results in the best possible health plan for the City and County of San Francisco, the Health Commission put forward eight specific recommendations that stemmed from four public hearings; the Health Commission Task Force on CPMC's IMP, a work group using a consensus model, met to discuss and analyze progress in fulfilling these recommendations which resulted in the following agreements with CPMC:

1. Recommendation: CPMC should increase its charity care, including but not limited to Healthy San Francisco, to a share comparable to other hospitals in San Francisco.
   Agreement: CPMC will increase its charity care contribution 79% in a five-year period, from $5,315,000 in 2007 to $9,500,000 by 2012.

2. Recommendation: CPMC should increase its care of patients with Medicaid to a share comparable to other hospitals in San Francisco.
   Agreement: CPMC will continue to serve Medicaid patients throughout its system, retaining its Medicaid contract with the State of California providing access through the Sutter Pacific Medical Foundation clinics and the St. Luke's Health Care Center. CPMC will also increase its amount of Medicaid shortfall (the uncompensated portion of providing care to Medicaid patients) by 22% in a five-year period, from $53,369,000 in 2007 up to $65,000,000 by 2012.

3. Recommendation: CPMC should replace lost skilled-nursing facility (SNF) beds with long-term care services for an equal number of persons.

Agreement: CPMC will provide a total of 100 skilled nursing beds, retaining the 38 beds currently located at the Davies Campus and adding 62 new SNF beds. Because of the shortage of SNF beds in the community, no existing community-based beds will be utilized. CPMC will maintain ongoing reports to the Commission concerning these options and future decisions.

4. Recommendation: CPMC should replace lost sub-acute beds with placements for all individuals currently in those beds.
   Agreement: CPMC chairs the San Francisco Hospital Council work group, to develop concrete solutions for providing sub-acute care beds in the community. The recommendations will be heard by the Hospital Council in June 2010. When the St. Luke's inpatient tower is decommissioned, CPMC will place all remaining sub-acute care patients in its other hospital campuses, or in community facilities.

5. Recommendation: CPMC should make a commitment that the St. Luke's campus will be operated as a community hospital for at least 20 years.
   Agreement: CPMC is constructing a new $250,000,000 inpatient facility at St. Luke's and is committed to maintaining St. Luke's as an integral part of their larger healthcare system. In September 2008, CPMC's Board of Directors unanimously accepted the recommendations of the Blue Ribbon Panel, directing executive management to include a revitalized St. Luke's Campus, with all the services of a community hospital, as part of CPMC's IMP.

6. Recommendation: CPMC should ensure that all of the recommendations of the Blue Ribbon Taskforce be fully implemented.
   Agreement: CPMC will implement all the recommendations of the Blue Ribbon Panel, with the two exceptions. SNF beds will be provided within the CPMC system and through new community-based facilities. Inpatient pediatric beds will be built into the new Cathedral Hill Hospital where all the support services and specialties necessary for safe and effective care will be available. These actions will provide for the services to patients envisioned by the Blue Ribbon Panel.

7. Recommendation: The Health Commission, DPH should establish a time-limited working group with representation of a dedicated membership to analyze progress realizing these recommendations.
   Agreement: The Health Commission convened the CPMC IMP Task Force.

8. Recommendation: CPMC should continue to partner with all sectors of the community, including Chinese Hospital, its affiliates, and the Chinese community to provide fair and affordable access to its services; and,
   Agreement: CPMC has committed to continuing its long standing partnership with Chinese Hospital, its affiliates and the Chinese community; and

WHEREAS, on March 2, 2010, the Health Commission heard the final report of the Task Force outlining the agreements that had been reached through the consensus process; now

THEREFORE BE IT RESOLVED, the Health Commission confirms the agreements listed above as progress towards but not full implementation of the Commission's specific recommendations regarding charity care, Medicaid, sub-acute services and commitment to operate St. Luke's as a community hospital for twenty years; and,

BE IT FURTHER RESOLVED, CPMC will continue to provide the Health Commission separate charity care information for St. Luke's for as long as the hospital licenses are separate. When the hospital licenses are consolidated in 2012, CPMC will no longer provide campus-specific reporting. At that time, CPMC's charity care reporting will be revisited by the Commission. CPMC will report discharges of patients who live in St. Luke's primary service area for all campuses; and,

BE IT FURTHER RESOLVED, commencing one calendar year after acceptance of the Report of the CPMC Task Force by the Health Commission and coinciding with the hospital's reporting cycle to OSHPD, CPMC will provide written annual updates to the Commission progress towards full implementation of the recommendations in the prior year.

BE IT FURTHER RESOLVED, CPMC will report quarterly to the Health Commission through its Finance and Planning Committee on progress of the agreements listed above and the Van Ness/Cathedral Hill and St. Luke's facility development plans; and,

BE IT FURTHER RESOLVED, the Health Commission expects CPMC to continue its upward trajectory level of charity care and services to Medicaid patients and to ultimately commit to a percentage amount comparable to other hospitals in San Francisco; and,

BE IT FURTHER RESOLVED, the Health Commission is forwarding this resolution to the Planning Commission and to the Board of Supervisors for incorporation into the Planning Commission's Conditions of Approval for CPMC's future facilities building plans. This will ensure accountability and oversight and keep the public informed of CPMC's progress as the Institutional Master Plan is implemented.

I hereby certify that the San Francisco Health Commission at its meeting of March 16, 2010 adopted the foregoing resolution.

Mark Morewitz
Health Commission Executive Secretary