

Addressing San Francisco's Vulnerable Post-Acute Care Patients

Analysis and Recommendations of the
San Francisco Post-Acute Care Collaborative

2018



ACKNOWLEDGMENTS

We are very grateful to the many individuals who shared their time and expertise with the San Francisco Post-Acute Care Collaborative (PACC). They include staff from San Francisco hospitals, nursing facilities, community organizations, San Francisco Department of Public Health, San Francisco Department of Aging and Adult Services, and San Francisco Department of Homelessness and Supportive Housing. Their valuable input and feedback directly contributed to the formation of the PACC’s three recommended solutions to address the needs of San Francisco’s most vulnerable post-acute care patients.

We also thank the San Francisco Health Commission and the San Francisco Board of Supervisors. Their commitment to solving San Francisco’s post-acute care challenges inspired the PACC’s efforts to address the needs of underserved post-acute care patients.

– San Francisco Post-Acute Care Collaborative

COMMON REPORT ABBREVIATIONS AND TERMS	
ADLs	Activities of Daily Living—daily self-care activities such as bathing, dressing, self-feeding, etc.
CLF	Community Living Fund— provides for home and community-based services, or a combination of equipment and services, to support aging in place and in the community.
CMS	Centers for Medicare & Medicaid
DAAS	San Francisco Department of Aging and Adult Services
DAH	Direct Access to Housing—service-enriched, subsidized permanent supportive housing for adults experiencing homelessness who are low-income San Francisco residents with special needs.
DPH	San Francisco Department of Public Health
DP/SNF	Distinct Part Skilled Nursing Facility
HCBA	Home and Community-Based Alternatives Waiver—the HCBA Waiver provides care management services to persons at risk for nursing home or institutional placement.
FFS	Fee-for-Service
IHSS	In-Home Supportive Services—a Medi-Cal program providing those with limited income who are disabled, blind, or over the age of 65 with in-home care services to help them remain safely at home.
Low-to-Middle Income	Individuals whose income ranges from 100 percent of the Federal Poverty Level to middle-income, defined as two-thirds to double the U.S. median household income
LOCUS	Level of Care Utilization System for Psychiatric and Addiction Services
LTSS	Long-Term Services and Supports—represents a wide range of services to help people live more independently, by assisting with personal and healthcare needs and activities of daily living.
PACC	San Francisco Post-Acute Care Collaborative
RCFE	Residential Care Facilities for the Elderly—refers both to the RCFE licensure category within California and facilities under this license type, e.g., board and care homes and assisted living facilities. Note: RCFEs can serve a limited number of adults 18-59 years; most residents (75 percent) must be age 60 or older
SNF	Skilled Nursing Facility
SROs	Single-Room Occupancy hotels

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EXECUTIVE SUMMARY

Like cities and counties across the country, San Francisco has experienced significant changes in how health care is paid for and delivered in recent years. The Triple Aim framework for optimizing health system performance has been leading this health care system transformation: improve the patient experience, improve the health of populations, reduce the cost of health care. Other changes include a shift away from episodic care in favor of more integrated health management approaches to delivering health care, and the expansion of health insurance coverage for millions of Americans under the Affordable Care Act (ACA). All health care sectors, including post-acute care, have been responding to these trends. As post-acute care reimbursement structures evolve, this sector will continue to undergo dramatic changes.

San Francisco began examining the availability and accessibility of post-acute care services in August 2015, when the San Francisco Department of Public Health (DPH), in partnership with other city agencies, hospitals, and community providers, launched the San Francisco Post-Acute Care Project. The San Francisco Health Commission recommended the project be undertaken to analyze the impact of the closures of several San Francisco acute care hospital Distinct Part/Skilled Nursing Facility (DP/SNF) units on the City and County of San Francisco and its residents. The report identified three critical post-acute care challenges:

- ▶ San Francisco is at risk for an inadequate supply of skilled nursing beds in the future.
- ▶ Medi-Cal beneficiaries with skilled nursing needs have limited options in San Francisco.
- ▶ Post-acute care placements for some vulnerable populations are difficult to find in San Francisco.

A chief recommendation in the Post-Acute Care Project's final report, *Framing San Francisco's Post-Acute Care Challenge*, adopted by the San Francisco Health Commission, was to form a San Francisco Post-Acute Care Collaborative (PACC). The purpose of the PACC is to identify solutions to improve the availability and accessibility of post-acute care services for vulnerable populations and Medi-Cal beneficiaries in San Francisco.

The PACC was formed in March 2017. Sponsored by the Hospital Council of Central and Northern California, PACC members include leaders from San Francisco private nonprofit hospitals, DPH, San Francisco Department of Aging and Adult Services (DAAS), a major skilled nursing facility, and other stakeholders. Members developed the following project mission and vision statements to guide the 10-month PACC process:

MISSION STATEMENT	VISION STATEMENT
<ul style="list-style-type: none">▶ To identify implementable, financially sustainable solutions to the post-acute care challenge for high-risk individuals in the City and County of San Francisco. *	<ul style="list-style-type: none">▶ Empowered individuals and families through strengthened social supports, collaboration, and partnership.

*High-risk individuals are defined as non-benefited, under-benefited, and/or hard to transition.

To understand which San Francisco post-acute care populations were most vulnerable and merited priority attention, PACC members reviewed multiple reports and data sources. The information summarized salient post-acute care issues for high-risk populations, such as the diverse needs of vulnerable post-acute care patients and San Francisco’s limited SNF, subacute, and supported community living options for low-income post-acute care patients.

The following key findings from an **April 2017 PACC Hospital Point-in-Time Survey** added crucial data about the numbers, needs, and characteristics of patients waiting for post-acute care placement:

- ▶ 117 patients were waiting for post-acute care placement across eight acute care hospitals.
- ▶ Most of these patients had Medi-Cal, half required post-acute custodial-level care or 24-hour supervision.
- ▶ Many presented with behavioral health challenges, dementia, substance use problems, or severe mental illness.

Based on the information presented and subsequent discussion, the PACC identified two population subgroups of high-risk post-acute care patients as the most “stuck” at a level inappropriate to their needs.

POPULATION SUBGROUP A	POPULATION SUBGROUP B
<ul style="list-style-type: none"> ▶ Post-acute care patients who meet the following criteria: cognitively impaired, indigent or low- to middle-income, and requiring 24/7 supervision. <p><i>Cognitive impairment refers to an inability to independently self-manage activities of daily living (ADLs), such as eating, bathing, dressing, toileting, etc.</i></p>	<ul style="list-style-type: none"> ▶ Patients requiring post-acute care services who are behaviorally challenging as a result of any of the following diagnoses: traumatic brain injury; dementia, substance abuse, hypoxia; and mental health disorders—psychotic, mood, personality, and substance use. <p>Note: most patients in this subgroup are indigent or low-to middle-income.</p> <p><i>Behavioral challenges include violent, aggressive, sexually acting-out, impulsive, verbally abusive and/or loud, non-redirectable, wandering, and non-compliant/non-adherent behavior; and active substance use.</i></p>

Analysis of the needs of these subgroups—recognizing that they primarily comprise individuals with low incomes and limited social supports—revealed that supported living settings were more appropriate for a significant number of these patients than SNFs. Moreover, the PACC affirmed that placing post-acute care patients in the right care at the right time will positively affect patient flow in SNFs. However, to ensure SNF bed availability for low-income residents who need this level of care—now and in the future—the PACC recommends that the City, with partner stakeholders, continue to explore local and regional SNF opportunities.

The PACC identified three solutions to address the gaps in care for both subgroups. Acknowledging that the City is at capacity serving these groups, e.g., subsidizing supportive

housing and Residential Care Facilities for the Elderly (RCFE) placements, the solutions are structured as public-private partnerships. The recommendations are:



Adopt a standardized post-acute care assessment tool, Level of Care Utilization System (LOCUS), which all San Francisco acute care hospitals will use.



Establish a citywide roving placement team, available to all San Francisco acute care hospitals, to assess behaviorally challenging patients difficult to place in post-acute care and provide behavioral and medication management recommendations to support patient discharges to the least restrictive setting appropriate to the patient's needs.



Increase access to supported living alternatives in San Francisco for low-income patients with dementia or behavioral challenges due to cognitive impairment and behavioral health diagnoses. This solution is two-pronged: A) fund subsidies and other support to increase access to independent housing with wraparound services and RCFEs in San Francisco for patients who can live supported in the community; B) advocate for expanding the supply of affordable RCFEs in the mayor's housing initiative.

The PACC solutions are the outcome of a deliberative process. LOCUS and the roving placement Team promote systems change; increasing access to supported living settings supports individual patient needs. The intent of the recommended solutions and this report is to spark further conversation among a broad group of stakeholders about appropriate next steps to take to address San Francisco's post-acute care challenge. The PACC believes that through a public-private partnership, a broad coalition of stakeholders can effectively respond to this challenge.

The next step for San Francisco's post-acute care effort is for the PACC to develop an operational plan to guide implementation of PACC-recommended solutions.

The infographic on the following page illustrates the post-acute care collaborative process and proposed solutions.

San Francisco's Post-Acute Care Collaborative Process

The report, *Framing San Francisco's Post-Acute Care Challenge* (2016), recommends the formation of a Post-Acute Care Collaborative (PACC)

In 2017, PACC convenes and identifies needs and gaps in care for San Francisco's vulnerable and Medi-Cal post-acute care patients and proposes solutions.



SOLUTIONS

Standardized Level of Care Assessment Tool

Roving Placement Team

Access to Supportive Living Alternatives

Systems Change

Services and Advocacy

OUTCOMES



Public-Private Partnerships to address post-acute and long term care needs



Quality health care in the right place at the right time

SAN FRANCISCO POST-ACUTE CARE COLLABORATIVE PROJECT DESIGN

The San Francisco Post-Acute Care Collaborative (PACC) was led by Co-Chairs Kelly Hiramoto, Director of San Francisco Health Network Transitions of the San Francisco Department of Public Health; and Daniel Ruth, President and Chief Executive Officer of the Jewish Home of San Francisco. Throughout the 10-month project, the co-chairs ensured the PACC hewed to its purpose: *to develop comprehensive and actionable solutions to the City’s urgent post-acute care challenges for high-risk, vulnerable patients*. A project team provided additional project support.

To guide the process, PACC members established a project structure that included mission and vision statements and a set of shared core values.

MISSION STATEMENT	
<ul style="list-style-type: none"> ▶ To identify implementable, financially sustainable solutions to the post-acute care challenge for high-risk individuals in the City and County of San Francisco. <p><i>(High-risk individuals are defined as non-benefited, under-benefited, and/or hard to transition.)</i></p>	
VISION STATEMENT	
<ul style="list-style-type: none"> ▶ Empowered individuals and families through strengthened social supports, collaboration, and partnership. 	
CORE VALUES	
<ul style="list-style-type: none"> ✓ Health care access ✓ Quality of life ✓ Serve others ✓ Transforming and enriching the lives of older adults and persons with disabilities ✓ Build relationships 	<ul style="list-style-type: none"> ✓ Honor all clients ✓ People first ✓ Transparency ✓ Honor diversity, culture, and underserved populations ✓ Think “outside the box”

With a strategic framework in place, the PACC reviewed and discussed the report *Framing San Francisco’s Post-Acute Care Challenge* and its three key findings:

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.
3. Post-acute care placements for some vulnerable populations are difficult to find in San Francisco.

The PACC project team complemented the report findings with the following information, summarizing salient post-acute care data and resources for high-risk populations in San Francisco:

- ▶ **San Francisco PACC Hospital Point-in-Time Surveys:** Two online hospital surveys were e-mailed to PACC hospital members during the project period (conducted on April 27, 2017, and October 5, 2017). The surveys collected data on patients waiting for post-acute care placement on both days (e.g., factors influencing delays in placement, demographics, etc.). Key findings from the surveys were presented to the PACC.

- ▶ **Key Informant Interviews:** The project team conducted 20 phone-based and in-person interviews with post-acute care stakeholders representing a diverse group of organizations and public programs working with and on behalf of high-risk post-acute care patients. Themes from the interviews were shared with the PACC.
- ▶ **Post-Acute Care Dashboard:** A summary table profiling medical, social support, and permanent supportive housing programs for post-acute care patients was developed, with an emphasis on programs serving low-income and high-risk post-acute care patients. (For additional information on many of these programs, see *Appendix A: Home and Community-Based Program Descriptions*.)
- ▶ **San Francisco Supported Community Living Programs and Program Gaps:** A detailed chart was compiled, outlining supported community living programs and program gaps relevant to the needs of low-income and high-risk post-acute care patients.

Analysis of the presented information, in conjunction with discussions about post-acute care patients requiring urgent attention, led the PACC to identify two subgroups of high-risk post-acute care patients as the most “stuck” at a level inappropriate to their needs:

SUBGROUP A	SUBGROUP B
Post-acute care patients who meet the following criteria: cognitively impaired, indigent or low- to middle-income, and requiring 24/7 supervision.	Patients requiring post-acute care services who are behaviorally challenging as a result of any of the following diagnoses: <ul style="list-style-type: none"> ▪ traumatic brain injury; ▪ dementia, substance abuse, hypoxia; and ▪ mental health disorders—psychotic, mood, personality, and substance use. Most patients in this subgroup are indigent or low- to middle-income.
<ul style="list-style-type: none"> ▶ <i>Cognitive impairment refers to an inability to independently self-manage activities of daily living (ADLs), such as eating, bathing, dressing, toileting, et</i> ▶ <i>Behavioral challenges include violent, aggressive, sexually acting-out, impulsive, verbally abusive and/or loud, non-redirectable, wandering, and non-compliant/non-adherent behavior; and active substance use.</i> 	

Two workgroups formed to develop implementable, financially sustainable solutions for each population subgroup. Major overlap in the workgroup solutions inspired the PACC to select one set of solutions appropriate to both post-acute care population subgroups. Three solutions were chosen. They represent the primary focus of the PACC and of this report.

The remaining report sections summarize the following: influential factors in post-acute care today, key findings from the PACC point-in-time surveys and stakeholder informant interviews, PACC recommended solutions, San Francisco’s SNF and subacute future, and next step recommendations.

Photographs throughout the remaining sections of this report show the PACC in action.

FACTORS INFLUENCING POST-ACUTE CARE TODAY

Factors influencing post-acute care today span new proposed Medicare payment models and the role of Medicaid; an integrated population health management approach to delivering health care; and increased local and state health system recognition of the impact of health care disparities on vulnerable post-acute care communities, e.g., low-income individuals, persons of color, etc.

Medicare's Proposed Post-Acute Care Changes and the Role of Medicaid

Medicare is a federal program that provides health coverage for individuals age 65 and older and certain younger people with disabilities. Part A is hospital insurance and Part B is medical insurance. Medicare does not cover long-term services and supports (LTSS), defined as a broad range of support services needed by people who have limitations in their capacity for self-care, because of a physical, cognitive, or mental disability or condition. It is, however, the primary payer for the four traditional post-acute care settings: long-term acute-care hospitals; inpatient rehabilitation facilities; SNFs; and the patient's home, through home health agencies.

Building on previous recommendations to reduce Medicare post-acute care spending in these four settings, the Medicare Payment Advisory Commission (MedPAC) recently recommended implementing a unified payment system for post-acute care.¹ The prospective payment system would cover the four settings with payments based on patient characteristics, not the site of service. The impetus for this proposed payment restructuring is MedPAC's commitment to improving the quality and efficiency of post-acute care. Under the current proposal, payments for care unrelated to a patient's characteristics would decrease (e.g., payment for patients receiving intense rehabilitation services after hip surgery), while payments for medically complex post-acute care patients would increase. Numerous post-acute care Medicare alternative payment pilots are underway.

Medicaid, unlike Medicare, provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. A joint federal and state program, Medicaid (Medi-Cal in California) provides benefits through Medicaid managed care or through a fee-for-service (FFS) delivery system. Medicaid managed care provides health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a fixed per member per month (capitation) payment for these services. Under Medicaid FFS, health care providers are paid for each service (e.g., office visit, test, or procedure).

Medicaid is the single largest payer of LTSS in the United States.² It covers long-term SNF care; some home and community-based services (HCBS) funded through state Medicaid waivers; and the Medicaid Managed Care program, which covers LTSS through capitated Medicaid managed care programs in certain states.³ Any changes to Medicaid coverage of LTSS are undertaken by states, which outline their proposed payment changes in their Medicaid State

Plan. The Centers for Medicare and Medicaid Services (CMS) review and approve all Medicaid State Plans.⁴

Framing San Francisco's Post-Acute Care Challenge underscored multiple challenges for Medi-Cal post-acute care patients:

- ▶ First, California has the highest number of dual eligible beneficiaries (medically complex, high utilizers of health care with Medicare and Medi-Cal) and one of the lowest Medicaid rates in the country. The state's low Medi-Cal reimbursement rate is consistently reported as a limiting factor in beneficiaries' access to both medical and post-acute care, including short- and long-term SNF care.⁵
- ▶ Second, post-acute care patients with behavioral difficulties associated with mental illness, traumatic brain injuries, dementia, and substance abuse are predominantly Medi-Cal beneficiaries.⁶ With characteristics requiring intense behavioral management and an undesirable insurance, this group is frequently difficult to place in all post-acute care settings.
- ▶ Last, obtaining an HCBS waiver, an alternative to SNFs for some Medi-Cal patients, is challenged by too few slots and limiting cost caps.⁷ Because Medi-Cal covers SNF care, notwithstanding the placement challenges associated with having this insurance, many post-acute care patients are placed in SNFs, even if they could transition to supported community settings.

Focus on Population Health Management

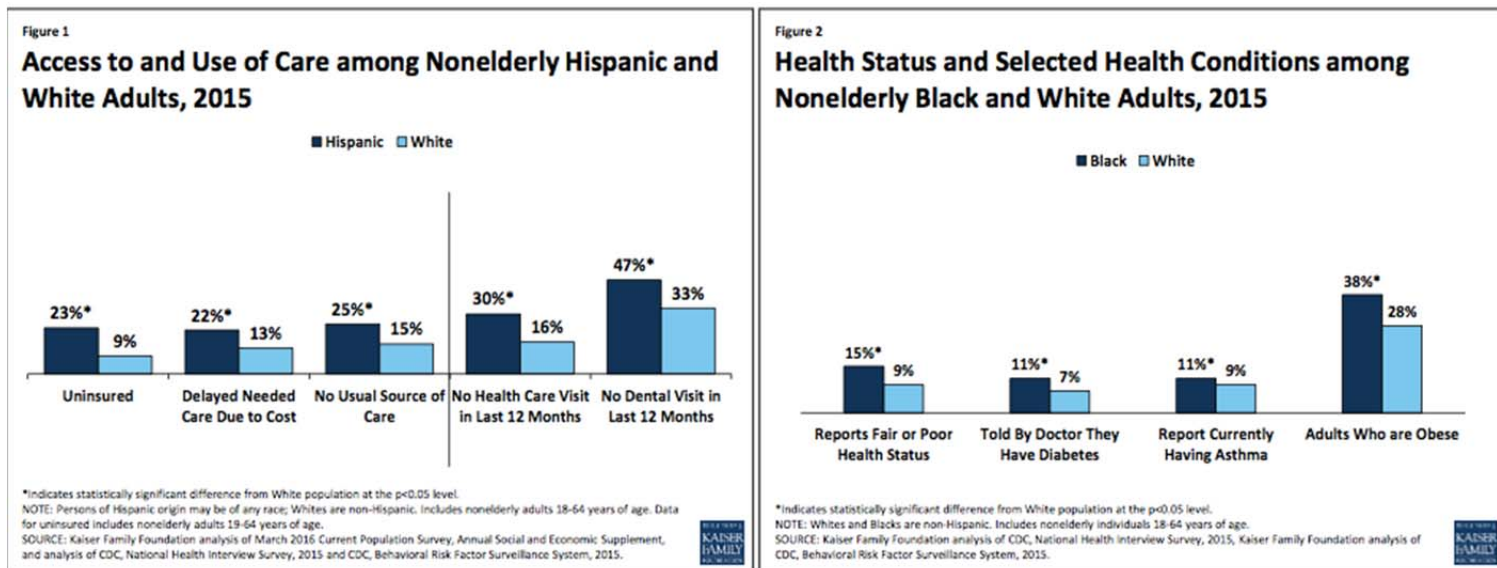
The field of population health management studies patient data to facilitate the delivery of health care services, such as disease prevention and health promotion strategies. Early health care interventions and supports are associated with reduced health care condition chronicity and expensive health care utilization.⁸

An important development in population health management is the growing recognition that socioeconomic and social determinants of health powerfully affect individual and population health anywhere on the continuum, including in post-acute care. Social determinants of health are the conditions in which people are born, grow, live, work, and age. They are shaped by the distribution of money, power, and resources—at the global, national, and local levels.⁹

Relevant examples of how post-acute care is affected by social determinants of health in California include the cost of board and care homes and caps on the amount of in-home care available through the In-Home Supportive Services (IHSS) program. Regarding the former, the cost of board and care homes is increasingly financially prohibitive for low-income individuals. For the latter, IHSS maximum hours of service per month reduce the ability of some people with greater care needs to remain in their homes. Because of these access barriers, low-income individuals are at increased risk of being transitioned to SNFs to receive the care they need. As the field of population health management continues to develop, additional research is needed to assess barriers to health care services and supports for underserved populations.

Reducing Health and Health Care Disparities

Health and health care disparities, which reflect differences between groups in their health status and ability to obtain care, are intimately tied to socioeconomic and social determinants of health. Federal attention to reducing health and health care disparities under the ACA has resulted in significant gains in health insurance coverage for low-income individuals and persons of color, but more remains to be done.^{10,11} A Kaiser Family Foundation report analyzing population, social, economic, and health data, shows that compared to Whites, Hispanics fare worse across measures of health access and use (Figure 1). It also shows that compared to Whites, Blacks fare worse across multiple health measures (Figure 2).¹²



Disparities in health care are not restricted to access and quality of care. They include health care status and outcomes, and affect a broad range of groups, including persons of color and individuals who are low-income; lesbian, gay, bisexual, and transgender (LGBT); have limited English proficiency; and many others.¹³

Although post-acute care has not been widely studied for health care disparities, several studies highlight that disparities exist in the quality, setting, and availability of post-acute care for low-income individuals and persons of color. Low-quality care, independent of the setting, is associated with poorer health outcomes.

In a study examining ADL outcomes for older adults who received post-hospitalization home care, Asian, Black/African American, and Hispanic patients experienced significantly less improvement compared with non-Hispanic Whites.¹⁴ Recognizing that more research is needed to clarify the range of factors that may be underlying this outcome disparity, the study researchers noted that one variable that may contribute to the lower rate of ADL disability recovery for these minority patients was the greater number of rehabilitative therapy visits received by non-Hispanic whites across all racial/ethnic groups.

In another post-acute care study, hospital discharge data was analyzed to determine the extent to which demographic, socioeconomic, and geographic disparities exist in the use of post-acute rehabilitation care for patients receiving total joint arthroplasty (knee or hip replacement surgery) across an eight-year period.¹⁵ Study findings indicated that in many instances, minority patients and those with Medicaid and lower socioeconomic status received less intensive care than individuals who were White or had private insurance. As an example, in the study's analysis of institution versus home health care, minorities who were uninsured or on Medicaid were less likely to receive the more intensive institutional level of rehabilitation care.

Both studies emphasize the need to further examine the quality and level of care provided to minority, low-income, and other disenfranchised patients in all post-acute care settings. They also point to the need to study individual, community, and system-level variables that influence access to post-acute care. Examples of these variables include the availability of caregivers and the level of support they provide, and social determinants of health, such as access to education, employment, quality of housing, health literacy, and access to primary care, etc.

Tools that can be used in all care settings to address disparities include ensuring that clinical best practices are equitably applied to all patients; engaging a workforce that includes diverse staff; and offering trainings, educational opportunities, resources, and other tools to educate staff and administration about health care disparities and how to eliminate them.¹⁶



L-R: Maggie Williams, Care Coordination Consultant, Kaiser; Mivic Hirose, Executive Administrator, Laguna Honda Hospital and Rehabilitation Center; Daniel Ruth PACC Co-Chair, President/CEO, Jewish Home of San Francisco



L-R: Shireen McSpadden, Executive Director, Department of Aging and Adult Services; Lauren Suarez, CEO, Kentfield Hospital

PACC POINT-IN-TIME SURVEYS AND KEY INFORMANT INTERVIEWS

San Francisco Hospital Point-in-Time Post-Acute Care Survey: April 2017

Eight San Francisco hospitals participated in the first PACC Hospital Point-in-Time Survey on April 27, 2017. (See list, right.) The purposes of the survey were to:

1. Estimate the number of patients currently in acute care hospitals who need placement in a post-acute care setting
2. Understand reasons for delays in placement
3. Determine which factors are most common among high-risk/hard-to-place patients.

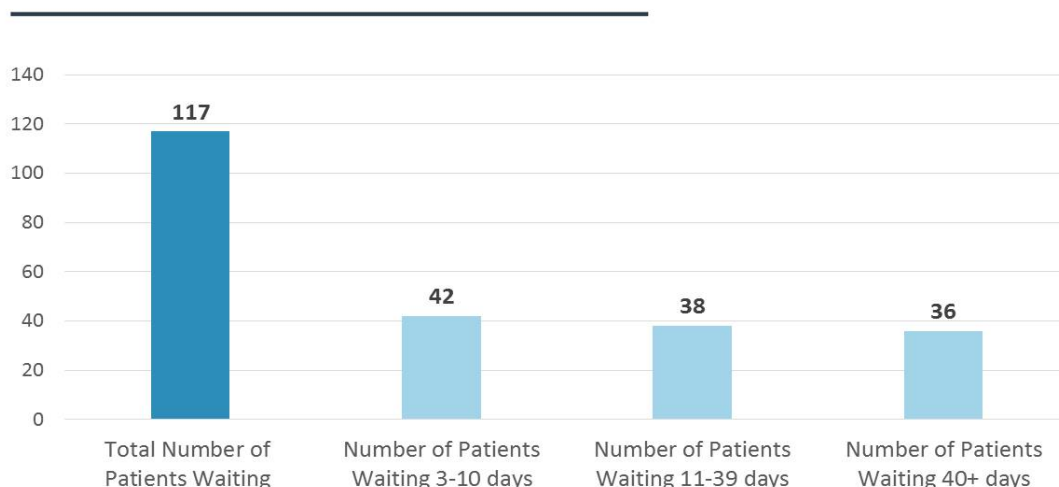
Key findings of the survey are summarized and illustrated in charts below.

117 patients were waiting for post-acute care placement in the eight participating acute care hospitals on Thursday, April 27, 2017.

Payer sources for this group included: Medi-Cal FFS (27), Medi-Cal Managed Care (38), Medicare (27), Medicare/Medi-Cal (21), and private insurance (4).

Figure 3 presents the number patients waiting for post-acute care placement across three different time frames: 3-10 days (42), 11-39 days (38), and 40 or more days (36). Hospitals with the most patients waiting across the three time frames were ZSFG (40), St. Francis (20), and UCSF (18).

Figure 3. April 27, 2017 Survey: Patients Waiting for Post-Acute Placement (n=117)



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In response to the question, “What are the key reasons you are unable to find placement for patients,” hospitals reported:

- ▶ “Patient’s previous SNF bed hold expired.”
- ▶ “Patient has dementia.”
- ▶ “Patient has long-term custodial needs and Medi-Cal.”
- ▶ “Patient presents with difficult behavior.”

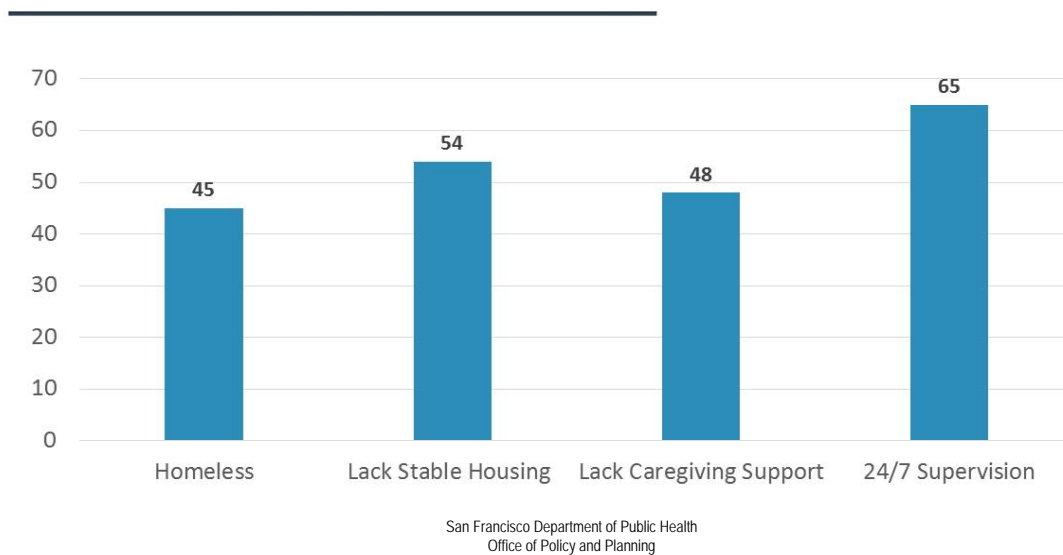
Leading patient behavioral characteristics reported by hospitals were:

- ▶ Behavioral health challenges (e.g., agitated or violent behavior, suicidal ideation, and psychotic disorders)
- ▶ Substance use
- ▶ Dementia

Primary social characteristics were the need for 24/7 supervision, lack of stable housing, lack of caregiving support, and homelessness (Figure 4).

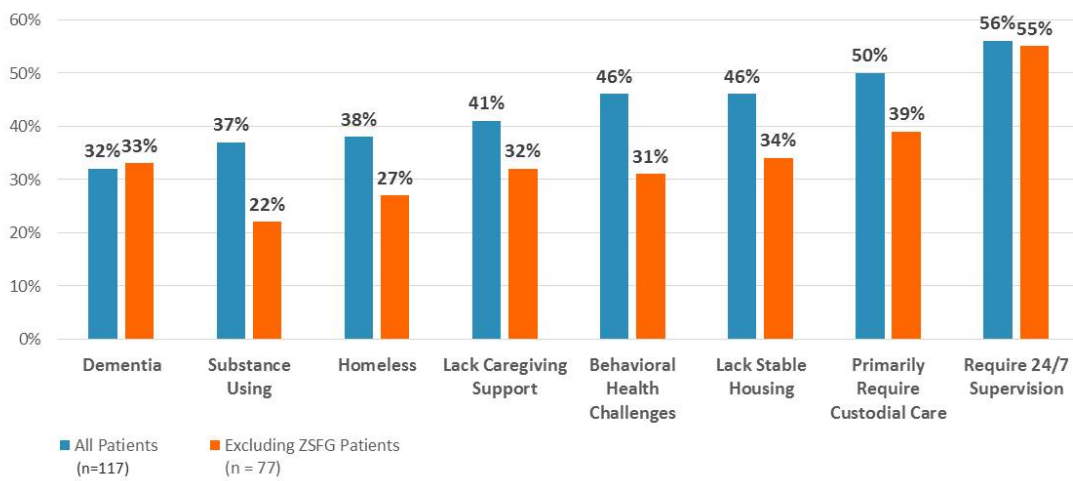
Note: Figures 4 (below) and 5 (following page) reflect that some patients had more than one behavioral health/social characteristic.

Figure 4. April 27, 2017 Survey: Patient Social Characteristics (n=117)



Analysis of the data revealed that approximately 59 (50 percent) of the 117 patients waiting for post-acute care placement were identified as requiring custodial care, and 28 (24 percent) could be accommodated in a lower level of care in the community. These findings are amplified in Figure 5, which summarizes behavioral and social characteristics for this group of patients. To assess the effect of ZSFG patients (ZSFG is the safety net public hospital for San Francisco, primarily serving low-income and vulnerable communities) the data was analyzed with and without ZSFG patients. Excluding ZSFG patients, the proportion of patients with dementia (33 percent) and patients who require 24/7 supervision (55 percent) remains constant.

Figure 5. April 27, 2017 Survey: Summary Patient Characteristics



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Findings from April survey helped the PACC begin to identify cognitively impaired, indigent and low- to middle-income, post-acute care patients requiring 24/7 supervision and patients who are behaviorally challenging as two critical groups of high-risk post-acute care patients. Both groups have significant post-acute care needs but limited support and placement options.



Monique Parrish, PACC Project Manager, LifeCourse Strategies

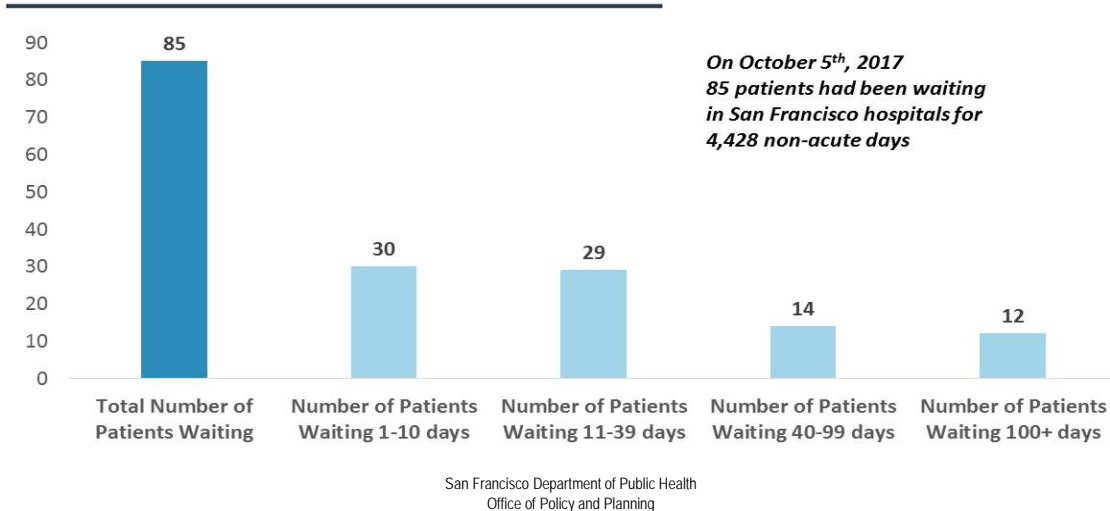
San Francisco Hospital Point-in-Time Post-Acute Care Survey: October 2017

A second PACC Hospital Point-in-Time Survey was conducted on October 5, 2017 to analyze changes in patient numbers and the factors influencing delays in post-acute care placement between April and October. Unlike the April survey, which asked hospitals for aggregate patient data, however, the October survey collected individual-level data including demographic data (age, gender, race/ethnicity).

The same eight San Francisco hospitals that participated in the first PACC post-acute care point-in-time survey participated in the second: California Pacific Medical Center (CPMC) Davies Campus, CPMC Pacific Campus, CPMC St. Luke's Campus, Kaiser San Francisco, St. Francis Memorial Hospital, St. Mary's Medical Center, University of California San Francisco Medical Center (UCSF), and Zuckerberg San Francisco General Hospital (ZSFG). Note: because CPMC reported patient data from the three CPMC hospitals on one survey, they are represented as "CPMC" in the data findings.

On October 5, 2017, **85 patients** were waiting for post-acute care placement in the eight participating acute care hospitals. Figure 6 presents the number of patients waiting for post-acute care placement across four different time frames: 1-10 days (30), 11-39 days (29), 40-99 days (14), and 100 or more days (12).

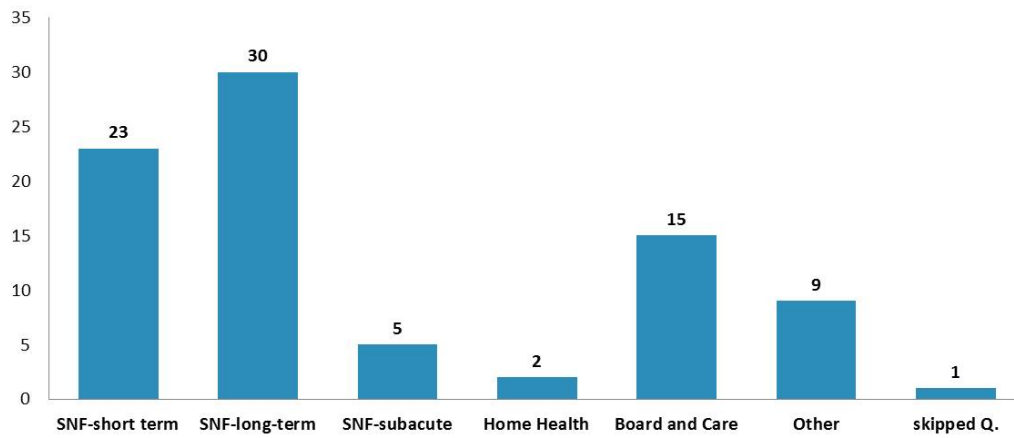
Figure 6. October 5, 2017 Survey: Patients Waiting for Post-Acute Placement (n=85)



Leading patient behavioral characteristics for the 85 patients waiting for post-acute care placement were behavioral health challenges, substance use, patients with dementia, and Medi-Cal patients with severe mental illness. Primary social characteristics were the need for 24/7 supervision, lack of stable housing, lack of caregiving support, and homelessness. As with some of the patients waiting for post-acute care placement in April, some October survey patients presented with more than one behavioral or social characteristic.

Among the 85 patients waiting for post-acute care placement, the primary desired post-acute care placement settings were long-term SNF (30), short-term SNF (23), and board and care home (15). (See figure 7.)

Figure 7. October 5, 2017 Survey: Desired Placement Setting (n=85)

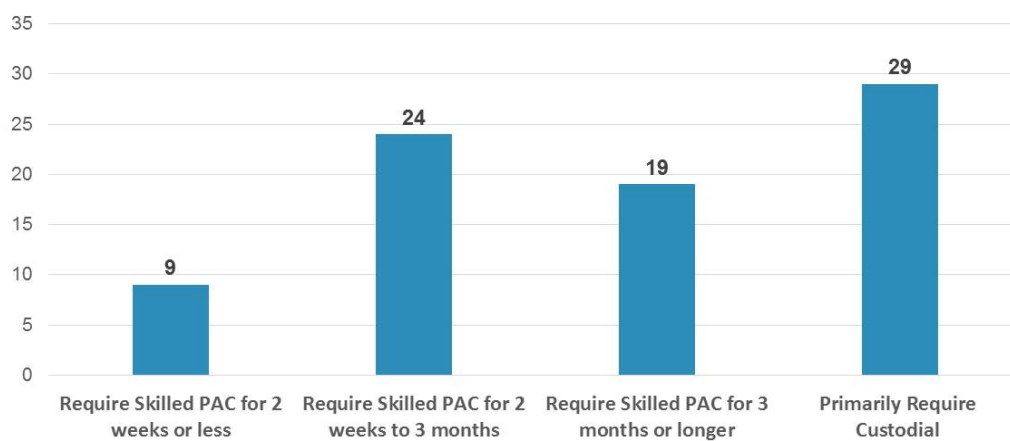


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Providing additional context to the desired placement information, data collected on patient acuity level (Figure 8) revealed that among patients waiting for placement (n=81):

- ▶ 29 (36 percent) required custodial care following discharge.
- ▶ 24 (30 percent) required post-acute care for two weeks to three months.
- ▶ 19 (23 percent) required post-acute care for three months or longer.
- ▶ 9 (11 percent) required post-acute care for two weeks or less.

Figure 8. October 5, 2017 Survey: Patient Acuity Level (n=81)



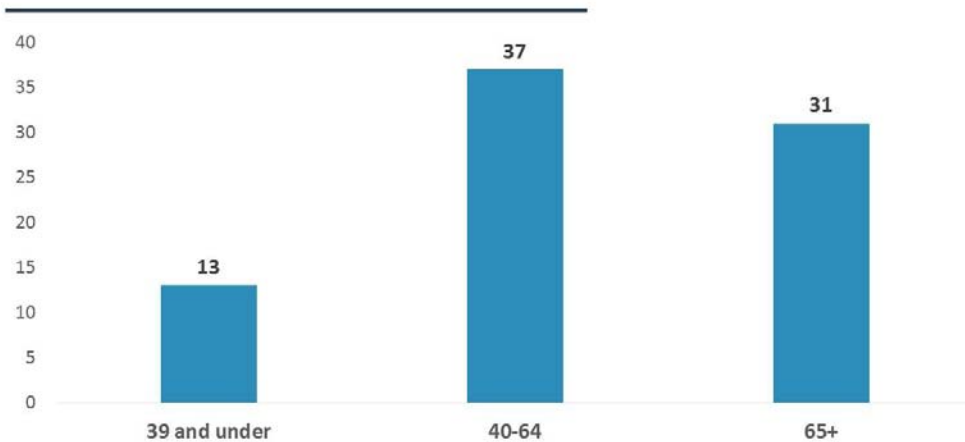
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As noted, the October survey collected information on age, gender, and race/ethnicity. Regarding gender, more men (56 percent) were waiting for post-acute care placement on October 5, 2017 than women (44 percent).

Figure 9 presents the breakdown of age reported for patients waiting for post-acute care placement (n=81):

- ▶ 13 (16 percent) were age 18-39
- ▶ 37 (46 percent) were age 40-64
- ▶ 31 (38 percent) were age 65 and older.

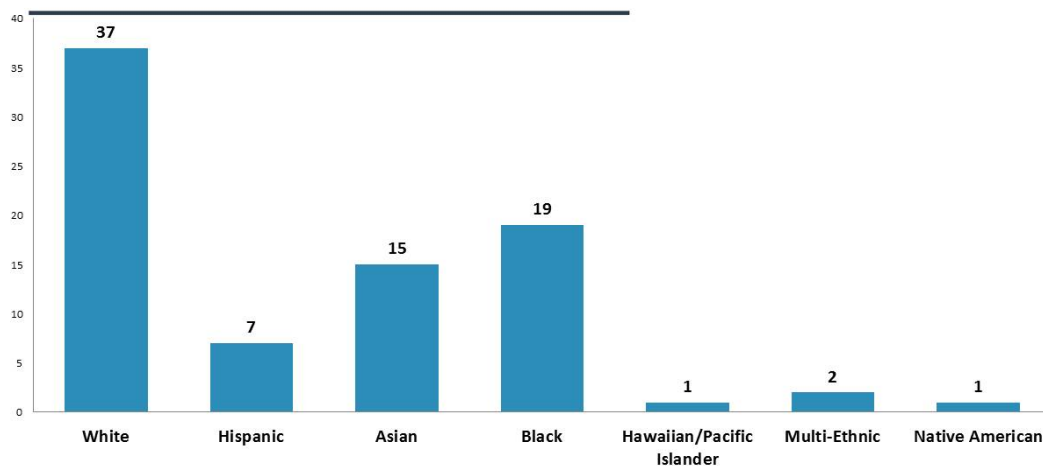
Figure 9. October 5, 2017 Survey: Patient Age (n=81)



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Figure 10 shows the breakdown in race/ethnicity (n=82): White (37), Black (19), Asian (15), Hispanic (7), Hawaiian/Pacific Islander (1), multi-ethnic (2), and Native American (1).

Figure 10. October 5, 2017 Survey: Patient Race/Ethnicity (n=82)



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Despite nuanced variation in the survey outcomes, key findings from the April and October Point-in-Time surveys highlight several common themes.

- ▶ First, significant numbers of patients waiting for post-acute care placement at both survey times were waiting for custodial care. Many of these patients could be accommodated in a community-based setting with appropriate long-term care supports (e.g., RCFE, independent housing with wraparound services).
- ▶ Second, both groups of patients share behavioral characteristics that include the following: substance use, behavioral challenges, severe mental illness, dementia, and traumatic brain injury.
- ▶ Last, it is important to note that for both surveys, when ZSFG patients were excluded, the percentage of patients with high-risk characteristics remained consistent.

Elizabeth Polek, Director of Patient Transition Management,
UCSF Medical Center

Key Informant Interview Findings

The project team conducted key informant phone and in-person interviews with over 20 stakeholders. Informants represented acute care hospitals, skilled nursing facilities, city departments, health plans, advocacy associations, and home- and community-based service providers. During the interviews, informants were asked to discuss their knowledge of and experience with a host of issues related to post-acute care, focusing specifically on the needs of high-risk post-acute care populations. To ensure relevance and appropriateness, the interview questions below were tailored to each interviewee's area of expertise and organization.

1. *What types of post-acute care services does your organization provide?*
2. *In what settings do you provide post-acute care?*
3. *How are the post-acute care services you provide funded?*
4. *Does your organization plan to provide, enhance, or expand post-acute care services?*
5. *What are the barriers and gaps in providing post-acute care for high-risk populations?*
6. *What are the opportunities to provide post-acute care for high-risk populations?*
7. *What ideas do you have to improve post-acute care in San Francisco?*

Informants identified a range of San Francisco post-acute care gaps and opportunities. From their responses, four themes emerged that were shared with the PACC: partnerships, workforce development needs, technology in post-acute care, and SNF and RCFE changing models of care. The themes represent stakeholder experiences with post-acute care and ideas for how to improve it, especially for high-risk populations in San Francisco.

- ▶ **Partnerships.** San Francisco, like many other cities around the country, is trying to balance finite resources with the emergent and growing health and social service needs of many low-income residents. Key informants unanimously recommended achieving this balance through partnership. Examples provided included 1) embedding care navigators in hospitals to assist with post-acute care discharges; 2) embedding hospital staff into post-acute settings to increase collaboration and quality; 3) sharing data systems; 4) leasing unused hospital space for post-acute care services; and 5) integrating housing with the Program of All-Inclusive Care for the Elderly (PACE) and other community-based programs, such as Community-Based Adult Services (CBAS).
- ▶ **Workforce Development Needs.** Families provide invaluable help and support to loved ones with serious illness and disability. As people live longer with chronic health conditions (including Alzheimer's disease), many caregivers can expect to care for loved ones with serious illnesses or disabilities for longer periods of time, but families cannot provide all the care needed. Ensuring quality of life and quality of care for older adults and persons with disabilities will be increasingly dependent on the availability of a competent direct care workforce.

Direct care workers provide critical assistance to seniors and individuals with chronic illnesses and disabilities in a wide range of areas (ADLs, medication management, light housekeeping) and settings (SNFs, RCFEs, and homes).^{17 18} To meet the needs of aging

residents and their families, key informants recommended that San Francisco include direct care workers in its workforce development strategy.

- ▶ **Technology in Post-Acute Care.** Technology affects all aspects of daily life today, including health care. Groundbreaking developments have occurred in how medication is dispensed, surgery is performed, disease progression is tracked, and health records are maintained. As San Francisco works to address the needs and gaps in care for San Francisco's post-acute care high-risk populations, key informants recommended that greater attention be given to how technology can be used to enhance PACC-recommended solutions.

One technological tool that should be explored for use in post-acute care is telehealth. Telehealth is increasingly used in urban, suburban, and rural communities.¹⁹ It is associated with faster and more responsive treatment, the elimination of costly and difficult patient travel, improved communication among providers, and lower health care costs. Telehealth has the potential to increase health care access and the quality of health care provided to residents living in diverse post-acute care settings, e.g., in their homes, supported community settings, and SNFs.²⁰⁻²³

- ▶ **SNFs and RCFEs: Changing Models of Care.** Key informants cited a multitude of changes in SNFs and RCFEs affecting the availability of these resources for post-acute care patients. San Francisco currently has 1,123 freestanding SNF beds and 1,319 hospital-based SNF beds, with no new beds planned for the immediate future. Beyond the critical issue of limited bed capacity, especially for Medi-Cal patients, two trends were reported for San Francisco SNFs: 1) a shift toward short-stay rehabilitation care for patients covered by Medicare or private insurance, over long-term care; and 2) limited SNF ability to accept patients with behavioral challenges. Patients admitted to SNFs with behavioral issues are frequently transferred back to the hospital.

RCFEs have experienced several significant changes too. RCFEs, including both assisted living facilities and board and care homes, are managing more residents with chronic health and ADL needs than in the past.^{24,25} As SNFs concentrate on patients with skilled care needs, many individuals with custodial care needs who previously would have been admitted to a SNF may be transitioned to RCFEs. However, costs for board and care homes which provide housing, meals, and general care assistance below the level of a skilled nursing facility, have been steadily rising. Today, the average monthly RCFE cost (which includes both assisted living facilities and board and care homes) in San Francisco is approximately \$4,300.²⁶ Low-income individuals who rely on Supplemental Security Income (SSI) receive, on average, \$1,180 per month. SSI is a federal income supplement designed to help aged, blind, and disabled people who have little or no income. Because of San Francisco's RCFE monthly rates, this community living alternative to SNFs for indigent or low-income individuals with some health and LTSS needs is cost prohibitive.

In response to changes in SNF and RCFE models of care, key informants recommended that post-acute care options for high-risk patients focus on the least restrictive settings appropriate to their needs. For some high-risk patients, these settings need to be both community-based and affordable.

PACC RECOMMENDED SOLUTIONS

Getting to the Solutions

The PACC-selected population subgroups for priority attention are 1) cognitively impaired, indigent and low- to middle-income, post-acute care patients requiring 24/7 supervision; and 2) patients who are behaviorally challenging as a result of any of the following diagnoses: traumatic brain injury; dementia, substance abuse, hypoxia; and mental health disorders (psychotic, mood, personality, and substance use). To develop proposed solutions to gaps in care for these subgroups, PACC members first agreed that all solutions will be funded through a public-private partnership. “A public-private partnership (P3) is a contractual arrangement between a public agency (federal, state, or local) and a private sector entity or entities. Through the agreement, the skills and assets of each sector (public and private) are shared in delivering a service or facility to meet the program and/or service needs of an agreed-upon population.”^Δ

Prior to discussing specific solutions for the two subgroup populations, the PACC participated in a series of strategic exercises and discussions about how best to meet the needs of individuals in the two subgroups. Given San Francisco’s limited SNF bed supply and how difficult it is to find a SNF bed for Medi-Cal patients in the city, addressing the SNF bed issue seemed a likely focal point for potential solutions. Instead, careful evaluation of the needs of the two subgroups—most of whom are low-income with limited social supports—revealed that supported living settings were more appropriate for many of these patients than SNFs.

Supported living settings offer a least restrictive environment for patients with ADL or behavioral health needs, and/or cognitive impairment, who could reside in a community setting with help. Examples of these settings are independent housing with support services (e.g., IHSS) and RCFEs. Several national trends highlight the viability of supported living as an appropriate alternative to SNF-level care for some individuals with nonskilled care needs.

- ▶ SNFs are increasingly focused on providing rehabilitative care to short-stay residents (e.g., less than three months) over long-stay patients. Some SNF payers have begun decertifying “custodial” patients (e.g., patients who need help with dressing, bathing, etc.), because their needs are not skilled. Federal Nursing Home Requirements, Code 42 U.S. Code § 1395i–3, state that SNFs are primarily engaged to provide skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services.
- ▶ Enabling people to live in the community with support is person-centered care that promotes individual autonomy, choice, and dignity.
- ▶ Increasing access to community living options for individuals with health care needs can free up SNF beds for those who need them.

^Δ The National Council for Public Private Partnerships: <https://www.ncppp.org/ppp-basics/7-keys/>

Patient flow is a critical issue for both acute care hospitals and SNFs. As San Francisco's population ages, appropriately managing patients at both levels of care is necessary to serve patients quickly and efficiently as their needs change. Fewer overall SNF beds in San Francisco today than a decade ago, and a catalyzed shift at Laguna Honda Hospital toward transitioning patients to supported community living settings, when possible, underscore the importance of ensuring that patients with short- and long-term skilled care needs have access to a SNF bed when needed. This is especially true for low-income Medi-Cal beneficiaries. Although the issue of SNF bed availability for this group of patients was not selected as a primary PACC focus, members affirm that placing all post-acute care patients in the right care at the right time will positively affect patient flow in SNFs. The importance of skilled nursing beds is further addressed in this report's section, *San Francisco's Skilled Nursing Facility and Subacute Future*.

With supported community living as the emerging focus for population subgroups A and B, two PACC workgroups formed. Each workgroup was asked to identify an appropriate set of solutions for its assigned subgroup. Major overlap in the workgroup solutions inspired the PACC to select one set of solutions, appropriate for the two distinct post-acute care populations with distinct needs and gaps in care. The PACC selected the following three solutions:

1. **Adopt a standardized post-acute care assessment tool**, Level of Care Utilization System (LOCUS), which all San Francisco acute care hospitals will use.
2. **Establish a citywide roving placement team**, available to all San Francisco acute care hospitals, to assess behaviorally challenging patients difficult to place in post-acute care, and provide behavioral and medication management recommendations to support patient discharges to the least restrictive setting appropriate to the patient's needs.
3. **Increase access to supported living alternatives** in San Francisco for low-income patients with dementia or behavioral challenges due to cognitive impairment and behavioral health diagnoses. This solution is two-pronged: A) fund subsidies and other support to increase access to independent housing with wraparound services and RCFEs in San Francisco for patients who can live supported in the community; and B) advocate for expanding the supply of affordable RCFEs in the mayor's housing initiative.

As an adjunct to these solutions, PACC members recommend that a comprehensive cost analysis of San Francisco's post-acute and long-term care continuum be undertaken as solutions are adopted for implementation. They also recommend that the third solution, *Increase access to supported living alternatives*, include a direct care workforce strategy, i.e., a plan to recruit, educate, train, and retain direct care workers to provide the care outlined in the solution.

The PACC solutions are the outcome of a deliberative process. LOCUS and the roving placement team promote systems change; and increasing access to supported living settings (from independent living with wraparound services to enhanced residential care facilities) supports individual patient needs. Each solution is presented in the following section as a proposal in summary format. The summaries provide enough concrete information for stakeholders to discuss the viability, financial sustainability, and potential impact of the solutions. Next steps will depend on the outcome of these assessments and corresponding collective action.



Solution 1: Adoption of LOCUS Tool

Hospitals adopt the Level of Care Utilization System (LOCUS) for post-acute care placement assessment

DEFINING THE ISSUE

- ▶ **Need:** San Francisco acute care hospitals currently use unique, hospital-specific post-acute care assessment and placement processes for behaviorally challenging patients. The absence of a standardized, evidence-based assessment tool contributes to increased patient lengths of stay, placement of post-acute care patients in settings that are not the least restrictive to their needs, and widely divergent post-acute care assessment and placement processes across city hospitals.
- ▶ **Gap:** No San Francisco acute care hospital, other than Zuckerberg San Francisco General Hospital (ZSFG), has adopted a standardized behavioral health assessment tool to assess and identify appropriate post-acute care discharges for patients with behavioral challenges. This significant gap means that most city hospitals are unable to appropriately match the needs of this patient group with available resources.
- ▶ **Solution:** All San Francisco acute care hospitals adopt the LOCUS tool for post-acute care placement assessment, currently used by DPH to assess and identify appropriate post-acute care discharges for patients with behavioral challenges at ZSFG. LOCUS will provide a common language, assessment approach, placement decision matrix, and data collection process for behaviorally challenging patients across all San Francisco acute care hospitals. Citywide use of LOCUS will additionally provide standardized data for hospitals to track placement patterns and address unfilled needs.

Note: LOCUS was created and validated for a psychiatric population (the LOCUS manual was designed to support this role). DPH has successfully used the tool, with modifications, for medical-surgical and dementia patients. (See *Appendix B: LOCUS Overview*.)

SUMMARIZING THE BENEFITS

Expected Outcomes

Through LOCUS, San Francisco hospitals will share a level of care assessment tool that assesses behaviorally challenging patients and identifies a corresponding appropriate discharge setting. There are several benefits to LOCUS. First, the tool will facilitate comprehensive assessments and responsive placements for patients with behavioral health needs, many of whom are Medi-Cal patients. When a Medi-Cal patient occupying an acute bed is assessed and quickly placed in a lower level of care appropriate to her or his needs, a bed becomes available for a patient with acute care needs. When this flow occurs, hospitals save money. The need to address the current bottleneck in discharges for this group of patients across San Francisco hospitals is significant. As highlighted in the PACC Hospital Point-in-Time Survey, on one day in April 2017, 117 patients were waiting for post-acute care placement across eight acute care hospitals.

Second, LOCUS will provide a citywide data tracking system, allowing hospitals and the City to work together to identify and respond to placement needs and gaps.

OUTLINING THE ELEMENTS

Scope of Proposed Service

Range of Service:

- ▶ **Assessment:** LOCUS will help hospitals identify patient strengths and limitations as well as an appropriate and corresponding level of care for post-acute care placement. As noted, the tool will allow for standardization in assessments and identification of placement needs across the acute care system in San Francisco. Equally important, the data generated from the tool can be used to develop a more adequate supply of discharge placements for post-acute care patients with behavioral health needs.
- ▶ **Available Tools:** The LOCUS (Adults) and CALOCUS (Children) level of care management tools were developed by members of the American Association of Community Psychiatrists (AACP); Deerfield Solutions is the provider of software for LOCUS and CALOCUS. See Figure 11 (following page) for cost information on available electronic versions of LOCUS and CALOCUS.

Patients Served

Based on the April 27, 2017, PACC Hospital Point-in-Time Survey, at least 54 of the 117 patients waiting for post-acute care placement met the criteria for the subdefinition of a behavioral health diagnosis, and 97 patients met the criteria for broader behavioral health diagnoses. Based on these numbers, all 117 patients would be appropriate for the LOCUS assessment. As noted, although the tool is validated only for behavioral health populations, the domains are applicable to patients with behavioral challenges and medical diagnoses. It can be used to inform level of care and placement recommendations for other patient groups.

Costs

The manual form (paper format) of LOCUS is free. Deerfield provides two electronic versions with an associated cost schedule: Service Manager Software and Reporter.

- ▶ **Service Manager:** A data repository that stores client demographics, retrieves and aggregates data, and maintains copies of all LOCUS evaluations. It is also a data tracking system that provides a clinical picture of a client's progress via ongoing patient assessments, throughout the treatment and recovery process.
- ▶ **Reporter:** A pay per evaluation website that allows the clinician to complete a LOCUS report online based on the client assessment. The website translates the assessment into a LOCUS score with a written report that can be printed. The Reporter does not collect any protected health information and does not provide long-term storage of evaluations.

Figure 11. Deerfield Electronic Version Costs

	ITEMS	ONE TIME ONLY	ONGOING MAINTENANCE
1	Service Manager Software	LOCUS: \$18,000 LOCUS & CALOCUS: \$22,000	
2	Reporter	As low as \$1.50 per evaluation	
3	Facility/Licensing Code Fees	Based on number of users Ranges from \$250 (5 users) to \$4,150 (200 users)	
4	Monthly User Fees		Based on number of users; ranges from \$50 (5 users) to \$440 (200 users)
5	Training (all trainings include 30 manuals)	1 day: \$2,100 2 days: \$3,900 3 days: \$5,400 4 days: \$6,600 Plus, travel and lodging at cost	
6	Manuals	\$18 plus shipping	

It is possible for LOCUS to be incorporated into an existing electronic health record system, e.g., LOCUS currently exists in the Netsmart information technology system.

Public-Private Partnership

The principal public-private partnership for this solution involves **all** San Francisco hospitals. All city acute care hospitals will use the same assessment standards for identifying the needs and appropriate level of care for patients with behavioral challenges. Funding the LOCUS project will require financial participation by all hospitals; however, the specifics of the contribution are to be determined. Expansion to SNFs may be considered, once LOCUS is citywide in hospitals.

Response to Low-Income Individuals

Findings from the April 27, 2017, PACC Hospital Point-in-Time Survey showed that 86 of the 117 patients waiting for post-acute care placement were identified as having Medi-Cal. Low-income people are likely to have fewer discharge options than middle- or upper-income people. Using a standardized tool to assess non-acute patients in acute care settings across the city would also provide critical demographic data necessary to ensure discharge parity across systems of care.

Risk Factors

Factors that could affect implementation include:

- ▶ Not all hospitals agree to adopt the LOCUS tool.
- ▶ Not all hospitals commit to contributing funds to purchase the LOCUS tool.

AFFIRMING THE VALUE

Summary

This solution will standardize assessment and placement processes for behaviorally challenging post-acute care patients across all San Francisco acute care hospitals, ensuring a uniform approach to matching patient needs with the least restrictive post-acute care setting appropriate to their needs.

The tool will additionally provide a mechanism for collecting data necessary to develop a more adequate supply of discharge placements that can appropriately meet the needs of behaviorally challenging post-acute care patients.

L-R: Sneha Patil, Senior Health Program Planner, Office of Policy and Planning, San Francisco Department of Public Health; Kelly Hiramoto, PACC Co-Chair, Director of San Francisco Health Network Transitions, San Francisco Department of Public Health



Solution 2: Roving Placement Team

Establish a citywide roving placement team

DEFINING THE ISSUE

- ▶ **Need:** Over the past several years, San Francisco acute care hospitals have experienced an upsurge in the number of post-acute care patients with significant behavioral health needs (e.g., mental health diagnoses, traumatic brain injury, dementia, and challenging behaviors associated with chronic substance abuse). Managing these patients is difficult; finding appropriate post-acute care placement for them is challenging. For example, most SNFs cannot accept acute care patients with behavioral problems, because they pose safety risks to residents and care challenges to staff. Under Title 22, California Code of Regulations, a SNF facility shall “accept and retain only those patients for whom it can provide adequate care.”
- ▶ **Gap:** Most San Francisco acute care hospitals have limited or no behavioral health experts available to assist staff with managing and placing post-acute care patients with behavioral challenges. This gap is met at ZSFG and a few other sites by a City-sponsored roving placement team that assesses low-income behaviorally challenging patients waiting for post-acute care placement. Because the team is at capacity, however, it is not available to all city hospitals.

Without access to a behavioral consult service, most San Francisco hospitals will continue to struggle to manage and place behaviorally challenging patients. Many of these patients remain in acute care when they could be assessed, managed, and returned to their prior residence or expeditiously transferred to a lower level of care.

- ▶ **Solution:** Create a **citywide** roving placement team (“Team”), so all city hospitals will have access to experts in assessing behaviorally challenging patients waiting for post-acute care placement. The Team will provide critical assessment support, ensuring that this group of patients is transitioned to settings that follow a policy of “matching patient needs with appropriate and available resources within the continuum of care.” Hospitals will also have an opportunity to learn from professionals employing best practices in the assessment of behaviorally challenging patients.

SUMMARIZING THE BENEFITS

Expected Outcomes

Discharging patients with behavioral challenges and post-acute care needs is a significant issue for all San Francisco hospitals. The Team will ensure that all hospitals have the assistance they need to comprehensively assess and identify post-acute care placements for these patients. Primary benefits of the Team for hospitals include increased acute care bed availability, due to reduced non-acute length of stays, and related cost savings.

The Team supports hospitals' commitment to delivering quality health care and maintaining patient flow. Ensuring patients' rights to live in the least restrictive, most appropriate setting in accordance with their needs is in alignment with these goals. Achieving this alignment, though, may necessitate a perspective change among hospital staff to:

1. Honor clients' right to choose, even when they make poor decisions;
2. Endorse non-institutional living first, when possible;
3. Be open to consultation from outside specialists; and
4. Understand that for some patients with significant behavioral challenges, a best available, safe discharge approach is necessary for hospitals to have the capacity to serve acute care needs.

While the City is responsible for multiple vulnerable patient populations, with a primary focus on the severely mentally ill, it has finite resources. With this solution, however, the return on investment (ROI) for the City is twofold. First, the addition of the citywide roving placement Team broadens San Francisco's capacity to serve more people, and second, the two roving placement teams would form a cooperative approach to serving this vulnerable community.

OUTLINING THE ELEMENTS

Scope of Proposed Service

Range of Service: The primary focus of the Team is **assessment** and **consultation**.

- ▶ **Assessment:** Using LOCUS or a similar assessment tool, the Team will identify patient strengths, limitations, and the appropriate level of care for post-acute care placement. Together, LOCUS and the Team will ensure a consistent approach to assessment, recommendations, approach to discharge, and access to resources for this challenging population across all San Francisco acute care hospitals. The combined tool and Team approach additionally reduces hospitals' risk for safety events and poor patient outcomes.
- ▶ **Consultation:** The Team will provide behavioral and medication management recommendations to support patient discharges to the least restrictive setting appropriate to the patient's needs (*see adjacent list of discharge options*).

In addition, the Team will have access to providers who can provide specialty assessments addressing addiction recovery, sexual behavior, violence risk, assistive devices, etc., to ensure patients are placed in settings with the support they need. The Team will also educate the hospital treatment team on patient behaviors that potential placement settings

can accept and what patient behaviors need to improve prior to transitioning patients to these settings. This is particularly important for patients assessed as SNF appropriate, because as noted, most SNFs do not accept patients with behavioral problems because of the risk disruptive behaviors pose to other residents in their care.

Placement: A second service level that covers arranging patient placements could be available at an additional cost. If this level were selected, the Team would work in partnership with hospital discharge planners to facilitate the placement and would monitor discharged clients until they are relocated to a more permanent placement. To facilitate patient access to longer term subsidized placements, the Team would interface with DPH, DAAS, the Department of Homelessness and Supportive Housing (HSH), and out-of-county resources.

Service Cost

The consult service charge will range from \$85 per hour for a neurobehavioral consult to \$150 per hour for psychiatrist or neurologist with a specialty (e.g., addiction recovery, dementia care, or addressing sexual/violent behavior). This charge does not cover an expanded Team placement role. For examples of roving placement team costs, see Figure 12 (following page).

Patients Served

The primary target populations are the two PACC high-risk post-acute care subpopulations:

- ▶ Post-acute care patients who meet the following criteria: cognitively impaired, indigent or low- to middle-income and requiring 24/7 supervision.
- ▶ Patients requiring post-acute care services who are behaviorally challenging as a result of any of the following diagnoses: traumatic brain injury; dementia, substance abuse, hypoxia; and mental health disorders—psychotic, mood, personality, and substance use. (*Behavioral challenges include violent, aggressive, sexually acting-out, impulsive, verbally abusive and/or loud, non-redirectable, wandering, and non-compliant/non-adherent behavior; and active substance use.*)

Figure 12. Roving Placement Team Cost Estimates: Staffing Examples by Location

	Staffing Option Examples	Base Salary	Estimated Fringe*	Indirect Expenses**	Total Cost
1	<u>Hospital Co-Located:</u>				
	Registered Nurse (1.0 FTE)	\$156,000	\$39,000		
	Social Worker (1.0 FTE)	\$106,080	\$26,520		
	Supervisor (0.25 FTE)	\$43,750	\$10,935		
		\$305,830	\$76,455	\$40,624	\$422,909
2	<u>DPH Co-Located:</u>				
	Registered Nurse (1.0 FTE)	\$139,750	\$67,080		
	Social Worker (1.0 FTE)	\$101,738	\$48,834		
	Supervisor (0.25 FTE)	\$43,255	\$20,765		
		\$284,743	\$136,679	\$44,425	\$465,847
3	<u>Outside Provider Co-Located:</u>				
	Neurobehavioral Occupational Therapist (1.0 FTE)	\$131,000	\$49,780		
	Social Worker (1.0 FTE)	\$106,080	\$40,310		
	Supervisor (0.25 FTE)	\$43,750	\$16,625		
		\$280,830	\$106,715	\$40,709	\$428,254

* Fringe is based on sponsor agency’s fringe benefit calculations: UCSF, 24 percent; DPH, 48 percent; and Crestwood, 38 percent.

**Indirect expenses represent the standard flat 12 percent of total costs.

Public-Private Partnership

- ▶ **Public:** The City-sponsored team would work in partnership with the acute care hospital Team, enhancing assessment and placement processes for patients with behavioral challenges.
- ▶ **Private:** Hospitals (and/or philanthropic partners) would be the likely candidates to fund the Team. Respecting how much a hospital is affected by post-acute care patients with significant behavioral challenges, funding by hospitals and/or philanthropic partners can be prorated—based on need and level of participation.
- ▶ **Community Partner:** The Team might benefit from sitting outside a hospital or City department to promote objectivity in the assessment process. If this approach were taken, an outside private entity would provide the staffing and support for the Team. Examples of potential community partners would be Crestwood Behavioral Health, Institute on Aging, Progress Foundation, or Baker Places.
- ▶ **Post-Acute Care Partners:** Once the Team is established, there may be an opportunity to expand the scope of the Team to cover working with post-acute care providers like SNFs. Expansion would be contingent on the effectiveness of the Team in acute care hospitals, and the willingness of post-acute care partners to fund it.

Response to Low-Income Individuals

Findings from the April 27, 2017, PACC Hospital Point-in-Time Survey showed that 86 of the 117 patients waiting for post-acute care placement were identified as having Medi-Cal. Low-income people are likely to have fewer discharge options than middle- or upper-income people.

Using a standardized tool to assess non-acute patients in acute care settings across the city would also provide critical demographic data necessary to ensure discharge parity across systems of care.

Risk Factors

Factors that could affect implementation:

- ▶ Not all hospitals will find value in contributing to the Team.
- ▶ A location for the Team cannot be found (e.g., hospital, City department, or community partner).

AFFIRMING THE VALUE

Summary

This solution solves the need for an expert consult team to assist San Francisco acute care hospitals with assessing and placing post-acute care patients with behavioral challenges.

L-R: Lauren Suarez, CEO, Kentfield Hospital; Liz Orlin, Chief Operating Officer, Tenderloin Neighborhood Development Corporation; Katie Lamont, Director of Housing Development, Tenderloin Neighborhood Development Corporation



Solution 3: Increase Access to Supported Living Alternatives

Increase access to Residential Care Facilities for the Elderly and independent housing with wraparound services

DEFINING THE ISSUE

- ▶ **Need:** Low-income post-acute care patients with behavioral challenges or care needs due to cognitive impairments or behavioral health diagnoses require increased access to supported living alternatives. Restricted access to these settings for patients who could live in independent housing with wraparound services or an RCFE with 24-hour care frequently results in transfers to SNFs both in- and out-of-county.
- ▶ **Gap:** San Francisco has a limited supply of supported living settings for low-income individuals, and even fewer that can manage and support individuals with dementia and behavioral challenges. Many of these patients need assistance with ADLs, 24-hour monitoring, or intensive support services. Because patients with these needs are difficult to transfer to post-acute care, they often remain in the acute care setting for long periods of time. When a post-acute setting is found, it is often a SNF in another county that has available beds and will accept Medi-Cal patients. Some discharging hospitals carry the costs (short- and long-term) of placing patients in out-of-county facilities.
- ▶ **Solution:** Promote patient flow in both acute care hospitals and SNFs by placing non-acute, low-income patients who can transition to the community in supported living alternatives. This solution is two-pronged: A) fund subsidies and other support to increase access to independent housing with wraparound services and RCFEs in San Francisco for patients who can live supported in the community; and B) advocate for expanding the supply of affordable RCFEs in the mayor's housing initiative.

Part A of this solution endorses hospitals collectively funding subsidies for up to five years to provide a stable alternative to SNFs. This would enable patients to have access to RCFEs and wraparound services they would otherwise not have.

PART A SOLUTION: Increase Access to Supported Living Alternatives

SUMMARIZING THE BENEFITS

Return on Investment (ROI)

General costs for an acute care bed per day average \$2,400.* Results from the second PACC Hospital Point-in-Time survey, conducted on October 5, 2017, indicate 51 patients were waiting for placement in three of the six San Francisco hospital systems (CPMC, St. Francis and St. Mary's—Dignity Health, UCSF) that participated in the survey. When this number is multiplied by the total number of days the 51 patients were waiting (3,816 days), estimated expenses for the three hospital systems together could be as high as \$9,146,400.

Expediently placing post-acute care Medi-Cal patients with behavioral challenges or care needs (due to cognitive impairments or behavioral health diagnoses) into independent housing with wraparound services or RCFEs, would do the following:

1. **Reduce** non-acute hospital length of stays.
2. **Increase** bed availability for appropriate acute care patients.
3. **Decrease** the practice of hospitals individually subsidizing RCFE placements, i.e., entering daily rate arrangements to ensure access to these beds. Since this type of discharge arrangement is predominantly short term and does not include long-term sustainable patient care or living plans, many of these transitioned patients cycle back to acute care hospitals.

The City subsidizes both supportive housing and RCFE (board and care home) placements and is now at maximum capacity with respect to expanding this resource allocation. In partnership with the City, however, hospitals can increase patient access to one or more of these resources by funding subsidies and other support for up to five years. Providing a period of extended subsidy support will provide a stable alternative to SNF care and will reduce emergency department and acute care admissions for this group of patients.

While there is a limited supply overall of supported living alternatives, the primary access barrier to RCFEs today is not supply; it is cost. San Francisco has 79 RCFEs, and the median monthly cost is \$5,940. Lower-cost RCFEs are still cost-prohibitive, with monthly rates that are more than double the average monthly SSI rate of \$1,180.

Through Part A of this solution, hospitals will incur cost savings associated with decreased administrative days, hospital readmissions, and expensive individual hospital RCFE patchwork placements. An added benefit is that a coordinated citywide response to providing appropriate levels of care for some of San Francisco's neediest patients will promote a unified approach to

* The \$2400 figure represents a rough estimate of direct costs per bed per day at San Francisco acute care hospitals.

negotiating rate agreements with facility owners and landlords. These outcomes will support quality-driven, least-restrictive placements for vulnerable San Francisco patients.

OUTLINING THE ELEMENTS

Scope of Proposed Service

Range of Service: Three supported community living alternatives offer a range of support (low, medium, and high) for this solution. Funding subsidies and other support (for up to five years) will increase access to them.

- 1. Low Support: Independent Housing with Wraparound Services** (e.g., private residences, shelters, SROs, DAH, etc.).
- 2. Medium Support: Residential Care Facilities for the Elderly** (board and care homes)—licensed facilities that provide room, board, 24-hour staffing, and assistance with things such as bathing, dressing, and medication management.
- 3. High Support: Enhanced Residential Care Facilities for the Elderly** (board and care homes plus enhancements)—licensed facilities that provide standard board and care home services plus enhancements such as medical condition supports, monitoring, and additional care provided by staff trained in managing cognitive and behavioral difficulties.

Patients Served

The primary populations served through this solution are the PACC population subgroups: cognitively impaired, indigent and mid- to low-income, post-acute care patients requiring 24/7 supervision; and patients requiring post-acute care services who are behaviorally challenging as a result of any of the following diagnoses: traumatic brain injury; dementia, substance abuse, hypoxia; and mental health disorders (psychotic, mood, personality, and substance use).

Not only were both subgroups significantly represented in the April 27, 2017, PACC Hospital Point-in-Time Survey, 24 percent of the 117 patients waiting for placement were identified as being appropriate for a nonskilled level of care. This number would be higher if hospital discharge staff were trained in using the LOCUS assessment tool and more knowledgeable about non-institutional alternatives and the community service network of care. In addition, some of the survey patients identified as eligible for supported living were homeless. Placing these patients in the community with support would provide a better placement match and would eliminate the search for SNFs that accept patients without a discharge destination.

Costs

Costs for increasing access to the levels of supported community living alternatives associated with this solution are outlined in the accompanying addendum (see Figures 13-16).

Public-Private Partnership

Funding this solution will require public-private collaboration and cooperation, with a tie-in to the City's affordable housing policies. Weighing the costs and impact of increasing access to the three levels of supported housing will influence which one or ones emerge as the most viable to pursue. Note: the San Francisco Health Plan, the Medi-Cal Managed Care Health Plan covering most of San Francisco's Medi-Cal beneficiaries, is committed to evaluating a formal proposal submitted to San Francisco Health Plan's leadership and governing board.

Examples of successful public-private partnership health and housing programs for post-acute care patients with dementia and behavioral challenges are profiled in the PACC final report (see *Appendix C: Innovative Models for High-Risk Post-Acute Care Patients*).

Response to Low-Income Individuals

Findings from the April 27, 2017, PACC Hospital Point-in-Time Survey found 86 of the 117 patients waiting for post-acute care placement were identified as having Medi-Cal. Low-income people are likely to have fewer discharge options than middle- or upper-income people.

Using a standardized tool to assess non-acute patients in acute care settings across the city would ensure parity for discharge across systems of care.

Risk Factors

Factors that could affect implementation include:

- ▶ Varying interest among hospitals and the City to fund subsidies and other support, vis-à-vis a public-private partnership, to increase access to supported living alternatives for difficult-to-place, low-income post-acute care patients with dementia or behavioral challenges.
- ▶ Coordinating the solution, at any level, may prove logistically and financially complex, causing delays and a possible loss in interest among key stakeholders.

AFFIRMING THE VALUE

Summary

This solution will increase patients' ability to return home or to another independent living setting with wraparound services, so they can age in place in their communities. It equally increases access to supported housing for difficult-to-place, low-income, post-acute care patients with dementia and behavioral challenges (as a result of traumatic brain injury; dementia, substance abuse, hypoxia; and mental health disorders—psychotic, mood, personality, and substance use), who have the capacity to live in these settings with support.

Solution 3 Addendum: Supported Housing and Wraparound Service Cost Estimates

A. Independent Supported Housing

This table outlines wraparound services that can be available to individuals to support their living in the least restrictive independent setting (e.g., private home, shelter, SRO, DAH). It also presents the costs for several supported housing options currently paid for by the City.

Figure 13. Estimated Supported Housing Options—Costs Paid by the City

SERVICES	LOCATION	SUPPORTED HOUSING OPTIONS COSTS PAID BY CITY
Community with Wraparound Services* <ul style="list-style-type: none"> ✓ Home care ✓ Meals ✓ Assistive devices (e.g., commode, safety rails, Emergency Response System, medication reminders) ✓ Peer supports ✓ Transportation (Paratransit, bus) ✓ Day program 	Shelter	Shelter
	Temporary Hotel	Temporary Hotel: \$900—\$1,000 per month + service costs (clients pay nothing)
	Supported Housing (Example is DAH)	DAH Unit: * Client pays 30 percent of her/his income; City pays balance (average \$41-\$70/day)

*Direct Access to Housing (DAH) is service-enriched, subsidized permanent supportive housing for adults experiencing homelessness, who are low-income San Francisco residents with special needs.

B. Residential Care Facilities for the Elderly (RCFEs)

More than 90 percent of California’s residential care homes are licensed for six or fewer residents who are housed in a private residential home setting (board and care homes). This table highlights services included in the board and care home setting (e.g., 24-hour staffing, home care, meals, assistive devices, medication management, etc.) and the cost for this form of residential care in San Francisco and out-of-county. The RCFE costs column presents costs for RCFE placement for low-income individuals, typically a SSI rate plus an additional daily rate. The additional daily rate range is provided for in- and out-of-county facilities.

Figure 14. RCFE Average Cost Estimates in San Francisco and Out-of-County

SERVICES	LOCATION	RCFE COSTS
Residential Care Facility for the Elderly (RCFE)* <ul style="list-style-type: none"> ✓ Meals ✓ Medication monitor ✓ Transportation assistance to medical appointments ✓ Basic activities onsite 	San Francisco	SSI rate + additional daily rate of \$20/day to \$40/day
	Out-of-County	SSI only—\$40/day for out-of-county board and care (placement requires added support to transfer residency to new county)
*Costs for undocumented clients to be determined		

C. Enhanced Residential Care Facility for the Elderly (Enhanced RCFEs)

Enhanced residential care facilities are board and care homes with the capacity to provide additional medical condition supports, monitoring, and care for individuals with dementia or cognitive impairment with behavioral challenges. The services and costs for this kind of board and care home, in San Francisco and out-of-county, are presented in this table.

Figure 15. Enhanced RCFE Cost Estimates in San Francisco and Out-of-County

SERVICES	LOCATION	RCFE COSTS
Enhanced Residential Care Facility for the Elderly = RCFE services PLUS : ✓ Medical condition supports (e.g., diabetes care, skin care (Stage 2 or less wounds), pulmonary care) ✓ Wander guard (delayed egress or other secure exits) ✓ Enhanced activity structure ✓ Increased monitoring; clients can be redirected	San Francisco	SSI rate + additional daily rate of: \$93/day to \$300+/day \$40/day to \$300+/day
	Out-of-County	SSI rate + additional daily rate of: \$230/day for high-end dementia care (San Francisco and out-of-county)

D. Wraparound Service Costs for Independent Living Settings

The following wraparound service cost estimates are based on the Community Living Fund (CLF) Resource Program FY 2016-2017 expenditures (CLF is managed by DAAS). These services could be financed through a public-private partnership (e.g., hospitals contributing community benefit dollars and the City contributing Community Living Fund dollars).

Figure 16. Wraparound Service Cost Estimates for Independent Living

SERVICES	SERVICE LEVELS OFFERED	CHARGES FOR EACH SERVICE
Transportation	Scalable (Per Need)	Medical escort: (\$32/hr.) Taxi vouchers: \$15-30 each way Medi-Van escort: \$260 each trip
Meals/grocery delivery	Scalable (Per Need)	Home-delivered meals: \$5.50 (Meals on Wheels), \$8.00 per meal (other providers) Food bags: \$40 per bag (SFM Food Bank) Delivery: \$6.80 (SFMFB subcontract)
Caregiving In-Home Care/IHSS IHSS has a maximum of 283 hours per month for people with severe disabilities	Scalable (Per Need)	CLF: Private pay rate estimate is \$32/hr. Monthly averages: <ul style="list-style-type: none"> • Cost: \$2,434 • Hours: 76 IHSS: Average 84 hrs./mo. Clients with judgment impairment (e.g., cognitive impairment, mental illness): <ul style="list-style-type: none"> • Moderate impairment: 111 hrs./mo. • Severe impairment: 223 hrs./mo.

Figure 16 Cont. Wraparound Service Cost Estimates for Independent Living

SERVICES	SERVICE LEVELS OFFERED	CHARGES FOR EACH SERVICE
Home modification/durable medical equipment (DME)	Scalable (Per Need)	<p>Home Modifications: One-time or clustered (e.g., at time of facility discharge/enrollment):</p> <ul style="list-style-type: none"> • Stair lift: cost ranges depending on need/situation \$12-18,000 range • Automatic door opener: average \$4,000 • Assistive devices: average cost \$436 <ul style="list-style-type: none"> ○ Grab bar: \$30 - \$200 ○ Shower chair: \$70 ○ Drop-arm commode: \$80
Case management/social worker support	Scalable (Per Need)	Average: \$835/mo. (based on total CLF cost, e.g., operating, staff support, capital, etc.)
Passive supervision (to prevent wandering/self-injury)	Scalable (Per Need)	Average \$32/hr.
Memory programs and adult day health center programs	Scalable (Per Need)	Average \$80-90/day; \$130/day for private pay
Housekeeping (clients unable to manage on own due to ADL/IADL impairment) *	Scalable (Per Need)	Same rate as in-home care: \$32/hr.
Financial counseling/fiduciaries (short of conservatorship)	Scalable (Per Need)	Average: \$164/mo.
Legal support (advanced directives, wills, etc.)	Scalable (Per Need)	\$300/hr.
Grants for miscellaneous needs: electronics, communication devices	Scalable (Per Need)	Average: \$153/year

*IADL references Instrumental Activities of Daily Living, e.g., bill paying, shopping, food preparation, etc.

PART B SOLUTION: Advocate for Expanding the Supply of Affordable RCFEs in the Mayor’s Housing Initiative

SUMMARIZING THE BENEFITS

Expected Outcomes

Ensuring that San Francisco has an adequate supply of affordable RCFEs to meet future needs is an imperative. Given San Francisco’s aging population projections, the City must be prepared to respond to the need for this resource over the coming decades. RCFEs offer an important community living alternative to SNFs. To increase access to RCFEs for low-income residents, hospitals in partnership with the City should advocate that affordable RCFEs be part of the mayor’s affordable housing initiative for San Francisco.

OUTLINING THE ELEMENTS

Scope of Proposed Service

The scope of proposed services that would be expanded in the mayor’s housing initiative include the following two levels of affordable RCFEs identified in part A of this solution:

1. RCFEs (board and care homes)
2. Enhanced RCFEs (board and care homes plus enhancements)

Patients Served

The primary populations that will be served through this solution include the PACC subgroups: cognitively impaired, indigent, and mid- to low-income, post-acute care patients requiring 24/7 supervision; and patients with behavioral challenges (as a result of traumatic brain injury; dementia, substance abuse, hypoxia; and mental health disorders—psychotic, mood, personality, and substance use), who have the capacity to live in these settings with support.

Costs

No costs are currently associated with this solution.

Public-Private Partnership

Through a partnership approach, hospitals, the City, and other stakeholders will coordinate efforts to advocate for the inclusion of affordable RCFEs in the mayor’s housing initiative.

Response to Low-Income Individuals

Increasing the number of RCFEs for low-income individuals would meet the future need for this resource for indigent adults with behavioral health needs or cognitive impairment.

Risk Factors

Not expanding this resource will likely result in delayed hospital placements for patients who can live in supported living settings, as well as inappropriate placements to SNFs.

AFFIRMING THE VALUE

Summary

Expanding the supply of affordable RCFEs through the City's housing initiative ensures that the vulnerable communities addressed by the PACC will have future access to them. It equally supports the 1999 Supreme Court's Olmstead decision, which affirms the right of individuals with disabilities, including older adults, to receive public benefits and services in the least restrictive and most integrated setting appropriate to their needs.

Austin Ord, Director of Post-Acute Care, Bay Area Care
Coordination, CPMC-Sutter Health

SAN FRANCISCO'S SKILLED NURSING FACILITY AND SUBACUTE FUTURE

Although the PACC elected to focus on supported community living options as the most urgent placement need for predominantly low-income, high-risk post-acute care patients with dementia or behavioral challenges, members were mindful of the SNF bed issue for San Francisco. Framing San Francisco's *Post-Acute Care Challenge* identified the city as at risk for an inadequate supply of skilled nursing beds in the future.²⁷ The report additionally underscored that Medi-Cal beneficiaries with skilled nursing needs have limited options in San Francisco. Myriad factors have contributed to these findings.

San Francisco is one of the most expensive cities in the country. With a high cost of living and a high cost of doing business, its small geographic size contributes to companies' cautiousness in building or expanding SNFs within city limits. Added to these significant complications is the issue of return on investment. Medicare covers a SNF stay 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. 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. Since Medi-Cal is the primary payer of SNF care, and Medi-Cal rates are significantly lower than Medicare and commercial insurance reimbursements, the financial incentive for companies to provide and expand SNF care for Medi-Cal patients is limited.

The following descriptions of SNF levels of care and care settings, patient length of stay, and factors that mediate SNF usage are presented to provide nuanced context and background to the SNF issue in San Francisco.

- ▶ General SNF care includes a range of skilled nursing services that include 24-hour supervision, physical, occupational and speech therapy, wound care, intravenous therapy, injections, monitoring of vital signs, and assistance with ADLs. Subacute SNF care is for patients with specialized needs such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management. SNF settings are either hospital-based—distinct part skilled nursing facility (DP/SNF)—or freestanding, meaning the facility is located outside a hospital and is often called a nursing home.
- ▶ SNF length of stay varies. Short-stay SNF patients have time-limited SNF care needs, generally less than three months, and may receive rehabilitation services (physical, occupational, and speech therapy), wound care, intravenous (IV) therapy, injections, and monitoring of vital signs and medical equipment. Short-stay subacute patients need a higher level of service for a limited time to wean off a ventilator, or time for staff to educate families on ventilator care before patients are discharged home. Long-term SNF patients have care needs that require 24-hour nursing care and monitoring, such as assistance with ADLs, like bathing, eating, dressing, feeding, transferring, and toilet hygiene. Long-term subacute SNF patients have complex care needs that require intensive skilled nursing. Many of these patients cannot be weaned off a ventilator or discharged to a lower level of care because of their care needs.

- ▶ Multiple factors mediate the need for and utilization of SNF care. The most influential factors include aging population projections; available family/caregiver support; access to post-acute care services that match patient needs and resources; and federal and state Medi-Cal policy. In addition to covering long-stays in SNFs, Medi-Cal is also an entitlement program, i.e., states cannot restrict SNF care for eligible Medi-Cal patients through wait lists.²⁸

The PACC discussed the issue of SNF bed needs for San Francisco residents, now and in the future. Members acknowledged the many challenges associated with increasing access to SNFs for Medi-Cal beneficiaries and increasing the number of SNF beds (including subacute beds) in San Francisco. Folded into these discussions were several relevant developments:

- ▶ St. Luke’s Subacute Unit, currently San Francisco’s only subacute care unit, will be closing June 2018 (CPMC will continue to care for the patients currently on the subacute unit within the CPMC system).
- ▶ Kindred HealthCare recently sold its four San Francisco SNFs (totaling 589 of the current 1,223 freestanding SNF beds) to Blue Mountain Capital Management LLC.
- ▶ San Francisco has only one long-term acute care hospital (LTAC), operated by Kentfield at St. Mary’s Hospital. LTAC is a short-term facility for patients with serious illness who need respiratory therapy, traumatic brain injury treatment, and pain management.

With invited stakeholders, the PACC made the following SNF bed issue recommendations:

1. Utilize existing Bay Area facilities to provide SNF and subacute care.

- ▶ Coordinate with neighboring counties Alameda, San Mateo, and Santa Clara to purchase or lease SNF and subacute beds to support an expansion of existing freestanding or hospital-based SNF and subacute beds for San Francisco residents.
 - ▶ Advocate for regional Medi-Cal enrollment and create Medi-Cal Health Plan letters of agreement that allow for patient transition across counties.
 - ▶ Create a formal governance structure to oversee regional SNF patient placement practices and protocols.
- Note: residents placed in regional SNF facilities, however, should be transferred back to a corresponding facility in San Francisco as space becomes available.

2. Utilize existing facilities to provide SNF and subacute care in San Francisco.

- ▶ Create a public-private partnership model to use existing health care facilities to provide SNF and subacute care in San Francisco.
- ▶ Explore utilizing unused space in hospitals, medical offices, and/or freestanding skilled nursing facilities to create new SNF beds and subacute units managed by freestanding SNF providers.

3. Facilitate access to the home and community-based alternatives waiver.

- ▶ Support a navigator/community liaison that will guide and assist SNF and subacute patients and their families interested in accessing the Home and Community-Based Alternatives (HCBA) Waiver. The navigator would provide patients/families with information about the HCBA Waiver, connect them with HCBA agencies, coordinate care for the patient at home in accordance with the requirements of the waiver, etc.

NEXT STEP RECOMMENDATIONS

Several priority next steps emanated from the PACC process. They include 1) responding to the PACC recommended solutions, 2) preparing for San Francisco's future SNF needs, 3) increasing high-risk post-acute care patient access to palliative care, and 4) going "upstream" to support community living and aging-in-place.

Responding to the PACC Recommended Solutions

Reaching consensus on the PACC's high-risk post-acute care populations and corresponding gaps in care took time and careful review of relevant information and data. At each juncture of the 10-month dedicated process, members of the PACC, in partnership with several subject matter experts who served as adjunct workgroup members, focused on matching the most urgent need with a practical and sustainable response. The result was three PACC-endorsed recommended solutions. The next step for San Francisco's post-acute care effort is for the PACC to develop an operational plan to guide implementation of selected PACC-recommended solutions. (Figure 17, on page 44, summarizes this next step.)

Preparing for San Francisco's Future Post-Acute Care Facility Needs

San Francisco has a limited supply of SNF beds for Medi-Cal beneficiaries and, as of June 2018, will have no subacute care unit. As highlighted in the previous report section, because of San Francisco's aging population, the high cost of doing business in San Francisco, and low Medi-Cal post-acute care reimbursement rates, the PACC recommends the City and its partner stakeholders explore increasing SNF bed availability, especially for Medi-Cal beneficiaries, regionally and locally. Regional SNF options may involve collaborating with Bay Area counties to purchase or lease SNF and subacute beds to support an expansion of existing freestanding or hospital-based SNF and subacute beds for San Francisco residents.

Local options include exploring unused space in hospitals, medical offices, and/or freestanding skilled nursing facilities in San Francisco to create new SNF beds and subacute units. Additional options include discussing with Blue Mountain Management Company (the purchaser of Kindred) opportunities to maintain and possibly expand long-term SNF beds in the company's San Francisco SNFs. As noted, since most San Francisco residents with SNF needs would prefer to go to a facility within the city, regional placement should be considered an interim option until transfers to a San Francisco SNF can be made.

Note: Jewish Home has indicated interest in exploring the opportunity to host a SNF facility on its campus, with bed availability for Medi-Cal beneficiaries. The proposed model would involve a public-private partnership. A recent example of this type of a public-private partnership model in San Francisco is the psychiatric subacute unit for Medi-Cal beneficiaries at St. Mary's Medical Center. St. Mary's is providing the unit space, Crestwood Behavioral Health is providing the trained psychiatric staff, and UCSF and DPH are providing funding support.

Increasing High-Risk Post-Acute Care Patient Access to Palliative Care

Palliative medicine is increasingly recognized as essential and valuable patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care provides services throughout the continuum for people facing serious illness and their families.²⁹⁻³¹ This involves addressing the physical, intellectual, emotional, social, and spiritual needs of patients and families in a holistic manner.

From relieving the symptoms, pain, and stress of serious illness for patients and families to addressing patient psychosocial and existential needs, the interdisciplinary specialty palliative care team supports the whole person.³² Because palliative care focuses on clarifying goals of care and includes advance care planning, it is also associated with the more appropriate use of health care resources.³³ Palliative care's essential components have contributed to its steady growth in hospital, outpatient, and community settings. Increasing access to palliative care for high-risk post-acute care patients would provide another layer of support to many individuals managing serious illness.

Going Upstream: Support Aging-in-Place and Community-Living

Throughout the PACC process, members supported developing responsive solutions to the immediate needs of vulnerable post-acute care populations, but they also repeatedly acknowledged the importance of going upstream, to ensure that older adults, now and in the future, can live in their communities. The path to achieving this aging-in-place reality for many San Franciscans involves identifying what additional supports or wraparound services are needed, which adults need them, and what funding and partnership process can sustain them.

The San Francisco Department of Aging and Adult Services (DAAS) has been leading efforts to support community living—options and supports—for older adults and persons with disabilities for many years. As the administrator of Title III Older Americans Act funds, San Francisco's Community Living and Dignity Funds and other support programs for older and disabled adults in San Francisco, DAAS assesses, identifies, and supports an array of services that support community living (e.g., wraparound support services, nutrition programs, and caregiver support). The Department also staffs the Long Term Care Coordinating Council, which advises the mayor on policy, planning, and service delivery issues for older adults and people with disabilities.

To meet the exigency of aging-in-place options, San Francisco organizations and services that support older adults and persons with disabilities are encouraged to partner with DAAS to develop these vital community-based living supports.

Figure 17. PACC Next Steps

Objective: Continue the PACC for a time to be determined to (1) develop a work plan for operationalizing selected PACC solutions and (2) guide and oversee implementation of the work plan.

Major Functions of the Workgroup:



Prioritize selected solutions for implementation.



Develop an operational blueprint for each selected solution, clarifying the following:

- Public-private partnership model (clarifies partner responsibilities and duration of partnership)
- Budget—including additional funding needed to support solution
- Entity managing and/or housing the solution
- Contract process with entity/entities to implement solution
- Operations (staffing, referral population, eligibility, referral processes, scope of service)
- Project timeline
- Metrics to assess outcomes with specific project benchmarks



Guide and oversee implementation.

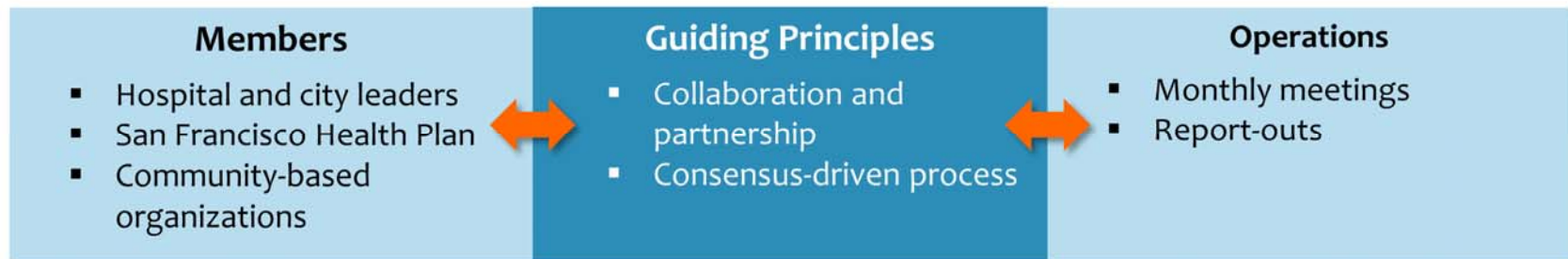


Report implementation progress to designated entities.



Partner with other city initiatives and programs that intersect with the PACC target populations and solutions, e.g., Whole Person Care Pilot, Emergency Department Behavioral Task Force.

How it Works:



CONCLUSION

The PACC's three recommended solutions: (1) LOCUS for post-acute care assessment and placement at all hospitals, (2) roving placement team, and (3) increased access to supported living alternatives, move the PACC closer to achieving its mission: *To identify implementable, financially sustainable solutions to the post-acute care challenge for high-risk individuals in the City and County of San Francisco.*

San Francisco faces multiple post-acute issues and needs. From meeting the needs of high-risk post-acute care populations, to increasing SNF beds in the city for low-income and underserved individuals, to promoting community-based supports and aging-in-place options, to addressing workforce needs, to expanding palliative care access, the urgencies are many.

No one agency, hospital, or community organization can solve San Francisco's post-acute care challenges. Whether the problem is how to use care facilities more efficiently to allow residents access to them when needed, or how to increase access to supported living options and services so people can remain in the community, the solutions to these challenges must ensure equity and be developed and implemented through collaboration and partnership.

APPENDIX A: HOME AND COMMUNITY-BASED PROGRAM DESCRIPTIONS

San Francisco Home and Community-Based Programs

Community Living Fund³⁴

The Community Living Fund (CLF) was created in 2006 by legislation introduced by the San Francisco Board of Supervisors. Through dedicated annual funds, CLF assists individuals who are currently, or are at risk of being, institutionalized by offering community-based services designed to keep individuals living independently and in the community. The program uses a two-pronged approach of 1) intensive case management and 2) purchased services/items to provide resources not available through any other mechanism to vulnerable older adults and younger adults with disabilities. CLF is considered the payer of last resort. Eligibility for CLF is restricted to individuals with income up to 300 percent of the federal poverty level. The CLF program is administered by DAAS through contracts with community-based organizations that are selected through a competitive bidding process (primary contract is with the Institute on Aging-IOA). Contracts are also awarded to organizations providing services that support community living, such as emergency home-delivered meals and transitional care for individuals returning home after a hospital stay. Funding has additionally been used to develop a training institute for professional case managers who work with seniors and persons with disabilities (SPDs).

Dignity Fund³⁵

The Dignity Fund ensures that San Francisco seniors and adults with disabilities are able to live with dignity, independence, and choice in their homes and communities through policy change and sustained funding of services and support. Established in 2016 (Proposition I, an amendment to San Francisco's City Charter), the Dignity Fund was given a baseline of \$38 million plus scheduled increases from the General Fund until June 30, 2037, to pay for programs and services to assist seniors and adults with disabilities. The Dignity Fund pays for programs and services to assist seniors and adults with disabilities: home and community-based long term care services and support, food and nutrition programs, consumer and caregiver education, empowerment and support, senior/disabled community and service centers, empowerment, self-advocacy and legal services program, and health and wellness. The Department of Aging and Adult Services (DAAS) administers the Dignity Fund.

Program of All-Inclusive Care for the Elderly³⁶

The Program of All-Inclusive Care for the Elderly (PACE) model of care provides a comprehensive medical/social service delivery system using an interdisciplinary team approach in a PACE Center that provides and coordinates all needed preventive, primary, acute, and long-term care services. Services are provided to older adults who would otherwise reside in nursing facilities. The PACE model enables eligible individuals to remain independent and in their homes for as long as possible. To be eligible, a person must be 55 years or older, reside in a

PACE service area, be determined eligible at the nursing home level of care by the Department of Health Care Services, and be able to live safely in their home or community at the time of enrollment.

San Francisco Department of Homelessness and Supportive Housing Direct Access to Housing³⁷

Initially established by the San Francisco Department of Public Health–Housing and Urban Health Section (SFDPH-HUH) in 1998, the Direct Access to Housing (DAH), now under the San Francisco Department of Homelessness and Supportive Housing (HSH), is a permanent supportive housing program targeting low-income San Francisco residents who are homeless and have special needs. A “low threshold” program that accepts adults into permanent housing directly from the streets, shelters, hospitals, and long-term care facilities, DAH strives to help tenants stabilize and improve their health outcomes despite co-occurring mental health issues, alcohol and substance use problems, and/or complex medical conditions. In addition to being an effective way to end homelessness, this supportive housing model reduces overutilization of emergency services and related costs. Unique in its on-site provision of wraparound support services, DAH currently houses over 1,700 formerly homeless people across 36 sites. DAH housing takes many forms, including master-leased single room occupancy hotels, units in new capital developments, set-aside DAH units in larger residential buildings owned by nonprofit providers, and units in a licensed residential care facility.

San Francisco Health Network Transitions Division³⁸

The goal of the Transitions Division is to ensure clients are stabilized in the most appropriate, least restrictive setting in the most cost-effective manner. SFDPH’s Transitions division primarily serves low-income, Medi-Cal-eligible, San Francisco residents with behavioral health issues, who need supervision, wraparound support, and subsidized placement to leave a hospital.

California Waiver Programs³⁹

Assisted Living Waiver

The Assisted Living Waiver (ALW) offers eligible seniors and persons with disabilities, age 21 and over, the choice of residing in either a licensed Residential Care Facility for the Elderly (RCFE) or an independent publicly subsidized housing with home health agency services as alternatives to long-term institutional placement. The goal of the ALW is to 1) facilitate a safe and timely transition of Medi-Cal eligible seniors and persons with disabilities from a nursing facility to a community home-like setting in an RCFE or public subsidized housing, utilizing ALW services; and 2) offer eligible seniors and persons with disabilities, who reside in the community but are at risk of being institutionalized, the option of utilizing ALW services to develop a program that will safely meet the person's care needs while continuing to reside in a RCFE or public subsidized housing.

Home and Community-Based Alternatives Waiver

The Home and Community-Based Alternatives Waiver is the former Nursing Facility/Acute Hospital Waiver (NF/AH). This waiver offers services in the home to Medi-Cal beneficiaries with long-term care conditions who meet the acute hospital, adult subacute, pediatric subacute, intermediate care facility for the developmentally disabled–continuous nursing care, and Nursing Facility A/B levels of care with the option of returning and/or remaining in their home or home-like setting in the community in lieu of institutionalization.

In-Home Operations Waiver

The In-Home Operations (IHO) Waiver was originally developed for individuals who had been continuously enrolled in a DHCS-administered waiver prior to January 1, 2002, and who primarily receive direct-care services rendered by a licensed nurse. This waiver offers services in the home to Medi-Cal beneficiaries with long-term medical conditions in their home or home-like setting in the community in lieu of institutionalization.

Multipurpose Senior Services Program Waiver

The objective of the Multipurpose Senior Services Program (MSSP) Waiver is to provide opportunities for Medi-Cal beneficiaries who are frail seniors age 65 or older to maintain their independence and dignity in community settings by preventing or delaying avoidable nursing facility placement. Care management is the cornerstone of this waiver and involves beneficiary assessment, person-centered care planning, service arrangement, delivery and monitoring as well as coordinating the use of community resources. Services that may be provided with MSSP funds include adult day care, housing assistance, chore and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, and communications services.

CBAS and IHSS Programs^{40,41}

Community-Based Adult Day Services (CBAS)

CBAS, formerly known as Adult Day Health Care, provides therapeutic and supportive services in an adult day care setting. CBAS is a Medi-Cal Managed Care benefit available to eligible Medi-Cal beneficiaries enrolled in Medi-Cal Managed Care. Eligibility to participate in CBAS is determined by the beneficiary's Medi-Cal Managed Care Plan. The program is jointly administered by the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), and the California Department of Aging.

In-Home Supportive Services (IHSS)

In-Home Supportive Services (IHSS) helps pay for services provided to low-income elderly, blind, or disabled individuals, including children, so that they can remain safely in their own home. Some of the services that can be authorized through IHSS include housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and

protective supervision for the mentally impaired. To qualify for IHSS services, you must be a resident of San Francisco living in your own home or an abode of your own choosing (not a board and care facility, nursing home, or hospital), a U.S. citizen or legal resident, have a Medi-Cal eligibility determination, and demonstrate functional needs for assistance with activities of daily living (i.e., unable to live safely at home without care). IHSS authorizes up to 283 hours per month per recipient; however, this represents only 4 percent of San Francisco IHSS users. The current average weekly hours authorized are 21 hours/week. Most IHSS providers are family or friends of the recipient. The IHSS program is administered by each county with oversight by the California Department of Social Services (CDSS).

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APPENDIX B: LOCUS OVERVIEW

The LOCUS [Level of Care Utilization System for Psychiatric and Addiction Services] tool was created in 1998 by the American Association of Community Psychiatrists (AACP).⁴² Deerfield Solutions is the exclusive software developer of the LOCUS and CALOCUS instruments for the AACP, providing two electronic versions of these instruments: Service Manager and Reporter.

The impetus for LOCUS was to create quantifiable measures to guide assessment, level of care placement decisions, continued stay criteria, and clinical outcomes for adults with mental health and addiction challenges. LOCUS has three main objectives: 1) to provide a system for assessment of service needs for adult clients, based on six evaluation parameters; 2) to describe a continuum of service arrays that vary according to the amount and scope of resources available at each “level” of care in each of four categories of service; and 3) to create a methodology for quantifying the assessment of service needs to permit reliable determinations for placement in the service continuum.

The six evaluation parameters are:

1. Risk of Harm
2. Functional Status
3. Medical, Addictive, and Psychiatric Co-Morbidity
4. Recovery Environment
5. Treatment and Recovery History
6. Engagement and Recovery Status

Each of the following six levels of care is defined using four variables that broadly describe the array of services, service intensity, and program characteristic according to: 1) Care Environment, 2) Clinical Services, 3) Supportive Services, and 4) Crisis Resolution and Prevention Services.

The six levels of care are:

1. Recovery Maintenance and Health Management
2. Low Intensity Community Based Services
3. High Intensity Community Based Services
4. Medically Monitored Non-Residential Services
5. Medically Monitored Residential Services
6. Medically Managed Residential Services, and an additional set of services called “Basic Services,” which define resources available to the general community

The LOCUS scoring methodology translates the assessment results from a set of ratings to a placement recommendation.

LOCUS is a dynamic system that is both valid and reliable. It is used to assess immediate services needs (e.g., clients in crisis), as well as to plan for client resource needs over time. It can also monitor changes in status or placement at different points in time.

APPENDIX C: INNOVATIVE MODELS FOR HIGH-RISK POST-ACUTE CARE PATIENTS

Post-acute care patients identified as high-risk, those who are non-benefited, under-benefited, and/or hard to transition increasingly present discharge challenges for acute care hospitals. The core discharge challenge for individuals in this group is matching their health insurance (especially if it is Medi-Cal), post-acute care medical need, and challenging characteristics with available resources. For some, the challenging characteristic may be dementia, traumatic brain injury, mental health, or substance use. Below are three post-acute care innovation models that provide creative solutions to high-risk post-acute care patient needs in three different California Bay Area counties: Contra Costa County, Alameda County, and San Mateo County.

The first model, presented below, is an integrated, tiered health and housing support model for older adults and persons with disabilities. Choice in Aging is a multiservice center planned for older adults and persons with disabilities in Contra Costa County. Beginning in 2018, Choice in Aging will begin constructing the Aging in Place Campus. The campus will support low-income older adults and persons with disabilities, and will include current Choice in Aging programs plus three supported community living alternatives for low-income frail and disabled adults.

A second innovative post-acute care service model is the Health Plan of San Mateo's Community Care Settings Pilot. The pilot was developed and launched during California's Coordinated Care Initiative (CCI), a voluntary three-year demonstration (2014-2017) for dual eligibles to receive coordinated medical, behavioral health, long-term institutional, and home- and community-based programs and services through a single organized delivery system. Under the CCI, all Medi-Cal beneficiaries including dual eligible beneficiaries in seven counties joined a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including LTSS. These services include Community-Based Adult Services (CBAS)—organized day program of health services, therapeutic activities, and social services for older adults and adults with disabilities; Multipurpose Senior Service Program (MSSP)—care management for adults age 65 and older; In-Home Supportive Services (IHSS)—personal care services provided to adults over age 65 and people (all ages) with disabilities; and nursing facility services—supports and services provided in an institutional setting. (For information about these and other community-based programs, see *Appendix A: Home and Community-Based Services*.)

In February 2017, the governor's office announced the CCI would be restructured to exclude IHSS. The administration reported that because of the IHSS Maintenance of Effort, the CCI demonstration was generating General Fund costs rather than savings.⁴³ Cal MediConnect and MLTSS will continue, but IHSS will no longer be a plan benefit beginning January 1, 2018. The Health Plan of San Mateo is currently exploring opportunities to continue funding the innovative Community Care Settings program, which has transitioned 176 members with 21 members preparing for transition. Because these critical transitions result in moving members

from aid codes that cover their costs in long-term care to aid codes that do not cover the costs of care in the community (e.g., in an RCFE), the health plan is using strategic investment funds matched with Whole Person Care dollars to cover these costs. In addition, the health plan has proposed, in conjunction with other plans and some advocacy groups, a new rate structure to the California Department of Health Care Services (DHCS) that would enable the Health Plan of San Mateo to flexibly fund wraparound services for members that are nursing home eligible.

A third innovative model is the Recuperative Care/Housing Fast Support Network. This model offers an expanded medical respite program to primarily homeless individuals in Alameda County. Broadly defined, medical respite is “acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized in an acute care hospital or skilled nursing facility.” Medical respite gives homeless men and women a safe place to recuperate from acute injury or illness and offers a range of support services, such as ongoing medical care, social work services, including assistance with access to entitlements (General Assistance, Food Stamps), Supplemental Security Income and disability applications, housing search, linkage to primary care, counseling and psychiatry services, legal services, and drug and alcohol counseling.

APPENDIX D: PACC MEMBERS AND ADJUNCT WORKGROUP MEMBERS

PACC MEMBERS	
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<p>Mivic Hirose, RN Executive Administrator Laguna Honda Hospital and Rehabilitation Center San Francisco Department of Public Health</p>	<p>Margaret G. Williams, RN, MBA, NE-BC, CPHQ Care Coordination Contracted Consultant Kaiser Permanente Greater San Francisco</p>
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