St Luke's Sub-Acute SNF Closure.
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From: Benson Nadell; Program Director;San Francisco LTC Ombudsman Program; Felton

I wish to enter the following points into public testimony pertaining to the confusing events leading up to this untenable decision by Sutter CPMC

As far back as the Lewin Report of 2009, there was criticism of SNF beds being omitted in the Master Plan, with a recommendation for more than those earmarked at the seismically safe Davies Campus. That report recommended that the Long Term Care Coordinating Council take a position. This was a bad referral.

At the time, The LTCCC was enthralled by Omstead Decision, The Davis and Chambers Class Action Lawsuit Settlement Agreements and a confusion between persons with disability being warehoused in institutions, and persons with complex medical conditions being professionally managed by round the clock nursing care. This Ombudsman has advocated for quality of care and life in SNF for years. At the time, I too thought it a good idea for as many as possible to be given the option of keeping their homes as receiving effective care-coordination-given the trend of SNF beds dwindling in number. There were many insoluble complex details in this home and community based emphasis on LTCCC. One was that the one-one staffing available to persons under IHSS was restricted to those eligible for M-Cal. The Medicaid Expansion, which ended at age 65 allowed for more to receive IHSS. The LTCCC was also under the spell of the various SCAN Foundation policy initiatives which were aligned CMS directions in getting persons out of nursing homes. This Ombudsman realized that living in most nursing homes, with shared bed rooms, unresponsive staff, absentee doctors, with little bed side manner, a reliance on behavioral control medications was an untenable way for persons to receive needed complex chronic disease management. The Ombudsman Program under Federal Law receives complaints about rights violations; under California Law, mandated abuse and neglect reports.

During this period there was confusion between two stereotypes: persons were no longer in nursing homes because they were disabled. No longer are there nursing homes for " custodial care". At the same time , with many living alone, there was an emphasis in self-direction and choice. But choice for many who acquire disability through an acute medical event, and live alone require supports which are often more complex than available through the city. The two law suits were focused on LHH with the city providing TCM and eventually funding for an expanded Community Living Fund. This was a good thing for persons at LHH who wished to, and were capable of returning to the community- often with new housing through Direct Access to Housing. In 2017 there is now competition with this housing with those coming through the new homeless department.

By contrast persons coming through other hospital systems were not able to access such Public Health and local funding(As of the present, IoA Community Living Fund, is taking referrals through DAAS Central Intake hub, with a wait-list).

The other stereo typifying narrative is that most elderly filing through hospital are on Medicare, and that with the reduction of length of stay those persons can now be discharged to community SNF which are

now the Post Acute Partners of most hospitals in SF. Post Acute is not long term care or focused on chronic disease management. These beds in the remaining free standing SNF are now utilized for shorter term stays of rehabilitation and recovery. Hospital based SNF had daily doctors; free-standing SNF did not. In addition staffing patterns , with high turnover, and poor supervision prevailed in these community based SNF.

No! Persons do not get a 100 days, under the various Medicare management care arrangements, a co-pay kicks in for the 21 day and beyond. Many do not have supplementary coverage. In addition those in these

Post- acute setting must make progress, get out of bed, and learn to climb stairs, let alone be able to transfer in and out of bed. Many do not reach that threshold and become uncovered. The Ombudsman Program receives complaints around this concatenation of factors:People are not ready; they have stairs, the home health agency did not arrive for days, the discharge plans did not cover details like meals, shopping food. In addition this Post Acute model of care did not result in ramping up of staff. Person are caught up in patterns of poor care and communication, lack of good interdisciplinary process. In addition the filing of appeal for more coverage, did not rely of person centered interviews but records electronically filed. It was bewildering for many.

The hospitals drove this process without any through- put on the process, except for bundled payment cases for elective surgery. This was a Medicare world gone awry.

What about complex medical coordination? That is long term care based on management of chronic illnesses. That is covered by Medi-Cal . Most of the Post Acute Partnering SNF did not want any more Medi-Cal persons occupying those Medicare utilized beds. So despite being Certified for billing Medi-Cal and already having residents who were long term care, these community based SNF are pressuring persons to get out, leave. If the person called the Ombudsman Program they would get the needed advocacy. These Post Acute SNF would complain that the Ombudsman was messing up their business plan. It must not be forgotten, under CMS and Title 22 All SNF have strong consumer and rights protections , which when enforced, can in this person centered comprehensive care environment, conflict with the business of patient flow in this Post Acute Environment.

This business plan in the aggregate is the consequence of combined hospital policies. If there is any direct causative factor for the elimination of the remaining long term care facilities, is lies with hospital decisions.

CPMC has closed most of its hospital based SNF which provided in-hospital rehabilitation. This cascaded into this new Post Acute World.

What about custodial care? there are no affordable or low income assisted living facilities . With small board and care homes there is no requirement for specialized staff to trouble shoot emerging chronic health conditions. Hospital emergency rooms only admit in patient those with traumatic or serious acute events. Many living in board and care are sent back to these sub standard setting by hospital ED, with no discharge plan other than instructions for a person unable to self manage care. The larger Assisted living type RCFE are expensive and with the absence of any comprehensive M-Cal Assisted Living, with rates set using regional market price average, many low income and moderate income, being asked to leave community SNF, have nowhere to go. Again, corporate hospital organizations say their responsibility stops at their doors. But ask any hospital –based MSW Discharge planner about this bleak landscape and they shake their heads.

No longer are persons in SNF for assistance with ADL alone. Now persons must be really sick with chronic medical problems.

So with Sutter-CPMC closing the Sub-Acute Unit of SNF beds, what strikes the Ombudsman Program is that these persons are the most dependent and most vulnerable. This is a long term care unit with specialized services under Medi-Cal. This is not a post acute setting where Medicare coverage dwindles after a few weeks. We must not confuse post acute with sub-acute. We must not confuse the Medicare silo of payments and services from the Medi-Cal one which pays long term care. If one reviews the recent history of Sutter CPMC with St Luke's, going back to the anti-trust suit, and the concessions with the then Board of Supervisors, St Lukes was always seen as a community hospital with a long list of services, which since 2000 have been eliminated piece meal by the Corporate Culture of Sutter –CPMC. The announced closing of the sub-acute unit, is of a piece with that top - down culture

Sutter CPMC has been contributory to the loss of long term care SNF beds in the community SNF indirectly, through the closing of their in-house DP/SNF beds at the California Campus and at St Luke's 8th floor. And now in its myopic , is closing the sub acute long term care unit at St Luke's.

Sure CPMC made a deal with City and County- money was contributed to certain NCO providing community services, from 2014-2016. But there is no answer to those in the future who may need sub-acute care. Other hospitals with sub-acute patients do not have adequate data after discharge. If those candidates were discharged to distances outside City and County there is no data as to mortality longevity or longitudinal stability. In the absence of such data, a false conclusion will be made that sub acute care is not necessary.

Go back to the Lewin Study; go back to recommendations for Hospital Council Report of 1997; To the Post Acute Report from 2/16. In an era of scarcity- cutting specialized beds is good for CPMC but not for the people of San Francisco.

No no ..This is not a matter of persons with disability being warehoused in institutions. It is a matter of those who need round the clock professional health care to maintain chronic illnesses: those on continuous oxygen, on ventilators, who need suctioning, who have tubes in their trachea. What Sutter CPMC is proposing is these persons being separated from daily visits from supportive families; being sent to free standing SNF in a world of Post Acute Care, where those with long term care needs are in the way of aggressive business plans.