
Framing San Francisco's Post-Acute Care Challenge

ACKNOWLEDGMENTS

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San Francisco Post-Acute Care Project Team

Common Report Abbreviations			
ACA	Affordable Care Act	SNF	Skilled Nursing Facility
ADLs	Activities of Daily Living	HCBS	Home and Community-Based Services
CPMC	California Pacific Medical Center	IADLs	Instrumental Activities of Daily Living
CMS	Centers for Medicare & Medicaid	LTSS	Long-Term Services and Supports
CCTP	Community Care Transitions Program	MedPAC	Medicare Payment Advisory Commission
DAAS	San Francisco Department of Aging and Adult Services	SFDPH	San Francisco Department of Public Health
DP/SNF	Distinct Part Skilled Nursing Facility		

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EXECUTIVE SUMMARY

Like many cities across the country, San Francisco's post-acute care continuum has undergone a dramatic transformation. In addition to mirroring the national trend toward fewer and shorter inpatient hospital stays, and increased discharges to home with home health (often in lieu of short-term skilled nursing facility stays), San Francisco has experienced other significant post-acute care changes. In 2011, California Pacific Medical Center (CPMC, part of Sutter Health) in San Francisco shared through its hospital rebuild discussions with the City that it expected to close its subacute skilled nursing facility unit (San Francisco's only subacute unit located on CPMC's St. Luke's campus) by 2019, when the new St. Luke's Hospital opens. As a result, the City's Development Agreement with CPMC required CPMC to work with San Francisco Department of Public Health and other hospitals to develop proposals for providing subacute care services in San Francisco.

Additionally, in 2014 and 2015, CPMC and St. Mary's Medical Center (part of Dignity Health in San Francisco) each, respectively, closed a hospital-based skilled nursing unit. The San Francisco Health Commission held Proposition Q^Ψ hearings following these closure announcements to review the impact on health care services in the community. Following the hearings on St. Mary's Medical Center skilled nursing unit closure in the spring of 2015, the Health Commission encouraged the San Francisco Department of Public Health (SFDPH), with other city agencies, hospitals, and community-providers, to research the needs for short-term skilled nursing and post-acute care services in San Francisco, and submit a report with recommendations to the Health Commission.

In response to the Health Commission's resolution, the San Francisco Post-Acute Care Project was launched in August 2015. The project design included the following core elements: a Project Team to oversee the project, clarified project terms, quantitative and qualitative data, research on alternative post-acute care models and settings, a Post-Acute Care Advisory Committee to guide development of project recommendations, and a final report to the Health Commission summarizing key findings and recommendations. Project Team and Advisory Committee members comprised diverse representatives from SFDPH, the San Francisco Department of Aging and Adult Services, San Francisco hospitals, community organizations, advocacy groups, and other stakeholder organizations.

Key findings from the San Francisco Post-Acute Care Project quantitative and qualitative data highlight three critical post-acute care challenges for San Francisco:

- 1) San Francisco is At Risk for an Inadequate Supply of Skilled Nursing Beds In the Future:** San Francisco's growing older population coupled with the high-cost of doing business in the city and low reimbursement rates for long-term skilled nursing care may result in a bed capacity problem in the future, i.e., available short and long-term beds for skilled nursing facility needs.
- 2) Medi-Cal Beneficiaries with Skilled Nursing Needs Have Limited Options in San Francisco:** Low Medi-Cal reimbursement rates for short- and long-term skilled nursing facility care and subacute care, and limited coverage for Home and Community Based Services (HCBS) waivers^Σ, limit skilled nursing options for Medi-Cal beneficiaries. Moreover, higher reimbursement for short-term Medicare patients has shifted skilled nursing facility practice toward short-term patients with Medicare, further limiting number of placement options for Medi-Cal patients.

^Ψ **Proposition Q** requires private hospitals in San Francisco to provide public notice prior to closing a hospital inpatient or outpatient facility, eliminating or reducing the level of services provided, or prior to the leasing, selling or transfer of management.

^Σ **HCBS Waivers** allow states that participate in Medicaid, [Medi-Cal in California], to offer home or community setting alternatives for individuals who would otherwise require care in a nursing facility or hospital. Services offered under the waiver must cost no more than the alternative institutional level of care, and recipients must have full-scope Medi-Cal eligibility

- 3) Post-Acute Care Placements for Some Vulnerable Populations Are Difficult to Find in San Francisco:** Key informant interviews and Advisory Committee discussions highlighted the difficulty of placing vulnerable patients in skilled nursing and long-term care. Vulnerable patients were predominantly described as individuals with progressive dementia, mental health disorders, and traumatic brain injury, or who are homeless or substance abusing.

Citywide Post-Acute Care Strategy

The San Francisco Post-Acute Care Project Team and Advisory Committee juxtaposed these urgent challenges with key project findings and their own post-acute care expertise and experiences. With a commitment to resolving San Francisco’s pressing post-acute care challenges, together they developed a final set of recommendations. The final set of recommendations (short-and long-term) include the following:

Short-Term Recommendations

- 1) Create a citywide Post-Acute Care Collaborative comprised of post-acute and home and community based service providers and other long-term services and supports stakeholders to further develop and implement San Francisco’s post-acute care strategy.
- 2) Explore new incentives and funding options to address current gaps in facility-based care and bring new skilled nursing facility (SNF), Residential Care Facilities for the Elderly, and subacute providers into the market.
- 3) Identify the total number of long-term SNF patients in San Francisco that could transition to the community (with a sustainable community living plan to ensure the most appropriate and least restrictive setting) to improve the flow of patients between facilities and the community.
- 4) Promote flexibility and expansion of community programs to care for post-acute care patients.

Long-Term Recommendations

- 5) Explore public-private partnerships to support alternative post-acute care settings.
- 6) Identify a process (e.g., an application or technology) for delivering real-time post-acute care information across acute care, post-acute care, home and community-based services.
- 7) Advocate for increased access to existing Medi-Cal Home and Community Based Services waivers.

These recommendations provide an initial framework for post-acute care change in San Francisco. Once the change process is underway, several issues merit further attention, including: developing a citywide subacute care strategy, which might include partnerships with regional subacute providers and developing alternative subacute settings; responding to San Francisco’s “hidden poor,” older adults with incomes above the federal poverty line who do not qualify for publicly-funded programs but are likely to need some post-acute and long term-care services they cannot afford; and, increasing the use of alternative home- and community-based post-acute care options. The latter may include evaluating the replicability of successful post-acute care service delivery models and alternative care settings identified in an environmental scan (conducted as a complement to the Post-Acute Care Project).

For years San Francisco hospitals and health systems have individually struggled with and tried to address, *mostly separately*, SNF bed supply and demand problems, Medi-Cal’s low reimbursement and funding levels for post-acute care, and the post-acute care needs of vulnerable populations. The San Francisco Post-Acute Care Project revealed the urgency and opportunity for all stakeholders across the post-acute care continuum to work together to resolve these post-acute care challenges.

INTRODUCTION

The Affordable Care Act (ACA) accelerated a shift away from traditional fee-for-service, volume-driven health care services to value-based payment models that encourage providers to focus on quality, outcomes, and cost containment. The law includes strategies promoting this direction change across the health care continuum, including acute and post-acute care. This dynamic shift, and much of the ACA, is consistent with the goals of the Institute for Healthcare Improvement's Triple Aim: improving the patient experience of care; improving the health of populations; and, reducing the cost of health care.¹

In recent years, greater attention has been focused on activating the ACA's health care reform mandate and the Triple AIM in post-acute care, broadly defined as care provided to patients following an acute care hospital stay. Traditional post-acute care settings generally include long-term acute care hospitals, inpatient rehabilitation facilities, skilled nursing facilities (SNFs), and home with home health agency services. New models and settings are emerging, however, driven in part by sector regulatory and financing changes, and growing support for community-based alternatives. In response to the changing post-acute care landscape, state and local healthcare systems are exploring opportunities to integrate the Triple AIM and flexibly meet the needs of patients across the care delivery continuum.

Like many cities across the country, San Francisco's post-acute care continuum has undergone a dramatic transformation. In addition to mirroring the national trend toward fewer and shorter inpatient hospital stays, and increased discharges to home with home health (often in lieu of short-term skilled nursing facility stays), San Francisco has experienced other significant post-acute care changes. In 2011, California Pacific Medical Center (CPMC, part of Sutter Health) in San Francisco shared through its hospital rebuild discussions with the City that it expected to close its subacute skilled nursing facility unit (San Francisco's only subacute unit located on CPMC's St. Luke's campus) by 2019, when the new St. Luke's Hospital opens. As a result, the City's Development Agreement with CPMC required CPMC to work with San Francisco Department of Public Health and other hospitals to develop proposals for providing subacute care services in San Francisco.

Additionally, in 2014 and 2015, CPMC and St. Mary's Medical Center (part of Dignity Health in San Francisco) each, respectively, closed a hospital-based skilled nursing unit. The San Francisco Health Commission held Proposition Q^Ψ hearings following these closure announcements to review the impact on health care services in the community. Following the hearings on St. Mary's Medical Center skilled nursing unit closure in the spring of 2015, the Health Commission encouraged the San Francisco Department of Public Health (SFDPH), with other city agencies, hospitals, and community-providers, to research the needs for short-term skilled nursing and post-acute care services in San Francisco, and submit a report with recommendations to the Health Commission. The recommendation was made to further understand the effect of St. Mary's, and other hospital-based skilled nursing unit closures, on city post-acute care services. Its timing provided an opportunity to also consider other factors impacting post-acute care, including healthcare system practice and payment changes, aging and chronic illness demographics, and the trend toward community-based living for older adults and persons with disabilities.

^Ψ **Proposition Q** requires private hospitals in San Francisco to provide public notice prior to closing a hospital inpatient or outpatient facility, eliminating or reducing the level of services provided, or prior to the leasing, selling or transfer of management.

In response to the Health Commission’s recommendation, the San Francisco Post-Acute Care Project was launched in August 2015. SFDPH, Dignity Health, and Sutter Health each contributed resources to the project.

Long-term acute care hospitals, inpatient rehabilitation facilities, and home health agencies are vital post-acute care components. Because none of these services was associated with significant access and delivery problems in San Francisco, they were not addressed in the Post-Acute Care Project. By contrast, the hospital-based skilled nursing unit closures did present a potential post-acute care resource challenge for San Francisco, so the closures became the initial project focus. To frame the project, Project Team members developed the following problem statement: *What is the impact of reduced skilled nursing facility beds on the need, supply, and gaps in post-acute care for San Francisco, now and into the future?* And to respond, they chose summarizing available and relevant skilled nursing facility data—current need, current utilization, future demand—and conducted key informant interviews.

Results from the data analyses (quantitative and qualitative) confirmed **bed capacity**, i.e., the availability of both short and long-term beds, is a common concern for San Francisco post-acute care stakeholders. The results also revealed that bed capacity and available alternative post-acute care services in the community for two distinct patient populations—Medi-Cal beneficiaries and vulnerable populations—posed critical and urgent challenges for all San Francisco acute care providers. Throughout the project, placing **Medi-Cal beneficiaries** and **vulnerable patients** (predominantly described as individuals who have behavioral problems caused by mental illness or dementia), who are homeless, or who are substance using), in SNFs (short- and long-term), subacute care, and Medi-Cal home-and community-based service (HCBS) waiver programs[♦] was identified as extremely difficult. Together, these three compelling issues formed the expanded focus of the San Francisco Post-Acute Care Project.

This report summarizes the San Francisco Post-Acute Care Project’s exploratory analysis of challenges and opportunities associated with San Francisco’s current post-acute care continuum. It presents major developments and trends in the post-acute care field, key project quantitative and qualitative findings, and promising post-acute care service delivery models and alternative care settings. It also presents strategic recommendations developed by both the Project Team and Advisory Committee that respond to the three emergent post-acute care challenges.

[♦] **HCBS Waivers** allow states that participate in Medicaid, [Medi-Cal in California], to offer home or community setting alternatives for individuals who would otherwise require care in a nursing facility or hospital. Services offered under the waiver must cost no more than the alternative institutional level of care, and recipients must have full-scope Medi-Cal eligibility.

PROJECT DESIGN

The Post-Acute Care Project design included the following core elements: a Project Team to oversee the project, clarified project terms, quantitative and qualitative data, research on alternative post-acute care models and settings, a Post-Acute Care Advisory Committee to guide development of project recommendations, and a final report to the Health Commission summarizing key findings and recommendations. Project Team and Advisory Committee members comprised diverse representatives from SFPDPH, the San Francisco Department of Aging and Adult Services (DAAS), hospitals, community organizations, advocacy groups, and other stakeholder organizations. (See Appendix E). Brief descriptions of key project elements are as follows:

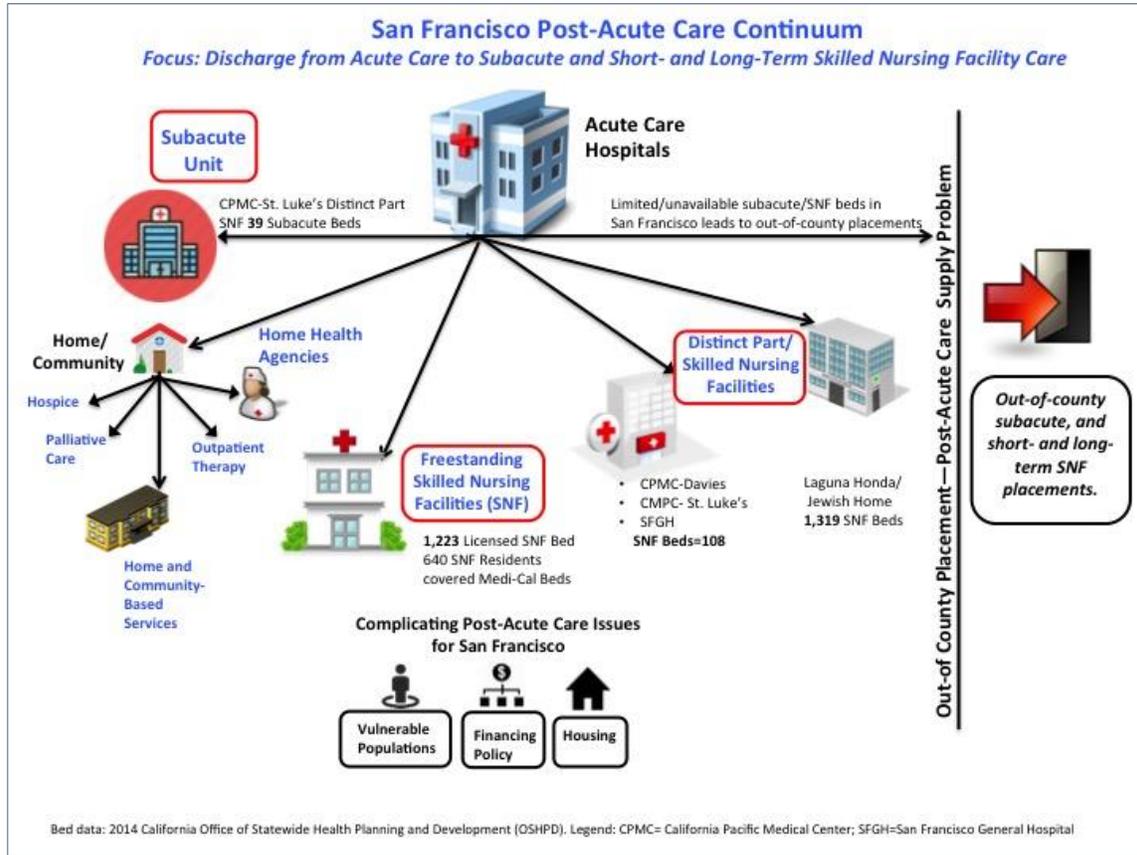
Quantitative Data: The Project Team analyzed Office of Statewide Health Planning and Development (OSHPD) data capturing hospital discharges to post-acute care and distinct part and freestanding skilled nursing facility utilization. In addition, CPMC provided data for the St. Lukes subacute unit.

Point-in-Time Survey: The Project Team conducted a brief phone survey with San Francisco acute care hospital discharge planners on October 21, 2015 to better understand how many San Francisco patients are unable or waiting to transition from an acute care hospital to a SNF on any given day.

Key Informant Interviews: The Project Team conducted 24 interviews with stakeholders representing acute care hospitals, skilled nursing facilities, city departments, health plans, and home and community based service providers. Stakeholders discussed the following regarding post-acute care in San Francisco: concerns, unmet needs, priorities, barriers, special populations, opportunities to increase short- and long-term SNF beds, community-based post-acute care alternatives, and collaboration opportunities to address current and future post-acute care in San Francisco.

Advisory Committee Meetings: The Project Team convened two Advisory Committee meetings to discuss project findings and identify recommendations to address San Francisco's post-acute care challenges. To visually summarize key project findings and inspire development of post-acute care recommendations for San Francisco, a series of poster-size graphics depicting San Francisco's post-acute care continuum discharge challenges were presented at the first San Francisco Post-Acute Care Advisory Committee meeting. The first in the series, *San Francisco Post-Acute Care Continuum: Discharge from Post-Acute Care to Subacute and Short-and Long-Term Skilled Nursing Facility Care*, shows common discharge pathways from acute care to subacute and short- and long-term skilled nursing facility care (below). (See Appendix C for the remaining post-acute care discharge scenarios.)

San Francisco Post-Acute Care Continuum: Discharge from Acute Care to Subacute and Short-and Long-Term Skilled Nursing Facility Care



At the second Post-Acute Care Advisory Committee meeting, members were assigned to small workgroups to review draft project recommendations proposed by the Advisory Committee and Project Team. Over 40 draft recommendations respectful of San Francisco’s racial, ethnic, sexual orientation, language, culture, and socioeconomic diversity were organized into four recommendation areas: 1) Ensure Appropriate Number of Skilled Nursing Care Beds by Increasing Supply and Reducing Demand; 2) Increase Options for Home and Community Based Care; 3) Improve Care Coordination Between Acute and Post-Acute Care Providers; and, 4) Promote Healthy Aging and Reduce the Risk for Institutionalization. From these recommendations, Advisory Committee members identified consensus driven recommendations to address San Francisco’s post-acute care needs now and in the future.

Environmental Scan: Collaborative Consulting, Inc., a member of the project team, conducted an environmental scan of successful post-acute care service delivery models and alternative care settings—and their individual components—from around the country. The purpose of the scan was to complement project quantitative and qualitative analyses of post-acute care in San Francisco, and to identify models and components the city might replicate or adapt to create a more innovative, community-based post-acute care delivery system.

DEVELOPMENTS AND TRENDS IN POST-ACUTE CARE

Recent developments and trends within the post-acute care continuum are fundamentally changing the delivery of post-acute care services. The most significant of these include Medicare regulatory and financing changes; Medicaid post-acute care payment policies and programs; new collaborations between acute care and post-acute care providers; aging population and illness projections, and the trend toward home and community-based post-acute care services.

Medicare Regulatory and Finance Changes to Post-Acute Care

Medicare is the primary payer for the four traditional post-acute care settings: long-term acute-care hospitals, inpatient rehabilitation facilities, SNFs (short-term/rehabilitation), and home through home health agencies. In response to changes in reimbursement policies, demographics, and technology, post-acute care utilization overall has increased since 2000.²⁻⁴ Reflecting this trend, Medicare post-acute care spending increased from \$32.8 billion in 2002 to \$62.1 billion in 2012. This near-doubling in spending for post-acute care services can be traced to the following: confusion and overlap with regard to services in the four settings; lack of a common assessment tool across settings; and, various strategies used by some post-acute care providers to increase Medicare payments within the designated prospective payment system.⁵ For these reasons and others, the Medicare Payment Advisory Commission (MedPAC) supports moving away from the current post-acute care prospective payment system and toward integrated payment and delivery services to improve quality of care and lower costs.²

This approach, which may be better achieved through accountable care organizations (ACOs) and bundled payments, supports the lowest cost mix of services necessary to achieve the best outcomes and improve care coordination across post-acute settings. Although post-acute care has trailed behind acute care with regard to payment and data reporting, an ambitious number of relevant reforms currently underway are dedicated to improving performance with lower costs, and aligning incentives to do both. The following are a few examples:⁵

- On October 1, 2016, the Centers for Medicare & Medicaid Services (CMS) measurement period for “risk-adjusted” hospital readmissions begins for SNFs.
- On October 1, 2017, SNF readmission information will be publicly available on Medicare’s Nursing Home Compare website.
- Under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, post-acute care providers will begin collecting uniform assessment data in 2018.
- Beginning in 2019, at least half of the payments to SNFs, inpatient rehabilitation facilities, long-term acute care hospitals, and home health agencies will be restructured using alternative payment models.
- Beginning in 2019, SNFs will be penalized for hospital readmissions.

Using a combined rollout of payment and quality improvement innovations, CMS anticipates redefining post-acute care for Medicare beneficiaries. Over the next several years, expected changes in the field include enhanced information technologies, data sharing between acute and post-acute care providers, improved access to post-acute care for beneficiaries, adoption of standardized assessment elements across settings (beginning 2018), and a detailed approach for a cross-setting payment system based on two years of uniform patient assessment data.

Changes to the current post-acute care continuum associated with Medicare will, in turn, impact all payers and their respective beneficiaries. What these changes will be and how they will affect the current continuum and the development of alternative models is unknown at this time.

Medicaid Post-Acute Care Payment Policies and Programs

Medicaid can be the primary or secondary payer source for individuals with post-acute care needs. Unlike Medicare, Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources; it also covers services not typically covered under Medicare, such as long-term services and supports (LTSS).⁹ Beyond numerous program differences and requirements, the two insurance programs have dramatically different cost and payment structures.

In the United States, Medicaid is the single largest payer for LTSS for low-income seniors and certain individuals with disabilities.⁶ In this capacity, Medicaid is the only federal health insurance program to cover services ranging from long-term skilled nursing facility care, to various HCBS programs—programs that support home and community living funded through state Medicaid Waivers—to the Medicaid Managed Care program, which provides Managed Long Term Services and Supports (MLTSS) in some states. Because each state designs and administers its own Medicaid program, there is great variation in state Medicaid funding for health care services, including LTSS.

Medicare reimbursement rates are typically higher than Medi-Cal reimbursement rates. This differential has played a role in SNFs' increased preference for providing rehabilitative care to short-stay residents under Medicare's skilled nursing facility coverage, over Medicaid's coverage for long-stay residents. One particular group, however, straddles both insurances—dual eligibles.⁷ Dual eligibles are medically complex, high utilizers of health care. Because of their dual status, Medicare is the primary payer for most services, with Medicaid paying for services not covered by Medicare, such as LTSS. Numerous CMS dual eligible initiatives and demonstration projects are exploring opportunities to improve care quality and care coordination, and reduce costs for this distinctive and expensive group of patients.

California has the highest number of dual eligible beneficiaries in the country.⁸ It also has one of the lowest Medicaid rates.⁹ A chief consequence of these lower rates is that health care providers, from physicians to skilled nursing facilities, are discouraged from providing services to Medi-Cal patients, independent of whether patients reside in expensive urban or medically underserved rural areas. Added to this significant challenge, the state has a marked history of fragmented financing (including fluctuating rate changes for SNFs) and service delivery for Medi-Cal LTSS. For example, in most California counties, long-term skilled nursing care is carved out of Medi-Cal Managed Care (which serves approximately 80% of the Medi-Cal population in California) while short-term rehabilitative stays are covered. Although multiple initiatives under the ACA have been moving the state toward substantive improvements in the Medi-Cal program, the changes have not fully addressed several post-acute care payment and policy challenges:

- Low Medi-Cal reimbursement rates have long been identified as a limiting factor in Medi-Cal patients' access to short-and long-term skilled nursing facility care.¹⁰
- Patients with behavioral difficulties (i.e., patients with mental illness, traumatic brain injuries, dementia, substance users), many of whom have Medi-Cal, are difficult to place and manage in

⁹ In this report, long-term services and supports (LTSS) references both institutional and community-based long-term services and support.

SNFs.¹¹

- California’s Medi-Cal waiver programs have successfully provided HCBS for some individuals, enabling them to live in the community instead of institutions. Yet the overall effectiveness of the waiver programs has been limited by too few slots, limiting cost caps, and inflexible eligibility and administration structures.¹²
- Medicaid’s [Medi-Cal] statutory framework makes coverage for SNF care generally easier for people to attain than an HCBS waiver, creating financial and accessibility biases toward institutionalization over community living with HCBS waiver services and supports.¹³

Opportunities for Acute Care and Post-Acute Care Collaboration

Fundamental to the proposed post-acute care reforms is a new dynamic between acute and post-acute care partners. Attention to accountability in quality reporting and payment (i.e., value-based purchasing) has incentivized hospitals and health systems to ensure that care coordination for discharged patients continues after patients leave the acute care setting.⁵ At the same time, post-acute care providers facing payment and practice reforms are encouraged to improve communication with acute care providers to reduce avoidable hospital admissions and provide appropriate quality-driven care. As people, funding, and resources move more fluidly between both groups of providers, the two care systems can potentially align in other areas to support their respective missions of providing the right care, at the right place, at the right time.

Two areas that hold promise for additional synergies between acute care and post-acute care providers are care transitions and palliative care. Care transitions refer to the movement of patients from one healthcare practitioner or setting to another, because their conditions and care needs change. These may include transitions from hospitals or nursing homes to home, with or without skilled services. National, state, and local efforts to address poorly executed care transitions over the past decade have resulted in lower avoidable hospital readmissions rates for many hospitals. Although CMS is limiting its funding for the Community-based Care Transitions Program (CTCP—Section 3026, Affordable Care Act), which tested models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries, many hospitals recognize the value of working with community partners to coordinate patient care post-discharge through a care transitions program.

Care transitions models vary widely in design, evidence-based status, interventions, and targeted outcomes. Models can have a teaching, case management, or coaching focus, or any combination of the three. Selection of a model typically depends on funding and the needs of the different partners. In their 2012 report, MedPAC stated, “In the future, with 30-day windows after discharge for hospitals and SNFs, both sectors would have an incentive to promote successful care transitions from one provider to the next and, in the case of patients going home, the coordination of follow-up.”³ Effective bridging of acute care and post-acute care providers may be further enhanced through care transitions programs.

Palliative care is another area in which acute and post-acute providers have an opportunity to work together to improve the quality and cost of care, while supporting patient and family care preferences. Palliative care is a recognized medical specialty as well as a philosophy and an approach to care. Rooted in the interdisciplinary hospice model of care, palliative care offers relief from suffering for patients with serious and complex illness. It equally addresses and promotes patient and family quality of life and includes similar services: pain and symptom management, advance care planning, goals of care discussion, and psychosocial and spiritual support. Like hospice, palliative care teams include doctors, nurses, social

workers, and chaplains. Unlike hospice, palliative care can be provided at any age and any stage of illness, and can even be combined with curative treatment. Many insurance plans, including Medicare and Medicaid, cover all or part of palliative care services.¹⁴ The largely underutilized Medicare hospice benefit, by contrast, is limited to patients in the last six months of life who are no longer pursuing curative treatment.

Many benefits of palliative care have been documented. It improves patient symptoms, quality of life, and patient and family satisfaction.¹⁵⁻¹⁷ Outcomes also include greater clarity in goals of care, avoided health crises, increased capacity to receive care safely in the home, and advanced care planning. In addition, patients reduce use of some health services (hospital admissions, intensive care unit stays, emergency department visits), and increase use of others (home-based health services and hospice care), resulting in lower overall health care costs.¹⁸⁻²²

Hospital palliative care programs have grown exponentially in recent years and community-based palliative care is gaining traction. Outside of the hospital setting, palliative care is provided almost anywhere patients are: SNFs, assisted living locations, community centers/clinics, extended care facilities, private residences, and residential hospice facilities.²³ While an integrated palliative care model that leverages common acute care and post-acute care provider interests may be years away, it is an encouraging model garnering increased federal and state attention.

Dramatic Aging Population and Chronic Illness Projections

As highlighted, the future of post-acute care across the country will be shaped by policy and payment changes. It will also be shaped by a number of other major factors and trends, including an aging population and the increased prevalence of chronic illness—including Alzheimer’s disease. Statistics show that people are living dramatically longer lives. In the United States greater numbers of people are living into their 80s, 90s, and 100s, a trend expected to continue. Not only will this swell of older adults represent the definition of diversity—racially, ethnically, linguistically, culturally, and socioeconomically—many will live with disabilities and chronic illnesses such as congestive heart failure, diabetes, chronic obstructive pulmonary disease, and Alzheimer’s disease.

As the population ages, the prevalence of chronic illness is also expected to rise. Chronic illness affects approximately 133 million Americans, representing more than 40% of the total population of this country.²⁴ By 2020, this number is projected to grow to an estimated 157 million, with 81 million having multiple conditions.²⁵ According to CMS, in 2009 public health spending represented only about three percent of health-care spending, while expenditures on chronic disease accounted for 75 percent of health-care costs.²⁶ Related to chronic illness, many older adults experience limited activities of daily living (ADLs—toileting, bathing dressing, etc.) and instrumental activities of Daily Living (IADLs—preparing meals, shopping, cleaning, etc.), as a result of their chronic health conditions. (Figure 1).²⁷

Figure 1: Medicare Enrollees Age 65+ with limitations in ADLs and IADLs who were in a long-term care facility (1992 – 2009)

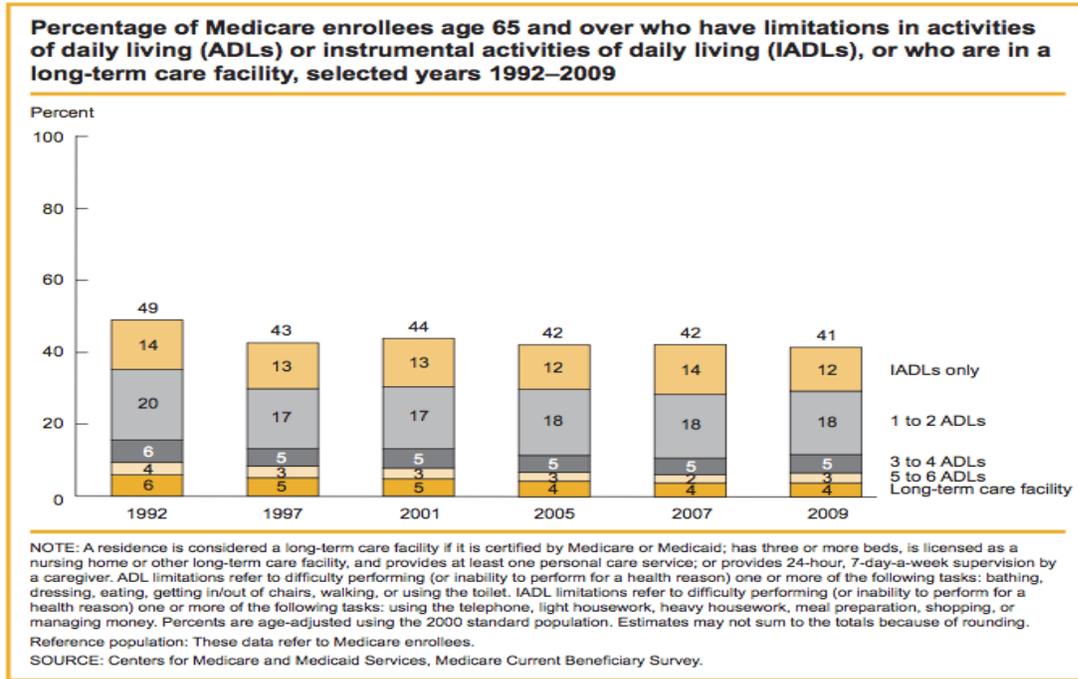
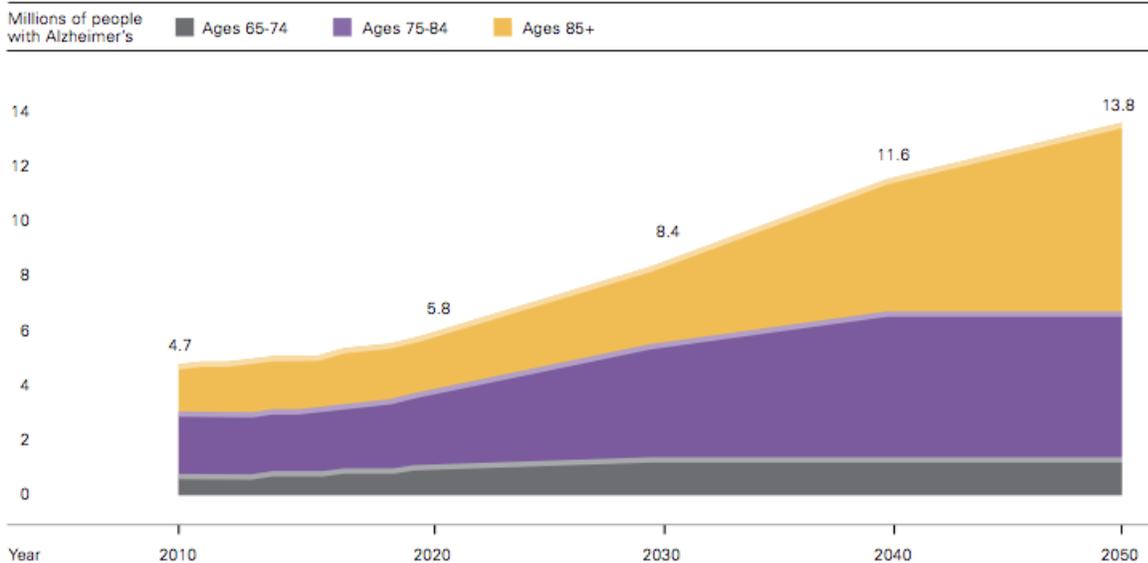


Figure 2: Alzheimer’s Projections for Adults Age 65+, 2010 – 2050

Projected Number of People Age 65 and Older (Total and by Age Group) in the U.S. Population with Alzheimer’s Disease, 2010 to 2050



Created from data from Hebert et al.^{120, A11}

The 2015 report, *Alzheimer's Disease Facts and Figures*, highlighted Alzheimer's disease as the most expensive disease in the United States.²⁸ A degenerative brain disorder, Alzheimer's is characterized by a decline in memory, language, problem solving and other cognitive skills that affect a person's ability to perform everyday activities. It is the most common form of dementia. Parallel with the projected future growth of the country's older population, the report stated that by 2025 the number of people age 65 and older with Alzheimer's disease is estimated to reach 7.1 million—a 40 percent increase from the 5.1 million people age 65 and older affected in 2015 (Figure 2).^{27, 28} Because individuals with Alzheimer's require increasing levels of supervision and personal care, improving the coordination of acute and post-acute care services for this community of adults, as well as individuals with other chronic health conditions and functional limitations is profoundly important.

Home- and Community-Based Post-Acute Care Services

Consistent with the principles of the disability rights movement and the 1999 Supreme Court's Olmstead decision (both affirm the right of individuals with disabilities, including older adults, to receive public benefits and services in the most integrated setting appropriate to their needs) there has been a movement away from institutional care and toward community-based living with services and supports. It is a change increasingly supported through both federal and state policy and funding. Although the majority of Medicaid funding is still directed to institutional care, since 1995, a significant portion has been directed from institutional care to home and community-based services and personal care.²⁹

KEY QUANTITATIVE FINDINGS

This section introduces the San Francisco Post-Acute Care Project key quantitative findings. Analyses and findings focus on identifying critical post-acute care demand and supply issues in San Francisco. For the purpose of this analysis, skilled nursing facilities are defined as follows:

- **Distinct part skilled nursing facility (DP/SNF):** a hospital-based facility, usually operated in a designated unit within an acute care hospital.
- **Freestanding skilled nursing facility:** a facility outside of a hospital commonly referred to as a nursing home.
- **Outside facility-SNF:** an OSHPD term used in the context of hospital discharge data. A hospital discharge to skilled nursing care may be to an “in-hospital SNF” or an “outside facility - SNF.” An “outside facility – SNF” for purposes of this report, is a hospital-based or freestanding facility that primarily provides skilled nursing care. This includes Laguna Honda Hospital, Jewish Home, and the 16 freestanding SNF facilities listed in Figure 17.
- **Subacute care:** specialized care for adults with high needs such as ventilator care. Subacute care can be provided by a freestanding SNF or a DP/SNF.

As previously noted, the San Francisco Health Commission under Proposition Q recently reviewed the closure of two acute care hospital distinct part skilled nursing facilities (DP/SNF). In 2014, California Pacific Medical Center (CPMC) closed 101 of its licensed DP/SNF beds at its California Campus. At the same time, it staffed an additional 18-licensed DP/SNF beds at its St. Luke’s Campus and 4 at its Davies Campus.^Σ Shortly after, in 2015, St. Mary’s Medical Center closed 32 licensed beds. As noted, CPMC plans to close its subacute unit at its St. Luke’s campus in 2019. With this closure, 40 subacute care beds and 39 DP/SNF beds will be eliminated.

Consistent with the decline in hospital-based Medicare reimbursement—due to legislative and regulatory changes - the number of DP/SNFs has declined nationally.³⁰ Of the 14,978 SNFs that furnished care in 2013 in the United States, only 5% of SNFs were located in hospitals—95% of SNFs were freestanding facilities.³¹ Since 2001, the number of DP/SNF beds in San Francisco has fallen by 43%, from 2,331 to 1,319, while the freestanding SNF growth has not increased at a comparable rate.³² Note: the steady decrease in DP/SNF beds may reflect the national trend toward fewer and shorter inpatient hospital stays, and increased discharges to home with home health—in lieu of short-term skilled nursing facility stays. Concurrent with these changes, San Francisco is experiencing an aging population, influenced by advances in medical technology and a substantial Baby Boom cohort expected to live significantly longer lives than previous generations. As a result, many older San Francisco residents are likely to require skilled nursing care now and in the future.

The remainder of this section will focus on: 1) demand for post-acute care; 2) the current supply of hospital, freestanding, and subacute skilled nursing beds; 3) factors that reduce demand for skilled nursing facilities; 4) and populations at risk of having unmet skilled nursing needs.

^Σ Note: 46 of the 101 licensed DP/SNF beds closed at the CPMC California Campus were staffed: with the addition of 18 licensed DP/SNF beds at CPMC’s St. Luke’s Campus and 4 at CPMC’s Davies Campus, the net reduction across the CPMC system of staffed DP/SNF beds in 2014 was 24.

Skilled Nursing Bed Demand in San Francisco

San Francisco’s Population is Aging

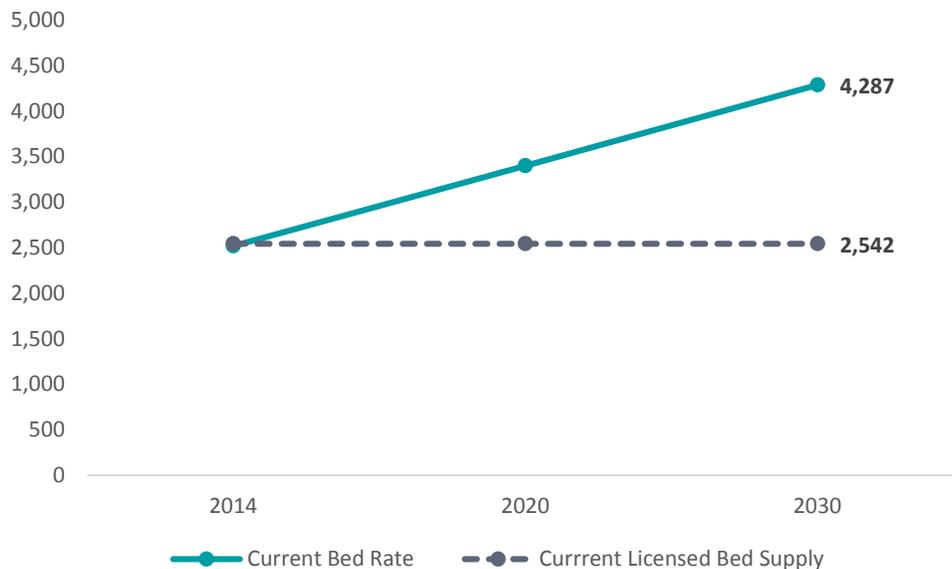
According to the 2014 American Community Survey, San Francisco’s population age 65 and older currently comprises 14% of the city’s population (approximately 113,000), compared to 12.9% of California’s total population. California Department of Finance 2014 population projections indicate that San Francisco’s population 65 and older will comprise 20% of the population by 2030 (approximately 192,000).³³

In addition to age, two key factors predict short and long-term skilled nursing care need: difficulty with ADLs (e.g., bathing and dressing) and having dementia.^{34 35 36} Currently, 38% of San Francisco seniors 65 and older and 7% of adults ages 18 to 64 report disabilities (approximately 80,000 total).³³ The most common difficulties reported are cognitive, walking, and independent living. Additionally, 13.3% of San Francisco Medicare seniors 65 and older are diagnosed with dementia. Assuming these rates stay the same, the number of seniors 65+ with disabilities and/or dementia will increase significantly by 2030.

San Francisco’s Skilled Nursing Bed Supply May Not Meet Future Demands

San Francisco currently has **2,542 licensed SNF beds**: 147 DP/SNF beds in acute care hospitals; 1,172 DP/SNF beds in hospitals that have acute care services but function predominantly as skilled nursing facilities, and 1,223 beds in freestanding facilities. Based on SNF bed and population data, San Francisco has approximately 22 SNF beds per 1,000 adults age 65 and older (short and long-term beds). If San Francisco were to maintain this current bed rate as the population ages, by 2030 the city would need **4,287 licensed SNF beds**—an increase of nearly 70% over the current supply (Figure 3). If the bed supply remains constant in the next 15 years, San Francisco’s bed rate would decrease to 13 SNF beds per 1,000 adults 65 and older. Rough estimations, based on available data, indicate that the bed rate for long-term Medi-Cal beds is much lower, 14 beds per 1,000 adults 65 and older.

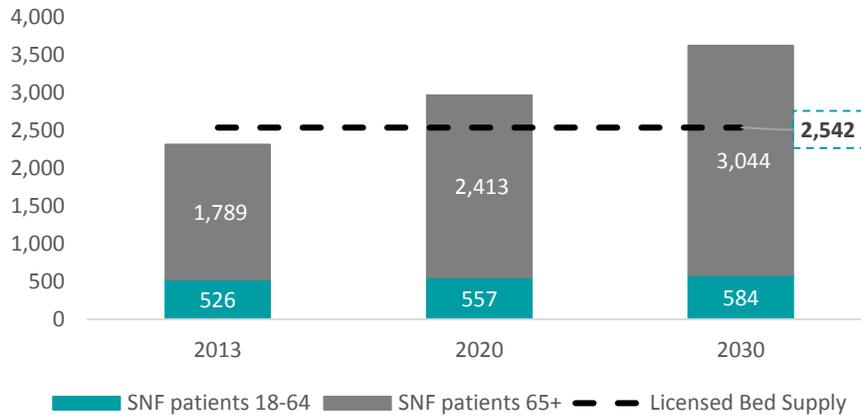
Figure 3: Current and Projected Skilled Nursing Bed Demand



Source: California Department of Finance 2014, Office of Statewide Health Planning and Development (OSHPD) 2013

Figure 4 below provides an estimate for the number of patients who may need institutional skilled nursing care in 2020 and 2030 based on the current utilization rate. The projected patient census is calculated by applying the rate of SNF patients per 1,000 adults in 2013 (for ages 18-64, and 65 and older) to population estimates for 2020 and 2030. At current rates of use, demand for San Francisco’s skilled nursing facilities would exceed supply by 2020 and patients age 65 and older would represent the greatest increase in growth.

Figure 4: Current and Projected Skilled Nursing Bed Patient Census



Source: California Department of Finance, Office of Statewide Health Planning and Development (OSHPD)

Bed and patient projections shown in Figures 3 and 4 are based on California Department of Finance population projections [source, 2010 U.S. Census].³⁷ (Note: projections may not capture regional trends and may overestimate population growth.) Because of San Francisco’s current high cost of living and limited availability of housing, population demographics may shift in the coming years as residents may choose to move outside of the city. According to the 2015 San Francisco City Survey, residents under 35 years of age, black residents, renters, and parents of children were most likely to say they planned to move out of San Francisco in the next three years.³⁸ Even if the aging population grows at a lower rate due to migration out of the city, San Francisco will still experience a significant growth of older adults.

Hospital Discharges Indicate Significant Demand for Post-Acute Care

The number of hospital discharges (see Figure 5 for hospital acute care bed size) to post-acute care is an indicator for skilled nursing demand. In 2013, San Francisco hospitals had a total 95,000 discharges (in and outside of San Francisco), 24% of which were to a post-acute care setting defined as an in-hospital DP/SNF, an outside facility - SNF, or home health care (Figure 6). A discharge to post-acute care is most common for seniors 65 and older (41% of all discharges vs. 13% of discharges for adults 18-64). Among seniors 65 and older, discharges to institutional skilled nursing care account for 18% (n = 6,211) of all discharges, and discharges to home health care account for 23% (n=8,139) of the total.

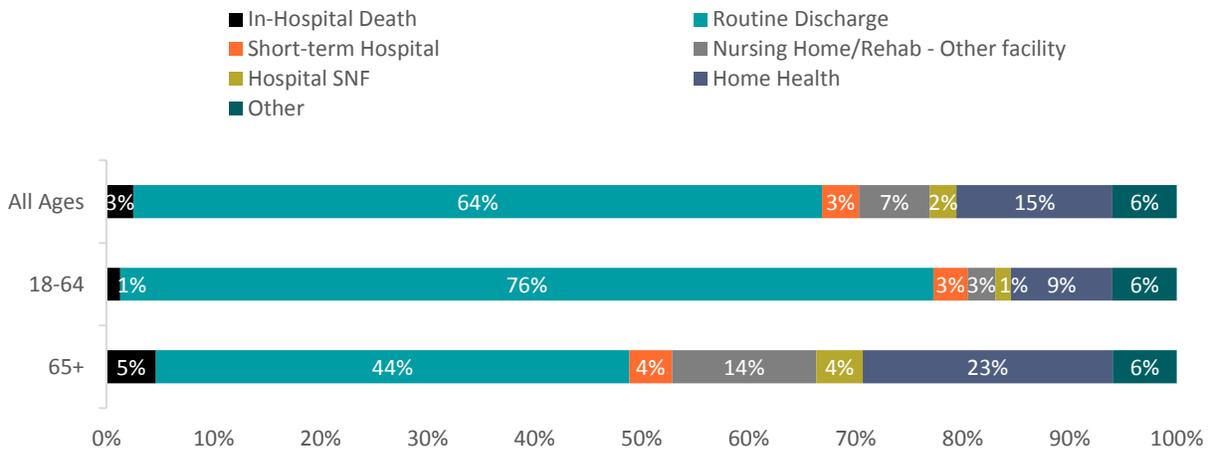
Figure 5: Acute Care Beds by Hospital, 2013

Hospital	Licensed Bed Number/Licensed Occupancy Rate	Hospital	Licensed Bed Number/Licensed Occupancy Rate
Chinese Hospital	54 / 57%	Kaiser	247/ 58%
CPMC Davies	189 / 36%	Zuckerberg San Francisco General Hospital	403 / 49%
CPMC California	299 / 30%	St. Mary's Medical Center	336 / 21%
CPMC Pacific	291/ 56%	St. Francis Memorial Hospital	253 / 32%
CPMC St. Luke's	149/ 27%	UCSF	720 / 77%

Source: California Office of Statewide Health Planning and Development, 2013

Occupancy rate is the percentage of licensed beds occupied during the OSHPD reporting period. This is calculated by dividing the number of patient (census) days by the number of licensed bed days.

Figure 6: Hospital Discharge Status, by Age Group, 2013



Source: California Office of Statewide Health Planning and Development, 2013

*Note: "Other" is defined as patients who left against medical advice, were discharged to "other care", jail, residential board and care facilities, an unknown destination or 'other'.

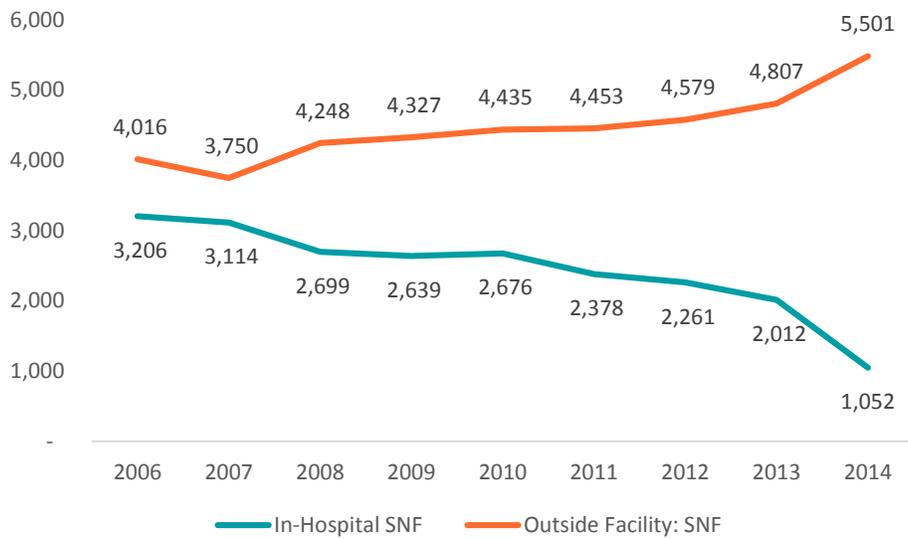
In 2014, San Francisco hospitals made 14,939 discharges for San Francisco residents of all ages to post-acute care settings (Figure 7). Approximately 6,553 of these were discharges to a skilled nursing facility, in or outside of the discharging hospital. The number of discharges to in-hospital DP/SNFs for all ages decreased by 1,050 from 2013 to 2014, and the number of discharges to an outside facility- SNF increased by 694. The increase in discharges to outside community SNFs is likely correlated with the closure of CPMC's California Campus DP/SNF. Note: Figures 7 – 12 present discharge data for San Francisco residents only

Figure 7: San Francisco Acute Hospital Discharges To Post-Acute Care

DISCHARGE SETTING	# Discharges All Ages		# Discharges 65+	
	2013	2014	2013	2014
In-Hospital DP/SNF	2,102	1,052	1,304	556
Outside Facility - SNF	4,807	5,501	3,743	4,317
Home Health	9,049	8,386	5,745	5,186
TOTAL	15,871	14,939	10,792	10,059

Source: California Office of Statewide Health Planning and Development, 2013 – 2014

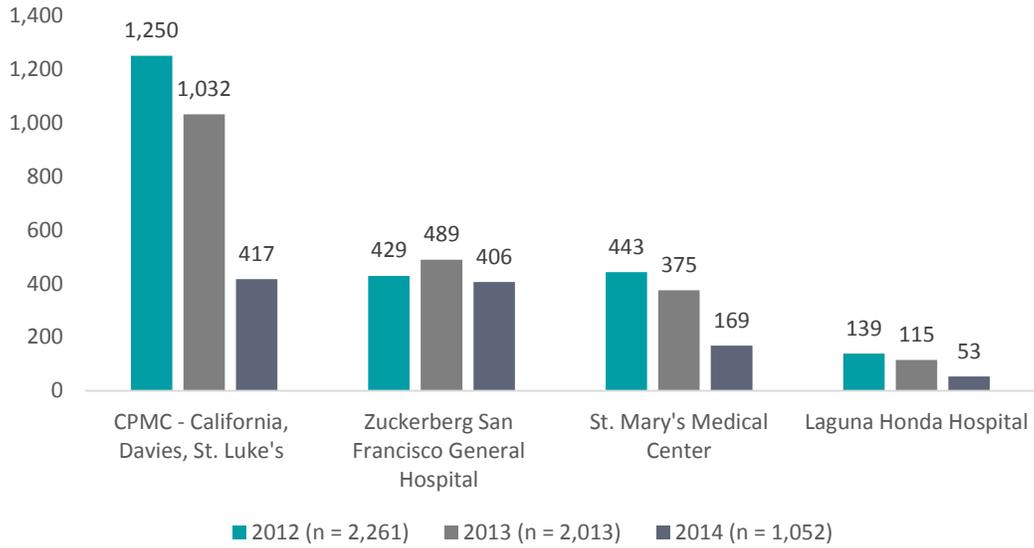
Figure 8: San Francisco Acute Hospital Discharges to SNFs, 2006 - 2015



Source: California Office of Statewide Health Planning and Development, 2006 – 2014

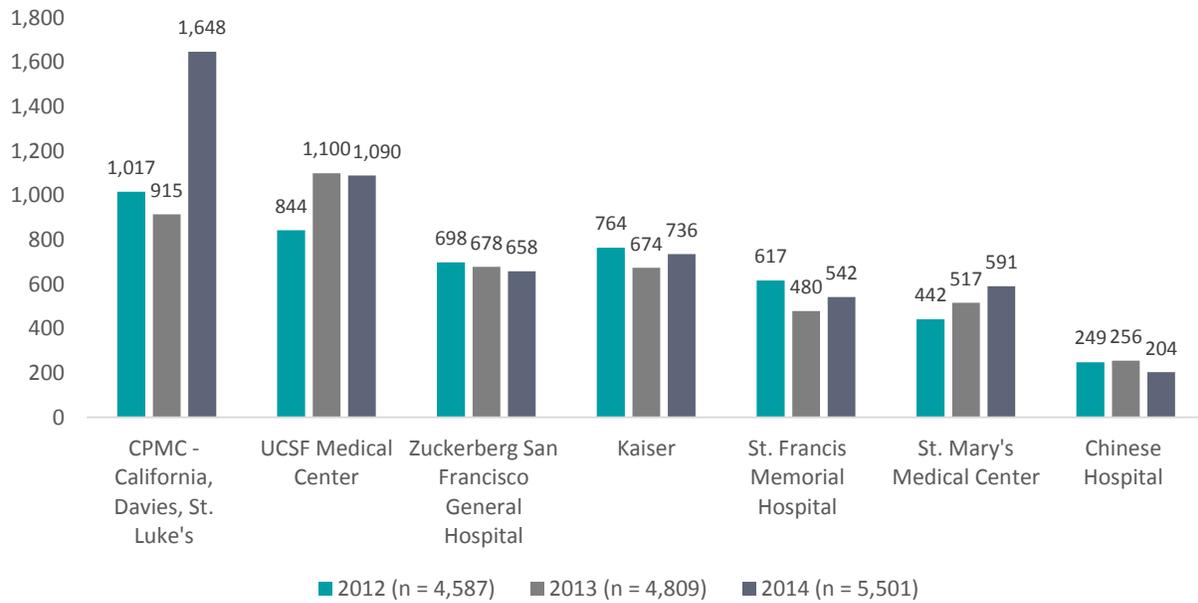
Figure 9 shows acute care hospital discharges to in-hospital DP/SNFs between 2012 - 2014. (Note: UCSF represents the University of California San Francisco Medical Center; ZSFG represents Zuckerberg San Francisco General Hospital.) CPMC had the most acute care hospital discharges to an in-hospital DP/SNF in 2012 and 2013 (a number consistent with CPMC’s large share of DP/SNF beds for both years). Figure 10 shows that CPMC, UCSF, and Dignity Health (represented by St. Mary’s Medical Center and St. Francis Memorial Hospital) each made more than 1,000 discharges to an outside SNF in 2014 for San Francisco patients.

Figure 9: Discharges to In-Hospital SNF by Hospital, 2012 - 2014



Source: California Office of Statewide Health Planning and Development, 2012 - 2014

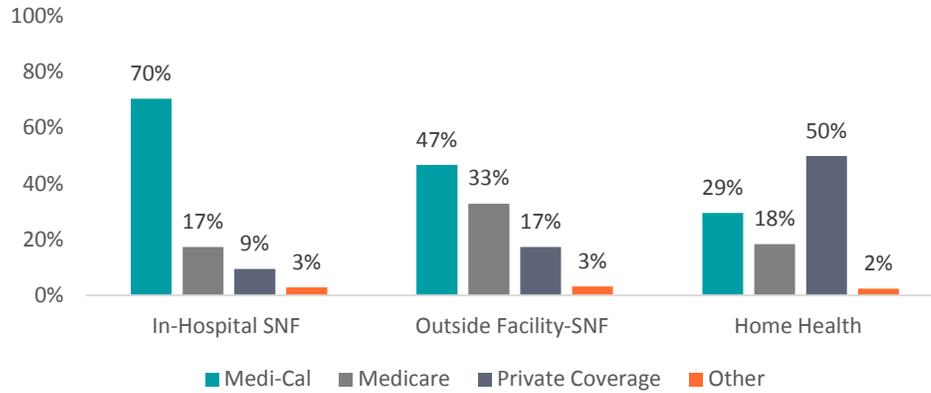
Figure 10: Discharges to Outside Facility - SNF by Hospital, 2012 - 2014



Source: California Office of Statewide Health Planning and Development, 2012 - 2014

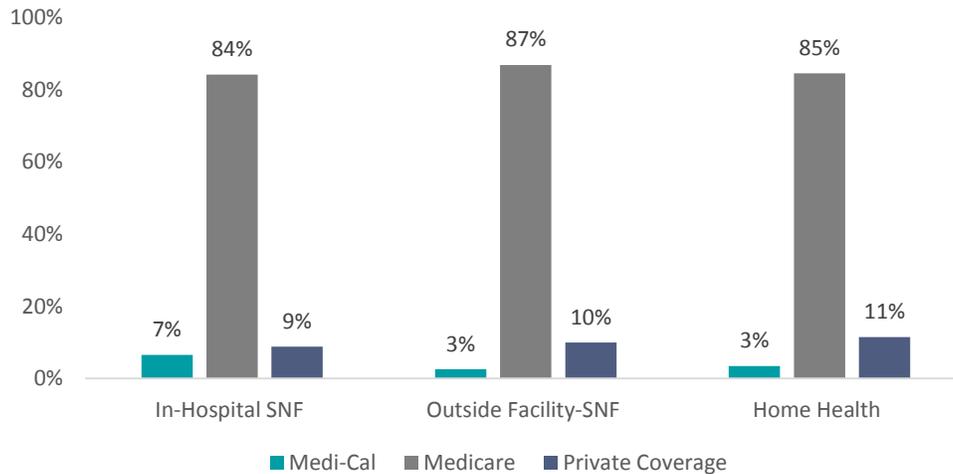
A patient’s payer source often influences discharge disposition and admission into a post-acute care facility. Medi-Cal is the primary payer for San Francisco residents 18-64 discharged to a SNF, indicating that younger residents with SNF-level care needs are low-income and disabled. Private coverage is the top payer for 18-64 discharges to home health, while Medicare is the primary payer for all adults 65 and older discharged to all post-acute care settings. (Figures 11 and 12.)

Figure 11: Hospital Discharge Dispositions by Payer Source, 18-64 (n = 4,387)



Source: California Office of Statewide Health Planning and Development, 2014

Figure 12: Hospital Discharge Dispositions by Payer Source, 65 + (n = 10,069)



Source: California Office of Statewide Health Planning and Development, 2014

Many Hospital Patients Experience Delayed Skilled Nursing Placement

The Post-Acute Care Project Team conducted a brief phone survey with San Francisco acute care hospital discharge planners to better understand how many San Francisco patients are unable or waiting to transition from an acute care hospital to a SNF on any given day. Across 10 San Francisco acute care hospitals surveyed on October 21st, 2015, approximately **67 patients were waiting to be placed in a SNF.**^Ω Discharge planners identified a number of common barriers to SNF discharge:

- **Payer Challenges:** Limited or no availability of beds (short- and long-term) for Medi-Cal patients. Hospitals cited difficulty placing Medi-Cal managed care patients in SNFs, noting few facilities are contracted with managed care health plans and those that do often have a Medi-Cal bed maximum allowance.
- **Behavioral Health:** San Francisco freestanding SNFs infrequently admit patients with mental illness, substance abuse, and traumatic brain injury. For example, one hospital reported having a Medi-Cal patient eligible for a lower level of care whom they could not place in a SNF because of his wandering. The patient remained in acute care for 100 days, until the hospital found and paid for an out-of-county Board & Care Home to care for him until a SNF bed could be found.
- **Language Barriers:** Limited number of facilities that can accommodate language needs of monolingual populations.
- **Patient Preferences:** Some patients prefer to be placed in San Francisco, which increases the wait time compared to out-of-county placement.
- **Family Preferences:** Family members insist patients are placed in a specific facility that has no openings.
- **Patient Unaware of Own Needs:** Patients insist that they can go home, but continue to readmit to the hospital because of inadequate care/supervision at home.

Out-of-county placement was cited by all hospitals as necessary to move the following patients from acute care to appropriate lower levels of care: subacute patients (except CPMC); Medi-Cal patients (especially those needing long-term bed placement); and, patients with behavioral difficulties, (i.e., individuals with dementia, mental illness, substance abuse, etc.).

Supply of Institutional Skilled Nursing Beds

The California Department of Public Health licenses SNFs as either: 1) a distinct part of a hospital (DP/SNF), or 2) a freestanding facility. Most skilled nursing beds in the country are located in freestanding SNFs. Additionally, Medi-Cal contracts with some facilities to provide subacute care, which is specialized care for adults with high needs such as ventilator care. Subacute care can be provided by a freestanding SNF or a DP/SNF (see page 28 and Appendix B for additional information on subacute care).

^Ω Interviewed hospitals include: St. Mary’s Medical Center, St. Francis Memorial Hospital, ZSFG, UCSF, Chinese Hospital, Kaiser, CPMC California Campus, CPMC Davies Campus, CPMC Pacific Campus, and CPMC St. Luke’s Campus.

San Francisco's Distinct Part Skilled Nursing Facility Closures Impact Available Skilled Nursing Bed Supply

San Francisco has five DP/SNF providers. Three acute care hospitals, CPMC St. Luke's Campus, CPMC Davies Campus, and ZSFG, currently hold DP/SNF 147 beds (note: 40 beds at St. Luke's are designated for sub-acute care), while an additional 1,172 DP/SNF skilled nursing beds are located at Laguna Honda Hospital and Rehabilitation Center (LHH) and the Jewish Home, the largest providers of institutional skilled nursing care in San Francisco.

LHH is a general acute care facility that provides acute care, post-acute, skilled nursing, and rehabilitation services to San Francisco residents. The hospital's patient population differs compared to patients in other DP/SNFs and freestanding SNFs in the city. Approximately 43% of LHH residents are between the ages of 18 and 64 and more than 96% of patient days are covered by Medi-Cal. In fiscal year 2013-2014, 66% of admissions to LHH were from Zuckerberg San Francisco General Hospital (ZSFG). The remaining admissions were from other acute care hospitals, home health agencies, or Board and Care Homes. On October 1, 2015, LHH reported 11 individuals on their long-term care waitlist.

The Jewish Home is San Francisco's second largest provider of skilled nursing care. More than 90% of patients at the Jewish Home are 65 and older and 76% of patient days are covered by Medi-Cal. On October 1, 2015, the Jewish Home reported approximately 100 people on their waitlist for long-term care.

Figure 13 profiles licensed DP/SNF beds in San Francisco acute care hospitals from 2013 to 2015; it also includes a projection of licensed beds in 2020, with an estimate in the change in licensed SNF bed availability from 2013 to 2020.

SAN FRANCISCO POST-ACUTE CARE PROJECT

Figure 13: Licensed SNF Beds in San Francisco Acute Care Hospitals: Years 2013-2015 & 2020 Projection

Hospital	2013 DP/SNF Beds	2014 DP/SNF Beds	2015 DP/SNF Beds	2020 Projected	Change from 2013-2020
ACUTE CARE					
Chinese Hospital	0	0	0	23	+23
CMPC - California Campus	101	0	0	0	-101
CPMC Davies Campus	38	38	38	38	0
CPMC St. Luke's Campus	79 (40 subacute)	79 (40 subacute)	79 (40 subacute)	0	-79
Kaiser	0	0	0	0	0
Zuckerberg San Francisco General Hospital	89	30	30	30	-59
St. Francis Memorial Hospital	0	0	0	0	0
St. Mary's Medical Center	32	32	0	0	-32
University of California, San Francisco	0	0	0	0	0
<i>Subtotal</i>	339	179	147	91	(-248)
PRIMARILY SKILLED NURSING					
Jewish Home	478	478	403	403	-75
Laguna Honda Hospital	769	769	769	769	0
<i>Subtotal</i>	1,247	1,247	1,172	1,172	(-75)
TOTAL	1,586	1,426	1,319	1,263	-323

Source: California Office of Statewide Health Planning and Development, 2013-2014; San Francisco Department of Public Health Policy and Planning

SNFs provide short-term or long-term care, or a combination thereof. Residents often consider facilities oriented toward long-term stays “home.” Whereas facilities oriented toward short-term stays, with a focus on rehabilitation or care following an illness or injury, have a resident community constantly in flux. San Francisco acute care DP/SNFs primarily provide short-term rehabilitative care, while Laguna Honda Hospital and the Jewish Home have a greater number of beds oriented towards long-term patient stays. Figure 14 below provides an estimate of the number of short and long-term beds in each DP/SNF.

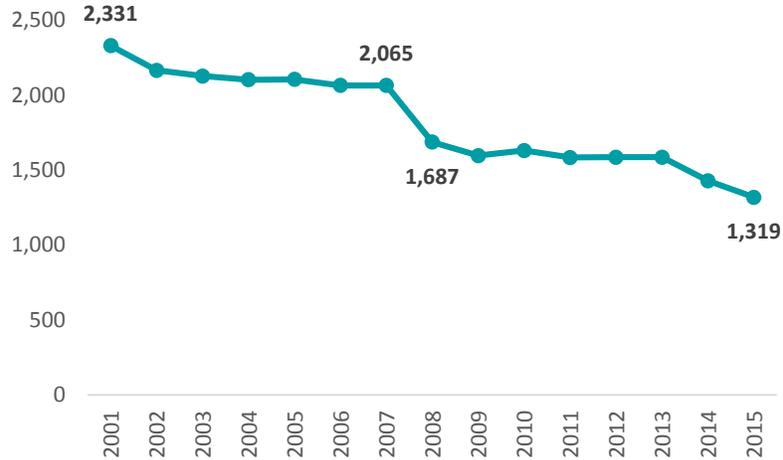
Figure 14: Estimate of Hospital-Based Short- and Long-Term SNF Beds in San Francisco, 2015

Hospital	Total Number of Beds	Short-term Bed Estimate	Long-term Bed Estimate
PRIMARILY ACUTE CARE			
Zuckerberg San Francisco General Hospital	30	30	0
CPMC Davies	38	38	0
CPMC St. Luke's	79	39	40 (subacute)
PRIMARILY SKILLED NURSING			
Laguna Honda	769	100	669
Jewish Home	403	80	323
TOTAL	1,319	287	992 (1,032 incl. subacute)

Source: San Francisco Department of Public Health, Office of Policy and Planning

Since 2001, the number of San Francisco hospital SNF beds has fallen by 43%. The drop in recent years is primarily due to DP/SNFs unit closures within acute care hospitals (Figure 15).

Figure 15: San Francisco DP/SNF Beds, 2001 - 2015



Source: California Office of Statewide Health Planning and Development, 2013-2014

San Francisco’s Freestanding Skilled Nursing Facilities Operate at Near Capacity

Freestanding SNFs commonly referred to as nursing homes, provide the majority of institutional short- and long-term care in the United States. San Francisco’s 16 freestanding SNFs provide 1,223 skilled nursing beds. (Figure 16). Kindred Healthcare is the largest provider in San Francisco with five facilities and approximately 50% (589) of the freestanding beds. Two Kindred facilities, Victorian and Nineteenth Avenue, are oriented toward long-term care, and two facilities, Tunnell, and Golden Gate, primarily provide short-term care (Figure 17).

Figure 16: Utilization of San Francisco Freestanding SNF Facilities

	2014 (16 facilities)
Licensed Beds	1,223
Licensed Bed Days	461,725
Patient Days	385,045
Patient Census 12/31/13	1,066
Admissions	3,466
Discharges	3,447
Patient Census 12/31/14	1,085

Source: California Office of Statewide Health Planning and Development, 2014

Figure 17: San Francisco Freestanding SNF Facilities, 2014

Facility	2014 Licensed SNF Beds	Patients Covered by Medi-Cal	Occupancy Rate
MEDI-CAL CERTIFIED			
Kindred Nursing And Rehabilitation - Golden Gate	120	105	99%
Kindred Nursing And Healthcare-Victorian	90	80	100%
Kindred Nursing And Rehabilitation-Nineteenth Avenue	140	135	99%
Kindred Transitional Care And Rehabilitation-Tunnell Center	180	67	89%
St. Anne’s Home	46	46	100%
Hayes Convalescent Hospital	34	3	93%
San Francisco Nursing Center	53	39	96%
San Francisco Health Care	168	99	85%
Central Gardens	92	66	84%
<i>SUB-TOTAL</i>	<i>923</i>	<i>640</i>	<i>--</i>
MEDICARE OR PRIVATE PAY (DOES NOT ACCEPT MEDI-CAL)			
Kindred Transitional Care And Rehabilitation – Lawton	68	0	78%
Laurel Heights Community Care	32	0	13%
San Francisco Towers	55	0	58%
Sequoias San Francisco Convalescent Hospital	50	0	92%
Sheffield Convalescent Hospital	34	0	87%
California Convalescent Hospital - San Francisco	29	0	52%
The Heritage	32	0	64%
<i>SUB-TOTAL</i>	<i>300</i>	<i>0</i>	
TOTAL	1,223	640	

Source: California Office of Statewide Health Planning and Development, 2014

Note: Laurel Heights Community Care staff reported the facility’s 2014 low occupancy rate was related to new management. Given reporting variation, rates may not reflect real-time occupancy.

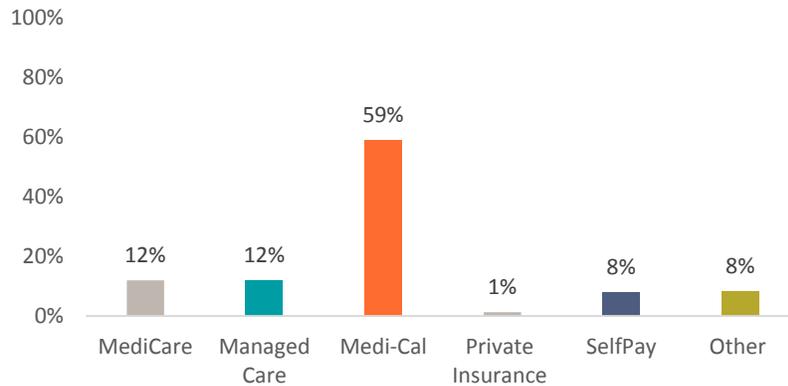
In Figure 17, occupancy rate is calculated using OSHPD reported patient and licensed bed days. If facilities do not staff the full number of licensed beds, this may result in a low occupancy rate.

Nine of San Francisco’s freestanding SNFs are Medi-Cal certified. Per the California Office of Statewide Health Planning and Development (OSHPD) 2014 SNF data, approximately 640 of the 1,223 licensed freestanding skilled nursing beds (52%) are occupied by patients with Medi-Cal coverage—the actual number of beds occupied by Medi-Cal patients, however, is likely to fluctuate throughout the year. In addition, the availability of beds for Medi-Cal long-term patients is limited. It is important to note that SNF data do not

distinguish whether beds are occupied by dual eligible patients that have both Medicare and Medi-Cal. What is known is that the majority of freestanding SNFs have high occupancy rates indicating that they generally operate at full capacity.

Annual census data reported by San Francisco SNFs to OSHPD in 2014 reveal that most SNF residents (59%) were covered by Medi-Cal (Figure 18). In total, 16 facilities made 3,337 discharges in 2014 but had an annual point-in-time census of 1,086 patients, potentially indicating a high volume of short-term patient discharges.

Figure 18: Freestanding SNF Patients by Payer Source, 2014 (n = 1,086)

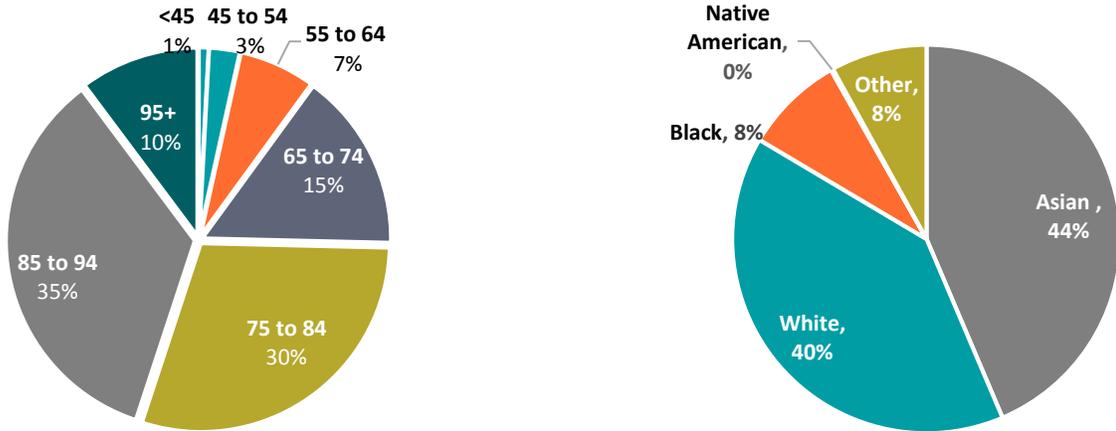


Source: California Office of Statewide Health Planning and Development, 2014

*Managed Care includes patients enrolled in Medicare and Medi-Cal managed health care plans

Almost all freestanding SNF users (90%) in San Francisco are 65 and older, and close to half (45%) are 85 and older. Asian and White adults comprise 84% of San Francisco freestanding SNF users (Figure 19).

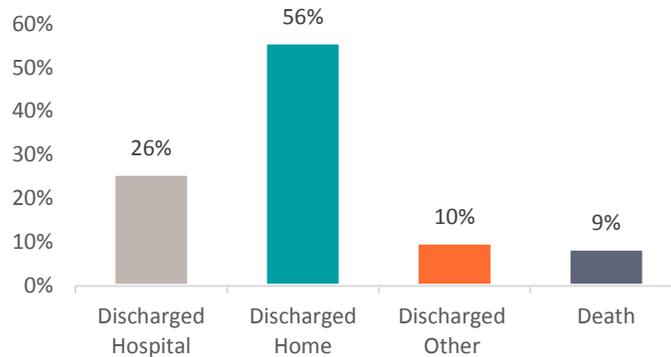
Figure 19: Freestanding SNF Patients, by Age and Race (n = 1,086)



Source: California Office of Statewide Health Planning and Development, 2014

The majority of admissions to freestanding SNFs (90%) are from hospitals. This referral pattern is likely related to the Medicare requirement of a 3-day qualifying inpatient hospital stay prior to admission to SNF. Figure 20 shows more than half of discharges from SNFs are to home, while more than one fourth are discharged to a hospital.

Figure 20 Freestanding SNF Discharge Dispositions (n = 3,447)

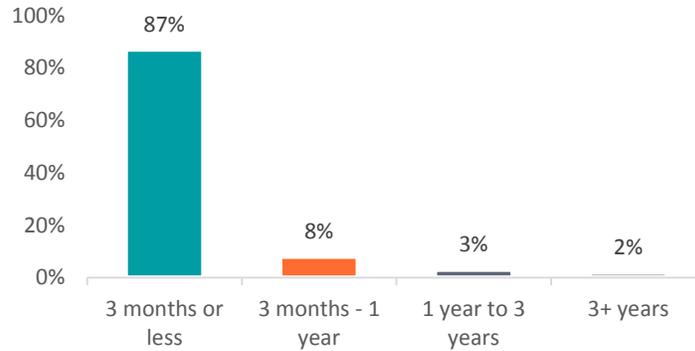


Source: California Office of Statewide Health Planning and Development, 2014

*Other refers to other LTC facility (3%), Residential Board and Care (1%), or Other (5%)

The majority of freestanding SNF discharges (87%) occur within 3 months or less—a discharge rate correlated to Medicare’s coverage of care in a SNF up to 100 days (Figure 21).

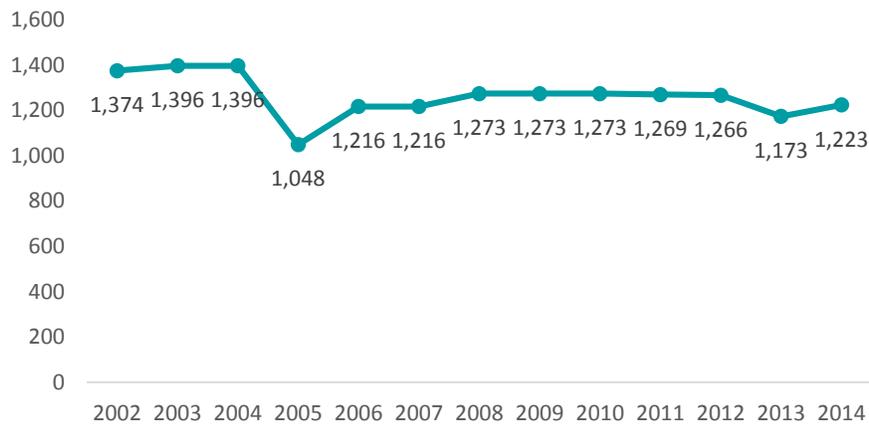
Figure 21: Freestanding SNF Discharges by Length of Stay, 2014 (n = 3,447)



Source: California Office of Statewide Health Planning and Development, 2014

Since 2002, the number of freestanding SNF beds has declined by 9% (Figure 22). The high cost of land and construction in San Francisco has been reported as a substantial barrier to maintaining, as well as increasing the number of SNF facilities and providers.

Figure 22: San Francisco Licensed Freestanding SNF Beds, 2002-2014



Source: California Office of Statewide Health Planning and Development, 2002-2014

*Note: Increase from 2013 to 2014 is the addition of Central Gardens

California Pacific Medical Center Operates San Francisco’s Only Subacute Unit

Subacute care is a level of care needed by a patient who does not require hospital acute care, but who requires more intensive skilled nursing care than is provided to the majority of patients in a SNF. CPMC St. Luke’s is San Francisco’s only provider of subacute care. As reported, the unit, which only accepts Sutter Health patients, is expected to close in the next few years, coinciding with the opening of CPMC’s new St. Luke’s Hospital.

Currently, St. Luke’s subacute unit provides care to 33 patients. More than 50% of patients have resided on the unit for two years or longer, 33% were admitted in the past year (Figure 23). In 2014, the unit discharged 35 patients (Figure 24). The majority of discharges were San Francisco residents (60%), and the most common primary diagnosis was chronic respiratory failure. Per CPMC data, the majority of patients discharged from the unit were covered by Medicare (71%), 23% were covered by Medi-Cal, and 4% by commercial plans. Of the 35 patient discharges in 2014, 66% occurred within three months or less of admission to the subacute unit. Although many subacute patients remain on the unit for years, others stay for short periods. The latter group includes patients discharged home with tracheostomy and ventilator equipment, when feasible (often financed by a Medi-Cal waiver), and those who expire on the unit. Most subacute patients are unable to step down to a level of care, and most freestanding SNFs are unable accept patients with tracheostomy or ventilator needs.

Figure 23: CPMC St. Luke’s Subacute Patient Census, 2014 (n = 33)

	N	%
PATIENT RESIDENCE		
San Francisco	24	72%
Outside City	9	27%
GENDER		
Female	18	54%
Male	15	45%
AGE		
Age 65 and under	19	58%
Age 65 +	14	42%
LENGTH OF STAY		
3 months or less	6	18%
3 months to 1 year	5	15%
1 year to 2 year	4	12%
2 years to 5 years	5	15%
5 years to 8 years	7	21%
8 + years	6	18%

Source: California Pacific Medical Center, 2014

Figure 24: CPMC St. Luke’s Subacute Patient Discharge Characteristics, 2014 (n = 35)

	N	%
PATIENT RESIDENCE		
San Francisco	21	60%
Outside City	14	40%
GENDER		
Female	14	40%
Male	21	60%
AGE		
Age 65 and under	16	46%
Age 65 +	19	54%
DISCHARGE DISPOSITION		
Died	7	20%
Home	28	80%
PAYER		
Medicare	25	71%
Medi-Cal	8	23%
Commercial	2	6%
LENGTH OF STAY		
3 months or less	23	66%
3 months to 1 year	7	20%
1 year to 2 year	2	6%
2 + years	3	8%

Source: California Pacific Medical Center, 2014

With the exception of CPMC, San Francisco acute care hospitals must transfer subacute patients to out-of-county facilities. This practice has transformed subacute care in San Francisco into a regional issue. In the greater Bay Area there are approximately 13 adult subacute units: four in Alameda County, two in Contra Costa County, two in Sacramento, one in San Mateo, and four in Santa Clara County. However, San Francisco hospitals cite challenges finding available beds in subacute units in Northern California.

Home- and Community-Based Elements That Reduce Demand for Institutional Skilled Nursing Care

As the institutional skilled nursing bed supply continues to decline in San Francisco, and nursing facilities shift toward short-term rehabilitative patients, San Francisco is at risk for an inadequate supply of skilled nursing beds for residents in the future. One approach to reducing the demand for institutional skilled nursing care is to increase the availability and integration of home- and community-based care. Key elements of home- and community-based care range from home-based health and personal care services, to community behavioral health programs, to community living options that include Residential Care Facilities for the Elderly (RCFEs—Assisted Living Facilities, Board and Care Homes) and alternative community housing arrangements, to community adult day services and social support programs. Advancing this approach in San Francisco is imperative, but doing it successfully requires addressing pressing challenges while creating opportunities to expand availability and access to these elements.

The most significant challenge to providing comprehensive home- and community-based care is cost for *both* providers and consumers. Programs are generally expensive to run and to access. A Kaiser Family Foundation report describing Medicaid and LTSS in the United States, found that home- and community-based care is generally less expensive than institutional-based LTSS, but the costs are still prohibitive for many individuals and families. In 2015, the median cost for one year of home health aide services (at \$20/hour, 44 hours/week) was almost \$45,800 and adult day care (at \$69/day, 5 days/week) totaled almost \$18,000.³⁹ Further, limited federal, state, and local funding for LTSS makes expansion in this area difficult, especially for government funded home- and community-based services. Government funded home- and community-based services come with significant financial and regulatory restrictions.⁴⁰ For example, most states have limits on home- and community-based care options (including waivers), such as waiting lists and cost caps. By contrast, nursing home care is a Medi-Cal entitlement program, meaning that states cannot create waiting lists for eligible patients needing care, and Medi-Cal covers the cost of nursing home care. As a result, Medi-Cal beneficiaries with long-term care needs are more likely to be placed in SNFs instead of community settings with needed services and supports. For now, out-of-county SNF placement is and will continue to be a reality for San Francisco residents due to limited bed availability, community-living alternatives, and higher care costs in San Francisco.

Several other challenges are important to note. The first is having enough stable, affordable housing, with support, to meet the needs of low-income older adults and persons with disabilities. Current housing and support service limitations impact the ability of these communities of adults to remain at home without adequate supervision and caregiver support. Unstable housing further restricts the ability of people to return home following an extended period of time in a facility. Living alone (40% of San Francisco seniors live alone) and having a limited social support system (family and friends), additionally limit the ability of some individuals to return to their homes or the community after a hospital or SNF admission. A second home- and community-based care challenge is that some in-home personal care and home health services have limited care hours. For example, Medicare's Home Health Agency provides 8 hours a day with a

maximum of 28 hours per week. Similarly, California’s In-Home Supportive Services (IHSS) program (Medi-Cal benefit) has limited personal in-home care hours. In San Francisco, IHSS recipients receive an average of 21 personal care hours/week. Both programs’ hour limitations limit the ability of some adults, for example those with moderate to advanced dementia, to remain in the home safely without round-the-clock supervision.

While these challenges merit attention, so do a number of opportunities. Chief among them is the opportunity for San Francisco to build on its existing framework of diverse home- and community-based care programs. In addition to the Long Term Care Coordinating Council⁹, San Francisco is home to a number of longstanding LTSS programs across city departments, hospitals, and community-based nonprofits. (See Appendix A: Home-and Community-Based Program Descriptions). The Chambers settlement^Σ of 2006, which alleged unnecessary institutionalization in LHH, further reinforced San Francisco’s commitment to providing community-based living options. The lawsuit set a precedent for the reduction of SNF beds in LHH, and catalyzed San Francisco’s shift toward home- and community based care. Since 2008, LHH, SFDPH, and DAAS have collaborated on the *Diversion and Community Integration Program* to provide long-term care services in a community integrated setting. Complementing San Francisco’s continuum of community-based living options, are several dynamic programs that promote community-based living over facility-based care in San Francisco. They include: the Program for all Inclusive Care for the Elderly (PACE) model of care, care transitions, and palliative care. (See below).

Program of All-Inclusive Care of the Elderly (PACE) is a pioneering community-based living program that enables nursing-home-eligible elderly to remain in the community. This innovative wrap-around service model provides coordinated and multidisciplinary services (e.g., adult day care, medical and rehabilitation services, social services, and hospital and SNF care when needed, etc.) for seniors with chronic care needs, providing them with the support they need to stay independent in their homes for as long as possible.⁴¹

The PACE model was developed in the 1970s by On Lok, a San Francisco organization serving seniors. Today, 104 PACE programs are operational in 31 states. Because of the success of PACE, legislation entitled the *PACE Innovation Act of 2015*, which allows the Centers for Medicare and Medicaid Services (CMS) to test innovations in the PACE model, including allowing PACE to serve high-need, high-cost individuals under 55, was introduced into Congress. On November 5, 2015, President Obama signed the Act into law. San Francisco is in a prime position to test pilot a PACE Innovation program for younger adults once the new law is implemented.

Care transitions programs can reduce avoidable hospital readmissions and associated health care costs.⁴² San Francisco was one of eleven federal Community Care Transitions Program (CCTP) participants in California. The CCTP demonstration tested models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. San Francisco’s CCTP, *San Francisco Transitional Care Program* (December 2012—June 2015), was

⁹ The Long Term Care Coordinating Council (LTCCC) is charged to: (1) advise, implement, and monitor community-based long term care planning in San Francisco; and (2) facilitate the improved coordination of home, community-based, and institutional services for older adults and adults with disabilities.

^Σ ^β Chambers v. City and County of San Francisco (2011).

a formal partnership between DAAS, Northern California Presbyterian Homes & Services/San Francisco Senior Center and multiple community-based organizations and hospitals. The program had two primary goals: help eligible older adults and adults with disabilities to transition safely from hospital to home; and, reduce unnecessary acute care hospital readmissions. Prior to the loss in federal funding, the program successfully improved transitions home and lowered readmissions for over 5,154 program participants.

DAAS has continued some elements of the Transitional Care Program in a modified program for IHSS beneficiaries, and those eligible for IHSS, to help them avoid hospital readmissions following an acute care hospital stay. To continue developing this and other preventative services and supports, San Francisco would benefit from a broad-based partnership of health and community service organizations (e.g., Health Plans, hospitals, SNFs, Assisted Living/Board & Care Homes, social service agencies, etc.) committed to enhancing post-acute care in the city.

Palliative care reduces the need for hospitalizations and some post-acute care services. As previously noted, palliative care not only relieves the symptoms, pain, and stress of serious illness, it addresses patients' emotional and spiritual needs. This whole person approach to care has proven successful in reducing patient suffering, and improving quality of life for patients and families. And because palliative care promotes greater clarity in goals of care, it is also associated with the more appropriate use of health care resources. San Francisco is committed to increasing the availability of palliative care services. In 2014, SFDPH and DAAS launched the San Francisco Palliative Care Task Force. The Task Force brought together a diverse group of representatives from leading health care and community organizations, advocacy and professional associations, as well as consumers and caregivers, to investigate San Francisco's current and future palliative care needs.

In addition to creating an inventory of dedicated palliative care services currently available in San Francisco, Task Force members identified priority short and long term palliative care recommendations to move San Francisco closer to meeting its current and future palliative care needs. The recommendations addressed quality (measuring the structures, processes, and outcomes of palliative care), finance (developing the business case for palliative care), systems (collaborating across health and community-based systems of care), and community engagement (promoting advance care planning). Following the conclusion of the three-month Task Force, the San Francisco Long Term Care Coordinating Council elected to continue the important work of the Task Force. The Council is currently implementing Task Force recommendations that promote advance care planning and increase palliative care access.

Vulnerable Populations

Throughout the Post-Acute Care Project, several vulnerable populations with current or future post-acute care needs emerged: 1) individuals with behavioral health needs (and substance abuse problems, dementia, traumatic brain injury, or who are homeless; 2) lesbian, gay, bisexual, and transgender seniors; and, 3) moderate-income seniors, ineligible for public programs. Addressing the post-acute care needs of these populations is central to improving San Francisco's post-acute care continuum.

Behavioral Health

Adults who have a mental health and/or substance abuse condition, and are medically complex, comprise a significant group of people who may need skilled nursing and long-term care services. In numerous stakeholder interviews, patients with mental illness, dementia, and traumatic brain injury *with* behavioral health issues were cited as very difficult to place in SNFs. Of all discharges to DP/SNF or freestanding skilled nursing facilities from San Francisco hospitals in 2013, 205 or 3% of discharges were patients with a mental disorder primary diagnosis consisting of an ICD 9 diagnosis 290-319 (2013).⁴³ Codes include diagnoses for psychosis, neurotic, personality and nonpsychotic mental disorders, or mental retardation. It is important to note that many acute care patients whose behavioral health issues limit their post-acute care placement options may not have a documented mental health, substance abuse, or neurological diagnosis. This lack of documentation can prevent or delay patients' receiving appropriate post-acute care.

The SFPD Transitions division experiences difficulties placing patients with behavioral health issues in facilities in San Francisco. Transitions primarily serves low-income Medi-Cal eligible San Francisco residents, many with behavioral health issues, who need supervision, wraparound support and subsidized placement to leave a hospital.⁴⁴ In fiscal year 2013-2014, SFPD Transitions placed 35 patients in skilled nursing facilities out of county, primarily neurobehavioral SNFs. Out-of-county facilities provide specialty care such as enhanced treatment programming, medical support (diabetes care, oxygen), dementia care, forensic support or are helpful for distancing substance users from familiar triggers. The Transitions team has indicated that low Medi-Cal payment for long-term SNF care has resulted in most skilled nursing facilities converting their beds to short-term rehabilitation beds. This leaves dementia and other behaviorally challenged clients with even more limited placement options.

Dementia

Alzheimer's is a common predictor of future skilled nursing need: adults with cognitive and functional decline and potential behavioral health problems are more likely to require supervision and skilled nursing care than adults without dementia. The challenge for San Francisco is the projected near doubling (40%) of persons with Alzheimer's age 55 and older in the city from 2015 (19,206) to 2030 (26,868).⁴⁵ To prepare for this change, in 2009, DAAS convened an expert panel to evaluate San Francisco's dementia care services, project the need for additional services, and prepare a plan and recommendations to address the needed services for the next 11 years (2009 to 2020).⁴⁶ The result was a comprehensive action plan entitled, *2020 Foresight: San Francisco's Strategy for Excellence in Dementia Care*. The plan was both prescient and timely; OSHPD 2014 data indicates that 208 patients with a primary diagnosis of Alzheimer's disease were cared for in 13 of San Francisco's 16 freestanding SNF facilities.⁴⁷

Homeless

In 2015, the San Francisco Homeless Point-in-Time Count found 6,686 individuals on the street or in a shelter in San Francisco.⁴⁸ At the time of the count, 23 homeless individuals were counted in hospitals. Additionally, 1,017 homeless adults were randomly surveyed. Forty-five percent of those surveyed were between the ages of 41 and 60 and 8% of respondents were 61 years or older at the time of the study. More than 67% of respondents reported one or more health conditions including chronic physical illness, physical disabilities, chronic substance abuse, and severe mental health conditions. Thirty-four percent of those with conditions reported a limited ability to take care of personal matters. Twenty-eight percent

of survey respondents reported a physical disability, 37% reported drug or alcohol use, and 35% reported psychiatric or emotional conditions. Given the prevalence of chronic conditions, and mental health and substance use among the homeless, if the current population remains a static, aging cohort, this population will likely need short and long-term care services in the future.

Lesbian Gay Bisexual Transgender (LGBT) Seniors

Many LGBT seniors have experienced health care discrimination and barriers to health care access. Approximately 18,000-20,000 LGBT seniors live in San Francisco.⁴⁹ To explore health and wellness issues facing San Francisco's LGBT older adults and develop actionable policy and program recommendations, the San Francisco Board of Supervisors established the LGBT Aging Policy Task Force in 2012. In 2013, the Task Force released their report, *Addressing the Needs of LGBT Older Adults in San Francisco: Recommendations for the Future*.⁴⁹ A major finding in the report stated, "...that LGBT participants have important strengths and resources that can foster their aging, health, and well-being, they also face significant risks, which can increase their vulnerability as they age." The report additionally found a lack of information and enrollment support for health services, health promotion, and mental health for LGBT seniors. In response to these findings, key health recommendations included: improve the friendliness of specific health and social services; provide training and services to help LGBT older adults as well as providers; and, collect quality data on the aging and health needs of LGBT older adults.

In April 2015, the San Francisco Board of Supervisors passed an ordinance to prohibit discrimination against lesbian, gay, bisexual, and transgender residents in long-term care facilities, further confirmation that the health needs of LGBT older adults must be addressed in plans to improve San Francisco's post-acute care continuum.

Seniors Ineligible for Public Assistance

Many moderate-income seniors struggle to meet their basic living needs. More than 772,000 older Californians are among the "hidden poor"—older adults with incomes above the federal poverty level (FPL) but below a basic standard of living as determined by the 2011 Elder Economic Security Standard™ Index (Elder Index).⁵⁰ A recent study found that since many public assistance programs are aligned with the FPL, the number of economically insecure older adults is significantly underestimated. As a result, thousands with significant need are denied aid.⁵¹ The highest rates of the hidden poor among older adults in California are found among renters, Latinos, women, individuals raising grandchildren, and people in the oldest age groups. In San Francisco, an estimated 29.8% of single elder households are estimated to be above 100% FPL but below the Elder Index.⁵² The challenge for many San Francisco moderate-income seniors is that they have incomes or assets too high to qualify for public programs—programs targeting low-income adults—but cannot afford to pay out of pocket for private pay long-term care services without risking falling into poverty. A recent study conducted by the San Francisco Controller's Office estimated 45,921 San Francisco seniors and persons with disabilities would not be able to afford a high-level of long-term care, if they needed it, nor would they be eligible for public assistance.⁵³

KEY QUALITATIVE FINDINGS: KEY INFORMANT INTERVIEWS

The Post-Acute Care Project Team conducted 24 interviews with stakeholders representing acute care hospitals, skilled nursing facilities, city departments, health plans, and home- and community based service providers. Stakeholders participating in the project key informant interviews discussed the following regarding post-acute care in San Francisco: concerns, unmet needs, priorities, barriers, special populations, opportunities to increase short- and long-term SNF beds, community-based post-acute care alternatives, and collaboration opportunities to address current and future post-acute care in San Francisco.

Three primary themes emerged from the interviews:

- **First**, San Francisco is at risk for an inadequate supply of skilled nursing beds in the future—includes subacute and short- and long-term SNF beds, with greater emphasis on long-term beds. (Note: Medicare beneficiaries generally do not have difficulties accessing SNF beds for short-stays.)
- **Second**, patients with behavioral challenges (dementia, mental illness, traumatic brain injury), as well as those who are homeless, and/or substance using, are extremely difficult to place in post-acute care facilities or in the community with post-acute supports.
- **Third**, placing Medi-Cal beneficiaries in skilled nursing facilities (short- and long-term), as well as in HCBS Medi-Cal waiver programs is hard, due to low reimbursement rates for facility care and waiver funding and regulatory limitations.

As a result of the above placement challenges, patients remain in acute care hospitals and unable to easily transition to appropriate lower levels of care.

Interview questions are presented below with the most common responses highlighted and explained.

1) *Based on the background presented and your experiences with post-acute, what concerns you most about subacute and short- and long-term SNF beds in San Francisco?*

- **Housing**—stakeholders reported that while some of the pressure related to the limited supply of SNF beds could be relieved with a greater supply of affordable housing with supports, housing costs in the city have escalated. In addition, many Board and Care Homes for low-income residents with health needs have closed (approximately 16 facilities and 80 RCFE beds have closed since 2011), and the option of Assisted Living facilities—predominantly private pay—is prohibitively expensive for many older adults.
- **Inadequate supply of SNF long-term beds**—San Francisco SNFs reportedly take few long-term care Medi-Cal patients, preferring to focus on short-term patients.
- **Out-of-county placements**—are increasingly necessary to place long-term care Medi-Cal patients and patients with the following characteristics: homeless, past/current history of substance use, behavioral difficulties caused by mental illness, dementia, or traumatic brain injury, and obesity.

2) *What specifically do you see as unmet post-acute care needs in these areas for San Francisco?*

- **Subacute services**—with only one subacute care unit currently in operation and slated to close in the next few years, the lack of adequate subacute care for San Francisco was widely cited as a major unmet post-acute care need and the reason for out-of-county subacute placements.
- **Limited short-term beds and extremely few long-term SNF beds for challenging patients**—limited short-term beds and virtually no long-term SNF beds in San Francisco for challenging patients have resulted in acute care hospitals assuming significant costs to care for both groups of patients until out-of-county SNF placements can be made (many hospitals subsidize out-of-county costs for these patients for long periods of time). Note: accessing short-term beds in San Francisco for *non-challenging* patients with Medicare or private insurance was reported not to be a problem.
- **Home-and community-based services (HCBS)**—current HCBS which involves everything from In-Home Supportive Services (IHSS) to various waivers (Assisted Living, Nursing Facility/Acute Hospital, San Francisco Community Living Support Benefit), and city programs such as the Diversion and Community Integration Program, and Direct Access to Housing have proven effective in keeping some at-risk individuals in the community. Despite the success of these programs, the need is greater than the current level of funding for these programs can support. (See Appendix A: Home-and Community-Based Program Descriptions).

3) *What should be San Francisco's priorities regarding subacute and short- and long-term SNF beds — now and in the future (2030)?*

- **Increased LTSS and HCBS support**—stakeholders strongly felt that community living programs with support could provide a viable short-and long-term SNF bed option. To achieve this, they suggested expanding the hours and duration of home health service, increasing IHSS hours to address medication and management of patients with dementia, and expanding the Community-Based Adult Services (CBAS) program.
- **More research**—support additional research to identify diagnoses and other characteristics for patients discharged from acute care hospitals to IHSS and out-of-county; research primary diagnoses for short- and long-term stay SNF patients with behavioral problems.
- **Create a Post-Acute Care Collaborative**—convene a Collaborative of all post-acute care stakeholders to meet regularly to review and address the issues and challenges of post-acute care for San Francisco. The collaborative should include home- and community based service providers and other long-term services and supports stakeholders, in addition to post-acute care providers.

4) *What are the barriers to meeting these post-acute care needs —now and in the future?*

- **Patient-level barriers** are predominantly experienced by patients who are: poor (i.e., Medi-Cal patients); have behavioral challenges (mental illness, dementia, or traumatic brain injury); homeless; substance using; without social support; obese; have a history of eviction; or who are frail older adults living alone in the community.
- **System-level barriers** include the following: current payment incentives for post-acute care are focused on short-term skilled or rehabilitation services over long-term facility stays; acute care and post-acute care providers are largely siloed from one another, with limited communication and care coordination; proliferation and expansion of home- and community-based services that could be more integrated into the post-acute care continuum are restricted by federal and state funding; the cost of living and housing in San Francisco limit post-acute care options for many patients; closure of several DP/SNFs; and, real estate and building development costs are a deterrent to the construction of new and rehabilitated SNFs in San Francisco.

5) *What are your thoughts about vulnerable populations (e.g., homeless, mentally ill, traumatic brain injury, etc.) and their needs for post-acute care? What can or should be done to address their needs?*

- **Patients with behavioral health problems**—stakeholders unanimously identified this group (those with mental illness, dementia, or traumatic brain injury), as a very difficult to place post-acute care population.
- **Lesbian, Gay, Bisexual, Transgender (LGBT)**—many older LGBT individuals are reluctant to enter SNFs and other facilities because of experiences with institutional discrimination. Findings from the San Francisco LGBT Aging Policy Task Force 2013 report, indicate a substantial number of older LGBT adults report being without family and social supports—a risk factor for needing post-acute care, and unable to age in place due to San Francisco housing costs.⁴⁹ Based on San Francisco’s Alzheimer’s projections, many older LGBT are also expected to develop dementia over the next few decades.
- **Homeless**—San Francisco’s homeless population, many with significant medical problems and a dual diagnosis (mental illness and co-occurring substance abuse problem), present a variety of post-acute care service and placement challenges for all providers.

6) *What opportunities exist to increase subacute and short- and long-term SNF beds in San Francisco?*

- **Engage SNFs**—work with existing SNF providers and the State to reserve more short- and long-term beds for Medi-Cal patients and those who are challenging to place in San Francisco’s freestanding SNFs. Request California Department of Health Care Services to administratively and financially support this recommendation.
- **Create new SNF unit(s)** — 1) encourage acute care hospitals to work with a SNF provider to open a SNF unit funded by all city hospitals, each hospital would have certain number of beds; 2) ask the city of San Francisco to provide financial incentives to SNF providers to build new or upgrade existing facilities, with a percentage of beds reserved for difficult-to-place populations.
- **Offer more medical respite**—increase medical and psychiatric respite facilities, like the Hummingbird Place (a Peer Psychiatric Respite facility at Zuckerberg San Francisco General).

7) *What are your thoughts about how community-based alternatives can help meet post-acute care needs in San Francisco?*

- **Expand IHSS**—advocate for expansion of IHSS (with the California Department of Social Services) to enable more beneficiaries to remain safely in their homes in lieu of institutions, especially for those requiring additional home-based services because of a dementia diagnosis.
- **Request HCBS Waiver reforms**—advocate for expanded, better funded, and more flexible HCBS waivers (e.g., Assisted Living Waiver, In Home Operations, Nursing Facility/Acute Hospital, and Multipurpose Senior Services Program) with the California Department of Health Care Services to increase waiver slots and individual cost caps, where appropriate; remove waitlists, and increase case management and other services. (See HCBS waiver description below.)

HCBS Waiver: Under the Medicaid statute, states have two options to offer HCBS to Medicaid beneficiaries with long-term care needs: 1) through a Medicaid (Medi-Cal in California) state plan benefit, or 2) through a 1915 waiver program. Regarding the first, the state plan must follow certain rules outlined in the statute (e.g., each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose; states may place appropriate limits on a service based on criteria such as medical necessity or functional level-of-care, etc.). California has several state plan community-based programs: In-Home Supportive Services, Adult Day Health Care, and Targeted Case Management. Under the 1915 waiver program, states have the authority to provide benefits that support community-based living in non-institutional settings, and that additionally do not need to be comparable across groups or statewide.⁵⁴

The Medicaid Home and Community-Based Services (HCBS) Waiver program, section 1915(c)

of the Social Security Act, was signed into law in 1981.⁵⁵ The legislation allows states to offer home- and community-based services in lieu of institutionalization for individuals served through the Medicaid program. Two factors influenced development of the waiver program: the need to slow the growth of Medicaid spending by providing services in less expensive settings, and recognition that many individuals at risk of being placed in medical facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.⁵⁶ Only individuals at risk for institutionalization are eligible for waiver services and the costs of waiver services must be less than what they would cost in an institutional setting.

HCBS waivers can be designed to offer a variety of services including case management, personal attendant services, adult day health care services, habilitation services, day treatment services, psychosocial rehabilitation services, mental health services, and other service. CMS oversees the administration and renewal of state HCBS waivers. In California, the Department of Health Care Services directly administers or oversees HCBS Medi-Cal programs, including eight 1915(c) HCBS waivers (brief summaries of waivers with asterisks are presented in Appendix A):

- Multipurpose Senior Services Program (MSSP) Waiver *
 - HIV/AIDS Waiver
 - HCBS Waiver for Persons with Developmental Disabilities (DD Waiver)
 - Assisted Living Waiver (ALW)*
 - Nursing Facility/Acute Hospital (NF/AH) – Transition and Diversion Waiver*
 - In-Home Operations (IHO) Waiver*
 - San Francisco Community Living Support Benefit (SFCLSB) Waiver*;
 - Pediatric Palliative Care (PPC) Waiver
- **Encourage San Francisco Health Plan** to work with city departments, acute and post-acute care providers, and community providers to increase institutional and HCBS coverage for Medi-Cal members. San Francisco Health Plan currently is contracted with 8 skilled nursing facilities in San Francisco: 5 Kindred facilities, San Francisco Health Care, San Francisco Nursing Center, and The Jewish Home.

8) *How can post-acute care stakeholders in San Francisco—city departments, hospitals, post-acute care providers, and others—collaboratively address current and future subacute and short- and long-term SNF need in the city?*

- **Improve Post-Acute Care flow**—enhance existing online tool addressing SNF bed availability used by some acute care and post-acute care providers to improve flow of SNF beds (match acute care hospital need with available SNF beds); increase providers using the tool.
- **Structure the San Francisco Post-Acute Care Collaborative** to meet regularly to address problems and identify and implement solutions to achieve a more integrated acute and post-acute care delivery system.

KEY QUANTITATIVE AND QUALITATIVE FINDINGS

Findings from the quantitative and qualitative data highlight the following post-acute care key challenges for San Francisco.

1) San Francisco Is At Risk for an Inadequate Supply of Skilled Nursing Beds In the Future

Skilled Nursing Bed Demand and Supply (Bed Capacity): San Francisco’s growing older population coupled with the high-cost of doing business in the city and low reimbursement rates for long-term skilled nursing care may result in a capacity problem for institutional skilled nursing care needs in the future.

- a. **Growing Aging Population:** San Francisco currently has 22 skilled nursing beds per 1,000 adults age 65 and older. If San Francisco were to maintain this rate as our population ages, the city would need 4,287 SNF beds –an increase of nearly 70% (1,745) over the current supply – by 2030. If the bed supply remains constant in the next 15 years, San Francisco’s bed rate would decrease to 13 SNF beds per 1,000 adults 65 and older.
- b. **Hospital Discharges:** In 2014 San Francisco acute care hospitals made close to 7,000 discharges to skilled nursing facilities.
- c. **Acute Care Patients Waiting Placement:** Health insurance status (i.e., Medi-Cal versus Medicare or private insurance), challenging patient characteristics, and family and patient preference are factors associated with delayed discharges and limited placement options for some patients transitioning from acute care to post-acute .

2) Medi-Cal Beneficiaries with Skilled Nursing Needs Have Limited Options in San Francisco

Patient Insurance (Payer): Medi-Cal patients are the most difficult to find placement for in SNFs, both short- and long-term care. Higher reimbursement for short-term Medicare patients has shifted skilled nursing facility practice toward short-term patients, leaving a limited number of options for long-term Medi-Cal patients. Medi-Cal beneficiaries also experience difficulty with placement in HCBS waiver programs and subacute care.

- a. **Medi-Cal SNF Placement:** Numerous factors and barriers are associated with placing Medi-Cal patients in SNFs for short- and long-term stays.
 - *Freestanding Skilled Nursing Facilities:* Nine of San Francisco’s 16 freestanding SNFs are Medi-Cal Certified (923/1,223 beds). At the time of the 2014 OSHPD reported annual SNF census, 640 beds were reported filled by Medi-Cal beneficiaries. As indicated in qualitative interviews with SNF stakeholders, this number fluctuates throughout the year.
 - *DP/SNFs:* The Jewish Home and Laguna Honda Hospital maintain waitlists for Medi-Cal long-term patients.

- *Hospital Discharges:* In 2014, acute care hospitals made more than 1,000 discharges to skilled nursing facilities for patients insured by Medi-Cal.
 - *Medi-Cal Enrollment:* More than 149,000 San Francisco residents are enrolled in Medi-Cal managed care. Additionally, 45,000 San Francisco residents are dual eligible for Medicare and Medi-Cal.
 - *Long-term Institutional Care:* Long-Term SNF care is an entitlement program covered by Medi-Cal. This creates a bias for institutional placement over limited HCBS waiver programs for patients requiring 24/7 skilled nursing care or supervision. Additionally, patients who do not qualify for Medi-Cal but cannot afford post-acute or long-term care services are a population at risk of having unmet health care needs.
- b. HCBS Medi-Cal Waiver Programs:** Nursing Facility/Acute Hospital Waiver (NF/AH); Assisted Living Waiver (ALW); Multipurpose Senior Services Program (MSSP), etc., provide viable post-acute care services and supports. Waiver waitlists, cost caps, inflexibility, and too few slots, however, impede the number of people able to remain in or transition to the community from long-term care institutions with the current waivers.
- c. Subacute Care:** Because most long-term subacute patients are Medi-Cal beneficiaries, subacute care represents another Medi-Cal payer and placement challenge. With the city's only subacute unit slated to close in 2019, subacute care must be addressed as vital component of the post-acute care continuum.

3) Post-Acute Care Placements for Some Vulnerable Populations Are Difficult to Find in San Francisco

Vulnerable Patient Populations: Key informant interviews and Advisory Committee discussions highlighted the difficulty of placing vulnerable patients in skilled nursing and long-term care. Vulnerable patients were described as individuals with dementia, mental health disorders, and traumatic brain injury, or who are homeless or substance abusing.

- a. **Skilled Nursing Facilities:** SNFs do not readily accept these patients for several reasons: disruption to other residents; inability to properly manage patient needs; increased risk of receiving state-issued facility citations/deficiencies and monetary penalties; and, increased risk that “vulnerable patients” will become facilities’ long-term SNF residents.
- b. **Hospital Discharges:** Many patients discharged from hospitals to post-acute care have mental health issues, substance abuse issues, and are homeless. As an example, in 2013, 205 or 3% of discharges were patients with a primary diagnosis of a mental disorder (ICD 9 diagnosis 290-319). For patients with an undocumented mental health or substance

abuse diagnosis transitioning to post-acute care, placement may be further delayed or limited.

- c. **In Home Supportive Services:** In Home Supportive Services, as currently structured, does not provide 24/7 caregiver support hours.

PROJECT RECCOMENDATIONS

At the second Post-Acute Care Advisory Committee, members worked in groups to carefully reviewed an assigned set of recommendations (see Appendix D for the table of draft recommendations) and worked together to identify and develop consensus driven priority recommendations. The workgroup process yielded a compelling set of priority recommendations. The final set of recommendations, short-and long-term, address the three urgent post-acute care challenges that emerged from the quantitative and qualitative analyses, and Advisory Committee member discussions: bed capacity, payer source (Medi-Cal), and vulnerable populations. Each recommendation includes a list of primary activities, strategic focus (Policy, Education, Research, Education, and Funding), designated purpose, and lead partner(s).

Because San Francisco has an array of successful care coordination, care transition, institutional diversion, and community-support programs, all efforts to enhance San Francisco's post-acute care continuum, through the priority recommendations, should be coordinated with existing programs. Existing programs include the Community Living Fund, SFDPH Direct Access to Housing, and SFDPH Transitions. For more information about these programs, please see Appendix A.

SAN FRANCISCO POST-ACUTE CARE PROJECT

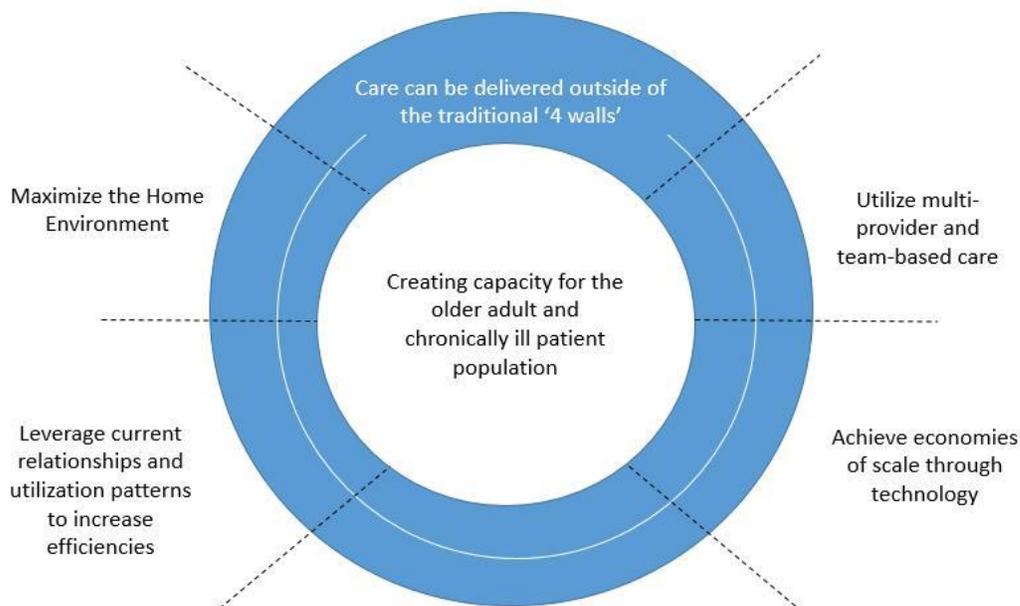
SHORT-TERM PRIORITY RECOMMENDATION	STRATEGY	PURPOSE	LEAD(S)/ PARTNERS
<p>1. Create a citywide Post-Acute Care Collaborative.</p> <ul style="list-style-type: none"> ➤ Collaborative to represent a public-private partnership of stakeholders from across the post-acute care continuum to: <ul style="list-style-type: none"> ➤ Promote information sharing. ➤ Improve patient referrals and care navigation. ➤ Identify and guide implementation of viable post-acute alternatives for vulnerable post-acute care patients, i.e., those with behavioral health problems. <p>* Collaborative to include front-line staff and possibly regional partners</p>	Operations	Establish citywide efforts to improve appropriate post-acute care services, with a focus on vulnerable populations	<i>Hospital Council, Department of Public Health, Department of Aging and Adult Services</i>
<p>2. Explore new incentives and funding options to address current gaps in institutional care and bring new SNF, Board and Care, and subacute providers into the market.</p> <ul style="list-style-type: none"> ➤ Advocate for revised land use policies for providers ➤ Promote provider incentives in the Health Care Services Master Plan ➤ Encourage health plans to fund new SNF partnerships <p>*Explore priority processing for post-acute providers and encourage the transfer of beds to new providers in the event of provider turnover</p>	Policy	Maintain existing SNF bed supply; ensure availability of SNF and post-acute care options to meet growing aging population	<i>Post-Acute Care Collaborative, Hospital Council, Department of Public Health</i>
<p>3. Identify the total number of long-term SNF patients in San Francisco that could transition to the community.</p> <ul style="list-style-type: none"> ➤ Summarize potential long-term SNF population for transition: number, support needs, and eligibility for HCBS waivers and alternative settings that could support a return to home/community living. 	Research	Increase transition of patients out of institutional care to increase SNF short- and long-term bed availability	<i>Institute on Aging, San Francisco Health Plan</i>
<p>4. Promote flexibility and expansion of community programs and affordable housing to care for post-acute care patients.</p> <ul style="list-style-type: none"> ➤ Advocate for post-acute care in community settings (e.g., Hospital at Home Model, Board & Care Homes, Assisted Living Facilities, Single-Room Occupancy Hotels, etc.) to accommodate post-acute care patients ➤ Expand the IHSS model to include all vulnerable patients, independent of insurance. ➤ Support ongoing affordable housing advocacy to increase living options for low-income post-acute care patients 	Policy & Funding	Increase resources for vulnerable patients by expanding current options	<i>Department of Aging and Adult Services</i>

LONG-TERM PRIORITY RECOMMENDATION	STRATEGY	PURPOSE	LEAD(S)/PARTNERS
<p>5. Explore public-private partnerships to support alternative post-acute care settings.</p> <ul style="list-style-type: none"> ➤ Evaluate the option of pooling acute care hospital and other resources to fund short-term skilled care beds, as well as long-term housing for Medi-Cal and vulnerable populations. ➤ Explore the viability of a capitated and tiered funding for post-acute Medi-Cal patients (e.g., higher need, higher reimbursement rate) ➤ Engage philanthropy in public-private partnerships to address vulnerable post-acute care populations ➤ Explore public-private partnership models/components profiled in the Environmental Scan (Appendix E) 	Funding, Policy	Increase home- and community-based options & improve transition of patients out of institutional care	<i>Post-Acute Care Collaborative</i>
<p>6. Identify a process—application/technology—for delivering real-time post-acute care information (acute care, post-acute care, HCBS).</p> <ul style="list-style-type: none"> ➤ Select a post-acute care application /technology that provides: <ul style="list-style-type: none"> ○ Post-acute care resource information ○ A database to link current LTSS/HCBS capacity to hospital post-acute care patient needs (e.g., gap analysis/process map); pathways/options for post-acute care patients with varying needs and payer sources. ○ Information about patient transitions between levels of care to help providers identify appropriate care pathways and post-acute settings. ➤ Educate acute care, primary care, and LTSS providers about post-acute care using selected technologies 	Education, Operations	Improve collaboration between acute and post-acute care providers, ensure all available post-acute care resources are utilized, expedite transition of patients into the community	<i>Post-Acute Care Collaborative</i>
<p>7. Advocate for increased access to existing Medi-Cal HCBS program waivers.</p> <ul style="list-style-type: none"> ➤ Advocate for increased slots and cost caps for the following waivers: Nursing Facility Acute Hospital Waiver, San Francisco Community Living Support Benefit Waiver, Multipurpose Senior Services Program Waiver 	Policy	Increase number of residents able to use waiver services, Increase reimbursement rates for HCBS post-acute care providers	<i>Post-Acute Care Collaborative, San Francisco Department of Public Health, Department of Aging and Adult Services, Disability Rights California</i>

Environmental Scan

Collaborative Consulting, Inc., a member of the project team, conducted an environmental scan of successful post-acute care service delivery models and alternative care settings—and their individual components—from around the country. The purpose of the scan was to complement project quantitative and qualitative analyses of post-acute care in San Francisco, and to identify models and components the city might replicate or adapt to create a more innovative, community-based post-acute care delivery system.

The scan highlighted models for delivering creative post-acute care services in diverse settings. From the scan, multiple themes emerged that underscored the value of *out-of-the-box* thinking to meet the post-acute needs of older adults and adults with chronic illness wherever they are. The themes included: multi-provider or team-based approaches to care delivery, leveraging current infrastructure and relationships between providers to maximize efficiency, achieving economies of scale through technology, maximizing the home environment, and understanding that funding innovation may be necessary until policy and reimbursement reform is enacted. See visual below.



A brief summary of the environmental scan's post-acute care models and approach to addressing San Francisco's post-acute care challenges are presented in Appendix E. The scan will serve as a resource for the Post-Acute Care Collaborative.

CONCLUSION

Major findings from the San Francisco Post-Acute Care Project data analysis reveal significant skilled nursing facility bed challenges for San Francisco, with respect to supply, demand, and gaps in care. Over the past 15 years, the supply of institutional skilled nursing beds in the city has fallen significantly: the number of hospital DP/SNF beds has fallen by 43%, and the number of freestanding SNF beds has fallen by 9%. Reduced SNF beds in conjunction with projected aging and chronic illness demographics in the city are concerning. Added to this, the shift in freestanding SNFs toward providing short-term rehabilitation may create a capacity risk for San Francisco seniors and adults with disabilities who need skilled nursing care and 24/7 supervision, especially for residents who are Medi-Cal only beneficiaries, need long-term care placement, or have behavioral health challenges.

Based on these and other significant quantitative and qualitative findings, three critical post-acute care challenges impacting many stakeholders in the post-acute care continuum emerged from the project's exploratory analysis: the adequacy of San Francisco's current and future supply of short- and long-term skilled nursing beds (primarily for Medi-Cal patients); placing patients with behavioral challenges (dementia, mental illness, traumatic brain injury), as well as those who are homeless, and/or substance using in any post-acute care setting (institutional or community-based); and, last, low Medi-Cal reimbursement rates and funding levels for SNF care (short-and long-term), HCBS waiver programs, and subacute care.

The San Francisco Post-Acute Care Project Team and Advisory Committee juxtaposed these urgent challenges with key project findings and their own post-acute care expertise and experiences. With a commitment to resolving San Francisco's pressing post-acute care challenges, they developed a project a final set of recommendations. The final set of recommendations (short- and long-term) include the following:

Short-Term Recommendations

- 1) Create a citywide Post-Acute Care Collaborative comprised of post-acute and home- and community based service providers and other long-term services and supports stakeholders to further develop and implement San Francisco's post-acute care strategy.
- 2) Explore new incentives and funding options to address current gaps in institutional care and bring new SNF, Residential Care Facilities for the Elderly (RCFEs), and subacute providers into the market.
- 3) Identify the total number of long-term SNF patients in San Francisco that could transition to the community (with a sustainable community living plan to ensure the most appropriate and least restrictive setting) to improve the flow of patients between facilities and the community.
- 4) Promote flexibility and expansion of community programs to care for post-acute care patients.

Long-Term Recommendations

- 5) Explore public-private partnerships to support alternative post-acute care settings.
- 6) Identify a process (e.g., an application or technology) for delivering real-time post-acute care information across acute care, post-acute care, and home- and community based services.
- 7) Advocate for increased access to existing California HCBS program waivers.

It is important to note several significant issues that surfaced during the Post-Acute Care Project process that are not fully addressed in this recommendation list, merit further attention. First, the future Post-Acute Care Collaborative is encouraged to develop specific recommendations to respond to the projected closure of CPMC's St. Luke's subacute unit—one possible reason they were not the focus of the priority recommendation is that the unit is not slated to close until 2019. Possible recommendations may include developing partnerships with regional subacute providers and exploring alternative subacute settings, such as subacute services at home.

Second, San Francisco's "hidden poor," described in the report as older adults with incomes above the federal poverty line but below a basic standard of living, represent a population often overlooked in community services and supports. Because this is a population at risk of falling into poverty when faced with serious illness, their post-acute care needs must be addressed in any future post-acute care plans. To ensure this, the Post-Acute Care Project Team strongly recommends the Collaborative engage representatives from diverse consumer groups in post-acute care planning and implementation efforts.

Finally, a crucial project finding with the potential to address supply and gaps in post-acute care—as highlighted in the initial project problem statement—is greater use of alternative home- and community-based post-acute care options. This approach is both practical and necessary. As discussed in the report, however, increasing the availability and integration of home- and community-based care, including government funded home- and community-based services, will require addressing current challenges and creating opportunities that offer responsive solutions. Both demand greater attention and resources to ensure this vital option to institutional skilled nursing care is further developed.

For years San Francisco hospitals and health systems have individually struggled with and tried to address, *mostly separately*, SNF bed supply and demand problems, Medi-Cal's low reimbursement and funding levels, and the post-acute care needs of vulnerable populations. The San Francisco Post-Acute Care Project revealed the urgency and opportunity for all stakeholders across the post-acute care continuum to work together to resolve these serious post-acute care challenges.

APPENDIX A: HOME AND COMMUNITY-BASED PROGRAM DESCRIPTIONS

San Francisco Programs⁵⁷

Community Living Fund.

In 2007, the City and County of San Francisco dedicated \$3 million to establish a Community Living Fund (CLF). This funding is renewed every year and is used for goods and services that help at-risk individuals continue living independently in their homes or leave institutions and return to community living. 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% 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 that provide 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 that work with seniors and persons with disabilities (SPDs).

Diversion and Community Integration Program.

The Diversion and Community Integration Program (DCIP) is a collaborative effort by DAAS and SFDPH. DCIP is a multi-disciplinary team of individuals from key programs from or funded by DAAS and SFDPH, focused on current residents of Laguna Honda Hospital (LHH) and those at risk of admission to LHH. Core group members bring significant expertise to working with this population and have the ability to authorize and commit to providing community-based services that promote and maintain independence and support quality of life. The team holds twice-monthly meetings to review cases of eligible clients, typically LHH consumers close to discharge (or former LHH residents that DCIP has already transitioned to the community that may need revisiting). The group develops a Community Living Plan for every eligible client to facilitate either discharge from LHH or diversion of LHH admission. This plan always includes the client's preferences and assessed needs, and specifies services that have been or will be arranged. Common services include IHSS home care, housing assistance, and intensive case management provided by CLF.

San Francisco Health Network Transitions Division

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 services low-income Medi-Cal eligible San Francisco residents, many with behavioral health issues, who need supervision, wraparound support and subsidized placement to leave a hospital.

San Francisco Department of Public Health Direct Access to Housing

Established by the San Francisco Department of Public Health – Housing and Urban Health Section (SFDPH-HUH) in 1998, the Direct Access to Housing (DAH) 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 is also fiscally prudent as it leads to cost savings by reducing overutilization of emergency services. Unique in its on-site provision of wrap-around 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.

Program of All-Inclusive Care for the Elderly. ⁵⁸

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 affords 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.

California Waiver Programs⁵⁶

Assisted Living Waiver.

The Assisted Living Waiver (ALW) waiver 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 a Residential Care Facility for the Elderly (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 his/her care needs while continuing to reside in a RCFE or public subsidized housing.

In-Home Operations Waiver.

The In-Home Operations (IHO) Waiver was originally developed for those 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, communications services.

San Francisco Community Living Support Benefit Waiver.

The San Francisco Community Living Support Benefit (SFCLSB) Waiver utilizes certified public expenditures for provision of waiver services to persons with disabilities age 21 and over who reside in the City and County of San Francisco and who are either homeless, residing in a nursing facility, or are at imminent risk of entering a nursing facility. Eligible individuals can move into licensed **Community Care Facilities (CCFs)** or **Direct Access to Housing (DAH)** sites (e.g., private homes). Services consist of care coordination, community living support benefits, and behavior assessment and planning in both CCFs and DAHs; and home delivered meals and environmental accessibility adaptations in DAH sites.

Skilled Nursing/Acute Hospital Waiver

The Skilled Nursing/Acute Hospital Waiver (SN/AH) 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.

Community Programs: Medi-Cal State Plan^{59, 60}

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 administered between the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), and CDA.

In-Home Supportive Services (IHSS).

In-Home Supportive Services 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.

The majority of IHSS users in San Francisco are female and over the age of 65. Forty percent live alone and 80% are on Supplemental Security Income (SSI). Chinese residents represent the highest users of IHSS (42%) and Caucasian residents the second highest (24%). Nearly every IHSS recipient utilizes domestic and related assistance such as domestic services, routine laundry, grocery shopping, errands and other shopping, meal clean up, and accompaniment to medical appointment. IHSS authorizes up to 283 hours per month per recipient however this represents only 4% of San Francisco IHSS users. The current average weekly hours authorized is 21 hours/week. The majority of IHSS providers are family or friends of the recipient.

Figure 1: IHSS Active Cases, 2014 (N = 22,556)

	N	%
Male	8,684	38%
Female	13,872	62%
Under 65	5,979	27%
65+	16,577	73%
Lives Alone	8,978	40%
SSI	18,006	80%

Source: San Francisco Human Services Agency Planning Unit, 2014

Figure 2: Ethnicity of IHSS Active Cases (n = 22, 446)

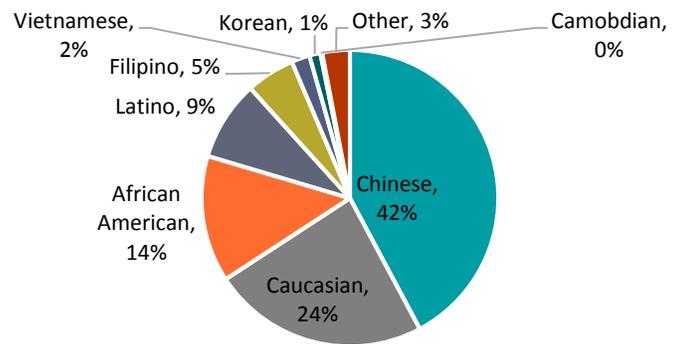
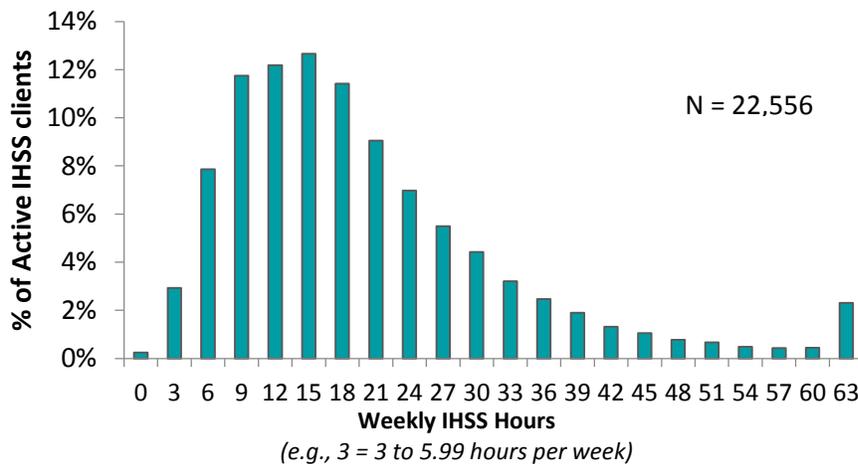


Figure 3: IHSS Active Clients by Authorized Hours per Week



Source: San Francisco Human Services Agency Planning Unit, 2014

Home Health Agencies

Home health agencies provide care for Medicare and Medi-Cal beneficiaries who are homebound and need skilled nursing or therapy. To be eligible for Medicare’s home health benefit, beneficiaries must need skilled care that is part-time or intermittent, defined as fewer than 7 days each week or less than 8 hours each day over a period of 21 days (or less) with some exceptions in special circumstances. Beneficiaries must also be unable to leave their home without considerable effort. Unlike skilled nursing facility coverage, Medicare does not require a preceding hospital stay to qualify for home health care. In San Francisco, discharges to home health are the most common post-acute care discharge.

Note: home health care is *different* from in-home care. A physician must deem home health care medically necessary. In addition, home health care services are time-limited and focus primarily on intermittent skilled nursing care and therapy (physical therapy, speech-language pathology, occupational therapy), and can be reimbursed by Medicare, Medi-Cal, and private insurance. By contrast, in-home care focuses on providing personal care, supervision, household support, etc. Generally, in-home care is private pay; however, some local, state, and federal programs may cover in-home services for eligible individuals. In California, In-Home Supportive Services (IHSS) provides people with low-income who have disabilities or are 65 years old or older with in-home and personal care services. Last, some agencies may provide both home health and in-home care.

Figure 1: San Francisco Home Health Agencies, 2014

Home Health Agency	Annual # of Clients	Payments Accepted
American Carequest	1,516	Medicare & Medi-Cal
Arcadia Home Care And Staffing	158	Medicare & Medi-Cal
Bay Area Care Team Inc.	54	Medicare & Medi-Cal
Cross Roads Home Health Care & Hospice	638	Medicare & Medi-Cal
Health At Home	1,217	Medicare & Medi-Cal
Health Link Home Health Agency	559	Medicare & Medi-Cal
Incare Home Health Services	574	Medicare & Medi-Cal
Kaiser - Hospital Home Health	1,053	Medicare & Medi-Cal
North Cal Home Health Care, Inc.	232	Medicare
On Lok Senior Health Services	68	Medi-Cal
Self-Help Homecare & Hospice	897	Medicare & Medi-Cal
Seniors At Home	26	Private Pay
Sutter Visiting Nurse Association And Hospice	3,405	Medicare
UCSF Home Health Care	2,647	Medicare & Medi-Cal
TOTAL	13,044	

APPENDIX B: MEDI-CAL CRITERIA FOR SKILLED NURSING FACILITY CARE

The California Department of Health Care Services provides the following criteria for Medi-Cal skilled nursing facility care, including continuing care (extensions and prolonged care), and subacute care coverage.⁶¹

I. Criteria for Determining Admission to SNFs

Criteria for admission to SNFs are contained in California state regulations (Title 22, CCR, Section 51335) and are applied on a statewide basis. Those criteria for admission and extension of stay (continuing care) are as follows:

- A. Need for patient observation, evaluation of treatment plans, and updating of medical orders by the responsible physician
- B. Need for constantly available skilled nursing services. A patient may qualify for SNF services if the patient's care involves one or more of the following conditions:
 1. Conditions such as the following weigh in favor of SNF Placement:
 - a. Dressing of postsurgical wounds, decubitus ulcers, leg ulcers, etc. The severity of the lesions and the frequency of dressings will be determining factors in evaluating whether they require SNF care.
 - b. Tracheostomy care, nasal catheter maintenance.
 - c. Indwelling catheter in conjunction with other conditions. Its presence without a requirement for other skilled nursing care is not a sufficient criterion for SNF placement.
 - d. Gastrostomy feeding or other tube feeding.
Colostomy care for initial or debilitated patients. Facilities shall be required to instruct in self-care where such is feasible for the patient.
 - e. Colostomy care alone should not be a reason for continuing SNF placement.
 - f. Bladder and bowel training for incontinent patients.
 2. Patients whose medical condition requires continuous skilled nursing observation of the following may be in a SNF depending on the severity of the condition. Observation must, however, be needed at frequent intervals throughout the 24 hours to warrant care in an SNF.
 - a. Regular observation of blood pressure, pulse, and respiration as indicated by the diagnosis or medication and ordered by the attending physician.
 - b. Regular observation of skin for conditions such as decubitus ulcers, edema, color, and turgor.
 - c. Careful measurement of intake and output as indicated by the diagnosis or medication and ordered by the attending physician.
 3. If the patient needs medications which cannot be self-administered and requires skilled nursing services for administration of the medications, SNF placement may be appropriate for reasons such as the following:

- a. Injections administered during the evening or night shift. If this is the only reason for SNF placement, consideration should be given to other therapeutic approaches or to the possibility of teaching the patient or a family member to give the injections.
 - b. Medications prescribed on an as needed basis. This will depend on the nature of the drug and the condition being treated and frequency of need as documented.
 - c. Use of restricted or dangerous drugs if required more than during the daytime, requiring close nursing supervision.
 - d. Use of new medications requiring close observation during initial stabilization for selected patients. Depending upon the circumstances, such patients may also be candidates for intermediate care facilities (ICFs).
4. A physical or mental functional limitation.
- a. Physical limitations. The physical functional incapacity of certain patients may exceed the patient care capability of ICFs.
 - 1) Bedfast patients.
 - 2) Quadriplegics or other severe paralysis cases. Severe quadriplegics may require such demanding attention (skin care, personal assistance, respiratory embarrassment) as to justify placement in SNF.
 - 3) Patients who are unable to feed themselves.
 - 4) Patients who require extensive assistance with personal care such as bathing and dressing
 - b. Mental limitations. Persons with a primary diagnosis of mental illness (including mental retardation) when such patients are severely incapacitated by mental illness or mental retardation. The following criteria are used when considering the type of facility most suitable for the mentally ill and mentally retarded person where care is related to the patient's mental condition.
 - 1) The severity or unpredictability of the patient's behavior or emotional state.
 - 2) The intensity of care, treatment. services, or skilled observation that the patient's condition requires and
 - 3) The physical environment of the facility, its equipment, and the qualifications of staff and
 - 4) The impact of the particular patient on other patients under care in the facility.
 - c. The general criteria identified above are not intended to be either all-inclusive or mutually exclusive. In practice, they should be applied as a total package in evaluation of an approved admission.

II. Continuing Care Determinations

A. Regular Extensions

Extensions of stay in SNFs require reauthorization by the Medi-Cal consultant every four months except for those patients who have been identified as "prolonged care" patients (see B, below). Regular extensions are based on the same criteria as initial authorizations.

B. Prolonged Care Determinations

The "prolonged care" classification recognizes that the medical condition of selected patients requires a prolonged period of skilled nursing care. The prolonged care classification is intended

only to eliminate unnecessary, costly paper work for both the State and providers of service. Reauthorizations for prolonged care at the SNF level of care are approvable for up to one year. Therefore, all patients are considered regular or nonprolonged care unless the patient meets the criteria for prolonged care.

Medical functional factors of the patient must support a sound professional judgment that a prolonged period of care will be required. The following medical/functional factors shall be used to reach the decision on prolonged care status:

1. Highest indications of need for prolonged care.
 - a. Total or severe incontinence, which despite bowel and bladder training has failed to improve.
 - b. Bedridden and/or comatose or semicomatose states.
 - c. Conditions which have resulted in quadriplegia, hemiplegia, spasticity, rigidity, and uncontrolled movements, tremors, or deformity dependent upon severity or intensity.
 - d. Conditions which require a high degree of prolonged medical nursing support and supervision (depending upon the patient's ability to participate responsibly in the patient's own care). These include complex regimens of oral and/or parenteral medications and diet to control diabetes, cardiac conditions, seizure disorders, hypertension, tumor conditions, obstructive pulmonary conditions, infectious conditions, and pain.
 - e. Conditions which require a high degree of prolonged mechanical nursing support and supervision (depending upon the patient's ability to participate responsibly in the patient's own care). These include tracheostomies, gastrostomies, colostomies, catheters, NIG tubes, IPPB machines, irrigation procedures, medicinal installation procedures, dressing changes, and conditions requiring sterile technique.
 - f. Conditions requiring medical/psychiatric/developmental nursing support and supervision (dependent upon severity and the patient's ability to participate responsibly in the patient's own care). These include extreme confusion and disorientation, inability to communicate, unacceptable physical, sexual, or verbally aggressive behavior, and anxiety or depression which is secondary to the medical/physical condition (e.g., terminal cancer). Note: Conditions which are psychogenic as opposed to organic are generally considered transitory in nature. They constitute poor justification for authorizing prolonged care.

2. Important indications of need for prolonged care. (Usually requiring two or more of the following factors.)
 - a. Conditions outlined in c, d, e, and f above, but of lesser severity, intensity, or degree than alluded to in section 1 above.
 - b. Occasional incontinence-on bowel and bladder retraining programs.
 - c. Debilitating conditions including extreme age, which indicate a need for preventive nursing care and supervision to avoid skin breakdown, fractured bones, nutritional deficiency, or infectious conditions.
 - d. Cases in which the documented history gives clear indication that changes in the "status quo" will likely lead to levels of care which are more costly to the Medi-Cal program.

3. Supporting indications.

The relative importance of factors in this category is determined by the relationship with factors from a and b of 1 above. Any one factor in this category standing alone is not sufficient to establish prolonged care status. However, items in this category will add to the weight of facts to support a finding of prolonged care status.)

- a. Conditions outlined in a and b of 1 above but of lesser severity, intensity, or degree than alluded to in those sections.
- b. Cases in which the documented history and/or diagnosis gives clear indication of progressive incapacitation.
- c. Dependence for activities of daily living-dependent upon degree.
- d. Sensory impairment.
- e. Generalized weakness or feebleness.
- f. Behavioral management problems.

III. Subacute Level of Care-Criteria for Determining Admission or Extension of Stay (Continuing Care).

Subacute level of care, authorized by Medi-Cal, is defined in Title 22, California Code of Regulations (CCR), Section 51 124.5. Authorization shall be based on medical necessity and the lowest cost service in accordance with Title 22, CCR, Sections 51003 and 51303.

An initial Treatment Authorization Request shall be required for each admission. Extensions of stay require reauthorization by the Medical Consultant every two months. Prolonged care may be authorized for up to a maximum of four months. Extensions are based on the same criteria as initial authorizations.

Minimal standards of medical necessity for this level of care include:

- A. Physician visits medically required at least twice weekly during the first month and a minimum of at least once every week thereafter.
- B. Twenty-four hour access to services available in a general acute care hospital.
- C. The need for special medical equipment and supplies such as ventilators which are in addition to those listed in Title 22, CCR, Section 5151(b).
- D. Twenty-four hour nursing care by a registered nurse.
- E. Any one of the following three items:
 - 1) A tracheostomy with continuous mechanical ventilation for at least 50 percent of the day; or
 - 2) Tracheostomy care with suctioning and room air mist or oxygen as needed and one of the six treatment procedures listed in Section F: or
 - 3) Administration of any three of the six treatment procedures listed in Section F.

F. Treatment Procedures

1. Total parenteral nutrition (TPN).

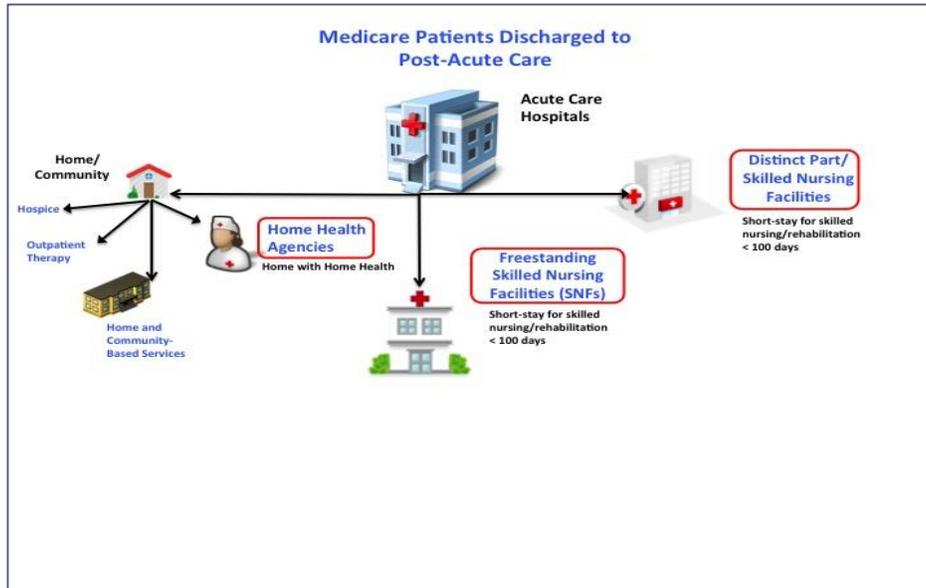
SAN FRANCISCO POST-ACUTE CARE PROJECT

2. Inpatient physical, occupational, and/or speech therapy, at least two hours per day five days per week.
3. Tube feeding (NG or gastrostomy).
4. Inhalation therapy treatments during every shift and a minimum of 4 times per 24-hour period.
5. Continuous IV therapy involving administration of therapeutic agents or IV therapy necessary for hydration or frequent IV drug administration via a peripheral and/or central line without continuous infusion such as via Heparin lock.
6. Debridement, packing, and medicated irrigation with or without whirlpool treatment.

APPENDIX C: POST-ACUTE CARE DISCHARGE SCENARIOS

The graphic below, *Medicare Patients Discharged to Post-Acute Care*, shows typical discharge pathways for a Medicare patient with short-term needs (below). This post-acute care patient group experiences the fewest discharge challenges. Several factors contribute to this outcome: Medicare’s higher reimbursement rate, patients’ skilled care needs are short versus long-term, and the fact that many in this group have a viable home or community setting as their final discharge destination.

Graphic #2: Medicare Patients Discharged to Post-Acute Care



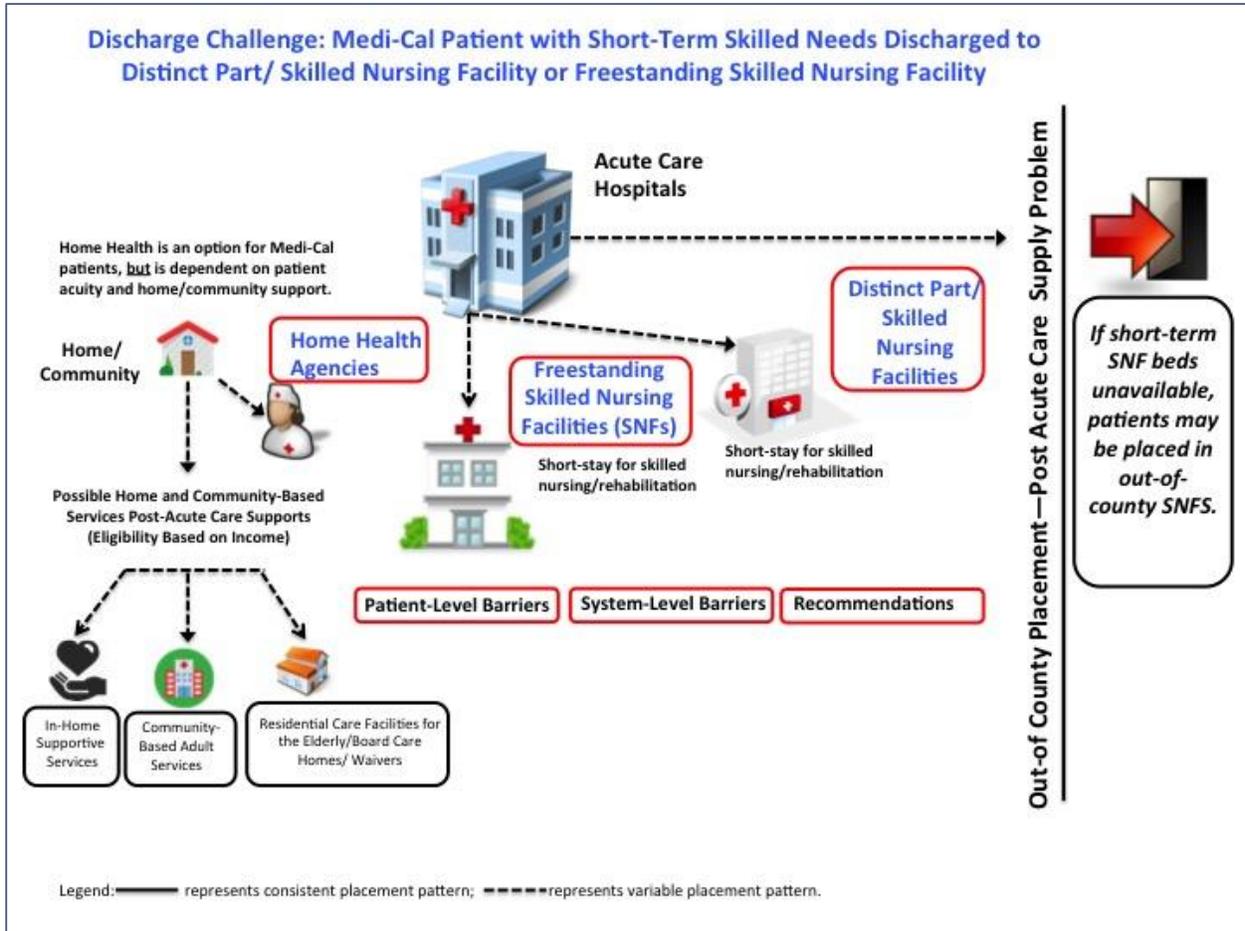
The next four graphics in the series depict significant post-acute care patient discharge challenges:

1. *Medi-Cal Patient with Short-Term Skilled Needs Discharged to Distinct Part/Skilled Nursing Facility or Freestanding Skilled Nursing Facility*
2. *Dual Patient (Medicare & Medi-Cal) Discharged to Distinct Part/ Skilled Nursing Facility or Freestanding Skilled Nursing Facility with Long-Term Skilled Nursing Care Need/“Potential Need”*
3. *Medi-Cal Patients with Special Characteristics (Behavioral Health, Homeless, Substance Using) Discharged to Distinct Part/Skilled Nursing Facility or Freestanding Skilled Nursing Facility*
4. *Patient Discharged to Subacute Care.*

To gain a deeper understanding of the factors influencing these post-acute care challenges for San Francisco, and the trend in out-of-county SNF and subacute placements for this group of patients, Advisory Committee members were divided into four workgroups. Each workgroup was given a specific post-acute care discharge challenge (with an accompanying hypothetical patient profile). Workgroups were tasked with identifying potential patient and system-level barriers for their assigned discharge challenge, as well as corresponding recommendations to address the barriers. Graphics 3-6 present these discharge challenges, with workgroup identified key barriers and recommendation. (Note: recommendations from this exercise were used to inform initial project recommendations).

Graphic #3. Medi-Cal Patient with Short-Term Skilled Needs Discharged to Distinct Part/ Skilled Nursing Facility or Freestanding Skilled Nursing Facility

Patient Profile: Ms. Smith is a 45 year-old female Medi-Cal beneficiary with an acute care diagnosis of worsening Cellulitis discharged to a SNF for 2 weeks of IV antibiotic treatment.



Patient and System-Level Barriers:

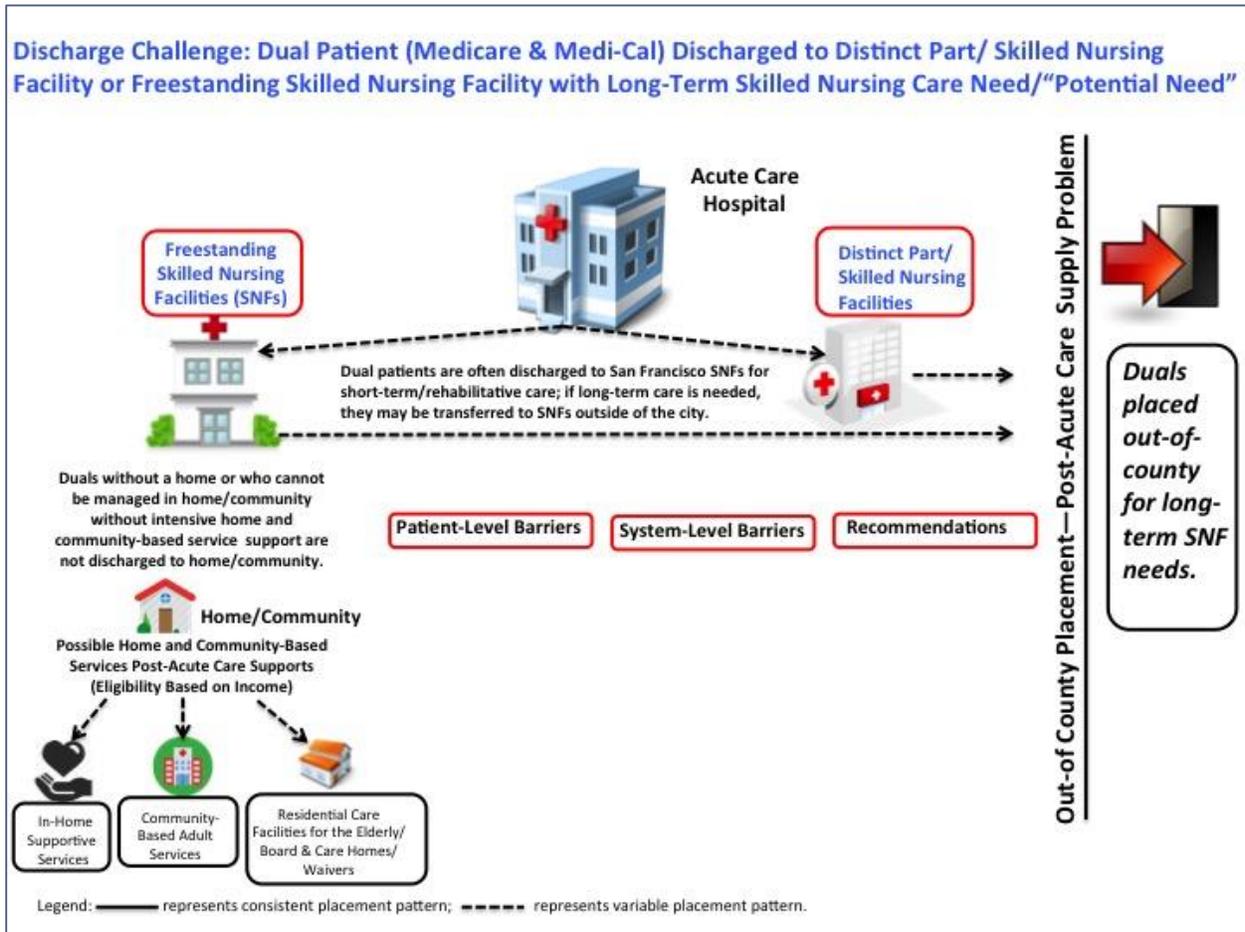
- Patient-level barriers to DP/SNF or SNF may include: behavioral/substance use problems, unstable discharge plan home due to limited family/psychosocial support, marginal housing.
- System-level barrier: patient’s Medi-Cal insurance (difficult to find DP/SN unit or SNF to take short-term Medi-Cal patient with infusion needs).

Recommendations

- Establish short-term SNF placement for Medi-Cal patients with infusion needs; create outpatient fusion options; seek funding for additional alternative sites of care where patients with short-term medical needs can reside if necessary, such as Board & Care Home or Adult Foster care.
- Create and use a universal post-acute care referral process and screening tool.

Graphic 4. Dual Patient (Medicare & Medi-Cal) Discharged to Distinct Part/ Skilled Nursing Facility or Freestanding Skilled Nursing Facility with Long-Term Skilled Nursing Care Need/“Potential Need.”

Patient Profile. Mrs. Jones is a 75-year-old female Accident admitted to the hospital with a “Failure to Thrive” diagnosis. She has High Blood Pressure, Diabetes, Chronic Obstructive Pulmonary Disease, and is status-post a Cerebral Vascular Accident. Prior to her hospitalization, Mrs. Jones fell several times at home. Her elderly husband is her caregiver, but he is overwhelmed and receives minimal IHSS support. The patient is discharged to a DP/SNF unit or SNF—she may not be able to return home.



Patient and System-Level Barriers:

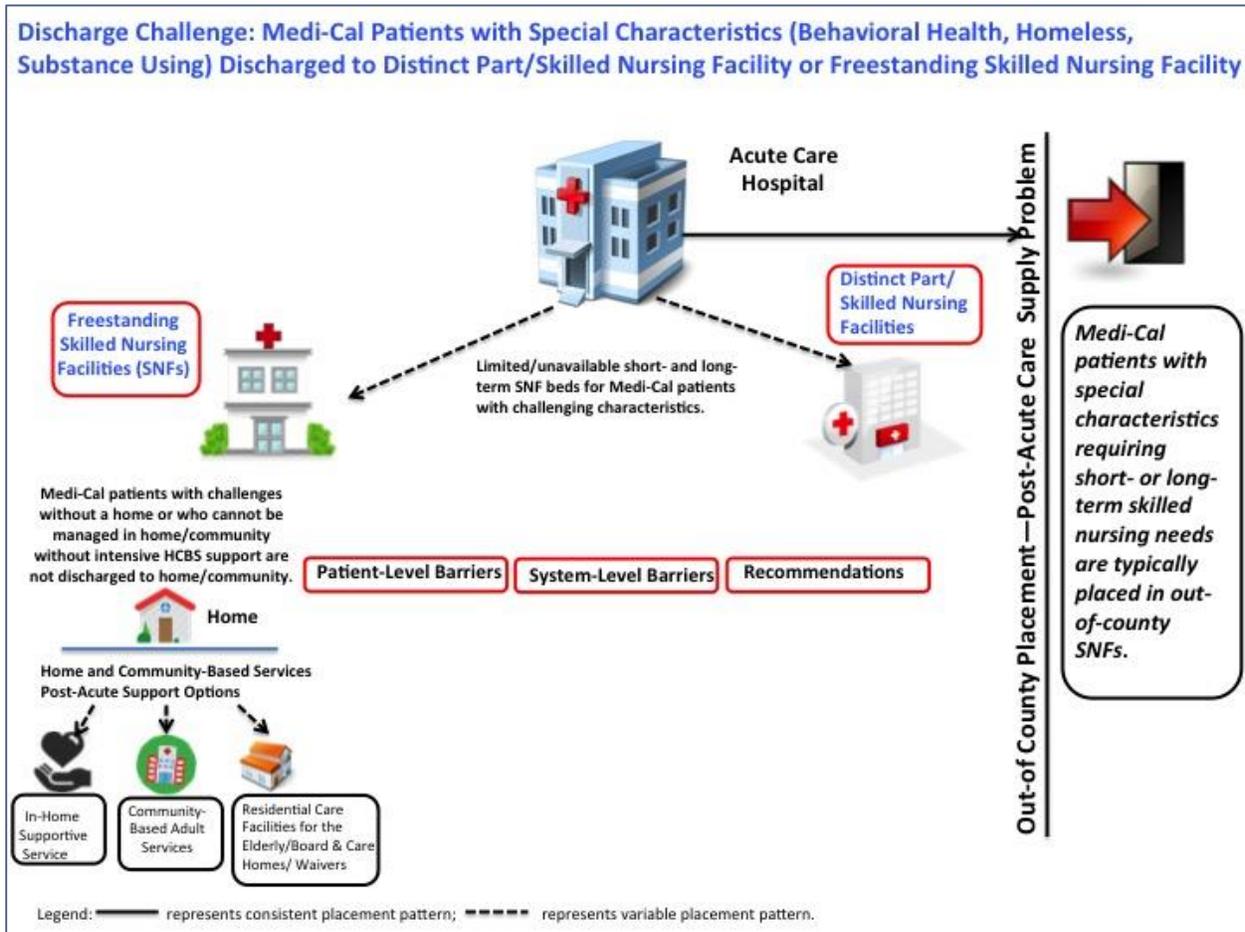
- Patient-level barriers to DP/SNF or SNF may include: multiple comorbidities; no skilled needs per Medicare guidelines; elderly/frail; inadequate caregiver support; and poor discharge plan.
- System-level barrier: Lack of short and long-term care SNF beds in San Francisco; poor SNF reimbursement under Medi-Cal; and, limited IHSS hours.

Recommendations

- Educate acute care providers/SNF/patients and families about post-acute care options.
- Provide greater care coordination and flexible program/beneficiary funding so patients at risk for acute and post-acute care can avoid institutionalization.

Graphic 5. Medi-Cal Patient with Special Characteristics (Behavioral Health, Homeless, Substance Using) Discharged to Distinct Part/Skilled Nursing Facility or Freestanding Skilled Nursing Facility.”

Patient Profile. Mr. Lucas is a 57 year-old marginally housed male, with a history of Schizophrenia, Polysubstance Abuse, and recent motor vehicle accident resulting in a left below-the-knee amputation. Mr. Lucas was admitted and left the hospital twice in the last month against medical advice. He recently returned to the emergency department with a worsening infection in his stump and the threat of losing more of his leg if not treated with a 6-week course of IV antibiotics and additional debridement in a SNF.



Patient and System-Level Barriers:

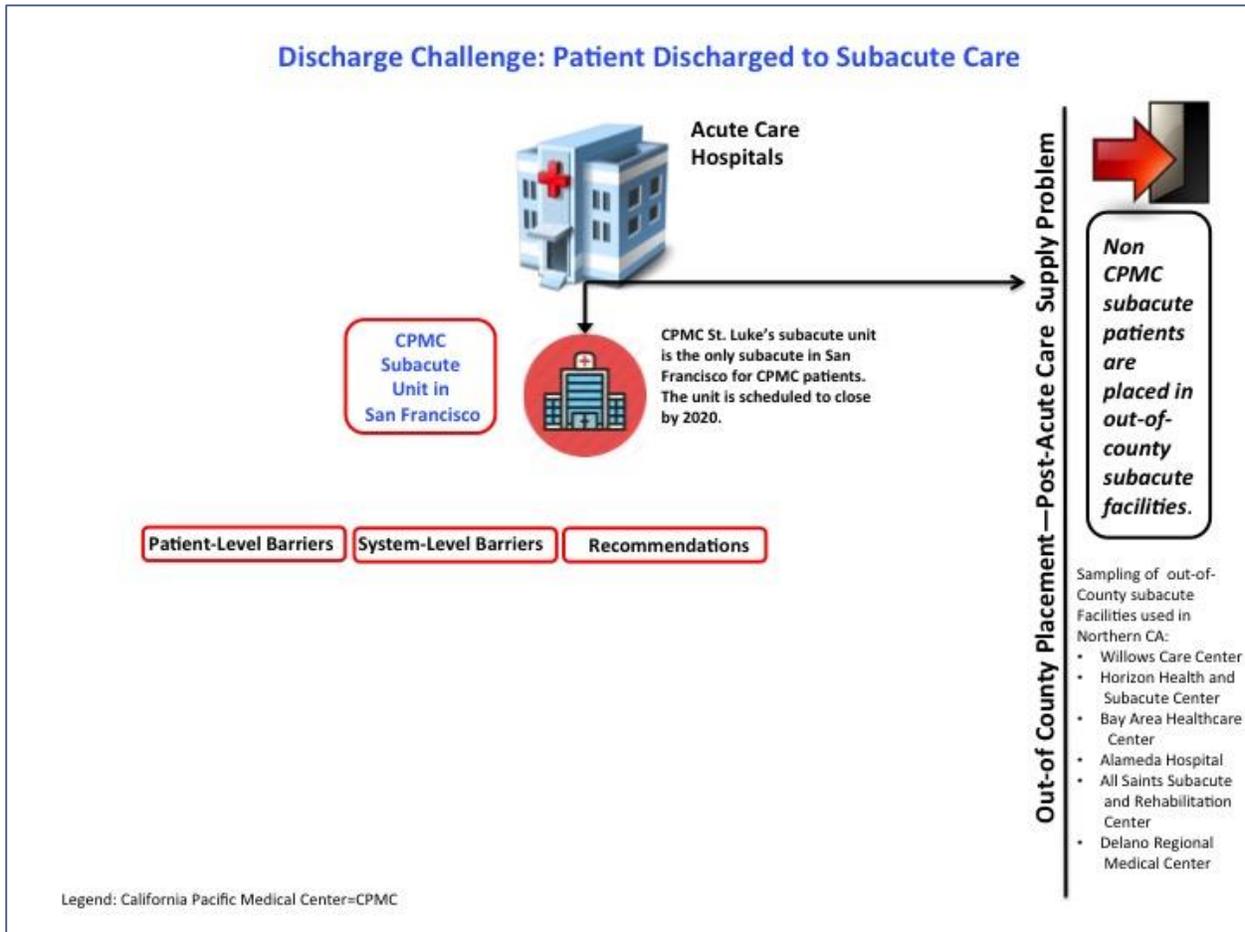
- Patient-level barriers to SNF may include: inadequate housing and psychosocial support, substance abuse, behavioral health challenges, unstable discharge plan.
- System-level barriers: Medi-Cal insurance—low reimbursement rate; unavailable/limited community services and supports; wait time for IHSS plus waitlists for HCBS Waiver Programs.

Recommendations

- Establish Medi-Cal SNF rates based on complexity and other characteristics; promote flexible use of Medi-Cal to fund placement in Board and Care homes, substance treatment facilities, etc.; provide timely linkage and access to HCBS and behavioral health support services.

Graphic 6. Medi-Cal Patient with Special Characteristics (Behavioral Health, Homeless, Substance Using) Discharged to Distinct Part/Skilled Nursing Facility or Freestanding Skilled Nursing Facility.”

Patient Profile. Mr. Flanders is a 65-year-old male admitted through the emergency department with Sepsis. During his hospitalization, he had a complicated intensive care unit (ICU) stay that required a tracheotomy and nasogastric tube feedings. Mr. Flanders is extremely deconditioned due to his ICU stay and needs to be transferred to subacute care; however, he is a non- California Pacific Medical Center patient (meaning: he cannot be transferred to CPMC’s subacute unit).



Patient and System-Level Barriers:

- Patient-level barriers to subacute may include: straight Medi-Cal or Managed Care Medi-Cal, uncertain long-term discharge plans, limited or complicated psychosocial support.
- System-level barriers: no subacute units in San Francisco beyond CPMC; medical providers are uncomfortable treating subacute patients.

Recommendations

- Establish stronger connections with subacute units outside of San Francisco; explore opportunities to use Long-Term Acute Care Hospitals (LTACH) flexibly to address some subacute patient needs; establish a subacute In-Home Operations Medi-Cal Waiver.

APPENDIX D: POST-ACUTE CARE ASSESSMENT PROJECT DRAFT RECOMMENDATION CATEGORIES

Purpose: The purpose of the Post-Acute Care Project is to respond to the decrease in hospital-based skilled nursing facility beds in San Francisco and to assess and respond to the overall need, supply, and gap in post-acute care services and supports in the City.

Goal: The project goal is to prepare a report for the San Francisco Health Commission that summarizes relevant post-acute care data (e.g., current need, current utilization, and future demand); research on community-based alternatives; and actionable and responsive post-acute care recommendations guided by the Advisory Committee. The intent of the recommendations is to improve post-acute care services in San Francisco, especially for those with unmet needs.

Vision: *Whole Person Whole City Post-Acute Care Strategy*

Project Definition: Post-acute care is generally defined as a range of medical services that support an individual's continued recovery from injury, illness or management of a chronic illness. For the purposes of this project, the post-acute care definition only addresses short- and long-term skilled nursing care and subacute care (does not include Long-term Acute Care Hospitals or Inpatient Rehabilitation Facilities).

Recommendations below include ideas developed both by the Post-Acute Care Advisory Committee and the Post-Acute Care Project Team and are divided into four broader categories: **1) Ensure Appropriate Number of Skilled Nursing Care Beds by Increasing Supply and Reducing Demand; 2) Increase Options for Home and Community Based Care; 3) Improve Care Coordination Between Acute and Post-Acute Care Providers; and 4) Promote Healthy Aging and Reduce the Risk for Institutionalization.** At the November 19th meeting the Advisory Committee will further review, add, and prioritize recommendations.

1. Ensure Appropriate Number of Skilled Nursing Care Beds by Increasing Supply and Reducing Demand

Increase Skilled Nursing Bed Availability	Programmatic	<ul style="list-style-type: none"> ➤ Explore the viability of a Regional Partnership to address San Francisco’s post-acute care supply, needs, and gaps. The Partnership to consider: <ul style="list-style-type: none"> ➤ Creating hospital-SNF contracts for short and long-term stays (in and out-of-county) to eliminate the current fragmented system of individual hospital-SNF contracts and patient placements; and, ➤ Hospital-subacute contracts (out-of-county) to eliminate the current fragmented system of individual hospital-subacute provider contracts and patient placements
	Policy	<ul style="list-style-type: none"> ➤ Incentivize providers to open, expand, or retrofit current buildings to increase skilled nursing beds in San Francisco (i.e. short-term medical care, long-term residential care, and beds for patients with complex medical and/or behavioral needs) ➤ Encourage San Francisco Health Plan to expand contracts with outside county facilities to increase placement options and timely access to post-acute care services ➤ Increase reimbursement rates for Medi-Cal patients in SNFs (consider increased rate levels for patients with complexity, including behavioral management)
	Additional Research	<ul style="list-style-type: none"> ➤ Explore integration of alternative models (PAC environmental scan) that would increase San Francisco’s skilled nursing facility bed availability in Francisco’s market
Reduce Demand by Transitioning Patients to Appropriate Levels of Care	Programmatic	<ul style="list-style-type: none"> ➤ Promote patient flow and ongoing utilization reviews to facilitate patient transfers to appropriate levels of care when they no longer needs SNF level of care ➤ Require skilled nursing facilities (SNFs) to collaborate with other post-acute stakeholders to develop transition programs to move skilled nursing residents to the community in a timely manner with continued services and supports ➤ Encourage early referrals and access to palliative care and hospice to decrease utilization of institutional care
	Policy	<ul style="list-style-type: none"> ➤ Assess opportunities to promote palliative care access recommendations through existing entities ➤ Eliminate three-day mandatory hospital stay for Medicare patients (requirement does not apply to Medicare or Medi-Cal managed care patients) to reduce unnecessary hospital expenses and improve the timeliness and flow of patients from acute care to post-acute care settings.
	Additional Research	<ul style="list-style-type: none"> ➤ Identify how many/ what kind of patients who currently reside in SNFs could reside elsewhere.
Develop Innovative Post-Acute Care Models	Programmatic	<ul style="list-style-type: none"> ➤ Consider using Long-Term Acute Care Hospitals flexibly to address a broader post-acute care need. ➤ Consider very short-term SNF placement for Medi-Cal patients needing infusion or other skilled care; if possible arrange for outpatient infusion.

2. Increase Home & Community-Based Post-Acute Care Options

Expand Home and Community Based Services (HCBS)	Programmatic	➤ No recommendations identified thus far
	Policy	<ul style="list-style-type: none"> ➤ Revise eligibility criteria and application processing time for Medi-Cal Home and Community Based Services (HCBS) to expedite timely linkage and access to services ➤ Promote flexible use of Medi-Cal funding to cover Residential Board and Care, substance use treatment, and housing for post-acute care patients ➤ Increase In-Home Supportive Services funding and hours ➤ Increase access to Medi-Cal Waivers (Assisted Living, Nursing Facility/Acute Hospital) ➤ Create federal and state funding incentives for providers to offer home and community options in lieu of institutionalization ➤ Support federal and state policy and payment changes to support needs of San Francisco’s post-acute care patient population including housing, behavioral health support, and adequate reimbursement for home and community-based services
	Additional Research	➤ No recommendations identified thus far
Promote Post-Acute Care Options in the Community for Medi-Cal Patients with Complex Needs	Programmatic	➤ Create a Workgroup of the Regional Partnership, similar to the Diversion and Community Integration Program , tasked with reviewing and ensuring (with plans & funds) expedited home discharges for long-term skilled nursing patients.
	Policy	<ul style="list-style-type: none"> ➤ Create and fund community services to support Medi-Cal patients with behavioral needs or continued substance use treatment after discharging from acute care ➤ Explore the use of Board and Care Homes, single room occupancy hotels, medical respite, shelters, designated skilled nursing facility unit, and a collaborative stand-alone short-term care unit in a medical facility as viable options for providing short-term, post-acute care in the community for Medi-Cal patients with complex and/or behavioral needs (special populations).
	Additional Research	➤ Identify the number of Medi-Cal patients with behavioral health issues discharged each year from all City hospitals to a suboptimal post-acute care or out-of-county setting
Develop Alternative Sites of Care	Programmatic	➤ Implement public-private partnerships to fund alternative post-acute care settings and support services (e.g., SNF partnerships with community programs)
	Policy	➤ Assess the viability of implementing alternative models of post-acute care (see environmental scan)
	Additional Research	<ul style="list-style-type: none"> ➤ Continue to track successful post-acute care models under Medicare bundled payment and other HCBS service models ➤ Explore expanding high-acuity home based-care provided by some San Francisco hospitals (i.e., UCSF) through the Regional Partnership

3. Improve Care Coordination Between Acute and Post-Acute Care Providers

<p>Increase Family Engagement and Provider Coordination and Communication</p>	<p>Programmatic</p> <ul style="list-style-type: none"> ➤ Create and use a universal referral process (includes online and 24/7 phone hotline) and screening tool to facilitate appropriate post-acute care placement in San Francisco--to ensure standardized assessment, care coordination, and referrals across settings and providers ➤ Promote greater partnerships between acute and post-acute care providers (including primary care providers) via e-mail, phone, etc. ➤ Establish citywide post-acute care education program to inform all stakeholders (providers/physicians/SNFs/community-based organizations and patients and family) about post-acute care and home and community based settings. Consider partnering with the San Francisco Long Term Care Coordinating Council Palliative Care education effort. ➤ Convene a workshop for post-acute care providers to share best practices in family engagement in transitional care, provider coordination and communication.
	<p>Policy</p> <ul style="list-style-type: none"> ➤ No recommendations identified thus far
	<p>Additional Research</p> <ul style="list-style-type: none"> ➤ As part of a proposed educational effort, consider administering pre/post survey of post-acute stakeholders to assess outcomes and satisfaction.

4. Promote Healthy Aging and Reduce the Risk for Institutionalization

<p>Promote Healthy Aging and Reduce the Risk for Institutionalization</p>	<p>Policy</p> <ul style="list-style-type: none"> ➤ Promote whole person care for high risk residents through the coordination of health, behavioral health, and social service programs ➤ Increase collaboration between hospitals, primary care providers, and community-based organizations to support healthy aging and functional decline ➤ Enhance opportunities to work with complex patients with behavioral health issues and polysubstance use to reduce hospitalization and post-acute care needs
	<p>Programmatic</p> <ul style="list-style-type: none"> ➤ Develop an inventory of current citywide programs that support healthy aging, aging in place, and disease management/health care prevention
	<p>Additional Research</p> <ul style="list-style-type: none"> ➤ No recommendations identified thus far

APPENDIX E: ENVIRONMENTAL SCAN RECOMMENDED APPROACHES AND MODELS

To complement quantitative and qualitative project analyses of post-acute care in San Francisco, Collaborative Consulting, Inc. conducted an environmental scan of successful post-acute care service delivery models and alternative care settings—and their individual components—from around the country. The purpose of the scan was to identify models and components San Francisco might replicate or adapt, as it moves toward a more innovative and community-based post-acute care delivery system. A four-pronged approach to addressing San Francisco’s post-acute care challenge along with nine post-acute care models are presented in Collaborative Consulting Inc.’s *Environmental Scan for the San Francisco Post-Acute Care Project* report, and briefly highlighted in this section.

The environmental scan four-pronged approach to improving post-acute care in San Francisco includes:

- Creating a regional partnership network that fully encompasses the entire spectrum of the acute and post-acute community, ranging from institutional care providers to community-based organizations to provide a fully supported, structured care continuum that adequately and efficiently addresses the needs of all patients requiring post-acute care in San Francisco.
- Developing a collaborative stand-alone facility to care for difficult-to-place patients, ensuring that the clinical and social needs of this high risk/high utilization portion of the city’s population are met.
- Building the necessary partnerships and acumen for delivering hospital-level care in a home-based environment, freeing up the necessary beds and resources for higher acuity patients at area hospitals and skilled nursing facilities.
- Pursuing policy and payment reform to accommodate the needs of San Francisco’s post-acute care patient population.

Highlighting the accuracy of the environmental scan’s four-pronged approach, variations of three of the four approaches were recommended by project key informants and members of the Post-Acute Care Advisory Committee. Their recommendations included: convening a broad-based collaborative of San Francisco and regional post-acute care partners to improve post-acute care services for all San Francisco patients; developing multiple settings to care for difficult-to-place post-acute care patients, such as single room occupancy hotels, shelters, Board and Care Homes; and, advocating for post-acute care policy and payment changes, i.e., establishing a tiered Medi-Cal rate based on acuity, expanding the cost-caps and numbers of slots for Medicaid Home and Community-Based Services Waivers, etc.

All four approaches, including the one approach not cited by project stakeholders—delivering hospital-level care in a home-based environment—offer San Francisco a viable starting place for making positive changes in the post-acute care continuum. Added to these grounded approaches, the environmental scan presents nine models with the potential to further respond to current gaps in post-acute care services and supports within the city. All nine models are briefly presented in this section. They include: Post-Acute Care Network, Hospital at Home & Mobile Acute Care Team (MACT), Heal, SnapMD, HOME Choice, Community Care Settings Pilot (Health Plan of San Mateo), Elder Services of the Merrimack Valley, Medical Respite Care Center. Note: several of the models list considerations for San Francisco.

Nine Models of Interest

Post-Acute Care Network (PAC Network)

Organization Examples: Kettering Health Network, Summa Health System, Lehigh Valley Health System, Geisinger Health System, Franciscan Alliance

Organization Types: Health Systems/Hospitals

Program/Project Names: PAC Network/Coordinated Care Network (CCN)/Preferred Provider Network

Program Summary

[Post-Acute Care Network \(PAC Network\)](#) offers hospitals and health systems opportunities to partner with post-acute care providers. Once the network is developed, efforts are made to improve the coordination and communication among providers to improve patient transitions among settings. In addition to improving transitions, PAC networks aim to coordinate care through the implementation of care pathways and best practices. For most PAC networks, any patient requiring post-acute care would be encouraged to use a network provider and to follow the programs/structure of the network.

Considerations for San Francisco

San Francisco has a unique opportunity to develop a comprehensive PAC Network on a larger scale, incorporating multiple acute care providers. In addition to aligning more closely with PAC providers within the city, San Francisco also has the unique opportunity to include many of the community-based organizations already established within the city to further integrate patient care across the entire continuum.

Hospital at Home

Organization Name: Johns Hopkins University School of Medicine [Baltimore, MD]

Organization Type: Medical School/Academic Medical Center

Program/Project Name: Hospital at Home

Program/Project Type: Home-based care

Program Summary

[Hospital at Home](#)[®] provides hospital-level care in a patient's home as a full substitute for acute hospital care. The program is offered to patients who require hospital admission for certain diseases, such as community-acquired pneumonia, congestive heart failure, chronic obstructive pulmonary disease, and cellulitis. Patients who meet specific medical eligibility criteria can receive hospital-level care—including diagnostic tests and treatment therapies from doctors and nurses—in their own home. Mobile Acute Care Team (MACT) is currently testing episodic bundling as reimbursement through a Center for Medicare and Medicaid Innovation (CMMI) Healthcare Innovation Award. Hospital at Home is currently not reimbursable under the Medicare Fee-for-Service payment system.

Compared to hospital stays, Hospital At Home outcomes include: reduced length of stay; reduced mean cost of care; fewer patient episodes of delirium (acute confusion); less likelihood of prescribing sedative medications or chemical restraints for patients; and lower rates of stress experienced by family members related to their loved one's care.

Mobile Acute Care Team Services (MACT)

Organization Name: ICAHN School of Medicine at Mount Sinai [New York, NY]

Organization Type: Medical School/Health System

Program/Website: Mobile Acute Care Team Services/ <http://blog.mountsinai.org/blog/tag/mact-program/>

Program/Project Type: Home-Based Care

Program Summary

The [Mobile Acute Care Team \(MACT\) Services](#) is based on the Hospital at Home model and has proven successful in a variety of settings to treat patients requiring hospital admission for selected conditions at home, such as community-acquired pneumonia, congestive heart failure, chronic obstructive pulmonary disease, and cellulitis. The core MACT team—physicians, nurse practitioners, registered nurses, social workers, community paramedics, care coaches, physical therapy, occupational therapy and speech therapy, and home health aides—provides a host of ancillary services. Services include community-based radiology, lab services, nursing services, durable medical equipment, pharmacy and infusion services, telemedicine, and interdisciplinary post-acute care services for 30 days after admission. After 30 days, the team ensured a safe transition back to community providers and provides referrals to appropriate services.

Building on the success of Hospital at Home, the team recently built a related program, [Sub-Acute Rehabilitation at Home](#), to care for patients requiring sub-acute care following an inpatient stay. Sub-acute care delivery such as rehabilitation and ongoing nursing care is conducted in the patient's home, bringing all care providers and necessary equipment to the home environment. MACT is currently grant-funded through the Center for Medicare and Medicaid Innovation's Health Care Innovation Awards. All staff salaries and contracted services are paid for using this grant.

Considerations for San Francisco

The Hospital at Home and MACT models offer a potential solution to San Francisco's shortage of sub-acute and skilled nursing care beds by providing the same level of care in the home environment.

HEAL

Organization Name: Heal [Los Angeles, San Francisco, Silicon Valley, Orange County, San Diego]

Organization Type: Visiting physician practice

Program/Website: Heal/ <https://getheal.com/>

Program Type: Home-Based Care

Program Summary

[Heal](#) is a smartphone application that enables patients/families to schedule same-day physician visits at their home, place of employment, etc. for common ailments. Patients are typically charged a flat rate (\$99/visit). Heal is currently in network with Anthem, United Health Care, Blue Shield of California, Cigna, and Aetna and plans to partner with Medicare Advantage.

Considerations for San Francisco

Heal currently has a presence in the Bay Area and is interested in pursuing meaningful collaborations and partnerships. Using this type of 'on demand' demand care delivery service, San Francisco may be able to accommodate more post-acute care patients in their homes and other non-institutionalized settings.

SnapMD & Milk on Tap

Organization Name: SnapMD & Milk on Tap [SNAP is based outside of Los Angeles, CA]

Organization Type: Technology and patient education provider

Program/Websites: SnapMD/Milk on Tap/<http://snap.md/> <https://milkontap.com/>

Program/Project Type: Virtual Care/Telemedicine

Program Summary

[SnapMD's Virtual Care Management \(VCM\)](#) telemedicine platform allows providers to arrange secure one-on-one live video, audio and text message consultations with patients. MilkOnTap uses the SnapMD platform to offer moms trusted feeding advice from experienced lactation experts by connecting them via online video consults and forums 24 hours a day, seven days a week, 365 days of the year. New mothers do not need to leave their homes to receive essential lactation advice and can connect with a lactation expert at any time – day or night. Since the virtual “visit” is conducted in the patient’s home, the lactation expert can view environmental factors that may be playing a role in lactation issues.

Considerations for San Francisco

SnapMD’s cloud-based platform could be used to virtually connect patients and providers across the continuum. Additionally, using a teaching model similar to Milk on Tap, patients and caregivers could receive education from experts in the comfort of their own home.

HOME Choice

Organization Name: Ohio Department of Medicaid [Ohio]

Organization Type: State-Based Medicaid Program

Program/Project Name: HOME Choice

Program/Website: Community-Based Care and Transitions/

<http://medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice.aspx>

Program Summary

[Ohio's HOME Choice](#), a federal Money Follows the Person program, transitions eligible Ohioans from institutional settings to home and community-based settings, where they receive services and supports at home and in their communities. HOME Choice currently ranks first nationally in transitioning individuals with mental illness into home-based settings, and second in overall transitions completed. Eligibility for HOME Choice requires that participants:

- Have resided in a Medicaid-funded facility for at least 90 days at the time of discharge;
- Have care needs evaluated by HOME Choice staff;
- Qualify for Medicaid; and
- Move into qualified housing.

HOME Choice is considered a “wrap around” program that provides a full range of critical services and supports to a patient for the first 365 days following a facility discharge. Services may include: transition services and coordination, care management, skills training, nursing, social work, etc. Patients and families are empowered to participate in developing viable patient discharge plans.

Considerations for San Francisco

Home Choice offers a model for addressing the needs of difficult-to-place populations, such as behavioral health patients, back into the community with appropriate services and supports.

Community Care Settings Pilot

Organization Name: Health Plan of San Mateo, Institute on Aging, and Brilliant Corners (Housing)

Organization Type: Local, Non-Profit Health Care Plan [San Mateo, CA]

Program/Project Name: Community Care Settings Pilot (California Coordinated Care Initiative, Cal MediConnect—California’s Dual Eligible Integration Demonstration)

Program/Website: Community-Based Care and Transitions/ <http://www.ioaging.org/services/all-inclusive-health-care/community-care-settings-pilot-program/>

Program Summary

The **Community Care Settings Pilot program (CCSP)** assists Health Plan of San Mateo County members to transition out of nursing facilities and back to living independently in the community. CCSP also provides services to individuals living in the community, or those who are in acute care settings at imminent risk of institutionalization. CCSP staff work with staff from Aging and Adult Services, In-Home Supportive Services, Behavioral Health and Recovery Services, to plan and guide individual transitions, ensuring the most efficient use of existing community resources, including housing and healthcare. CCSP’s primary focus is to support community living in place of institutionalization. To meet member needs, CCSP utilizes Coordinated Case Management, Purchase of Services, and Housing Retention and Placement.

Considerations for San Francisco

Cal MediConnect health plans are responsible for providing their enrollees all Medicare and Medi-Cal benefits and services, including medical care, long-term care, behavioral health care, and social supports. Although San Francisco is not a Coordinated Care Initiative—Cal MediConnect site at this time, the city is encouraged to continue exploring, with its health plan partners, opportunities to serve Medi-Cal managed care members with more comprehensive, cost-efficient long-term services and supports.

Elder Services of the Merrimack Valley

Organization Name: Elder Services of the Merrimack Valley [Lawrence, MA]

Organization Type: Area Agency on Aging (AAA), Non-Profit Agency

Program/Website: Community Care Transitions Program (CCTP)/ <http://www.esmv.org/programs-services/community-care-transitions-program/>

Program Summary

Elder Services of the Merrimack Valley, an Area Agency on Aging in Northeast Massachusetts, received federal funding for the Community Care Transitions Program (CCTP), under the Affordable Care Act, from 2012-2015. The CCTP demonstration tested models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. In partnership with six area hospitals, Elder Services chose to implement the Coleman Care Transitions Intervention (CTI), a low cost, low intensity four-week care transitions model. CTI empowers patients to feel more confident in medication self-management; using a patient-centered health record; making primary care provider/specialist appointments; and, knowledge of “red flags” – indicators that a health condition is worsening and how to respond. Although no longer federally funded, Elder Services is continuing CCTP.

Considerations for San Francisco

San Francisco was also a CCTP site; however, the city stopped receiving federal CCTP funding in July 2015, at which time the program was formally concluded. With an established care transitions infrastructure, San Francisco is encouraged to explore all options to re-launch the program.

Medical Respite Care

Organization Name: San Francisco Medical Respite Care Program [San Francisco, CA]

Organization Type: Community Based Organization

Program/Website: Medical Respite Care/

<https://www.sfdph.org/dph/comupg/oprograms/HUH/medrespite.asp>

Program/Project Summary:

Medical respite care is defined as “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.” Medical respite provides homeless individuals with short-term residential care so that they may rest in a safe environment while accessing medical care and other supportive services.

The mission of the Medical Respite Program is to provide recuperative care, temporary shelter, and coordination of services for medically and psychiatrically complex homeless adults in San Francisco. Clients are primarily admitted from SF General Hospital and Trauma Center as well as from the City's private hospitals and the VA Medical Center.

The Medical Respite Program provides a wide variety of medical and social services:

- Referral to Primary Care
- Management of Urgent Care needs
- Nursing care, medication management, patient education, and wound care
- Social services and case management
- Links to benefits and housing
- Substance Abuse and Mental Health referrals
- Transportation to medical and social services appointments
- Three meals a day
- After care and support provided by the Respite Alumni Network

Considerations for San Francisco

The Respite Care model when applied to a non-homeless patient population may provide an interesting alternative care setting to traditional home healthcare and facility-based skilled nursing care. With wrap-around medical care and social services, this model has similarities to that of a PACE (program for all-inclusive care for the elderly) program, and may help to address capacity issues for both acute and post-acute care providers.

Summary

The environmental scan post-acute approaches and models offer a flexible framework for improving San Francisco’s post-acute care continuum. By looking outside the scope of traditional acute and post-acute care delivery models, San Francisco can significantly advance both the availability and accessibility of post-acute care services and supports within the city. The next step is engaging a diverse group of city and post-acute care providers to finalize and implement a San Francisco post-acute care strategy.

APPENDIX F: SAN FRANCISCO POST-ACUTE CARE ADVISORY COMMITTEE & PROJECT TEAM

Post-Acute Care Advisory Committee Members

- **Margie Baran**, Executive Director, In-Home Supportive Services Consortium
- **Pat Blaisdell**, Vice President, Continuum of Care, California Hospital Association
- **Irin Blanco**, Utilization Management Nurse Manager, San Francisco General Hospital
- **Barbara Brownell**, Director of Social Work, Dignity Health
- **Matija Cale**, Inpatient UM Manager, San Francisco Health Plan
- **Idy Chan**, Health at Home
- **Colleen Chawla**, Deputy Director of Health/Director of Policy & Planning, San Francisco Department of Public Health
- **Amy Chiu**, Regional Manager, Strategy and Business Development, California Pacific Medical Center
- **Peggy Cmiel**, Chief Nursing Officer, Chinese Hospital
- **Traci Dobronravova**, Associate Director, Seniors at Home
- **Linda Edelstein**, Senior Planner, San Francisco Department of Aging and Adult Services
- **Ann Gors**, Division President, Vibra Healthcare; CEO, Kentfield Rehabilitation & Specialty Hospital
- **Dustin Harper**, Vice President of Community Living Services, Institute on Aging
- **Anne Hinton**, Executive Director, San Francisco Department of Aging and Adult Services
- **Mivic Hirose**, Executive Administrator, Laguna Honda Hospital and Rehabilitation Center
- **Kevin Hogan**, Chief Operations Officer, Jewish Senior Living Group
- **Crystal Jackson**, Clinical Liaison, Kindred Hospital, San Francisco Bay Area
- **Michelle Javid**, Manager of Business Development, Seniors at Home
- **Cindy Kauffman**, Chief Operating Officer, Institute on Aging
- **Mary Lanier**, Chief Administrative Officer Davies Campus, VP Specialty Services, California Pacific Medical Center
- **Mario LeMay**, Jewish Home
- **Melissa McGee**, Long Term Care Principal Investigator; Facilitator, Long Term Care Coordinating Council, San Francisco Department of Aging and Adult Services
- **Robert Newcomer**, Professor Emeritus, Department of Social & Behavioral Sciences, University of California San Francisco
- **Gabija Nezabitauskaite**, Senior Clinical Liaison Kindred Transitional Care and Rehab
- **Jackie Petrys**, Inpatient UM Nurse, San Francisco Health Plan
- **Eizabeth Polek**, Director of Case Management, University of California San Francisco Medical Center
- **Matthew Powondra**, Jewish Home
- **Judith Rooke**, Kindred Transitional Care and Rehab
- **Anna Sampera**, Director Utilization Management, Hospital Administration, San Francisco General Hospital
- **David Serrano Sewell**, Regional Vice President, Hospital Council of Northern & Central California
- **Molly Shane**, Assistant Director of Case Management, University of California San Francisco Medical Center
- **Matthew M. Verscheure**, Director of Homecare Services - San Mateo, HOMEBRIDGE
- **Emily Webb**, Director, Community Health Programs, California Pacific Medical Center
- **Abbie Yant**, Vice President Mission, Advocacy and Community Health, Saint Francis Memorial Hospital

- **Ruth Zaltsmann, MKT BPCI Clinical Program Manager, St. Mary's Medical Center – Saint Francis Memorial Hospital**

Post-Acute Care Project Team Members

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- **Linda Edelstein**, Senior Planner, San Francisco Department of Aging and Adult Services
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- **Kelly Hiramoto**, Director of Placement, San Francisco Department of Public Health
- **Mivic Hirose**, Executive Administrator, Laguna Honda Hospital and Rehabilitation Center
- **Mary Lanier**, Chief Administrative Officer Davies Campus, VP Specialty Services, California Pacific Medical Center
- **Monique Parrish**, Director, LifeCourse Strategies*
- **Lori Peterson**, Chief Executive Officer, Collaborative Consulting, Inc.
- **Erin Lockwood**, Collaborative Consulting, Inc.
- **Mary Beth Maley**, Collaborative Consulting, Inc.
- **Sneha Patil**, Senior Health Program Planner, San Francisco Department of Public Health*
- **Emily Webb**, Director, Community Health Programs, California Pacific Medical Center
- **Abbie Yant**, Vice President Mission, Advocacy and Community Health, Saint Francis Memorial Hospital

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