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INTRODUCTION

In the spring of 2005, the Office of the Controller of the City/County of San Francisco contracted with Health Management Associates (HMA) to evaluate the effectiveness of the continuum between acute and long-term care services provided by the San Francisco Department of Public Health (the Department). In order to accomplish this assessment, HMA assembled a team of senior staff that included three former public health and hospital system leaders (including a physician), a national long-term care expert and two former state Medicaid Directors. The work was divided between two major components of the overall charge: 1) assessing the mission, structure, leadership and operation of the Department as a “seamless” continuum of care and making specific recommendations to assure greatest possible integration; and 2) examining the current state and the appropriateness of long-term care services that are and should be available for the population that the Department has determined that it serves and proposing actions to make those services more effective.

The development of the report that follows is the result of myriad interviews of key stakeholders (both within and external to the Department), site visits to Department facilities and observation of clinical and administrative activities, review of data and previous reports, and group meetings with clinicians, business leaders, union representatives, political leaders, advocates, and others with clear impressions about the current state and future challenges for the Department.

HMA has approached the development of this report fully cognizant of the multitude of reports that have preceded it, often addressing the same subject. The findings and recommendations contained in the document have attempted to take into account the unique history, culture, political environment and other factors that have a bearing on change. Being right isn’t enough; it has to be right for San Francisco. We have tried to keep these factors in mind and couple them with our own knowledge and experience about best practices and lessons from other public health and hospital systems around the country.

HMA would like to thank both the Office of the Controller and the Department leadership for allowing us the opportunity to work on this important project.

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EXECUTIVE SUMMARY

Health Management Associates (HMA) was contracted by the Controller of the City/County of San Francisco to perform an assessment of the San Francisco Department of Public Health (the Department) focusing on: 1) the general structure and functioning of the elements of the Department as a “seamless” continuum of care, and 2) the appropriateness and the operational effectiveness of the long term care (LTC) services provided within the Department. Over the course of three months, the HMA team interviewed more than 100 people, reviewed previous reports and analyses, participated in clinical activities within the Department and drew on experiences of similar systems throughout the country. The following is a summary of the findings and recommendations, documented more thoroughly in the full report, generated by this effort.

General Findings and Recommendations Related to the San Francisco Department of Public Health as an Effective Continuum of Care

- The Department has within its purview a scope of acute medical, public health and behavioral health services that would be enviable to other public health and hospital systems in the country, and is replicated in very few.
- The Department is led by smart and capable people committed to providing high quality care to the most vulnerable populations and neighborhoods in San Francisco.
- The per capita contribution of the people of San Francisco to health care related services is one of the most generous in the nation.
- There has been a notable effort to assure cultural competency throughout the Department’s programs and facilities.
- The services offered by the Department are not limited to those directly provided in its hospitals and clinics but include a broad range of private sector “partners”.
- The Department is significantly and often negatively impacted by the involvement of myriad special interests (politicians, unions, advocates, etc.) and the culture of responding to each of these influences has resulted in a fragmented approach to the delivery of health care services.
- The Health Commission, rather than functioning as a single venue for accountability (as a Board of Trustees for the system) has often served as a forum for the varied special interests.

- The ability of the Department to be effective and efficient is dependent in large part on the willingness of the political leadership to allow it to manage within an extremely complex health care delivery environment. The role of the political leadership should be to establish mission, set overall policy and advocate for the dollars needed to support the delivery of services and the role of the Department is to lead, to set a vision, to assure the effective delivery of services. Those roles are currently unclear.
- Unlike many public systems that are driven by a focused mission to operate a delivery system for a targeted number of indigent people, the Department, fueled by the demands of the multitude of messages received by the community, is faced with responding to a series of missions (acute care delivery system for the indigent, long-term care provider for the entire elderly population of San Francisco, behavioral health services provider/funder, protector of the health of the public). There has been only limited success in integrating those missions into a coherent focus.
- The operation of an integrated delivery system has not been prioritized for the Department or the civic leadership. The management of such a system is complex and requires different expertise and focus than the broader role of running a health department with multiple missions.
- The various components of the Department are, on their own, of very high quality; the integration of the parts of the continuum is minimal and inadequate.
- The lack of integrated planning and management within the Department results in: duplication of services, gaps in services, lack of sound budgeting that looks beyond the immediate finances of one facility or program, missed opportunities for comprehensive clinical approaches to complex populations, short-sighted capital allocations.
- Past efforts at creating an integrated system were viewed by many in the Department as simply creating another new program, not as a new way of running a delivery system. There are sound lessons to be learned, however, from the failure of previous attempts at integration to assure that the mistakes are not repeated. Those failures, however, may have discouraged some who would have otherwise been leaders in an integrated system.
- There are strong desires throughout the system to function in a more deliberate and integrated fashion but those desires have not been harnessed and directed.
- The current fragmented approach will not be conducive to assuring the sustainability of the public health and hospital system as it is faced with increasing demand and diminishing resources, a situation being faced by nearly every other similar system in the country.

- The tendency of the broader community and its leadership to empanel task forces and committees to develop reports on various aspects of the delivery of health services in San Francisco seems to have resulted in a great deal of time and energy spent with little significant change. Further, it is uncertain whether such advocacy-based planning actually does represent the interests of the broader San Francisco community.
- Now is the time to take a hard look at the mission(s) of the Department, the needs of the targeted populations both now and in the future, the resources available within all components of the Department to address these needs, the current gaps and duplications that could be addressed by greater integration, the potential for real partnerships with other providers to maximize efficiency.
- The Department has the opportunity, if it focuses on developing a truly integrated approach to health service delivery, to be one of the most comprehensive and effective public health and hospital systems in the country.

Recommendations

- 1) The Director of the Department should assemble an **Integration Steering Committee** of senior administrative and clinical leadership from the components of the Department's delivery system: San Francisco General Hospital, Laguna Honda Hospital, and Community Programs (with additional representation from the jail health services) This Committee should:
 - Meet at least every two weeks;
 - Be Chaired by the Director of the Department;
 - Be small and high-level enough to serve as an honest and interactive forum to guide the work of clinical, financial, capital and operational work groups (see below);
 - Be focused on specific projects that improve quality and performance in order to fashion an integrated system of care;
 - Collaborate with the work groups on the establishment of priorities;
 - Assure that information is provided to the work groups to allow for accurate and evidence-based initiatives;
 - Serve as the body to set the vision for the Department, assure the interaction of the various work groups to successfully implement and sustain integration initiatives, and monitor and resolve system issues that impact delivery system integration.

The work of the Steering Committee should be organized by work groups made up of key senior staff who are both given the responsibility for formulating

integrated approaches and assurances that their recommendations will be acted upon. These work groups should:

- a) Be composed of key operational people (both leaders and frontline staff) for each defined area from each of the Department's facilities with authority to make change;
- b) Seek initially "low-hanging fruit" projects that will result in quick victories and keep people at the table;
- c) Identify priorities in collaboration with the Steering Committee and assign small teams (each with a defined leader, or "champion") for 3-4 week redesign efforts;
- d) Bring results to the Steering Committee and develop mechanisms for assuring sustainability;
- e) Continue this process by moving on to other initiatives while assuring that previous projects are monitored, sustained and, if appropriate, replicated;
- f) Analyze the obstacles to collaboration and to developing approaches on a system-wide basis; and
- g) Begin to develop a structure that assures ongoing integration as a way of doing business, effectively replicating successes.

The work groups that should be created for this process are:

Clinical Operations integration. Clinicians who have leadership capacity and a commitment to finding specific ways to assure an effective continuum of care across the elements of the Department should be appointed by the Steering Committee to form the Clinical Operations work group. This work group should be charged with developing quality initiatives for patients that cross the continuum of care (and are not limited to care within any one institution), assuring that the services provided for patients served by the system are provided in the most appropriate venue possible, and that opportunities to maximize integrated approaches are pursued. They should be guided by the rapid improvement process defined above and identify both short-term problems to be solved (such as the appropriate venue to care for patients needing less than six weeks of IV antibiotic therapy) and longer term issues that will change the nature of service delivery (such as an integrated plan for all mental health services between San Francisco General Hospital, Laguna Honda Hospital and Community Programs). The clinical integration will begin to function as an integrated medical staff, although decisions about the ultimate structure for such integration should not be addressed immediately. This work group will also address the issues related to the operational integration of the system, setting priorities for operational and policy integration (i.e., the referral process between institutions, coordinated service lines such as chronic renal dialysis) and establish short-term and long-term projects. This work group should also assist in the identification of system policies and procedures that hinder integration and develop plans to resolve those obstacles.

Capital integration. The Steering Committee should establish a mechanism for systematically addressing the capital needs for all components of the system, actively exploring the potential for joint ventures between the facilities. Although two longer-term issues for this effort should be the potential synergies between the rebuild initiatives of Laguna Honda and San Francisco General Hospital (i.e., renal dialysis, SNF beds, behavioral units, rehabilitation) and the implementation of Department-wide information systems, priority should also be given to shorter-term collaborative initiatives. Capital decisions should simply not be made or priorities set until the system-wide impact is clearly explored through this process.

Finance integration. The Steering Committee should direct the development of an integrated approach to revenue generation, budgeting and cost-reduction. While the Department has been aggressive in many financial arenas open to public hospitals, there are others that haven't been and should be pursued (i.e., physician UPL payments that can generate additional payments for medical staff and have been successfully implemented in other states, federal match of the cost to the Department for inpatient care of jail inmates). Budgeting should be accomplished through a joint process of identifying, as a system, areas of both potential revenue generation and cost cutting and by assessing the short and long-term impacts of these moves on other areas of the system. Financial strategies and budget development should be driven by the mutually agreed upon clinical and operational priorities of the development of an effective continuum of care, not the reverse. To the extent politically and fiscally possible, the budget decisions of the Department should not be second-guessed or over-turned at the micro-management level by the Health Commission, the Mayor or the Board of Supervisors.

- 2) Throughout the year, the Director will **report to the Health Commission and the Mayor (and the general public)** on progress made in the development of an integrated system. The work plan will raise issues that will result in the need for thoughtful and hard decisions to be made about the priorities for the public system in San Francisco as it attempts to meet the challenge of growing need and fewer resources.
- 3) At the end of one year, the Steering Committee will integrate the initial clinical, capital, financial and operational priorities into a **delivery system integration work plan** that will also address structural and leadership restructuring to assure that the integrative efforts are maintained and used as a vehicle for ongoing planning, budgeting, clinical oversight, policy formation, etc. The worse possible outcome would be for this effort would be for the "integrated delivery system" to become just another "silo" within the Department, rather than a new way of operating.
- 4) The Department should begin now to recruit a **Chief Operating Officer** for the Department whose sole focus is on the management of the health care delivery

system. The position should be a full-time job, not an additional duty for an existing administrator, and should require significant health delivery system management experience. The role and reporting structure of the Department leadership will need to be clearly defined to assure that the creation of the position is not simply used to hide dysfunction but is, rather, the catalyst to a forced march toward an integrated delivery system. The COO will need to be infused with the responsibility for the management of the health care system while the Director's role will truly become that of CEO, focusing on setting the overall Department vision, actively pursuing connections between the Department and the rest of City/County government, playing a leadership role on public health issues throughout the broader community, with state agencies and nationally.

Findings and Recommendations Specific to the Long-Term Care (LTC) System of the San Francisco Public Health Department

- There is a high level of commitment to, and concern about, San Francisco's LTC service system. The provider and advocacy communities are very engaged and have dedicated a large number of volunteer hours working on LTC-related issues.
- The Department's long-term care system is complex and includes: San Francisco General Hospital (SFGH), Laguna Honda Hospital (LHH), and the division of Community Care Services as well as several private providers in and outside the County. The long-term care system serves many elders and persons with disabilities in need of Department services, including individuals with mental health and substance abuse problems.
- External LTC resources substantially impact the Department's ability to address systemic concerns, including the ability to provide community-based services as an alternative to skilled nursing facility (SNF) services. A number of significant LTC resources are the responsibility of other programs outside of the Department. These resources (cash assistance, adult day care, In-Home Support Services, (IHSS), meals, transportation, etc.) are not optimally coordinated with the Department.
- The LTC system is fragmented, both internal and external to the Department, with certain elements not only less than fully integrated, but in some cases hostile to integration. Previous efforts to address this fragmentation across all components of the LTC system have met with limited success. There have been a number of task forces and committees who have studied the issues and submitted reports over an extended period of time. These reports provide findings and recommendations concerning a broad range of LTC issues, including the fragmentation of the LTC system, the need for additional community-based resources especially housing, and case management needs. In fact, many of the prior findings and recommendations are similar to some of those contained in this

report. While progress has been made, and much work is currently in process, the gains to date have been limited relative to need.

- Lack of progress on many issues identified in the various prior reports seeking to strengthen community-based care is the result of, in substantial part, failure to vest authority, responsibility, and accountability with a specific person. The prior committees and task forces represent several constituency groups. These groups are either not responsible for the areas impacted by change, or are charged with a specific “piece” of the change, and the change tends to occur without a direct connection to the larger LTC system. Internal to the Department, a variety of people bear some percentage of responsibility, but only the Director has overall responsibility for the Department’s long-term care system.
- The line between governance and management is frequently crossed reinforcing the fragmentation and less than optimal outcomes. The culture and history of the community has led to a blurring of the lines between governance and management has prevented implementation of policies directed at integration of LTC resources and decisions that are based on sound clinical judgment.
- The Department should reduce the need for SNF services by using public/private partnerships to develop, or promote the development of, community-based services especially housing, transportation and adult day health care, rather than invest resources in additional institutional services. The reasons for this change in focus are many:
 - The Department must address United States Department of Justice concerns as well as findings from the recent California Department of Health Services LHH licensure survey.
 - The County is poised for rebuilds of each of its two major healthcare institutions. The decisions made in the short-term will impact the County’s quality of care, level of integration, and flexibility for the next thirty years.
 - The use of facilities of over 1,000 beds for care has been abandoned nearly everywhere and we are not aware of any modern day rebuilds approaching this number. Nationally, 52% of certified SNFs have 100 or fewer beds and another 42% have between 100 and 199 beds.
 - New nursing homes should probably be no larger than 100 - 200 beds. This allows for reasonable quality control, patient safety, and good economics. There is some research being done and some operating models that purport to show significant improvement in quality of life for patients while achieving similar costs to larger institutions in small facilities. The disparate interests of various parties should not be permitted to be used to justify “business as usual” in regards to the rebuild of LHH.
 - Community-based LTC can be a cost-effective way to avoid or delay nursing home residency for many people with LTC needs.

- A significant portion of persons residing at LHH have been identified as persons who could be served in a community-based setting if such settings and ancillary LTC support services were more readily available.
 - Duplication of the acute care component at the new LHH facility does not appear to have merit unless there is a particular need for services that cannot be met at SFGH. Once the new LHH is in place, the ability to meet JCAHO standards should no longer be an issue and there should be a single license under SFGH. This would require Medical staff integration that should increase communication, integration, and improved patient movement both ways within the system. The savings from not duplicating these expensive services at LHH can be reinvested throughout the continuum.
- San Francisco appears to be committed to a rebuild at the LHH site of a minimum of 780 beds. It must be noted that San Francisco has taken on a large role in public provision of institutional care for seniors and the disabled. Most Medi-Cal or Medicaid eligible patients reside in private (primarily for profit) nursing homes across the country. Public systems provide primarily for the difficult to place post acute population. Some public systems have no resources deployed in institutional-based LTC (including such massive systems as LA County, Dallas, and Houston). Of eighteen freestanding SNFs in San Francisco, seven reported no Medi-Cal days in FY 2003-2004 and had occupancy rates ranging from 71 to 85%. There appear to be opportunities for the Department to pursue collaborative efforts with private SNF operators, especially those with lower occupancy rates.
 - The flow of patients between SFGH and LHH is inextricably impacted by the condition of the entire LTC service system. LHH serves a large portion of the SNF patients in San Francisco having 1,214 of 3,582 or thirty-four percent of all licensed SNF beds (although not all of these beds can be used due to physical plant limitations). A lack of timely access to suitable housing and “wrap around services” limits the ability of SFGH and the TCM program to divert persons in need of nursing home care to alternative settings. In addition, LHH likewise has limited capacity to discharge patients to the community. Meanwhile, patients remain at SFGH at an average cost of \$2,150/day or are sent out of county (at a cost ranging from \$125 to \$300 a day). This “back-up” of persons in need of SNF care is also driving a costly conversion plan at SFGH. Currently, SFGH expects to add Med/Surg SNF beds by relocating staff and renovating an area to accommodate this at a cost that may be as high as \$5 million.
 - The flow of patients between SFGH and LHH and into the community is impacted by “special populations” that are hard to place, and that spend extended periods of time waiting for a “suitable placement”. These populations include persons with dementia or traumatic brain injury who have severe behavioral disturbances, and those who have a diagnosed mental illness and require skilled nursing facility services but who are believed to have behaviors that cannot be addressed at LHH. In addition, the current physical plant at LHH is not conducive to meeting the needs of persons who require privacy and frequent opportunities

for quiet time and de-escalation. Some LHH staff members believe they could provide care for these persons with adequate specialized training and staffing. Furthermore, it appears that at least some of the disagreements around flow of patients from SFGH to LHH have been specific to special populations. In this instance, both SFGH and LHH have legitimate reasons to believe the other facility should accept the patient, when in reality a new approach is needed.

- There is a legitimate concern that patients discharged into the community are sent to places that are safe and meet their needs. This concern should inform and guide efforts rather than impede efforts to develop a LTC system that is in accordance with the national movement for community-based care and seeks to provide an array of choices for people with LTC needs.
- Institutional costs at LHH and at SFGH are high relative to available reimbursements in the SNF environment. As a county owned distinct part SNF, LHH receives on average \$271 per patient day in state and federal funds. The total cost is nearly \$397 per patient day and after other revenues are collected, the cost to the general fund is \$95 per patient day. It should be noted that these are averages. An indigent patient that is ineligible for Medi-Cal would be paid for with general funds only. SFGH's SNF costs are more than \$600 per day based on their last cost report. Due to better payor mix and inclusion with the hospital, there is no specific general fund allocation to SFGH's SNF. However, a similar payor mix as is used at LHH would require a general fund contribution of at least \$185 per day for the SFGH SNF if identified separately.
- LHH costs are impacted by an unusually high level of physician involvement relative to more "traditional" SNFs. A LHH physician performs rounds at SFGH for the purposes of screening and approving persons for potential admission to LHH, and LHH physician staff are present on LHH units on a daily basis. This level of involvement is especially unusual in regard to screening of patients at SFGH for admission to LHH. While a physician must personally approve in writing a recommendation that an individual be admitted to a facility (42 CFR 483.40) nursing homes typically employ case managers with a health care background and/or credentials to complete screenings for admission and make recommendations to the physician.
- Information systems at LHH and for certain community-based services are significantly below par. The systems at LHH do not allow for appropriate management by providing an automated census and hours of nursing care at all times. Certain financial functions that could be used for evaluation of contract performance involve manual elements that if automated could improve timeliness of reporting and corrective action. The Sorian system is supposed to resolve some of these issues. Any delay in implementation of new information systems seriously impairs the Department's ability to manage programs and resources efficiently.

- Case management services for persons with LTC needs, a critical part of the solution to diverting people from institutional care and facilitating safe and satisfactory community-based living, is not always available to persons in need of or receiving LTC services. San Francisco has a variety of case management programs, but if a person does not “fit” one of these programs, they may not have access to a case manager. Even if a person does have a case manager, they may not be receiving the type of case management assistance required to assist them in managing their entire range of LTC needs. Further, in some instances, persons may receive assistance from a variety of sources and may have multiple case managers contributing to fragmentation and the potential for duplication of care. A recent survey of San Francisco case managers and supervisors revealed that more than half of case managers (57%) report that case management services are being duplicated, and when clients have more than one case manager, a lead case manager is not always designated. Meanwhile, all program supervisors reported that more intensive levels of case management are the most needed but currently unavailable type of case management for clients.

Recommendations

- 1) The Department should recruit an experienced **Long Term Care (LTC) Director**. As one of the largest city/county-funded LTC systems in the country, it is essential that one person be charged with the responsibility for the oversight and direction of all Department activities specific to long-term care programs and services. This person should have nursing home experience and expertise with home and community-based long-term care programs and should report to the COO to assure both policy and operational coordination between all elements of the delivery system. The LTC Director should also work cooperatively with DHS and DAAS, the institutional leadership and community providers. In this manner, the Department would coordinate across programs to ensure LTC policy is implemented in a manner that benefits the LTC needs of San Franciscans from the system-wide perspective. The Department should charge the COO in conjunction with the LTC Director, with responsibility for non-medically necessary days at SFGH related to lack of placement availability, DOJ compliance, the creation of new programs, admission/transfer/discharge policies specific to SFGH and LHH, and identification of staff training needs to meet consumer LTC needs.
- 2) The Mayor and Board of Supervisors, upon the recommendations of the Department and Health Commission, should **determine and then support the scope of city/county responsibilities in regard to LTC services for San Franciscans** and clearly articulate these responsibilities. They should, within that scope, expressly commit to the provision of community-based LTC services whenever possible. In order to support the continuum of care for LTC services within the public system, the Mayor should actively advocate for Medi-Cal funding of such SNF alternatives as Assisted Living.

- 3) The Department should implement a **uniform assessment of need for all persons seeking Department-funded LTC services**. This assessment should incorporate risk factors associated with LTC institutional placement (such as ADL impairments, advancing age, cognitive decline/impairments, and living alone). This mechanism would remove the current, and sometimes emotional, basis for access to certain services and prioritize access to LTC services using a more objective and need-based system. The Department should also ensure each person accessing Department-funded LTC services receives choice counseling in order to make an informed decision concerning the option to receive home and community-based services as an alternative to institutional care. The Department should employ staff or contract with an independent entity to conduct these assessments. Further, the city/county should consider system-wide (e.g. external to the Department) implementation of the uniform assessment process.
- 4) The Department should manage the **rebuild LHH (which appears to be set at 780 beds) as 3 or more subunits** in order to mitigate the potential problems operating a facility of this size. In addition, the Department should review current facility plans to ensure the facility meets the needs of hard to place persons. The plan should be adjusted as necessary based on this review to maximize resident safety and staff's ability to provide care. In addition, the Department should address staffing and training needs specific to the LHH rebuild now in order to ensure development of the best staffing configurations and program models specific to the layout and projected patient population of the new facility.
- 5) The Department should not construct any additional beds beyond those already committed to at the LHH site (780) but rather should explore the potential for **contracting with existing private SNFs or creating new publicly-funded small SNFs** (ideally no larger than 100-200 beds) in order to reduce the need for out-of-county placements and address the need for additional SNF beds, if any, that might develop in the coming decades. The ability to bring the public Medi-Cal rate to these public/private ventures could expand capacity for more appropriate, community-based SNF capacity.
- 6) All persons with LTC needs should have access to a **community-based case manager** while residing in the community or during periods of transition (such as hospitalization or admission to a SNF for rehabilitation or recovery) who is responsible for ensuring health and welfare and for assisting the person with accessing and coordinating necessary services, regardless of funding source. For persons with multiple case managers, utilize intensive case management or designate "lead case managers" with the authority to work across programs and settings. The city/county should increase its investment in case management in order to facilitate utilization of community-based LTC resources.
- 7) **The LHH rebuild should include a LHH primary care clinic operating under the Department's FQHC license**, depending on the total projected density of the final LHH site. The clinic can provide a variety of functions including access to primary

care physicians, specialists and psychologists for persons at LHH preparing for discharge, persons discharged from LHH desiring to maintain their connections to LHH and, on a space available basis, as a clinic which serves persons with special needs (e.g. LTC needs) residing in the surrounding community. In addition, specialists from UCSF/SFGH could utilize the clinic to provide specialty visits to LHH residents.

- 8) **The Department should rethink current proposals to undergo a costly remodeling of existing space at SFGH** to accommodate more SNF beds, until all other alternatives are exhausted. It is recommended that working with existing private partners to develop the necessary capacity is the more rational approach, if LHH and community placements are not sufficient to meet demand. If necessary, a portion of the SFGH Behavioral Health Center (BHC) currently designated as an IMD could be returned to SNF status to accommodate the need for additional SNF beds for Medi-Cal recipients and relocate existing residential beds at BHC to other settings. While the placement of these services into a community setting may be challenging, there are both clinical as well as financial advantages. If this change becomes necessary, consider managing the BHC with the current leadership, but place the BHC SNF beds under the LHH license. This would optimize reimbursement by eliminating the IMD designation of the BHC. It should be the last option attempted only after other efforts at reclassification fail. Alternately, relocate a portion of the existing acute psych beds at SFGH to the BHC to free-up space at SFGH.
- 9) The rebuild of LHH should resolve the building issues that kept the facility from qualifying for JCAHO accreditation. With this constraint removed, **LHH should be merged under the SFGH license**. This action will allow the distinct part SNF reimbursement to continue without the unnecessary cost of duplicating acute care services in the new LHH, which is not recommended, and should restore Medi-Cal reimbursement for the SNF units at the BHC, since the total SNF beds (LHH plus BHC) will no longer result in the BHC being subject to the IMD exclusion. Further, the integration of the two medical staffs would increase communication and maximize productivity of physicians and other resources.
- 10) The Director of the Department should initiate a **"summit" of the public entities providing SNF services in San Francisco, San Mateo and Alameda counties** in order to create cost effective placement opportunities for each other. There are existing and/or potential new opportunities for collaboration that should be explored, ranging from facilitating the movement of patients to the appropriate counties to creative financing and management to expand overall LTC service capacity.
- 11) The Department, with the full support and active participation of the Mayor, should **actively pursue a set of Medi-Cal priorities**, including: seeking a change to the "first-come, first-served" method for access to Medi-Cal HCBS waiver services to a priority-based system, where persons currently residing in or at imminent risk of placement in a SNF have a high priority for HCBS waiver enrollment, securing an Assisted Living Waiver for San Francisco (as is now in place in other California

counties), enacting changes to the residency requirements specific to Medi-Cal IHSS permitting use of county funds as certified match for IHSS provided in non-institutional settings other than a person's own home and proposing a Medicaid state plan amendment allowing reimbursement to public nursing homes to be made up to actual cost (with the county contributing the match for the amount between the private rate and cost). In addition to the Mayor, the Department should enlist support from the DOJ, advocacy groups and unions for this Medi-Cal agenda.

- 12) In a systematic way, the Department should **identify a range of LTC options for persons with complex care needs who lack appropriate placements**, such as persons with severe behavioral disturbances, who have a traumatic brain injury, Alzheimer's disease or other conditions and formulate a Department-wide solution to meet their needs. This response will likely include the development of special facilities (including specialized SNFs and/or Residential Care Facilities), or contracts with SNF and/or RCF providers to provide specialized care to these persons. Training issues that are limiting the appropriate placement of patients at LHH should be addressed as part of this systematic planning. The Department should convene a monthly meeting of the major sectors of the LTC continuum controlling the LTC resources (primarily LHH, SFGH, housing, and community-based programs and the Department of Aging and Adult Services) in order to review the status of "hard to place individuals" and update/revise strategies to access LTC services for this group. During the period prior to completion of the LHH rebuild, the Department should consider serving persons who require greater security due to behavioral disturbances (and who are determined to be inappropriate for admission to LHH) at the SFGH/BHC where security personnel are readily available. However, this option will result in the loss of Medi-Cal reimbursement because the SNF beds located within the BHC are considered an IMD and subject to the IMD exclusion.
- 13) The Department should develop, through the use of public/private partnerships, a **range of housing options for persons who would otherwise require SNF services**. These options should include apartments (with access to ADHC and clinic services recommended) and assisted living units (licensed as RCFEs/RCFs). A portion of these RCFs/RCFEs must be able to accommodate non-ambulatory persons. The Department should also complete an inventory of the existing housing infrastructure capacity's ability to meet the residential needs of San Franciscans in need of long-term care services and supports and develop an online (Internet based) bed control tracking system to monitor the availability of all beds in the community, owned or contracted for by the department. This system should be able to classify the beds by type of services available. Finally, the Department should develop a plan to work with the appropriate state and federal agencies (CTCAC, CDLAC, and HUD) responsible for providing funding for low-income housing to prioritize funding for housing for persons at imminent risk of entering, or waiting to leave, a nursing facility.
- 14) The City/County should consider local funding (e.g. non-Medi-Cal) of **"wrap-around services" for persons who could be living at home**, or in other non-

institutional settings and who are either leaving LHH or at imminent risk of placement at LHH, when necessary and cost-effective.

- 15) The Department should issue an RFI to **assess the benefits of contracting LHH pharmacy services to a third party**. The majority of nursing homes nationally contract pharmacy services out to third parties. This initiative could address the current lack of a unit dose system, potentially provide immediate funding for the acquisition of the 3rd party rights and inventory, and make available clinical specialists that could save nursing time.
- 16) The Department should assign a **high priority to information system needs of the Department**, particularly extending the Department IS system to LHH and Community Behavioral Health programs and clinics.
- 17) The Department should pursue **claiming additional federal matching funds on certain portions of the system related to mental health administrative work**. There is a limit to the annual match allowable and the Department may be close to that limit; however, certain states have received exceptions for extraordinary circumstances and the current situation may qualify.

BACKGROUND

Throughout the country, local governments are beginning to take greater notice of the health care systems, facilities and programs that they fund and operate in order to assure access to their communities' most vulnerable residents. Over the past decade, it has become increasingly clear that there will not be a national answer anytime soon to the growing numbers of the uninsured, or to the spiraling costs associated with caring for them. Further, there are renewed efforts at the federal level to close off vehicles that local governments have used in the past to match their health care contributions maximizing the amount of revenue available to pay for health care services in public hospital systems. States, with ever-widening budget holes, are no longer the next line of defense in the health care safety net. They are beginning to abdicate responsibility as well, as the most likely "fix" for state budget problems is often a paring back of Medicaid programs, which vie with education in most states as the largest single expenditure.

The public sector actions are only further exacerbated by the fact that employers are reacting to rising health care costs by finding new ways to limit their responsibility for providing health care coverage for their workers. They are implementing a variety of strategies in order to stave off the effects of double-digit annual cost increases of insurance premiums, including expanding the cost of employees buying into insurance plans, eliminating dependent coverage, limiting medical services covered, or abandoning the provision of coverage altogether.

Cities and counties across the country are becoming the new epicenter for the growing crisis fueled by decreased federal matching dollars, constrained state resources, and a consistently growing number of people needing health services without any way to pay for them. This "trickle down" effect, coupled with the sky-rocketing cost of delivering medical care, is hitting local governments hard, particularly those who have made a historical commitment to providing access to health care services for their most vulnerable populations and communities. There is no place to pass off the responsibility and there is no way to avoid the problem as people keep coming to public hospitals and clinics for their care. In fact, local governments are feeling the pressure as both a provider of care to the indigent and an employer who must meet the costs of health care benefits for their own workforce.

San Francisco has taken on the responsibility of this care to a greater extent than most other cities and counties in the nation and is now in the position of determining how best to continue this commitment. In other communities, public hospital systems have reacted to the mounting demand and the diminishing resources in a variety of ways. Some have started to limit access to those perceived to not be "eligible" for such benefits (undocumented workers, out-of-county residents, etc.). Others have closed clinics and cut

services that have been deemed to be “money losers.” Still others have imposed lay-offs of personnel or cut vacant positions. Many of these responses, however, have been shortsighted and haven’t taken into account the impact of cuts in one part of the system on others. For example, closing a clinic may be easier than closing a hospital but the resultant increase in Emergency Department (ED) utilization may nullify the savings generated by closing the clinic in the first place.

The most effective responses to the mounting pressures on public health and hospital systems have been those that took a multi-year approach, thoroughly assessing the populations to be served and the scope of services needed to be provided, determining the clinical and operational efficiency of the system itself (including hospitals, clinics, support programs, and long-term care) in providing these services, evaluating potential relationships with other providers to avoid duplication, and identifying the actions that need to be taken in order to fill the gaps in the system that are preventing it from operating at maximum efficiency. This response requires hard work and commitment to doing the right thing rather than simply taking the easiest route. It may even require “rational rationing,” although that is preferable to the irrational rationing that is occurring across the country in public health and hospital systems today.

CHAPTER 1: THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH AS AN EFFECTIVE CONTINUUM OF CARE

Introduction

In examining the role of the Department as a health care delivery system, HMA focused on the mission, structure, leadership and operations of the key elements of the Department charged with providing direct medical care in a health care delivery system: San Francisco General Hospital, Laguna Honda Hospital, and Community Programs (including the primary care and behavioral health clinics). The health services provided at the San Francisco Jail were also viewed as part of this delivery system. This review process included interviews with leaders of the Department and its facilities, clinical directors, frontline workers, advocacy groups, business leaders, politicians and union representatives. In addition, group sessions were held with nurses, physicians, administrators, referral workers, and others to solicit ideas about how well the “system” works today and how it could function more effectively in the future. Demographic data was examined to make assumptions about the health care demands on the public system and potential issues for the future. Budgets were evaluated to determine how funding was allocated and how revenue was generated. Past reports were reviewed and discussions were held related to their accuracy and the success or failure in implementing recommendations.

The general findings and recommendations described below are a result of this review process, coupled with the knowledge of other approaches taken in similar health care systems throughout the country.

General Findings

The San Francisco approach to assuring access to healthcare for the underserved is unique. **The San Francisco Department of Public Health (the Department) has within its purview a scope of acute medical, public health and behavioral health services that would be enviable to other public health and hospital systems in the country.** Most local communities that operate a public health and hospital system concentrate on the delivery of acute care services to the medically indigent. Over the past decade, many of these hospital-dominated systems have expanded their acute care scope to include primary care clinics, many in community settings. However, not many public systems maintain long-term care capacity as part of their continuum of care (Chicago and New York are two of the relatively few) and those systems focus primarily on the long-term care needs of those who have been acute care patients of the system. Further, almost no other public health and hospital system in the country has the scope of mental health, substance abuse and supportive services that are available through the Department in San Francisco. This historic commitment offers enormous opportunities for a comprehensive

continuum of care if these services are integrated and forge a seamless approach to health care delivery.

San Francisco, as a civic community, continually demonstrates its support of the Department and its institutions and programs. Its financial investment in health care services is second to none in the nation. The average county in the country that supports a public health and hospital system provides approximately \$64 per person in local tax revenue, while San Franciscans contribute more than \$400 per capita. This is a significant commitment, one that is regularly reiterated in public hearings, referenda and other venues. The city/county appears determined to continue to assure a full scope of services to a population that extends well beyond the traditional target of the medically indigent to include, for example, institutional care for the elderly in the community and supportive services to populations, whether or not they are patients of the health care delivery system. This public endorsement of the multiple populations and missions of the Department, while positive in light of the federal and state abdication of responsibility, can also be problematic, as will be discussed below, when efforts are made to make the system function more seamlessly and to fully utilize all available resources.

The demographics of San Francisco pose a significant challenge to the development of an effective continuum of health care services. The populations that are reliant on the Department for health care services are, in many ways, very different from those that comprise the patient populations of other public health and hospital systems. For example, there appear to be more people who are homeless and have co-morbidities of substance abuse and mental illness than other cities experience. There are a number of variables that illustrate the difference between the San Francisco community and the nation as a whole that are described more fully in the Appendices of this report. Some highlights of these demographic differences between San Francisco and the rest of the country include:

- Its population is growing at a slower rate;
- Its residents are better educated;
- It has a larger number of single people;
- Its population is more likely to be foreign-born;
- Its household incomes are generally higher;
- It has a higher cost of living, particularly related to housing;
- Its residents spend a higher proportion of their incomes on housing;
- Its population is older;
- While the poverty rate is lower than that of the state or the nation, its poor tend to be younger;
- Its disabled population tends to be older; and
- While its death rate is lower, certain causes of death (unintentional injury, suicide, homicide, drug-induced death) are higher.

Understanding these demographics is critical in designing an effective continuum of care for the people that the Department is to serve. While most public systems care for large populations of pregnant women and children, for example, the Department has a patient

population that is predominately adults with chronic diseases, often further complicated by mental illness and/or substance abuse. Determining the inter-relationship of services should take into account the characteristics and needs of these populations, both today and into the future. These demographics should guide decisions about the allocation of resources, the development of services, the negotiation of partnerships.

San Francisco appears to have established a culture of “entitlement” that empowers a wide variety of individuals and organizations to have an impact on the operation of the Department and its facilities and programs. **The involvement of politicians, unions, special interest groups, community activists and others into the most minute policy decisions impacting the Department’s operations is unprecedented.** While this involvement is indicative of the support of the public commitment to health care access, it also fosters a fragmented approach to the creation and management of an effective health care system. It can, and often does, result in the rule of the most vocal, rather than the rule of the most rational approach to assuring health care delivery for a defined population with a limited scope of resources. For example, a decision by the Department to cut a certain program that can be demonstrated to be unsuccessful can be over-turned by the intervention of a Supervisor who has been pressured by one special interest group, often requiring the reinstatement of that program and cuts elsewhere of programs or people who may have proven valuable but do not have the political cache. While many other public health and hospital systems across the country experience significant problems with external interests (patronage interfering with hiring processes, bad decisions from governing boards, being preyed upon by the press), it is our experience that few other public health and hospital systems are operated with such intensive involvement of so many often competing special interests. This process—which appears to be more the rule than the exception--makes sound management based on comprehensive analysis and understanding of mission very difficult.

The Department is led by smart and capable people committed to providing high quality care in an integrated way to the most vulnerable populations and neighborhoods in San Francisco. HMA was impressed by the quality of the leadership of the Department and its institutions, both at the administrative and clinical levels. There are strong desires throughout the system to function in a more deliberate and integrated fashion but those desires have not been harnessed and directed. Past efforts at creating an integrated system (such as the Community Health Network, or “CHN”) were viewed by many in the Department as simply creating another new program, not as a new way of running a Department-wide delivery system. There are sound lessons to be learned, however, from the failure of previous attempts at integration to assure that the mistakes are not repeated. Those failures may have discouraged some who would have otherwise been leaders in an integrated system. As a result, the culture of retreating into the protection of individual programs and facilities becomes the order of the day and less effort is spent on making the component parts of the system function seamlessly around the needs of the patients.

The various components of the Department are, on their own, of very high quality; however, the integration of the parts of the continuum is minimal and inadequate.

The quality of the services provided at Department hospitals and clinics and through community-based programs are some of the best publicly-provided services in the country. There has been a notable effort to assure cultural competency throughout the Department's programs and facilities. The physician staff that practices at San Francisco General Hospital, Laguna Honda Hospital and in the community clinics are highly competent and, despite periodic strains, the relationship between the Department and the University of California at San Francisco is one of the better medical school-hospital affiliations that we have seen. Further, the Department has taken steps to expand its service scope by contracting with other providers in the community so the continuum is not limited to those services directly provided in its hospitals and clinics but include a broad range of private sector "partners."

However, unlike many public systems that are driven by a focused mission to operate a delivery system for a targeted number of indigent people, the Department, fueled by the demands of the multitude of messages received by the community, is faced with responding to a series of missions (acute care delivery system for the indigent, long-term care provider for the entire elderly population of San Francisco, behavioral health services provider/funder, protector of the health of the public). There has been only limited success in integrating those missions into a coherent focus. The operation of an integrated delivery system has not been prioritized for the Department or the civic leadership. The management of such a system is complex and requires different expertise and focus than the broader role of running a health department with multiple missions.

The lack of integrated planning and management within the Department has very specific and negative implications. This lack of integration results in: duplication of services, gaps in services, lack of sound budgeting that looks beyond the immediate finances of one facility or program, missed opportunities for comprehensive clinical approaches to complex populations, short-sighted capital allocations. In meeting with various groupings of clinical and administrative staff throughout the Department, as well as with the unions that represent Department front-line workers, it was clear that there are significant opportunities for effectiveness and efficiency that are lost because of the lack of a structure for a system-wide approach to planning and program development that is based on the needs of the patients being served, often the same patients moving through myriad components of the system. A short list of examples of opportunities that have been missed are described below:

Chronic Renal Dialysis. The dialysis unit at San Francisco General Hospital is perennially on the list of potential cuts in the Department budget. Most patients who receive chronic renal dialysis can get some medical coverage, but the higher cost of operating the unit at the hospital appears to make it vulnerable at budget time. However, it is generally agreed that the unit could at least pay for itself and be better for continuity of care if it were expanded to accommodate a larger number of patients. Because of the lack of available chairs, patients are often admitted to the hospital so that they can be dialyzed as inpatients, taking up beds unnecessarily and contributing to the acute bed shortage that results in

diversion from the Emergency Department. The hospital also is dialyzing patients (an average of four at a time) from the jail, and an average of 15 patients from the Department's managed care plan, getting reimbursed for neither group (and the benefit to the rest of the system is not counted into the overall financial assessment). Private vendors are hesitant to take problematic patients, causing further inpatient backlogs while slots are trying to be secured. Doctors at San Francisco General now follow patients both within the hospital and at outside facilities. They are sending out those who pay better primarily because they can't get them slots at the hospital. Meanwhile, Laguna Honda Hospital is sending out patients to be dialyzed in private sites (or at San Francisco General) and is paying for costs of service, transportation and staff to accompany the patient. The plans for the new Laguna Honda include a 6-chair dialysis unit that only takes into account the needs of that hospital. Meanwhile, the need for renal dialysis continues to climb. This is a prime example of a service that would benefit from system-wide exploration into the development of one dialysis unit for all of the Department's patients.

IV Antibiotic Therapy. A significant volume of patients could be discharged from acute care beds at San Francisco General Hospital if there was a way to assure that they continued to receive their IV-administered antibiotics for a period of time after they left the hospital. This is one of the patient populations that has been the subject of a great deal of controversy when they were sent to Laguna Honda Hospital as they are often younger, and sometimes have problems that the staff at Laguna Honda did not feel comfortable addressing. Because there was no system-wide focus on this group of patients, there has been no coordinated approach to figuring out what to do with them. Meanwhile, they contribute to the back-up, expensive in both dollars and impact on acute care capacity, at San Francisco General Hospital. In discussions with clinicians from both of the Department's two hospitals, it was clear that there could be other therapeutic options (including outpatient venues that would minimize the need for any inpatient care at all) for this population if there was a mandate to develop one as an integrated system.

Department Information System. A major concern throughout the Department is the lack of information about the patients who move through it. Decisions have been made in the past in a seemingly short-sighted way about the extension of the information network to all components of the delivery system. In particular, the lack of inclusion of both the behavioral health clinics and Laguna Honda into the information system has clearly limited the ability of the Department to function with optimum continuity. This lack of inclusion now appears to be on a path to be rectified but is indicative of the lack of a system-wide approach.

Rebuilds of San Francisco General and Laguna Honda Hospitals. The need to rebuild both of the Department's hospitals should mandate that priority be given to identify all possible capital and operational synergies between the two efforts but little of that coordination appears to have taken place. In addition to the renal dialysis example, there are 60 rehabilitation beds being projected for the new Laguna Honda yet little discussion seems to have taken place related to the rehabilitation patients that are currently being sent out of San Francisco General to private hospitals (most of whom are insured and could bring revenue into the Department if they remained in the system). There should be a system-wide process in place to assure maximum coordination and creativity in assessing the rebuilds of these two facilities to assure that opportunities are not missed or that duplications are not accepted.

The Health Commission, rather than functioning as a single venue for accountability (i.e., as a Board of Trustees for the system) has instead often served as a forum for the varied special interests. The Board of Supervisors has also at times played an intrusive role. The ability of the Department to be effective and efficient is dependent in large part on the willingness of the political leadership to allow it to manage within an extremely complex health care delivery environment. The role of the political leadership of the City/County (the Mayor and the Board of Supervisors) should be to establish mission, set overall policy and advocate for the dollars needed to support the delivery of services. The role of the Health Commission should be to function as the Board of Trustees of the health care delivery system, assuring sound management and accountability of the Department and providing an organized venue to receive community input. The role of the Department, in addition to its broader public health mandate, is to lead and effectively manage a health care delivery system that assures the effective provision of services for a defined population of patients. These roles are currently unclear.

The current fragmented approach will not be conducive to assuring the sustainability of the public health and hospital system as it is faced with increasing demand and diminishing resources, a situation being addressed by nearly every other similar system in the country. Further, the tendency of the broader community and its leadership to empanel task forces and committees to develop reports on various aspects of the delivery of health services in San Francisco seems to have resulted in a great deal of time and energy spent with little significant change. It is uncertain whether such advocacy-based planning actually does represent the interests of the broader San Francisco community.

The Department has the opportunity, if it focuses on developing a truly integrated approach to health service delivery, to be one of the most comprehensive and effective public health and hospital systems in the country. It is our experience that the San Francisco Department of Public Health is one that can actually be "fixed." Other systems around the country are over-whelmed by lack of resources, unmet demand, lack of leadership and ambiguous community support. San Francisco is far ahead on most of

those issues. Now is the time, however, to take a hard look at the mission of the Department, the needs of the targeted populations both now and in the future, the resources available within all components of the Department to address these needs, the current gaps and duplications that could be addressed by greater integration, the potential for real partnerships with other providers to maximize efficiency. The health care crisis in this country is simply that—a crisis. The epicenter for the crisis will be local communities as states and the federal government are not addressing the mounting problem of the uninsured and the spiraling costs of health care. Becoming as focused and creative as possible at the local level will be critical to meeting the impending challenges.

Recommendations

- 1) The Director of the Department should assemble an **Integration Steering Committee** of key administrative and clinical leadership from the components of the Department's delivery system: San Francisco General Hospital, Laguna Honda Hospital, and Community Programs. A representative from the health care services at the jail should also be included. This Committee should:
 - Meet at least every two weeks;
 - Be Chaired by the Director of the Department;
 - Be small and high-level enough to serve as an honest and interactive forum to guide the work of clinical, financial, capital and operational work groups (see below);
 - Be focused on specific projects that improve quality and performance in order to fashion an integrated system of care;
 - Collaborate with the work groups on the establishment of priorities;
 - Assure that information is provided to the work groups to allow for accurate and evidence-based initiatives;
 - Serve as the body to set the vision for the Department, assure the interaction of the various work groups to successfully implement and sustain integration initiatives, and monitor and resolve system issues that impact delivery system integration.

The work of the Steering Committee should be organized by work groups made up of key senior staff who are both given the responsibility for formulating integrated approaches and assurances that their recommendations will be acted upon. These work groups should:

- a) Be composed of key operational people (both leaders and frontline staff) for each defined area from each of the Departments facilities with authority to make change;
- b) Seek initially “low-hanging fruit” projects that will result in quick victories and keep people at the table;

- c) Identify priorities in collaboration with the Steering Committee and assign small teams (each with a defined leader, or “champion”) for 3-4 week redesign efforts;
- d) Bring results to the Steering Committee and develop mechanisms for assuring sustainability;
- e) Continue this process by moving on to other initiatives while assuring that previous projects are monitored, sustained and, if appropriate, replicated;
- f) Analyze the obstacles to collaboration and to developing approaches on a system-wide basis; and
- g) Begin to develop a structure that assures ongoing integration as a way of doing business, effectively replicating successes.

The work groups that should be created for this process are:

Clinical Operations integration. Clinicians who have leadership capacity and a commitment to finding specific ways to assure an effective continuum of care across the elements of the Department should be appointed by the Steering Committee to form the Clinical Integration Committee. This Committee should be co-chaired by clinicians from different divisions within the system and should be charged with developing quality initiatives for patients that cross the continuum of care (and are not limited to care within any one institution), assuring that the services provided for patients served by the system are provided in the most appropriate venue possible and that opportunities to maximize integrated approaches are pursued. They should be guided by the rapid improvement process defined above and identify both short-term problems to be solved (such as the appropriate venue to care for patients needing less than six weeks of IV antibiotic therapy) and longer term issues that will change the nature of service delivery (such as an integrated plan for all mental health services between San Francisco General Hospital, Laguna Honda Hospital and Community Programs). The clinical integration efforts will result in the medical staffs of the institutions within the Department to begin to function as an integrated medical staff, although decisions about the ultimate structure for such integration should not be addressed immediately. This group should also focus on priorities for operational and policy integration (i.e., the referral process between institutions, coordinated service lines such as chronic renal dialysis) and establish short-term and long-term projects. The workgroup should also assist in the identification of system policies and procedures that hinder integration and develop plans to resolve those obstacles.

Capital integration. The Steering Committee should establish a workgroup to systematically addressing the capital needs of all components of the system, actively exploring the potential for joint ventures between the facilities. Although two longer-term issues for this effort should be the potential synergies between the rebuild initiatives of Laguna Honda and San Francisco General Hospital (i.e., renal dialysis, SNF beds, behavioral units, rehabilitation) and the implementation

of Department-wide information systems, priority should also be given to shorter-term collaborative initiatives. Capital decisions should simply not be made or priorities set until the system-wide impact is clearly explored through this process.

Finance integration. The Steering Committee should direct the development of an integrated approach to revenue generation, budgeting and cost-reduction. While the Department has been aggressive in many financial arenas open to public hospitals, there are others that haven't been and should be pursued (i.e., physician UPL payments that can generate additional payments for medical staff and have been successfully implemented in other states, federal match of the cost to the Department for inpatient care of jail inmates). Budgeting should be accomplished through a joint process of identifying, as a system, areas of both potential revenue generation and cost cutting and by assessing the short and long-term impacts of these moves on other areas of the system. Financial strategies and budget development should be driven by the mutually agreed upon clinical and operational priorities of the development of an effective continuum of care, not the reverse. To the extent politically and fiscally possible, the budget decisions of the Department should not be second-guessed or over-turned at the micro-management level by the Health Commission, the Mayor or the Board of Supervisors.

- 2) At the end of one year, the Steering Committee will integrate the initial clinical, capital, financial and operational priorities into a **delivery system integration work plan** that will also address structural and leadership restructuring to assure that the integrative efforts are maintained and used as a vehicle for ongoing planning, budgeting, clinical oversight, policy formation, etc. The worse possible outcome would be for this effort would be for the "integrated delivery system" to become just another "silo" within the Department, rather than a new way of operating.
- 3) Throughout the year, the Director will **report to the Health Commission and the Mayor** (and the general public) on progress made in the development of an integrated system. The work plan will raise issues that will result in the need for thoughtful and hard decisions to be made about the priorities for the public system in San Francisco as it attempts to meet the challenge of growing need and fewer resources.
- 4) The Department should begin now to recruit a **Chief Operating Officer** for the Department whose sole focus is on the management of the health care delivery system. The position should be a full-time job, not an additional duty for an existing administrator, and should require significant health delivery system management experience. The role and reporting structure of the Department leadership will need to be clearly defined to assure that the creation of the position is not simply used to hide dysfunction but is, rather, the catalyst to a forced march toward an integrated delivery system. The COO will need to be infused with the

responsibility for the management of the health care system while the Director's role will truly become that of CEO, focusing on setting the overall Department vision, actively pursuing connections between the Department and the rest of City/County government, playing a leadership role on public health issues throughout the broader community, with state agencies and nationally.

Conclusion

The most pressing challenge facing the Department and, in reality, the entire community, is maintaining the current level of mission. It is likely that the amount of money available to the Department will not substantially increase in the years to come and it is also likely that the demand for those services and the costs of those services will only continue to grow. Thus, the Department must concentrate on becoming as effective and efficient as possible in order to continue to meet its expansive and multiple missions, which, it is important to note, no one has suggested altering. To become an effective continuum of care, it will be vital for the Department to: 1) **understand the population** that it is to serve (who are they, what services to they need, how will these needs change in the future); 2) **understand the elements of the system** (facilities, programs, services) currently being operated or funded by the Department; 3) **determine the current and future gaps** in that continuum of care that have an impact on the most efficient delivery system; 4) **develop a plan for addressing those gaps** (clinically, financially, structurally, and operationally) that will build upon San Francisco's historic commitment and excellence but that will also be sustainable in the long run.

CHAPTER 2: THE LONG-TERM CARE (LTC) SYSTEM OF THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

One of HMA's objectives was to understand the current operation of the Department long-term care (LTC) system, including the flow of patients between San Francisco General Hospital (SFGH) and Laguna Honda Hospital (LHH). In addition, HMA sought to identify barriers in the broader community that are preventing timely access, or adequate access, to a range of LTC options for persons served by the Department who are in need of skilled nursing facility services.

HMA met with key stakeholders including Department staff at LHH, staff at SFGH, and at the Division of Community Care Services (including TCM staff), staff of the Department of Human Services and of the Department of Aging and Adult Services, and representatives of advocacy organizations and provider organizations serving persons with disabilities and elders. In addition, HMA conducted preliminary discussions with the DPH Director, the Deputy Director, for Medical Care Services, California Department of Health Services and staff. HMA also reviewed materials that document the work San Francisco has undertaken over the last decade to address health care and social service needs in the City.

As HMA met with these key stakeholders and reviewed materials, it became apparent that many stakeholders and providers in San Francisco have been studying the potential demand for LTC services (including home and community-based LTC services) in San Francisco, as well as the problems with the current LTC service system, and have made recommendations to address these problems during this time period. These efforts have frequently been directed and supported by the City and County of San Francisco and have involved the Mayor and other key persons in City/County government, as well as members of the provider and consumer community.

The scope of the Continuum of Care project's LTC activities have generally been focused on three issues: the planned Laguna Honda Hospital rebuild, the flow of patients between LHH and SFGH (including the controversial LHH admissions policy), and improvements in the community-based LTC system.

The Long-Term Care Continuum

The Department's LTC system is complex and includes San Francisco General Hospital (SFGH), Laguna Honda Hospital (LHH), and the Division of Community Care Services and several private providers in and outside the County. The LTC system serves many elders and persons with disabilities in need of Department services, including individuals with mental health and substance abuse problems.

A number of significant LTC resources are the responsibility of programs external to the Department. For example, the Department of Human Services (DHS) and the Department

of Aging and Adult Services (DAAS) housed within the City/County Human Services Agency are responsible for:

- Cash assistance;
- Medi-Cal;
- Food Stamps;
- In-Home Supportive Services (IHSS) program;
- The Information, Referral and Assistance Program (which includes the Network of Supports for Community Living, a multilingual, community-based Web site that provides comprehensive long-term care services, information and education, and a call center);
- Neighborhood Resource Centers for Seniors and Adults with Disabilities; and
- Older Americans Act services such as care management, nutrition programs including meals-on-wheels, transportation, Adult Social Day Care, legal and Family Caregiver services.

Other programs of note located within DHS/DAAS are the public conservator, public guardian, adult protective services, representative payee program and county Veterans Service Office.

California Medi-Cal administers the In-Home Support Services program and several home and community-based services (HCBS) waivers. The Golden Gate Regional Center is responsible for ensuring the needs of persons with mental retardation and developmental disabilities are met.

The involvement of so many governmental entities contributes to the fragmentation of the LTC system and key components of this system are outside the Department's control. Certain elements are not only less than fully integrated, but in some cases hostile to integration.

There have been a number of task forces and committees that have studied LTC issues and submitted reports over the past decade. Each group has consistently documented problems common to many LTC systems throughout the country, including:^{1, 2}

- Lack of coordination/collaboration/communication among LTC programs and services;
- Service gaps;
- Duplication of services;

¹Draft Concept Paper for San Francisco's Long-Term Care Integration Pilot Project. Department of Public Health, City and County of San Francisco. August 26, 1998. p. iv.

²Living With Dignity in San Francisco. Department of Aging and Adult Services, City and County of San Francisco. April 2004. Page 26.

- Insufficient or difficult to understand information concerning LTC service options;
- Lack of choice concerning where services are provided;
- Limited or difficult access to range of LTC options;
- A focus on institutional care; and
- A limited emphasis on consumer needs.

The timeline for the major San Francisco LTC task forces and work groups since 1996 is described below:

- In **November 1996**, the Board of Supervisors established the Long-Term Care Pilot Task Force to improve LTC services for older and disabled adults and to integrate the financing and administration of LTC services under a capitated, at-risk payment system for the full continuum of medical, social and supportive services. The work of the Task Force was intended to further the development of an integrated long-term care service delivery system.
- The Task Force subsequently issued a draft report and set of recommendations in **August 1998**³ but the Department dissolved the project in **April 2001**, while continuing a commitment “to improve long-term care services for older and disabled adults, which may involve expansion of home and community-based services, but without capitated managed care as its primary goal”.⁴
- In the **Spring of 2001**, a hospital and nursing home discharge task force was formed and subsequently issued a report and set of recommendations in **2003**.⁵ The recommendations included: strategies to improve coordination of services; increase access to transportation, housing, money management/case management, and IHSS; create a centralized information and referral system; develop consistent standards for hospital and nursing home discharge; expand the Ombudsman Program; develop peer supports and medical case aides to facilitate successful transitions home; and lobby for increased income and asset levels for Medi-Cal and increased SSI/SSP amounts for persons in board and care homes (e.g. residential care facilities).⁶
- Also in **2001**, responsibility for improving community-based services as part of the LTC and supportive services delivery system and increasing collaboration across county departments was transferred from the Department to the DAAS.⁷

³Draft Concept Paper for San Francisco’s Long -Term Care Integration Pilot Project. Department of Public Health, City and County of San Francisco. August 26, 1998.

⁴San Francisco Department of Public Health. Resolution No. 09-01: Revising the Department of Public Health’s Role In Long-Term Care Planning, and Participation In California’s Long-Term Care Integration Pilot Program (AB 1040). April 17, 2001.

⁵Hospital and Nursing Home Discharge Planning. Final Report and Recommendations, May 2003.

⁶Living With Dignity In San Francisco. Department of Aging and Adult Services, City and County of San Francisco. April 2004. Page A-17-19.

⁷Living With Dignity In San Francisco. Page 5.

- In **April 2004**, under the direction of the Mayor, a Living with Dignity Policy Committee published a strategic plan for the period 2004 through 2008 to improve community-based LTC and supportive services in San Francisco.⁸ The Living with Dignity Strategic Plan recommended 15 workgroups to achieve the recommended improvements.⁹

- In **November 2004**, a Long-Term Care Coordinating Council (LTCCC) was appointed by the Mayor to monitor community-based LTC planning and facilitate the improved coordination of these services. The LTCCC has been assigned the “responsibility of overseeing all implementation activities identified in the “Living with Dignity” strategic plan and is required to present regular reports and updates on implementation progress to the LTCCC.¹⁰ The workgroups are listed in Table 1.

Workgroups Included in the Living with Dignity Strategic Plan
1. Hospital Discharge Planning
2. Community Placement
3. Case Management Collaboration
4. Neighborhood Partnerships
5. Public Relations and Marketing Plan
6. Mental Health Access
7. Conservatorship
8. Quality Standards
9. IHSS Workforce Improvement
10. Revenue Generation
11. Public Policy and Financing
12. Accessible Housing
13. Laguna Honda Hospital Assisted Living
14. Paratransit Funding Committee
15. Medicaid Waiver Planning and Coordination

- Most recently, the LTCCC summarized the issues it has been exploring since January. An **April 2005** resolution No. 2-042105 was drafted to support the financing of home and community-based services in view of the LHH rebuild issues.
- On **May 6, 2005**, motions were adopted to transmit the resolution to the Mayor with additional motions on creation of a more appropriate diversion program for people with serious mental illness away from LHH.
- On **May 10, 2005**, the LTCCC drafted a set of “Principles Concerning the Replacement of Laguna Honda Hospital.”¹¹
- A **May 20, 2005** LTCCC memo to the Mayor's Office recommended that the day health-housing model - already developed in San Francisco - be considered as an alternative to replacing some of the nursing facility beds at Laguna Honda Hospital (LHH). The LTCCC also provided a day health and housing model concept paper to the mayor.

⁸Living With Dignity In San Francisco. Department of Aging and Adult Services, City and County of San Francisco. April 2004.

⁹ Living With Dignity In San Francisco. Page 23.

¹⁰ Press Release. City and County of San Francisco Office of the Mayor. November 30, 2004.

¹¹ San Francisco LTCCC. “Principles Concerning the Replacement of Laguna Honda Hospital”. Draft dated May 10, 2005 and LTCCC Resolution No. 2-042105. April 21, 2005.

- The LTCCC released the first draft of the Community Placement Plan on **June 20, 2005**. The plan recommends approaches in order to ensure safe and healthful transitions from LHH and other institutional settings to successful placements in the community for older adults and younger adults with disabilities in San Francisco. The recommendations included in this plan were endorsed by the LTCCC on **June 16, 2005**, and the LTCCC continues to refine the plan.

While progress has been made in areas such as development of an information and referral system and of new housing options, and much work is currently in process, the gains to date have been limited relative to need.

Negative findings from oversight agencies have resulted in an urgent need to accelerate the development of a full range of residential options (institutional and community-based) and associated supports.

- In **June 1997**, the Department of Justice (DOJ) conducted site visits, record reviews, and interviews at LHH in response to a complaint filed by several LHH residents alleging civil rights violations. The DOJ found that “there is a pattern of egregious conditions that violate residents’ constitutional and federal statutory rights”.¹²
- In **2000**, the DOJ filed a friend of the court brief in support of the plaintiffs in *Davis v. California*, a lawsuit alleging that the City and County of San Francisco was violating federal Medicaid law and the ADA by denying individuals with disabilities access to community services.
- In 2001 and 2002, the DOJ and the Department of Health and Human Services toured LHH to determine ADA compliance and progress in addressing prior findings. In **April 2003**, the DOJ wrote another letter to the City of San Francisco stating that the City continued to be in violation of the ADA and continues to fail to ensure that LHH residents were being served in the most integrated setting possible.¹³ The DOJ noted instances where a person entered LHH for a short stay (e.g. respite) and subsequently lost their housing or where a person’s name came up on the housing list but the persons did not move due to lack of psychological readiness. The DOJ documented the tendency for persons residing at LHH to habituate to institutional living and to become increasingly reluctant to leave

¹² Letter to Mayor Brown from the US DOJ entitled: Investigation of Laguna Honda Hospital. May 6, 1998. From Bill Lan Lee, Acting Assistant Attorney General, Civil Rights Division. Page 2.

¹³ Letter to City Attorney Dennis Herrera from the US DOJ entitled: Investigation of Laguna Honda Hospital and Rehabilitation Hospital. April 1, 2003. From Ralph Boyd, Assistant Attorney General, Civil Rights Division. Page 2.

following initial indications they had wanted to return to the community. They also questioned the cost-effectiveness of rebuilding LHH.¹⁴

- A recent state licensure survey and complaint visit at LHH which documented serious problems with quality of care, proposed imposition of sanctions and a freeze on Medi-Cal payments for new admissions.

In addition, there has been a shift in consumer preferences for LTC services, away from institutional care and toward community-based options such as assisted living and other options, which permit greater participation in the community and “aging in place”.

Findings

The San Francisco financial commitment and extensive number of work groups and reports demonstrate the **high level of commitment to, and concern about, San Francisco’s LTC service system**. However, it is possible that the ongoing exploration of issues and recommended remedies has to some degree distracted attention from implementation efforts.

The current management and governance structure of the Department is not conducive to comprehensive and timely progress in development of the range of LTC options. The most recent work in the LTC area is being carried out by the City/County Long Term Care Coordinating Council (LTCCC), formed as an advisory body. The LTCCC lacks the authority necessary to ensure that required changes to the LTC system will be accomplished. The LTCCC was appointed as an advisory body to: (1) oversee the implementation of “Living With Dignity: A Strategic Plan to Make Improvements in the System of Community-Based Long Term Care for Older Adults and Adults with Disabilities (2004-2008)”¹⁵; and (2) provide advice and policy guidance on all aspects of LTC in San Francisco. The formation of the LTCCC demonstrates a community commitment to addressing LTC system needs. However, progress will be difficult without clear lines of authority and responsibility.

The line between governance and management is frequently crossed reinforcing the fragmentation and resulting in less than optimal outcomes. For example, in February 2004, the Department initiated a Patient Flow Committee, comprised of LHH and SFGH staff, charged with overseeing and implementing the on-going admission and discharge of residents into LHH. The Committee goal was to improve patient flow from SFGH to LHH, significantly reducing staff time spent on transfers and the number of days spent by patients at SFGH awaiting transfer to a lower level of care. In March 2004, the Department Director issued a revised LHH admission policy that gave first priority for

¹⁴ Letter to City Attorney Dennis Herrera from the US DOJ entitled: Investigation of Laguna Honda Hospital and Rehabilitation Hospital. April 1, 2003. From Ralph Boyd, Assistant Attorney General, Civil Rights Division. Pages 25 – 29.

admissions to LHH to persons at SFGH awaiting discharge to a SNF. In February 2005, following public opposition to the March 2004 revision from various stakeholders and interest groups, the mayor directed the Director to rescind the March 2004 revision. This type of interaction blurs the lines between governance and management and has likely prevented implementation of policies directed at management and integration of LTC resources based on sound clinical judgment.

The limited progress implementing prior recommendations to improve LTC and strengthen community-based care is substantially the result of failure to vest authority, responsibility, and accountability with a specific person. The prior committees and task forces represent several constituency groups. These groups are either not responsible for the areas impacted by change or are charged with a specific “piece” of the change, and the change tends to occur without a direct connection to the larger LTC system. Within the Department a variety of people have some amount of responsibility to implement changes, but only the Director has overall responsibility for the Department long-term care system.

Recommendations

- As one of the largest City/County-funded LTC systems in the country, **it is essential that one person is charged with the responsibility for the oversight and direction of all Department activities specific to LTC programs and services.** Therefore, the Department should recruit an experienced Long-Term Care (LTC) Director. This person should have nursing home experience and expertise with home and community-based LTC programs. The LTC Director should report to the Chief Operating Officer (COO) to ensure both policy and operational coordination across all elements of the delivery system. The LTC Director should also work cooperatively with DHS, DAAS, the institutional leadership at SFGH and LHH, and community providers. In this manner, the Department would coordinate across programs to ensure LTC policy is implemented in a manner that benefits the LTC needs of San Franciscans from the system-wide perspective. The Department should charge the COO, in conjunction with the LTC Director, with responsibility for addressing non-medically necessary days at SFGH related to lack of placement availability, DOJ compliance, the creation of new programs, admission/transfer/discharge policies specific to SFGH and LHH, and identification of staff training needs to meet consumer LTC needs.
- In addition to establishing accountability for the Department’s LTC system, the **Mayor and Board of Supervisors, upon the recommendations of the Department and Health Commission, should determine and then support the scope of city/county responsibilities in regard to LTC services for San**

Franciscans and clearly articulate these responsibilities. They should, within that scope, expressly commit to the provision of community-based LTC services whenever possible. In order to support the continuum of care for LTC services within the public system, the Mayor should actively advocate for Medi-Cal funding of such SNF alternatives as Assisted Living.

Access to Department LTC Services

The lack of a unified Department LTC system contributes to allocation of LTC resources by programs and funding streams rather than allocation based on uniform measures of need. For example, the LHH revised admission policies dated February 22, 2005 (Laguna Honda Hospital-wide Policies and Procedures, File: 20-03) describe policies and procedures for admitting persons to LHH which prioritize persons for admission based on the place they are residing at the time of request for admission. First priority for admissions are persons at home, wards of the Public Guardian or clients of Adult Protective Services (APS) who have been determined to require urgent admission by the LHH admitting physician. Patients at SFGH ready for discharge to a SNF are second priority, with persons not in a medical facility having third priority, patients at another SF medical facility having fourth priority and lastly SF residents who are currently residing outside of San Francisco. This type of policy does not ensure that persons with the greatest need have access to LTC services provided at LHH.

In contrast, other LTC systems are developing methods to prioritize access to LTC services, including LHH based on a uniform assessment of need, rather than on factors such as location at the time of referral (i.e. at home, at SFGH, etc.). An increasing number of states are using uniform assessment tools to assess all persons seeking Medicaid-funded LTC services. For example, Maine and Florida screen all persons seeking access to SNFs, including private pay clients (e.g. persons who will be paying for services themselves). Following this assessment, each person receives choice counseling, which is designed to inform the person about the range of LTC services, both institutional and community-based. Colorado and Wisconsin have developed uniform assessment tools, which are valid across “populations” – primarily elders, adults with physical disabilities, and persons with a mental illness.

Florida utilizes the results of their uniform assessment tool as the basis for prioritization of persons seeking access to several of Florida’s home and community-based services (HCBS) waivers who meet nursing home level of care. The Florida Department of Elder Affairs (DOEA) administers the tool. The results of the assessment are scored and weighted based on factors associated with admission to nursing homes. These factors include frailty, living alone, the presence of certain medical conditions such as a bed sore, cancer, dementia, emphysema, liver conditions, pneumonia, or stroke, the number of prescribed medications and weight changes. The current scoring is converted to a risk score, which is then used to prioritize access to HCBS waiver services.

Findings

Access to LTC services in San Francisco are not based on uniform measures of need. Elders and persons with disabilities are admitted into programs based not on medical priority, but by available programs and funding streams. There is no way to determine if persons with the greatest need for DPH LTC services have priority access to such services.

Recommendations

- **The Department should implement a uniform assessment of need for all persons seeking Department-funded LTC services,** which incorporate risk factors associated with LTC institutional placement (such as ADL impairments, advancing age, cognitive decline/impairments, and living alone). This mechanism would remove the current, and sometimes emotional, basis for access to certain services and prioritize access to LTC services using a more objective and need-based system. The City/County should also consider eventual system-wide (e.g. external to the Department) implementation of the uniform assessment process. The Department can utilize a process similar to Florida's to provide for a more objective method to prioritize admission to LHH and access to community-based services. As part of the implementation of a uniform assessment and prioritization process, the Department should employ staff or contract with an independent entity to conduct these assessments. Florida uses state staff of the DOEA to conduct and score assessments for most persons seeking access to HCBS waivers who would otherwise enter a nursing facility. This allows for completion of the assessment by staff who do not provide services and who are more likely to be objective when conducting the assessment.
- The Department should **also ensure each person accessing Department-funded LTC services receives choice counseling** in order to make an informed decision concerning the option to receive home and community-based services as an alternative to institutional care.

The Laguna Honda Hospital Rebuild

It must be noted that San Francisco has taken on a large role in the public provision of institutional care for seniors and persons with disabilities. Most Medi-Cal or Medicaid eligible patients reside in private (primarily for-profit) nursing homes across the country. Public systems provide primarily for the difficult to place post acute population. Some public systems have virtually no resources deployed in institutional-based LTC (including such massive systems as Los Angeles County, Dallas, and Houston).

LHH serves a large portion of the SNF patients in San Francisco having 1,214 of 3,582 or thirty-four percent of all licensed SNF beds (although not all of these beds can be used due to physical plant limitations). In fact, approximately one of every seven hundred sixty San Franciscans resides at LHH (based on the LHH January 2005 average census and the State of California 2005 San Francisco population projections). Information concerning LHH and the LHH rebuild is available on the Department's website at:

<http://www.dph.sf.ca.us/chn/LagunaHondaHosp/default.htm>

HMA completed a review of staffing at LHH. The unique challenges posed by the physical facility as well as its size make comparisons with other facilities and standards difficult. The numbers reviewed and the recent state survey results did not yield consistent conclusions. It appears nurse staffing might be high; however, recent survey results indicate patient safety remains a concern. Other departments appear adequately staffed, but discussions indicated that staffing on certain shifts was problematic requiring nurses to fill gaps. Finally, we noted certain functions normally handled by case managers or social workers were being performed by physicians, such as admission screening.

Discussions and planning for the LHH rebuild have been underway since 1991's approval of an Institutional Master Plan, followed in 1999 with the approval of a bond measure to fund the rebuild, and most recently this year with the Health Commission's approval of Resolution 08-05 "Concurring With the Recommendation to Proceed with the Construction of the East Building at Laguna Honda Hospital", which supports the construction of 780 beds. LHH buildings have been determined to be seismically unsound and the facility is not accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), primarily as a result of physical plant deficits.

It appears that San Francisco's unusual investment in publicly-operated LTC SNF beds has remained at a very high level as a result of several factors. First, California's free-standing weighted average non-state government-owned SNF reimbursement rates are, at \$122 a day, significantly lower than all sources of Medi-Cal revenue for LHH SNF days (which are reimbursed at a rate of \$230 per day). Private sector SNF providers are less likely to provide care to Medi-Cal recipients at such low rates when they can instead admit higher paying private patients. Second, the City/County has undertaken a broader mission in regard to Department-funded SNF services than is usual for public health systems, which generally provide SNF care only to uninsured patients referred from the public hospital. Finally, alternatives to SNF care in San Francisco such as assisted living

and supportive housing are not readily available. San Francisco is reported to have lost a significant number of assisted living (Residential Care Facility (RCF) or Residential Care Facility for the Elderly (RCFE) beds for low-income persons, and has no RCF beds for non-ambulatory low-income persons. Alternatives to SNF care, such as assisted living and supported housing, are not readily available or affordable.

Findings

While it appears that 780 SNF beds will be constructed at the LHH site, a SNF of this size is contrary to all national trends. The use of facilities with more than 1,000 beds for SNF care has been abandoned nearly everywhere and HMA is not aware of any

modern day rebuilds approaching this number. Nationally, fifty-two percent of certified SNFs have one hundred or fewer beds and another forty-two percent have between one hundred and one hundred ninety-nine beds. (See Appendix A.)

United States Nursing Homes (NHs)¹⁵

Number of Beds	Number Of NHs	Percent of NHs
000 - 099	8,271	51.5%
100 - 199	6,741	42.0%
200 - 299	811	5.0%
300 - 399	161	1.0%
400+	76	0.5%

There is some research being done and some operating models that purport to show significant improvement in quality of life for patients while achieving similar costs to larger institutions in small facilities, such as the Green House (clusters of ten-room houses licensed as SNFs) in Mississippi. For a summary of the Green House refer to Appendix B.

In addition, LHH was recently surveyed by the California Department of Health Services and cited for a range of violations including several patient-to-patient altercations resulting in injury. The findings have resulted in a threatened loss of certification and loss of Medi-Cal reimbursement for all new admissions (although payment could be subsequently restored retroactively). Based on LHH's recent licensure survey and national trends it is clear that new nursing homes should probably be, at most, in the 100 to 200 bed range. This allows for reasonable quality control, patient safety, and good economics.

There has been much public discourse concerning San Francisco's need for SNF beds and a 1997 SNF bed study attempted to project coming bed need, recognizing the developing movement toward community-based care as an alternative to care in nursing

¹⁵ Data Source: CMS Online Survey, Certification, and Reporting (OSCAR) database: The information on the nursing homes' characteristics derived from OSCAR are prepared by each nursing home at the beginning of the regular State inspection. This information is reported by the nursing homes themselves. It is reviewed by nursing home inspectors, but not formally audited to ensure data accuracy. In addition, this information changes frequently as residents are discharged and admitted, or resident conditions change. The data is submitted during the nursing home's most recent survey date - therefore the data age varies. <http://www.cms.hhs.gov/medicaid/services/lcdata.asp>

homes.¹⁶ It is exceedingly difficult to project SNF bed need. **Projections of need for SNF beds are inherently unreliable for a variety of factors** including variation in state Medicaid funding policies regarding SNF services and alternative community-based services, poverty rates among persons most likely to seek SNF services, and community attitudes toward caring for disabled or elderly family members at home. In addition, **irrespective of historic utilization of SNF beds, the Department has several compelling reasons to limit the number of beds to be rebuilt at LHH**, including:

- The increasing use of, and consumer desire for, community-based alternatives to nursing home care;
- The options available to partner with private providers to enter into agreements to purchase and lease-back SNF facilities; and
- The need to operate “manageable” SNFs no larger than 200 beds (and ideally even smaller).

Finally, it will be important as the rebuild moves forward to evaluate staffing requirements in light of the new building, changing patient needs, and regulatory issues. Similarly, training needs also should be assessed.

Recommendations

- **The Department should not construct any additional beds beyond those already committed to at the LHH site but rather, if the need for additional SNF beds arises in the future, should explore the potential for contracting with existing private SNFs or creating new publicly-funded small SNFs (ideally no larger than 100-200 beds).** This would reduce the need for out-of-county placements and address the need for additional SNF beds, if any, that might develop in the coming decades. The ability to bring the public Medi-Cal rate to these public/private ventures could expand capacity for more appropriate, community-based SNF capacity. The Department should also propose a Medicaid state plan amendment allowing reimbursement to public nursing homes to be made up to actual cost (with the county contributing the match for the amount between the private rate and cost). This would provide greater opportunities for the county to enter into partnerships with private SNF providers, improving financing and quality of care, while also recognizing the increased cost of doing business in San Francisco.
- **The Department should manage a 780 bed rebuilt LHH as several (3 or more) subunits in order to mitigate the potential problems associated with**

¹⁶ San Francisco Nursing Facility Bed Study. The San Francisco Section of the West Bay Hospital Conference. May 1997.

- operating a facility of this size.** In addition, the Department should review current facility plans to ensure the facility meets the needs of hard to place persons. The plan should be adjusted as necessary based on this review to maximize resident safety and staff's ability to provide care. In addition, the Department should address staffing and training needs specific to the LHH rebuild now in order to ensure development of the best staffing configurations and program models specific to the layout and projected patient population of the new facility.
- **Following completion of the rebuild, LHH should be merged under the SFGH license.** This action will allow the distinct part SNF reimbursement (e.g. higher reimbursement) to continue without the unnecessary cost of duplicating acute care services in the new LHH, which is not recommended. This should also restore Medi-Cal reimbursement for the SNF units at the BHC, since the total SNF beds (LHH plus SFGH Behavioral Health Center (BHC)) will no longer result in the BHC being subject to the IMD exclusion. Further, the integration of the two medical staffs would increase communication and maximize productivity of physicians and other resources.
 - **The LHH rebuild should include a LHH primary care clinic operating under the Department's Federally Qualified Health Center (FQHC) license,** depending on the total projected density of the final LHH site. The clinic can provide a variety of functions including access to primary care physicians, specialists and psychologists for persons at LHH preparing for discharge, persons discharged from LHH desiring to maintain their connections to LHH and, on a space available basis, as a clinic which serves persons with special needs (e.g. LTC needs) residing in the surrounding community. In addition, the clinic could be utilized by specialists from UCSF/SFGH providing specialty visits to LHH residents.
 - **The Department should also rethink current proposals to undergo a costly remodeling of existing space at SFGH to accommodate more SNF beds, until all other alternatives are exhausted.** It is recommended that working with existing private partners to develop the necessary capacity is the more rational approach, if LHH and community placements are not sufficient to meet demand. San Francisco occupancy rates in free-standing nursing facilities in 2003-2004 was reported below ninety percent for eleven of seventeen facilities, with eight having occupancy rates of eighty-five percent or below. Lower occupancy facilities may be especially interested in entering into partnerships with the Department. See Appendix C for a list of free standing SNFs in San Francisco and their occupancy rates and payor mix. If necessary, a portion of the SFGH Behavioral Health Center (BHC) currently designated as an IMD could be returned to SNF status to accommodate the need for additional SNF beds for Medi-Cal recipients and relocate existing residential beds at BHC to other

settings. While the placement of these services into a community setting may be challenging, there are both clinical as well as financial advantages. If this change becomes necessary, consider managing the BHC with the current leadership, but place the BHC SNF beds under the LHH license. This would optimize reimbursement by eliminating the IMD designation of the BHC. For an explanation regarding the Institutions for Mental Diseases (IMD) exclusion, see Appendix D. It should be the last option attempted only after other efforts at reclassification fail. Alternately, relocate a portion of the existing acute psych beds at SFGH to the BHC to free-up space at SFGH.

- **The Director of the Department should initiate a "summit" of the public entities providing SNF services in San Francisco, San Mateo and Alameda counties in order to create cost effective placement opportunities for each other.** There are existing and/or potential new opportunities for collaboration that should be explored, ranging from facilitating the appropriate movement of patients among counties to creative financing and management to expand overall LTC service capacity.
- **The Department issue an RFI to assess the benefits of contracting LHH pharmacy services to a third party.** The majority of nursing homes nationally contract pharmacy services out to third parties. This initiative could address the current lack of a unit dose system, potentially provide immediate funding for the acquisition of the 3rd party rights and inventory, and make available clinical specialists that could save nursing time.

Improving Patient Flow

One of the most pressing issues facing the Department, and a primary focus of this report, concerns the flow of patients between SFGH and LHH. At present, there are people at SFGH in the SNF unit (4A) awaiting discharge to a suitable LTC setting. In some instances, discharge to home, to supported living (i.e. a community like Presentation Senior Community) or to a board and care facility (RCF/RCFE) would be a viable option if:

- high quality residential options had vacancies; and
- adequate wrap-around services were available; and
- arrangements for discharge could be made in the generally short time frame (days to weeks) necessary to open-up beds at SFGH for people who need short-term SNF care.

Similarly, there are people at LHH (ninety people have been identified as ready for discharge within one hundred eighty days) who may find it difficult to leave LHH due to

a lack of viable options in the community. Another thirty-five people at LHH could be served in the community, but will remain at LHH because they need placement at a RCF which can accommodate non-ambulatory persons, none of which exist in San Francisco at present. There are additional persons at LHH who could be served in the community if adequate community-based options existed and if such persons chose to move to a community-based setting.

Absent an appropriate residential setting, many persons at the SFGH SNF unit who might have chosen, for example, to go to an apartment with wrap-around supports will be referred and admitted to LHH. Some persons may await admission for a period of time because a suitable bed is not available at LHH.

Furthermore, it appears that at least some of the disagreements around flow of patients from SFGH to LHH have been specific to persons with complex care needs. Some persons at SFGH are not admitted to LHH because they are determined by the LHH admissions coordinator and/or committee to have care needs which cannot be met at LHH. This includes persons with severe behavioral disturbances who do not require the services at the SFGH/BHC, or who do not have a diagnosed mental illness but who are believed to have behaviors that cannot be addressed at LHH. People with complex care needs include persons with dementia, traumatic brain injury or specific neurological disorders who have severe behavioral disturbances. Some LHH staff believe they could provide care for these persons with adequate specialized training and staffing. In this instance, both SFGH and LHH have legitimate reasons to believe the other facility should accept the patient, when in reality a new approach is needed.

Even a short delay in discharging persons from SFGH has serious financial repercussions for the Department and ultimately for the entire system of care when the average cost of care is \$2,150/day at SFGH and, for out-county-placements, an additional \$125 to \$300 a day above the SNF cost. This “back-up” of persons in need of SNF or alternative care is also driving a costly conversion plan at SFGH. Currently, SFGH expects to add Medical/Surgical SNF beds by relocating staff and renovating an area to accommodate this at a cost that may be as high as \$5 million.

Findings

The days of care accumulated at SFGH while people in need of SNF services await discharge can be reduced by diverting people from SFGH to alternative (and appropriate) settings, including community-based settings or specialized SNFs, and by facilitating discharge of persons from LHH to community-based settings in order to free-up beds at LHH.

A portion of persons residing at LHH have been identified as persons who could be served in a community-based setting if such settings and ancillary LTC support

services were more readily available. TCM estimates that 84% of LHH residents could be relocated to community-based settings. LHH staff estimate the number to be much smaller (about 150 people), with ninety people identified as being within 180 days of discharge and another thirty-five people who are interested in discharge but who need a RCF/RCFE able to accept non-ambulatory persons, none of which exist at present. Estimates of the number of persons who could leave a nursing home or other institutional setting can vary substantially. For example, TCM assesses the maximum potential for discharge based on removing all barriers to community-placed residence, including a person's reluctance to leave LHH because it has become their home. LHH staff has identified the persons residing at LHH who want to leave and for whom it is likely there will be appropriate community-based options available absent any changes to the current LTC system.

Recommendations

- In order to address the needs of persons with complex care needs, **the Department should systematically identify a range of LTC options for persons with complex care needs who lack appropriate placements.** This response will likely include the development of special facilities (including specialized SNFs and/or Residential Care Facilities), or contracts with SNF and/or RCF providers to provide specialized care to these persons.
- **Training issues that are limiting the appropriate placement of patients at LHH should be addressed as part of this systematic planning.** The Department should also convene a monthly meeting of the major sectors of the LTC continuum controlling the LTC resources (primarily LHH, SFGH, housing, and community-based programs and the Department of Aging and Adult Services) in order to review the status of “hard to place individuals” and update/revise strategies to access LTC services for this group. During the period prior to completion of the LHH rebuild, the Department should consider serving persons who require greater security due to behavioral disturbances (and who are determined to be inappropriate for admission to LHH) at the SFGH/BHC where security personnel are readily available. However, this option will result in the loss of Medi-Cal reimbursement because the SNF beds located within the BHC are considered an IMD and subject to the IMD exclusion.
- In order to accomplish diversion from SFGH or discharge from LHH, the **Department's LTC system needs to be “fluid” in permitting access to a range of LTC options** encompassing SNF beds, RCF/RCFE beds, supported housing and “wrap around” services (such as adult day health care, transportation and meals) which enable LTC needs to be met in a variety of settings (including in a person's own home). The flow of patients should occur across the entire LTC system

(including the portion of the larger LTC system external to the Department and described further in the section entitled “The Long-Term Care Continuum”).

- **The Department should reduce the need for institutional care by using public/private partnerships** to develop, or promote the development of, community-based services especially housing, transportation and adult day health care, rather than invest resources in additional institutional services. Community-based residential options such as Residential Care Facilities (aka board and care or assisted living) and supportive housing (such as the housing models at Presentation Senior Community and On Lok) are needed. In addition, “wrap around” services should also be enhanced to support community-based living options, including the option to remain at home when feasible. The development of housing and wrap-around services is discussed in further detail in the following section of this report entitled “Developing the Community-Based Long-Term Care Continuum”.

Developing the Community-Based Long-Term Care Continuum

Home-based LTC services and residential care facilities (often called assisted living facilities) are an increasingly popular choice for people who wish to delay or avoid entry to a nursing home. These community-based choices are for many people a cost-effective and satisfactory living option. At present, these choices are insufficient to support significant diversion of persons in need of Department SNF services or to support discharge of additional persons from LHH. Almost unanimously, people interviewed for this report believe that access to low-income housing is a major factor that will assist in serving more people in the community. San Francisco needs additional residential capacity and options for persons with a range of LTC needs and enhanced or new “wrap-around” services.

Housing

San Francisco has a range of community-based residential facilities, which are displayed in Appendix E. While residential capacity appears substantial, a large number of RCFs and RCFEs do not accept low-income, SSI recipients without subsidies or patch payments. An undetermined number of these facilities serve persons with mental retardation or with a mental illness and receive special payments to supplement the resident’s contribution.

San Francisco is reported to have lost 119 board and care homes (RCFs/RCFEs) with a capacity of 951 beds since 1987, many of which accepted low-income residents who

receive Supplemental Security Income (SSI).¹⁷ The last RCF in San Francisco which accepted low-income non-ambulatory residents, Victorian Manor, is reported to have converted to higher cost “assisted living” facility after closing and sending residents (about 110 persons) to LHH.¹⁸ There has been an increase of 1,693 “up-scale” assisted living beds since 1987, all of which cater to higher-income retirees.¹⁹

Several housing initiatives have been undertaken by the Department and by not-for-profit housing development groups working in conjunction with other community partners who are seeking to improve access to housing for low-income San Franciscans in need of LTC services.

The Department operates the Direct Assistance to Housing (DAH) Program, which targets housing to persons who are chronically homeless. The program identifies vacant or soon-to-be vacant buildings and negotiates long-term leases with the buildings’ owners. The leases are triple net leases (the owner leases to the Department, which leases to individuals) and the owner remains liable for capital improvements only. The Department contracts with entities for on-site management and maintenance. DAH has 600 units of housing that are occupied by people coming through the Department service system, such as persons discharged from the SFGH psychiatric unit, the Community-Based Housing Service Placement program, and persons receiving services from the high utilizer case management program. Thirty-three persons formerly residing at LHH are now residing in these units. The housing sites include access to case management, a roving behavioral health team, and medical services (which vary by location from on-site nursing services and clinics to periodic access to health care on-site).

New housing continues to be developed through the Mayor’s housing program, some of which will be targeted to elders or persons with special needs. Anticipated housing includes:

- 106 units at the former Plaza Hotel (studio apartments);
- 170 units at Mission Creek with 50 of these units dedicated to DPH frail elders;
- 200 senior units at Octavia Boulevard development (but availability is likely several years from now); and
- 109 units at 9th and Jessie Street Senior Housing.²⁰

One model of housing that has been successfully implemented in San Francisco is the single room occupancy (SRO) “hotel” operated in conjunction with an adult day health care center such as Presentation Senior Community. This day health-housing model is now operating successfully at 301 Ellis Street at Taylor and another day health-housing model, Mission Creek Senior Community, is now under construction at Fourth and Berry

¹⁷ Testimony of Benson Nadell to the Family Services Agency and Committee Members. February 28, 2005. Provided by the Department of Health.

¹⁸ HMA discussion with LHH staff June 30, 2005.

¹⁹ Testimony of Benson Nadell to the Family Services Agency and Committee Members. February 28, 2005. Provided by the Department of Health.

²⁰ Personal communication from Marc Trotz, Director of Housing and Urban Health, San Francisco Department of Public Health to Marshall Kelley (HMA). May 17, 2005.

Streets in Mission Bay. Presentation Senior Community was developed using HUD money, City/County funds, and donations. The facility houses ninety-two units, of which sixty are reserved for frail elders. Each resident may attend the on-site adult day health care program (a Medi-Cal covered service) where they participate in activities, in therapies such as physical and speech therapy, and receive meals, medications, personal care services and nursing services. Residents who need help with personal care and medications early in the morning or later in the evening use IHSS workers, a Medi-Cal covered service. A few residents have live-in family members who provide care. The facility has a security system, an on-site front desk clerk, maintenance services and communal areas including a large outdoor garden and patio area. The units are designed to be affordable for low-income residents. This type of housing is suited to persons who do not require overnight care.

Another housing option for persons who would otherwise enter a SNF is assisted living licensed as RCF or RCFE in California. The current lack of assisted living for low-income persons is related to the low rate of funding available to cover the cost of board and care, which for disabled persons (including elders who meet disability requirements) was \$772 a month in 2004.²¹ The majority of states now subsidize services such as personal care and nursing provided in ALFs through Medicaid programs, primarily using home and community-based services (HCBS) waivers.²² In most states with assisted living waivers, assisted living providers are reimbursed on a per diem basis to provide services such as personal care, transportation and medication assistance. The covered services and reimbursement rates vary by state and are summarized in Appendix F. California plans to implement an assisted living waiver pilot starting January 2006, and will serve people in:

- Sacramento 400 slots
- San Joaquin 200 slots
- Los Angeles 400 slots

HUD is an important funding source for housing initiatives, although HUD rules are not always conducive to targeting of housing to sub-groups of the needy, such as persons with disabilities with greater levels of ADL impairment. The Low-Income Housing Tax Credit (LIHTC) program is one of the most important sources of funding for special housing, and is administered through the IRS, rather than through HUD.

The LIHTC program utilizes five basic and sequential steps:²³

- The IRS allocates a specific dollar amount of LIHTC annually to each state.

²¹ 2004 California State Supplementation. Retrieved from the Social Security Administration. July 8, 2005. http://www.socialsecurity.gov/policy/docs/progdesc/ssi_st_asst/2004/ca.pdf

²² The Unequal Availability of Affordable Assisted Living Units in Florida's Counties. Golant, Stephen and Salmon, Jennifer. The Journal of Applied Gerontology, Vol. 23 No. 4, December 2004 349-369. Page 2.

²³ Using the Low Income Tax Credit Program to Create Affordable Housing for People with Disabilities. Emily Cooper and Ann O'Hara. April 2005 Issue of Opening Doors. Available online at: <http://www.c-c-d.org/od-April05.htm#Part%20One>

- Through a competitive process, the state awards these tax credits to specific affordable housing projects proposed by developers who must agree to meet LIHTC “affordability” requirements for a 15-year compliance period.
- Affordable housing developers sell the tax credits to private investors such as banks and corporations, which use the credits to reduce the amount of federal income tax they owe.
- The developer uses the money received from the sale of the tax credits – referred to as “tax credit equity” – to help finance the project.
- Once a LIHTC property is completed the owner/manager must select low-income tenants who are eligible for the affordable units, which must be included in all LIHTC properties for the duration of the 15-year “tax credit compliance period”.

LIHTCs can receive prioritization through set asides like the set-aside that has been crafted for certain rural projects in California. Set-aside programs effectively prioritize projects by permitting projects to compete for dollars that are "set-aside" and earmarked to support specific policy initiatives. A similar set-aside could be crafted for low-income housing projects for seniors or seniors at-risk of institutionalization.

A more detailed example of this arrangement is provided by the Illinois affordable housing agency, the Illinois Housing Development Authority (IHDA). In the 2005 Low Income Housing Tax Credit Qualified Allocation Plan for the State of Illinois, IHDA has indicated that in its competitive review process, "Applications will first be considered in the Set-Aside marked on the application. If an Application is not successful in the Set-Asides, it will be considered in the general pool." Set-asides are included for nonprofits, persons with special needs, and the elderly among others. The set-aside for elders reserves up to \$3 million in calendar year 2005. Since the tax credits are available for 10 years, this set-aside would be able to contribute between \$25-30 million in equity over 10 years. Additionally, this equity enables other low-income financing opportunities to be leveraged. Prioritizing affordable housing for elders and persons with disabilities would be a significant boost for community care over the long-term.

Recommendations

- **The Department should develop, through the use of public/private partnerships, a range of housing options for persons who would otherwise require SNF services.** These options should include apartments (with access to ADHC and clinic services recommended) and assisted living units (licensed as RCFEs/RCFs). A portion of these RCFs/RCFEs must be able to accommodate non-ambulatory persons. The LTCCC has developed a day health and housing model concept paper which describes the factors, projected costs and cost off-sets specific to this model (provided as Appendix G).

- **The Department should also complete an inventory of the existing housing infrastructure capacity's ability to meet the residential needs of San Franciscans in need of long-term care services and supports** and develop an online (Internet based) bed control tracking system to monitor the availability of all beds in the community, owned or contracted for by the Department. This system should be able to classify the beds by type of services available. A number of states have developed housing databases, which include search capabilities. A recent report comparing these databases ranked Oregon's system as the most fully developed. It includes the following features:²⁴
 - Search by City or County
 - Rent in Dollars or Income Percentage
 - Accept Section 8 Vouchers?
 - Proximity to Transit
 - Target Population
 - Utilities Included
 - Move-in Costs
 - Income Restrictions
 - Unit Description
 - Development Amenities
 - Neighborhood Amenities
- Finally, the **Department should develop a plan to work with the appropriate state and federal agencies (CTCAC, CDLAC, and HUD) responsible for providing funding for low-income housing to prioritize funding** for housing for persons at imminent risk of entering, or waiting to leave, a nursing facility.

Wrap-Around Services

Wrap-around services provide the necessary LTC supports that individuals require, to help them reside in the community. These services include:

- IHSS
- Adult day health care
- Respite care
- Transportation

²⁴ A Comparison of State Housing Locator Web Sites. Ray, Anne and Battista, Virginia. December 31, 2004. Available online at: <http://www.communitylivingta.info/files/59/2946/comparison.pdf>

- Meals
- Case management

California has an extensive IHSS program that provides personal care and related assistance to persons who have documented needs for assistance with activities of daily living. This assistance can be provided in an individual's home or in supported housing/apartments, but not in licensed residential care facilities. Limitations on the maximum number of IHSS hours (283 hours a month or approximately 9.4 hours a day during a 30-day month) are reported to be problematic for persons in need of extensive daily care in a community-based setting. In addition, because IHSS cannot be provided in Residential Care Facilities, and without access to an assisted living waiver, persons who could reside in a assisted living setting with some additional care, must pass this next "level of care" (e.g. licensed residential care) and enter a nursing facility.

California utilizes a variety of waivers that provide a range of services (which vary by waiver) designed to enable people to remain in their home as an alternative to living in an institutional setting (NF, ICF/DD or hospital, depending on the waiver). Each waiver provides case management/support coordination and other home and community-based services that vary by waiver. Examples of typical home and community-based services (HCBS) waiver services include respite, home health aid services and transportation. Some of the waivers permit provision of services to persons residing in congregate housing (such as RCFs). Each of the waivers has specific eligibility criteria, a limitation on enrollment and a limitation on annual cost. For summary information concerning the purpose of each waiver, enrollment, enrollment caps and effective dates refer to Appendix H.

California currently operates six home and community-based services (HCBS) waivers:

- Nursing Facility (NF) A and B Waiver
- Nursing Facility (NF) Sub-Acute Waiver
- Multi-purpose Senior Services Program (MSSP) Waiver
- In-Home Medical Care Waiver
- Developmentally Disabled Waiver
- AIDS Waiver

The Nursing Facility A and B Waiver, Nursing Facility, Sub-Acute Waiver and Multi-purpose Senior Services Waiver enroll persons who meet nursing facility level of care (e.g. would otherwise reside in a nursing facility). The AIDS waiver enrolls persons who require nursing facility or hospital level of care. The In-Home Medical Care Waiver enrolls persons who require hospital care for at least ninety consecutive days. The Developmentally Disabled Waiver enrolls persons who meet Intermediate Care Facility for the Developmentally Disabled (ICF/DD) care. Some of the waivers have additional functional, cognitive or diagnosis specific requirements.

California has a “first-come, first-served” policy for access to HCBS waiver services an approach that has been abandoned in many states due to litigation and implementation of policies designed to implement a method to ensure persons are enrolled into waivers at a reasonable pace. This policy is contrary to targeting resources to persons with the greatest need. There are currently about sixty-five people on the MSSP waiting list plus another four or five people at LHH on a separate MSSP waiting list.²⁵ TCM likewise has persons at LHH on the waiting lists for the NF A and B waivers.

There are some technical issues in regard to the HCBS waivers in California, which will likely limit the scope of waivers which can be developed specific to San Francisco. The California DHS reports difficulty achieving cost-effectiveness in the NF A and B waivers.²⁶ This appears to be directly related to California’s historically low reimbursement rates to free-standing (e.g. not part of a hospital) nursing homes. Because HCBS waiver costs must be no greater than the cost of care in a nursing home, the average nursing home cost for Medi-Cal recipients of about \$30,000 a year might be insufficient to support the cost of community services in high-cost areas like San Francisco for some recipients. Cost-effectiveness calculations for the HCBS waiver includes the cost of other Medi-Cal services such as physician services, prescribed drugs, and IHSS. This is a complex issue, which is beyond the scope of this paper.

Case management services for persons with LTC needs, a critical part of the solution to diverting people from institutional care and facilitating safe and satisfactory community-based living, is not always available to persons in need of or receiving LTC services. San Francisco has a variety of case management programs, but if a person does not “fit” one of these programs, they may not have access to a case manager. Even if a person does have a case manager, they may not be receiving the type of case management assistance required to help manage their entire range of LTC needs. Further, in some instances, persons may receive assistance from a variety of sources and may have multiple case managers thus contributing to fragmentation and the potential for duplication of care. A recent survey of San Francisco case managers and supervisors revealed that more than half of case managers (57%) report that case management services are being duplicated, and when clients have more than one case manager, a lead case manager is not always designated. Meanwhile, all program supervisors reported that more intensive levels of case management is the most needed but currently unavailable type of case management for clients.

²⁵Personal communication between HMA/Lux Consulting and Madelon Thompson at the Institute on Aging. E-mail: July 11, 2005.

²⁶Personal communication with HMA, Mitch Katz and Stan Rosenstein (Deputy Director, Medical Care Services, California Department of Health Services) and staff. Conference call June 29, 2005.

Recommendations

- **The Department, with the full support and active participation of the Mayor, should actively pursue a set of Medi-Cal priorities, including:**
 - seeking a change to the “first-come, first-served” method for access to Medi-Cal HCBS waiver services to a priority-based system, in which persons currently residing in or at imminent risk of placement in a SNF have a high priority for HCBS waiver enrollment;
 - securing an Assisted Living Waiver for San Francisco (as is now scheduled for implementation in other California counties) keeping in mind that the City/County might face some constraints in developing a HCBS waiver; and
 - enacting changes to the residency requirements specific to Medi-Cal IHSS permitting use of county funds as certified match for IHSS provided in non-institutional settings other than a person’s own home.

In addition to the Mayor, the Department should enlist support from the DOJ, advocacy groups and unions for this Medi-Cal agenda.
- **The City/County should also consider local funding (e.g. non-Medi-Cal) of “wrap-around services” when necessary and cost-effective for persons who are either leaving LHH or at imminent risk of placement at LHH, who instead could be living at home, or in other non-institutional settings.** These services could include respite care, companion services, transportation, meals, adaptive equipment and environmental accessibility modifications. ADHC could also be a cost-effective investment if this enabled a person who would otherwise enter LHH to remain at home.
- **All persons with LTC needs should have access to a community-based case manager** while residing in the community or during periods of transition (such as hospitalization or admission to a SNF for rehabilitation or recovery) who is responsible for ensuring health and welfare and for assisting the person with accessing and coordinating necessary services, regardless of funding source. For persons with multiple case managers, the Department should utilize intensive case management or designate “lead case managers” with the authority to work across programs and settings. The City/County should also increase its investment in case management in order to facilitate utilization of community-based LTC resources.

Recent Developments Related to Long-Term Care

Managed Care

States are under pressure to contain and/or reduce costs, including Medicaid costs, and the costs associated with LTC services and recipients are major components of a state's Medicaid budget. Elders (age 65 and over) make up ten percent of the Medicaid population but account for 26 percent of the total dollars expended, while persons who are blind or disabled make up 16 percent of the Medicaid population and account for 45 percent of the dollars expended. In other words, 71 percent of Medicaid expenditures fund services provided to elders, and persons who are blind or disabled, and this group is growing faster than any other.²⁷ Spending for LTC services now comprises 35 percent of Medicaid spending nationwide. In addition, the growth in national Medicaid spending is disproportionately attributable to elders and persons with disabilities, accounting for 57 percent and 25 percent respectively, of the growth in spending from 2003-2004.²⁸

State Medicaid programs have utilized varying forms of managed care over the years, with an initial focus on Medicaid managed acute care for low-income families with dependent children - the Temporary Assistance to Needy Families (TANF) group. States have more recently sought to enroll greater numbers of elders and persons with disabilities into traditional risk-based managed care (i.e. Medicaid HMOs) for their acute care services.

California proposes, under Medi-Cal reform, to increase enrollment of elders and persons with disabilities into managed Medicaid acute care (i.e. physician, hospital, ancillary services, etc.) Medicaid managed care generally provides a fixed monthly payment to managed care entities to provide specified services. If the entity expends more than the amount paid they incur a loss. Because these payments often are set based on projected savings, entities that do not coordinate care and facilitate timely access to services at the most appropriate intensity can face serious financial losses.

Some states have also undertaken managed LTC and integrated managed acute and long-term care in order to address a variety of objectives including cost containment, enhanced care management and recipient access to a broader array of community-based supports (and avoidance of high-cost institutionalization). Medicaid managed LTC (and Medicare/Medicaid managed LTC) programs are being implemented in more states. While enrollment in many of these programs has been small, a few states (Texas and Arizona) have enrolled significant numbers of persons with LTC needs.

Managed long-term care (LTC) originated in 1971 in California with the creation of the On Lok program for frail elders, providing health care and supportive services at a day

²⁷ Health Management Associates estimates based on CBO Medicaid baseline, March 2004.

²⁸ Kaiser Commission on Medicaid and the Uninsured analysis of CBO Federal Medicaid baseline, March 2002.

facility using integrated Medicare and Medicaid financing. Medicaid managed LTC expanded gradually over the next thirty years. Growth in managed LTC did not accelerate appreciably until 1996 when Wisconsin implemented the partnership program. States that have implemented managed LTC programs include:

- Minnesota (Senior Health Options Program)
- Florida (Nursing Home Diversion Waiver Program)
- Texas (State of Texas Access Reform Plus Long-Term Care (STAR+PLUS))
- Wisconsin (Family Care)
- Minnesota (ElderCare Development Partnerships)
- Massachusetts (MassHealth Senior Care Options)

In 2005, Medicaid managed LTC has become part of some states broader Medicaid reform efforts, including proposed managed LTC pilots in Florida and California. California's proposal²⁹ for the development of acute and long-term care integration (ALTCI) plans will provide comprehensive Medi-Cal services to enrolled seniors and adults with disabilities and will incorporate primary, acute and LTC services, including home and community-based services and providers in their networks. ALTCI health plan comprehensive coverage will be designed to help individuals maintain independence and avoid the need for inpatient nursing facility care whenever possible.

The proposal also includes the development and testing of a Long-Term Care Diversion and Assessment Protocol to assess and divert individuals from nursing facility care. Enrollment in ALTCI plans is projected to be:

- Orange County 74,139
- Contra Costa 27,092
- San Diego 89,417

Medicare Developments

At least two areas of the Medicare Modernization Act (MMA) may affect the course of development of Medicaid managed LTC in the states: Medicare Advantage Special Needs Plans and implementation of the Part D prescription drug benefit.

Medicare Advantage (MA) organizations (formerly Medicare+ Choice) will now be allowed to offer, and restrict enrollment to, specialized plans for distinct populations within Medicare through Special Needs Plans (SNPs). (Section 231 of the MMA.) Under this provision, two populations are defined:

²⁹ Medi-Cal Acute and Long Term Care Integration Proposal Overview. California Department of Health Services. Retrieved July 11, 2005. <http://www.dhs.ca.gov/medi-cal%20reform/>

- Institutionalized individuals: Medicaid eligible individuals residing, or expected to reside, continuously for 90 days or longer in a LTC facility that is either a skilled nursing facility (SNF) and/or a nursing facility (NF); and
- Dual eligible Medicare beneficiaries: Beneficiaries entitled to Medical Assistance under a State Plan under Title XIX. (Low-income Medicare recipients who are entitled to Medicaid.)

It is far too early to tell how many existing Medicaid managed care companies will react to the opportunity to develop a SNP or what impact these programs will have on state Medicaid programs serving people receiving LTC services. However, it is possible that the development of SNPs will accelerate managed care companies' interest in Medicaid managed LTC opportunities.

Medicare Part D Prescription Drug Coverage will begin on January 1, 2006. The most direct action in relationship to existing Medicaid managed care programs will be rate adjustments, moving the prescribed drug portion of capitated Medicaid rates from Medicaid to Medicare, with a significant downward adjustment to the Medicaid rate accordingly.

Consumer Directed Care

Consumer directed care in the LTC arena refers to a range of practices designed to place the consumer in the "driver's seat" in regard to the receipt of LTC services. Consumer direction can range from consumer development of the individual care plan or service plan, to hiring and firing of LTC workers, to management of cash disbursements from Medicaid. California has a long history of consumer direction as part of the design of the IHSS program, which includes consumer direction of workers and under some circumstances, provision of cash advances for the purchase of personal care and related services. The IHSS program consumer direction components were authorized for Medi-Cal funding in 2004 following approval of the IHSS+ Waiver, which uses the Federal Independence Plus 1115 Waiver template to permit Medicaid financing of cash payments to individuals who manage their own services. This waiver option was formalized following an initial research and demonstration project in Arkansas, New Jersey and Florida.

The Federal Centers for Medicare and Medicaid Services (CMS) is actively encouraging states to incorporate concepts specific to consumer direction into their Medicaid LTC waiver programs consistent with the goals contained in President Bush's *New Freedom Initiative*. The intended purposes are specifically to:

- Delay institutional or other high cost out-of-home placement by strengthening supports to families or individuals and permit the individual who requires long-term supports and services to live in the family residence or their own home.

- Recognize the essential role of the family or individual in the planning and purchasing of health care supports and services by providing individuals or their families control over an agreed resource amount.
- Encourage cost effective decision-making to purchase necessary supports and services.
- Increase family or individual satisfaction through the promotion of self direction, control and choice.
- Facilitate the states' abilities to meet their legal obligations under the Americans with Disabilities Act (ADA) and the Supreme Court *Olmstead* decision.³⁰

Additional information regarding Independence Plus is provided in Appendix I.

Single Point of Entry Systems

The national Aging and Disability Resource Center initiative, with grant funding provided through CMS, seeks to encourage states to develop single point of entry (SPE) systems using a comprehensive approach similar to the SPE systems implemented in Wisconsin and Oregon.

Wisconsin began operating Aging and Disability Resource Centers in 1998. These centers are required to provide the following services:

- Outreach activities
- Provision of information and assistance
- Long-term care options counseling, including pre-admission consultation for residential services
- Benefits counseling
- Eligibility screening
- Assistance with selection and enrollment into CMOs
- Data collection
- Emergency response capability

The resource centers provide information and other services to anyone requesting them. Wisconsin has developed a uniform Long-Term Care Functional Screen (LTCFS) used to perform level of care (LOC) evaluations, serve as a guide for options counseling, and serve as a source of research information that can be used to set managed long-term care

³⁰ State Medicaid Directors Letter #02-009. Centers for Medicare and Medicaid Services. May 9, 2002. <http://www.cms.hhs.gov/states/letters/smd50902a.pdf>

per member, per month (PMPM) rates in the future. Some of the CMOs are serving three populations: people with physical disabilities, people with developmental disabilities, and frail elders. Other CMOs are serving only persons over the age of 65.

Oregon has a statewide SPE system, Oregon ACCESS, for persons over age 65 and persons with physical disabilities, and includes persons with mental illness and persons with developmental disabilities in this system on a limited and voluntary basis. The SPE entities are a combination of state agencies and Area Agencies on Aging (AAAs). AAAs can choose to provide comprehensive SPE functions, including SPE services for persons with developmental disabilities and persons with mental illness, may conduct financial eligibility determinations and may manage Medicaid and cash assistance programs. AAAs that provide comprehensive services are referred to as Type B2 agencies. Type B2 agencies are the SPE for the Older Americans Act, Oregon Project Independence, Medicaid Long-Term Care and Cash/Medical Assistance/Food Stamps Programs.

While it is challenging to include multiple populations and benefit programs (such as Food Stamps, Medicaid, Older Americans Act, etc.) in an ADRC, the end result provides “one-stop” service to persons with LTC needs.

Some states are also pursuing “No Wrong Door” initiatives. These initiatives are more challenging to develop, requiring each potential “door” to the service system to have the capacity to provide information, intake and referral services across the spectrum of programs. These initiatives rely heavily on data system developments, which enable authorized users at any of the “doors” to access information concerning programs and clients. The Texas Integrated Eligibility Redesign System (TIERS) is an example of a comprehensive system which uses an Internet-based system to link over two dozen state agencies and which permits case workers to enter and retrieve data instantaneously across programs. See Appendix J for more information concerning TIERS.³¹

San Francisco funds, through the DAAS, Neighborhood Resource Centers, which function primarily in an information and referral capacity. At present the Department information systems do not support the capability to develop either a SPE or “No Wrong Door” approach. Information systems at LHH and for certain community-based services are significantly below par. The Sorian system is supposed to resolve deficits in the current information systems and provide for better management and program/service coordination. Any delay in implementation of new information systems seriously impairs the Department’s ability to manage programs and resources efficiently.

Recommendations

³¹ Texas Integrated Eligibility Redesign System (TIERS). Texas Health AND Human Services. June 2005. Retrieved July 12, 2005. Available online at: <http://www.hhs.state.tx.us/consolidation/IE/TIERS.shtml>

- **While San Francisco is not included in the initial ALTCI plan, the Department needs to be prepared for the eventual expansion of this model to San Francisco** (although HMA has no information at present regarding expansion beyond the pilot areas). The Department's ability to manage the LTC continuum will become increasingly important in a managed care environment. The Department also will need to monitor LTC developments in Medi-Cal and determine how best to participate in initiatives in a manner that benefits San Franciscans.
- **The Department should remain vigilant regarding managed LTC developments, in both the Medicare and Medicaid arenas.** The previous recommendations regarding a focus on the LTC continuum, coordination of services and improved access to community-based options can help the Department improve efficiencies and be better prepared for expanded and additional Medicaid managed care initiatives.
- As the Department continues to develop their LTC system, **the LTC Director undertake a review of the Department's current utilization of consumer direction in both community-based and institutional LTC programs and work with Department staff, community leaders, advocates and consumers to support further developments in this area.**
- **The Department should assign a high priority to information system needs of the Department,** particularly extending the Department IS system to LHH and Community Behavioral Health programs and clinics.
- **The Department should evaluate the desirability and feasibility of a SPE or "No Wrong Door" approach to managing access to Department-funded LTC resources.** This approach can facilitate implementation of a uniform assessment and prioritization system and choice counseling services recommended previously.

CONCLUSION

HMA is honored to have facilitated this assessment of the San Francisco Department of Public Health and, particularly to review in great detail the long-term care system that it operates and provides to the residents of San Francisco. We hope that the findings and recommendations contained within this report will be helpful to the Department and to the leadership of the City/County as it approaches even greater strains on an already frayed health care safety net. With focused attention to becoming a more seamless system of care, we believe that the people of San Francisco have the opportunity to have one of the most effective and efficient public health and hospital systems in the nation.

APPENDICES

APPENDIX A:	UNITED STATES NURSING HOMES: SIZE COMPARISONS
APPENDIX B:	THE GREEN HOUSE MODEL
APPENDIX C:	SAN FRANCISCO FREE STANDING NURSING FACILITIES – OCCUPANCY AND PAYOR MIX
APPENDIX D:	THE INSTITUTIONS FOR MENTAL DISEASES (IMD) EXCLUSION
APPENDIX E:	SUMMARY OF SAN FRANCISCO LTC RESIDENTIAL FACILITIES
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APPENDIX J:	TEXAS INTEGRATED ELIGIBILITY REDESIGN SYSTEM (TIERS)
APPENDIX K:	PROJECT INTERVIEW/INTERACTION LISTING
APPENDIX L:	SAN FRANCISCO CHARACTERISTICS
APPENDIX M:	GLOSSARY OF ABBREVIATIONS

Appendix A: United States Nursing Homes: Size Comparisons

Number of Beds	Total Beds	Number Of Residents	Average Occupancy Rate	Number Of NH	Percent of NHs	Overall Occupancy Rate
000 - 099	509,616	432,924	82	8,271	51.5%	85%
100 - 199	890,164	763,840	85	6,741	42.0%	86%
200 - 299	187,442	160,001	85	811	5.0%	85%
300 - 399	53,290	46,053	86	161	1.0%	86%
400+	41,711	37,004	89	76	0.5%	89%
<i>Total</i>	<i>1,682,223</i>	<i>1,439,822</i>		<i>16,060</i>		

Number of Beds						
Type Of OwnerShip	000 - 099	100 - 199	200 - 299	300 - 399	400+	Total
For profit - Corporation	4,323	4,239	435	56	12	9,065
For profit - Individual	186	144	16	1		347
For profit - Partnership	439	638	66	11	4	1,158
Government - City	110	6	5	1	1	123
Government - City/county	40	19	7	4	3	73
Government - County	223	168	45	21	19	476
Government - Federal	2	1				3
Government - Hospital distr	148	21	2	1		172
Government - State	56	45	17	11	6	135
Non profit - Church related	517	339	46	9	2	913
Non profit - Corporation	2,053	1,037	162	45	27	3,324
Non profit - Other	174	84	10	1	2	271

Data Source: CMS Online Survey, Certification, and Reporting (OSCAR) database: The information on the nursing homes' characteristics derived from OSCAR are prepared by each nursing home at the beginning of the regular State inspection. This information is reported by the nursing homes themselves. It is reviewed by nursing home inspectors, but not formally audited to ensure data accuracy. In addition, this information changes frequently as residents are discharged and admitted, or resident conditions change. The data is submitted during the nursing home's most recent survey date - therefore the data age varies.

<http://www.cms.hhs.gov/medicaid/services/lcdata.asp>

Appendix B: The Green House Model¹

Researchers at the University of Minnesota (UM) recently conducted a study of the effectiveness of a new model of nursing home care called the “Green House.” While traditional nursing home model emphasizes health and safety goals, the Green House model focuses on promoting quality of life for elders. The Green House approach involves 10 elders living in self-contained houses with private rooms and baths, supported by CNA-level resident assistants. Professional staff (RNs, MDs, SW, RT, PT, OT, etc.) form clinical support teams that visit each Green House. A group of Green Houses is licensed as a nursing facility and share administrative and clinical support teams.

The UM study compared three groups: residents at Cedars Health Care Center, a 140-bed traditional nursing home; Trinity Health Care, another nursing home operated by the same owner; and elders who were moved from Cedars to four 10-person Green Houses built in May 2003. Two of the Green Houses were populated by former residents of the locked dementia care unit. Vacancies in Green Houses were filled by admissions from Cedars. There were no statistically significant differences in gender, ADLs, levels of behavior problems across the facilities. However, Cedars residents were slightly more depressed and cognitively impaired.

The purpose of the UM study was to determine whether there were differences between traditional nursing home and Green House residents, family caregivers, and front-line staff in terms of satisfaction with standards of care and quality of life. The study revealed that Green House residents reported a better quality of life and greater satisfaction than those in the two control settings. In addition, compared to the two control settings, Green House family members reported greater satisfaction with their relative’s care and quality of life. They also reported greater satisfaction with how they as family members were treated. Finally, Green House staff reported that they felt more empowered to assist residents. Compared to the two control settings, Green House staff felt they knew the residents better, experienced greater intrinsic and extrinsic job satisfaction, and were more likely to remain in the job.

Quality indicators (QI) also favored the Green House model. MDS-based QI analyses over a two-year period showed either no difference in QIs or statistically significant advantages for the Green House. In addition, compared to the control settings, the Green House participants showed less ADL decline, less prevalence of depression, less incontinence without a toileting plan, and less use of anti-psychotics without a relevant diagnosis.

The findings provide robust support of the Green House model from residents, family, and staff compared to traditional nursing homes. There were almost no negative

¹ Summary of “Results From the Green House Evaluation in Tupelo, MS”, Presented at the Academy Health Annual Meeting on 6/25/05 by Kane, Rosalie A.; Cutler, Lois J.; Lum, Terry; and Yu, Amanda of the University of Minnesota.

findings. As a result, many other Green Houses are currently under development. The project is reported to be cost-neutral, with participating facilities comprised of ninety-nine percent Medicaid recipients.²

² Testimony of Judith Rabig to the Policy Committee, White House Conference on Aging. June 2, 2005. Available online at: <http://www.whcoa.gov/about/policy/meetings/Schmeiding/Rabig.pdf>

Appendix C: San Francisco Free Standing Nursing Facilities – Occupancy and Payor Mix

FACILITY NAME	BEDS	TOTAL PATIENT DAYS	OCCUPANCY RATE	PERCENT MEDICARE	PERCENT MEDI- CAL	PERCENT SELF PAY	PERCENT MANAGED CARE	PERCENT OTHER
SAN FRANCISCO TOWERS (EPISCOPAL HOMES FOUNDATION)	55	14,963	75%	10%	0%	61%	0%	28%
LAWTON HEALTHCARE CENTER (KINDRED HEALTHCARE INC.)	75	18,603	68%	29%	0%	56%	15%	0%
SEQUOIAS-SAN FRANCISCO CONV HOSP (NORTHERN CALIFORNIA PRESBYTERIAN HOMES)	49	12,619	71%	7%	0%	0%	0%	93%
CALIFORNIA CONVALESCENT HOSPITAL (TIMBERLAKE-FORREST INC.)	29	9,317	88%	0%	0%	100%	0%	0%
SHEFFIELD CONVALESCENT HOSPITAL (TIMBERLAKE-FORREST INC.)	34	10,005	81%	0%	0%	100%	0%	0%
HERITAGE THE	32	9,903	85%	0%	0%	100%	0%	0%
LAUREL HEIGHTS CONVALESCENT HOSPITAL	32	9,783	84%	0%	0%	100%	0%	0%
NOB HILL HEALTHCARE CENTER (KINDRED HEALTHCARE INC.)	180	58,484	89%	43%	21%	4%	27%	4%
HAYES CONVALESCENT HOSPITAL	34	10,807	87%	0%	38%	62%	0%	0%
CENTRAL GARDENS	92	26,735	80%	6%	60%	34%	0%	0%
GOLDEN GATE HEALTH CARE CENTER (KINDRED HEALTHCARE INC.)	120	43,345	99%	2%	74%	5%	10%	9%
S F COMMUNITY CONVALESCENT CENTER	116	39,894	94%	2%	75%	23%	0%	0%

FACILITY NAME	BEDS	TOTAL PATIENT DAYS	OCCUPANCY RATE	PERCENT MEDICARE	PERCENT MEDI- CAL	PERCENT SELF PAY	PERCENT MANAGED CARE	PERCENT OTHER
VICTORIAN HEALTHCARE CENTER (KINDRED HEALTHCARE INC.)	90	32,571	99%	4%	80%	3%	3%	9%
ST. ANNE'S HOME	46	15,622	93%	0%	81%	19%	0%	0%
CONVALESCENT CENTER MISSION STREET	53	18,660	96%	8%	85%	7%	0%	0%
GROVE STREET EXTENDED CARE & LIVING CTR (HELPING HANDS SANCTUARY OF IDAHO)	168	59,390	97%	8%	88%	4%	0%	0%
NINETEENTH AVENUE HEALTHCARE CENTER (KINDRED HEALTHCARE INC.)	140	50,687	99%	3%	90%	3%	1%	3%
MISSION BAY CONVALESCENT HOSPITAL	50	14,543	80%	0%	91%	9%	0%	0%

Data Source: FY 2003-2004 California Office of Statewide Health Planning and Development Healthcare Quality & Analysis Division.

Appendix D: The Institutions for Mental Diseases (IMD) Exclusion

The IMD exclusion was included in the original enactment of the Medicaid program in 1965. The exclusion was amended twice to permit Medicaid funding of inpatient hospital psychiatric services for persons under the age of 21 and Medicaid funding of ICF services for the elderly residing in IMDs.

The law, regulations and policies specific to the IMD exclusion are contained in the Social Security Act, Code of Federal Regulations and the State Medicaid Manual.

Social Security Act

Title XIX of the Social Security Act governs the Medicaid program. Section 1905 specifies the scope of eligibility and services for the Medicaid program. Section 1905(a)(27)(B) contains the Institutions for Mental Diseases (IMD) exclusion:

1905(a)(27)(B)

[The term “medical assistance” means payment of part or all of the cost of the following care and services]

(27) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary, except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

Section 1905(a)(16) permits states to cover inpatient psychiatric hospital services for individuals under age 21. Therefore, the IMD exclusion applies to non-elderly adults.

Note that the exclusion encompasses all Medicaid-funded services.

Code of Federal Regulations – Title 42

The Code of Federal Regulations (CFR) is a codification of the rules published in the Federal Register by the Executive departments and agencies of the Federal Government. Title 42 includes rules specific to the Medicaid program. Title 42, Sections 435.1008 and 1009 describe and define limits on federal financial participation (FFP) in regards to persons who are institutionalized and provides definitions specific to various types of

institutions, including IMDs. These sections of the CFR are provided in Appendix B for reference.

Of particular importance are the definitions of an “institution” (an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor) and an IMD (a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.)

State Medicaid Manual

CMS issues guidance to states through the State Medicaid Manual, letters to state Medicaid agencies, and other formal communications. The Medicaid Manual contains extensive guidance concerning IMDs and specifies the guidelines that CMS staff utilize when making a determination regarding the nature of a facility in regards to the IMD exclusion. Section 4390 is provided in its entirety as Appendix A.

The guidelines provided in the State Medicaid Manual address additional levels of detail concerning how to make a determination that an institution is an IMD, and includes a series of questions and issues specific to the needs of the residents of a facility, the nature of the services provided, the qualifications of the staff, the regulation of the facility and the location of the facility (in relationship to other facilities of a similar nature.)

For the purposes of the Medicaid program, an institution means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor. Therefore, a board and care facility, group home, nursing home and hospital serving four or more unrelated persons would each meet the definition of institution for Medicaid purposes.

If these institutions have sixteen or fewer beds and serve persons with a mental illness, regardless of the nature of the facility, the staff, the treatment provided or the diagnoses of the residents of the facility (“institution”), the facility is not subject to the IMD exclusion. However, in some instances the facility might be construed to be a component of another facility or entity. If the facility is co-located or within close proximity to another facility providing care to persons with a mental illness, a series of questions are explored by CMS to determine whether the facilities should be considered a single facility of greater than sixteen beds. Note that components that are certified as different types of providers, such as NFs and hospitals, are considered independent from each other. If the facility or facilities are determined to be institutions of more than sixteen beds, the facility must then be evaluated to determine whether the overall character of a facility is that of an IMD.

The determination regarding the overall character of a facility is made irregardless of how the facility is licensed. This issue was decided by the Supreme Court of the United States in 1985 in the case of the Connecticut Department of Income Maintenance v. Heckler, which found that: “An ICF may be an IMD, and the terms are not mutually exclusive. The Act's express authorization for coverage of services performed for individuals 65 or over uses language that plainly indicates that a hospital, a skilled nursing facility, or an ICF may be an IMD. Moreover, the Secretary's interpretation of the Act comports with the Act's plain language. And the legislative history does not reveal any clear expression of contrary congressional intent.”¹

The process that the Health Care Financing Administration (HCFA, now CMS) utilized in reaching a determination regarding the ICF in question is noted in the case:

“The Secretary has developed criteria designed to focus on what constitutes "primarily engaged" and "overall character." The review team utilized the following criteria when evaluating Middletown Haven, an ICF:

1. That a facility is licensed as a mental institution;
2. That it advertises or holds itself out as a mental institution;
3. That more than 50% of the patients have a disability in mental functioning;
4. That it is used by mental hospitals for alternative care;
5. That patients who may have entered a mental hospital are accepted directly from the community;
6. That the facility is in proximity to a state mental institution (within a 25-mile radius);
7. That the age distribution is uncharacteristic of nursing home patients;
8. That the basis of Medicaid eligibility for patients under 65 is due to a mental disability, exclusive of services in an institution for mental disease;
9. That the facility hires staff specialized in the care of the mentally ill; and
10. That independent professional reviews conducted by state teams report a preponderance of mental patients in the facility.”

States with any type of residential facility that provides “psychiatric/psychological care and treatment”, where “the current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases”, and which has more than sixteen beds, is likely to be subject to scrutiny concerning the IMD exclusion. Because a number of the guidelines in the State Medicaid Manual are non-specific or rely on the professional judgment of the surveyor, the final determination regarding a facility’s IMD status is subject to some degree of interpretation (and variability) specific to each surveyor.

¹ Access the case online at: <http://laws.findlaw.com/us/471/524.html>.

Medicaid Manual Excerpt

Section 4390. INSTITUTIONS FOR MENTAL DISEASES

A. Statutory and Regulatory Provisions.--The statutory provisions relating to institutions for mental diseases (IMDs) include two categories of covered services and a broad payment exclusion that can preclude payment for services provided to certain individuals in both participating and non-participating facilities.

1. IMD Coverage.--The original Medicaid legislation (P.L. 89-97) included a benefit for individuals 65 years of age or older who are in hospitals or nursing facilities that are IMDs. This provision is in §1905(a)(14) of the Act and regulations relating to this benefit are in Subpart C of 42 CFR 441.

In 1972, the Medicaid program was expanded (P.L. 92-603) to include inpatient psychiatric hospital services for individuals under age 21, or, in certain circumstances, under age 22. This provision is in §1905(a)(16) of the Act. Authority for using additional settings was enacted in P.L. 101-508. This benefit is currently being provided in a wide variety of psychiatric facilities. Regulations for this benefit are in Subpart D of 42 CFR 441.

Both IMD benefits are optional, except that inpatient psychiatric services for individuals under age 21 must be provided in any State as early and periodic screening, diagnosis and treatment (EPSDT) services if they are determined to be medically necessary.

2. IMD Exclusion.--The IMD exclusion is in §1905(a) of the Act in paragraph (B) following the list of Medicaid services. This paragraph states that FFP is not available for any medical assistance under title XIX for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. This exclusion was designed to assure that States, rather than the Federal government, continue to have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group.

3. IMD Definition.--In 1988, P.L. 100-360 defined an institution for mental diseases as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. This definition is in §1905(i) of the Act and in 42 CFR 435.1009. The regulations also indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

Facilities with fewer than 17 beds that specialize in treating persons with mental disorders can provide the types of services discussed in item 1 if they meet the regulatory requirements to provide these institutional benefits, but these facilities are not technically

IMDs. Because IMDs are defined to be institutions with more than 16 beds, the IMD exclusion applies only to institutions with at least 17 beds.

B. Guidelines for Determining What Constitutes an Institution.--When it is necessary to determine whether an institution is an IMD, the IMD criteria listed in subsection C must be applied to the appropriate entity. In most cases, there is no difficulty in determining what entity to apply the criteria to. But in cases in which multiple components are involved, it may be necessary for the HCFA regional office (RO) to apply the following guidelines to identify the institution to be assessed. Components that are certified as different types of providers, such as NFs and hospitals, are considered independent from each other.

1. Are all components controlled by one owner or one governing body?
2. Is one chief medical officer responsible for the medical staff activities in all components?
3. Does one chief executive officer control all administrative activities in all components?
4. Are any of the components separately licensed?
5. Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?
6. If two or more of the components are participating under the same provider category (such as NFs), can each component meet the conditions of participation independently?

The RO may also use other guidelines that it finds relevant in a specific situation. If the answer to items 1, 2, or 3 is "no," or the answer to items 4, 5, or 6 is "yes," for example, there may be a separate facility/component. If it is determined that a component is independent, the IMD criteria in subsection C are applied to that component unless the component has 16 or fewer beds.

C. Guidelines for Determining Whether Institution Is an IMD.--HCFA uses the following guidelines to evaluate whether the overall character of a facility is that of an IMD. If any of these criteria are met, a thorough IMD assessment must be made. Other relevant factors may also be considered. For example, if a NF is being reviewed, reviewers may wish to consider whether the average age of the patients in the NF is significantly lower than that of a typical NF. A final determination of a facility's IMD status depends on whether an evaluation of the information pertaining to the facility establishes that its overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases.

1. The facility is licensed as a psychiatric facility;

2. The facility is accredited as a psychiatric facility;
3. The facility is under the jurisdiction of the State's mental health authority. (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.);
4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs; and
5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases.

D. Assessing Patient Population.--The review team applying the guidelines must include at least one physician or other skilled medical professional who is familiar with the care of mentally ill individuals. No team member may be employed by or have a significant financial interest in the facility under review.

In applying the 50 percent guideline (see §4390.C.2), determine whether each patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline.

For purposes of determining whether a facility is subject to the IMD exclusion, the term "mental disease" includes diseases listed as mental disorders in the International Classification of Diseases, 9th Edition, modified for clinical applications (ICD-9-CM), with the exception of mental retardation, senility, and organic brain syndrome. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a subspecification of the mental disorder chapter of the ICD and may also be used to determine whether a disorder is a mental disease.

If it is not possible to make the determination solely on the basis of an individual's current diagnosis, classify the patient according to the diagnosis at the time of admission if the patient was admitted within the past year. Do not include a patient in the mentally ill category when no clear cut distinction is possible.

To classify private patients when review of their records is not possible, rely on other factors such as the surveyor's professional observation, discussion with staff of the overall character and nature of the patient's problems, and the specialty of the attending physician.

When the 50 percent guideline is being applied in a NF, the guideline is met if more than 50 percent of the NF residents require specialized services for treatment of serious mental illnesses, as defined in 42 CFR 483.102(b). Facilities providing non-intensive care for

chronically ill individuals may also be IMDs. All NFs must provide mental health services which are of a lesser intensity than specialized services to all residents who need such services. Therefore, in applying the 50 percent guidelines, it is important to focus on the basis of the patient's current need for NF care, rather than the nature of the services being provided.

E. Chemical Dependency Treatment Facilities.--The ICD-9-CM system classifies alcoholism and other chemical dependency syndromes as mental disorders.

There is a continuum of care for chemical dependency. At one end of the spectrum of care, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. If services are psychological in nature, the services are considered medical treatment of a mental disease. Chemically dependent patients admitted for such treatment are counted as mentally ill under the 50 percent guideline. Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs.

At the other end of the spectrum of care are facilities that are limited to services based on the Alcoholics Anonymous model, i.e., they rely on peer counseling and meetings to promote group support and encouragement, and they primarily use lay persons as counselors. Lay counseling does not constitute medical or remedial treatment. (See 42 CFR 440.2(b).) Do not count patients admitted to a facility only for lay counseling or services based on the Alcoholics Anonymous model as mentally ill under the 50 percent guideline. If psychosocial support provided by peers or staff without specialized training is the primary care being provided in the facility, the facility is not an IMD. The major factor differentiating these facilities from other chemical dependency treatment facilities is the primary reliance on lay staff.

Federal matching funds may not be claimed for institutional services when lay/social treatment is the primary reason for the inpatient stay. Facilities may not claim Medicaid payment for providing covered medical or remedial services in a nursing facility or hospital to patients admitted for treatment of chemical dependency and simultaneously claim that they are providing only lay or social services to those same patients when the 50 percent guideline is being applied. Facilities also may not avoid having their chemically dependent patients counted as mentally ill under the 50 percent guideline by withholding appropriate treatment from those patients. Facilities failing to provide appropriate treatment to patients risk termination from the program.

In determining whether a facility has fewer than 17 beds, it is not necessary to include beds used solely to accommodate the children of the individuals who are being treated. Children in beds that are not certified or used as treatment beds are not considered to be patients in the IMD and therefore are not subject to the IMD exclusion if they receive covered services while outside the facility.

4390.1 Periods of Absence From IMDs.--42 CFR 435.1008(c) states that an individual on conditional release or convalescent leave from an IMD is not considered to be a

patient in that institution. These periods of absence relate to the course of treatment of the individual's mental disorder. If a patient is sent home for a trial visit, this is convalescent leave. If a patient is released from the institution on the condition that the patient receive outpatient treatment or on other comparable conditions, the patient is on conditional release.

If an emergency or other need to obtain medical treatment arises during the course of convalescent leave or conditional release, these services may be covered under Medicaid because the individual is not considered to be an IMD patient during these periods. If a patient is temporarily transferred from an IMD for the purpose of obtaining medical treatment, however, this is not considered a conditional release, and the patient is still considered an IMD patient.

The regulations contain a separate provision for individuals under age 22 who have been receiving the inpatient psychiatric services benefit defined in 42 CFR 440.160. This category of patient is considered to remain a patient in the institution until he/she is unconditionally released or, if earlier, the date he/she reaches age 22.

Title 42 CFR, Sections 435.1008 and 1009.

Sec. 435.1008 Institutionalized individuals.

(a) FFP is not available in expenditures for services provided to--

(1) Individuals who are inmates of public institutions as defined in Sec. 435.1009; or

(2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under Sec. 440.160 of this subchapter.

(b) The exclusion of FFP described in paragraph (a) of this section does not apply during that part of the month in which the individual is not an inmate of a public institution or a patient in an institution for tuberculosis or mental diseases.

(c) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under Sec. 440.160 of this subchapter is considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.

Sec. 435.1009 Definitions relating to institutional status.

For purposes of FFP, the following definitions apply:

“In an institution” refers to an individual who is admitted to live there and receive treatment or services provided there that are appropriate to his requirements.

Inmate of a public institution means a person who is living in a public institution. An individual is not considered an inmate if--

(a) He is in a public educational or vocational training institution for purposes of securing education or vocational training; or

(b) He is in a public institution for a temporary period pending other arrangements appropriate to his needs.

Inpatient means a patient who has been admitted to a **medical institution** as an inpatient on recommendation of a physician or dentist and who--

(1) Receives room, board and professional services in the institution for a 24 hour period or longer, or

(2) Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

Institution means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

Medical institution means an institution that--

- (a) Is organized to provide medical care, including nursing and convalescent care;
- (b) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;
- (c) Is authorized under State law to provide medical care; and
- (d) Is staffed by professional personnel who are responsible to the **institution** for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the **institution**.

Appendix E: Summary of San Francisco LTC Residential Facilities

Overview

Although numerous residential facilities exist in San Francisco to provide long-term care (LTC) to clients, data about these facilities are dispersed across a multitude of organizations and government agencies. Between April and July 2005, the Continuum of Care Study team reviewed publicly available data on long-term care facilities in San Francisco to identify the total number of such facilities and their bed capacities. The goal of this exercise was to aggregate, for the first time, a comprehensive list of LTC residential facilities located in the City of San Francisco (excluding Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD)). In addition, project team members contacted skilled nursing facilities (a.k.a. nursing homes) to determine their occupancy rates, cost per day, and whether they participated in Medi-Cal/Medicare.

Types of Facilities

LTC facilities fall into several categories. Complicating matters, there are different names for licensure categories, operating categories, and names used to market these facilities to the general public. For purposes of the Continuum of Care Study, the following category types were used:

- **Skilled Nursing Facility (SNF):** Extended care facility that provides skilled nursing care or rehabilitation services for inpatients on a daily basis. These facilities may be free-standing SNFs or distinct part SNFs (DP-SNF), which are located in a hospital.
- **Residential Care Facility (RCF):** Licensed by the California Department of Social Services, RCFs provide care and supervision and assistance with activities of daily living, such as bathing and grooming. They may also provide incidental medical services under special care plans. The facilities can range in size from six beds or less to over 100 beds. The residents in these facilities require varying levels of personal care and protective supervision. (Also known as retirement homes, assisted living facilities or board and care homes.)
- **Residential Care Facility for the Elderly (RCFE):** Similar to RCFs, these facilities provide services to persons 60 years of age and over.
- **Residential Care Facility for the Chronically Ill (RCF/Chronically Ill):** Though similar to RCFs, these facilities represent a separate licensure category to provide services to persons who are chronically ill.
- **Hospice:** A program that provides special care for people who are near the end of life, often those who are terminally ill. Some hospices offer residential options for the terminally ill.
- **Residential Mental Health Facilities:** Licensed by the California Department of Social Services, these facilities are subcategorized by the type of treatment program being used. There are community treatment facilities, social rehabilitation facilities,

community residential treatment system facilities, mental health rehabilitation centers, and alcohol and drug residential centers within this category.

- **Other Housing:** In San Francisco, the Department of Public Health’s Direct Access to Housing program provides permanent housing with on-site supportive services for approximately 400 formerly homeless adults, most of whom have concurrent mental health, substance use, and chronic medical conditions. DAH is a “low threshold” program that accepts single adults into permanent housing directly from the streets, shelter, acute hospital or long-term care facilities. Other housing programs in San Francisco include federally funded facilities.

The following table summarizes the facilities located within San Francisco and their capacities.

San Francisco Residential LTC facilities

Facility Type	# Facilities	Bed Capacity
Skilled Nursing Facility	28	3,641
Residential Care Facility	98	908
RCF Elderly	99	3,189
RCF Chronically Ill	6	129
Hospice	4	Not available
Residential Mental Health	54	340*
SF DPH Housing	12	779
Other Housing	16	1,791

* Does not include alcohol and drug residential treatment facilities (numbers unavailable).

Appendix F: Selected States with Medicaid Assisted Living Waivers¹

State	Medicaid Waiver Reimbursement	Services
Alaska	Tiered payment schedule. An augmented service rate cost factor is available for clients whose needs warrant the hiring or designating of additional staff (i.e. homes caring for residents needing incontinent care, skin care, added supervision, and help with medication). Some residents also attend adult day care. The basic service rate is lower for residents attending day care at least three days a week.	Assistance with ADLs.
Arizona	Three rate classes, based on level of care: low, intermediate, and high skilled. The rates include room and board, which is paid by the resident. The monthly room-and-board amount is the resident's "alternative share of cost" (spend down) or 85% of the current SSI payment, whichever is greater.	Personal care services, skin maintenance, sufficient fluids to maintain hydration, incontinence care, and an assessment by a primary care provider for residents needing medication administration or nursing services.
Colorado	Flat rate, per diem basis. The Medicaid rate for services is \$36.03 a day. The rate covers oversight, personal care, homemaker, chore, and laundry services.	Oversight, homemaker, laundry, and chore services.
Florida	The waiver reimburses providers \$28 a day, \$840 a month, for services.	Assisted living (including personal care and intermittent nursing), incontinence supplies, case management.
Idaho	Based on plan of care	Medical administration and help with personal finances

¹Information sources, supplemented as noted. Bentley, Lyn. Assisted Living State Regulatory Review 2005. National Center for Assisted Living. March 2005. www.ncal.org; National Conference of State Legislatures. Medicaid Assisted Living Waivers. June 2005. <http://www.ncsl.org/programs/health/medicaidwaivers.htm>; CMS. State Waivers Programs and Demonstrations, 2004. <http://www.cms.hhs.gov/medicaid/waivers/waivermap.asp>; Care Scout. Assisted Living State Policy database, 2002. http://www.carescout.com/resources/assisted_living/state_policies/ar.html

State	Medicaid Waiver Reimbursement	Services
Illinois²	The service payment is based on 60% of the average nursing facility rate paid in the region. Because SLFs are not licensed, they may be certified as eligible food stamp vendors and receive these benefits for eligible residents. The average monthly service cost is \$1,883 paid by Medicaid. Residents pay, on average, \$455 for room and board and receive \$96 in food stamp benefits. The state makes payments for 30 days to hold a unit during a temporary absence (less a \$90 personal needs allowance) as payment for room and board	Intermittent nursing -Personal care -Medication oversight and assistance with self-administration -Laundry -Housekeeping -Maintenance -Social/recreational programming -Ancillary (transportation to group/community activities, shopping, arranging outside services) -24 hour response/security staff -Health promotion and exercise programming -Emergency call system
Iowa	Maximum reimbursement \$1,052 per month	Consumer-directed attendant care
Maryland³	Medicaid pays the lesser of the provider's usual and customary charge or \$1,563.75 a month for Assisted Living Level II services and \$1,972.50 for Level III services. Additional payments available for environmental modification and equipment	Personal care, monitoring to manage frequent behavioral difficulties, and assistance with taking medications.
Minnesota	Rates for assisted living services in the waiver program are capped at the state share of the average nursing home payment.	Home care aide (personal care) and home management tasks.
Mississippi⁴	\$33.18/day	Case management, personal care, homemaker services, chore services, attendant care, medication oversight, medication administration, therapeutic social and recreational programming,

² Illinois Department of Healthcare and Family Services. HCBS Waivers for Supportive Living Facilities. <http://www.dpaillinois.com/hcbswaivers/slf.html>

³ Maryland Legal Aid Bureau, Assisted Living Project. http://www.peoples-law.org/health/elderly_health_and_medical_care/ma-waiver.htm.

⁴ Mississippi Division of Medicaid HCBS Waiver programs. http://www.dom.state.ms.us/LTC_Alternative/HBCS_Waiver_Programs/body_hcbs_waiver_programs.html

State	Medicaid Waiver Reimbursement	Services
		intermittent skilled nursing services, transportation, attendant call system, and incontinence supplies.
New Hampshire	Flat Medicaid payment of \$1,250 a month in residential care facilities and \$50 per day in non-licensed elderly housing programs. Room and board is in addition to these amounts	Assisted living, environmental modification, assistive and medical equipment
Pennsylvania	The SSI payment in personal care homes is \$939.30, which includes the personal needs allowance of \$60 a month	A case manager coordinates services that include; environmental modifications, transportation, medical equipment and supplies, personal emergency response systems, home health, and counseling
Washington	Payment based on assessed needs of residents, and components for nursing staff, operations, and capital costs	Assisted living, medical equipment/supplies, skilled nursing, transportation
Wisconsin	Medicaid reimbursement is limited to 85 percent of the average statewide Medicaid nursing home rate excluding room and board. Rates are negotiated between facilities and the county	Assisted living services, transportation, and other therapies
Wyoming⁵	A three-tiered rate system that pays \$32 to \$40 per day. Room and board negotiated by resident and facility.	Case Management Assisted living facility Personal Care 24 hour supervision

⁵ Wyoming Waiver Chart. Brain Injury Association of the USA. Retrieved July 11, 2005.
http://www.biausa.org/Wyoming/docs/waiver_chart.doc

Appendix G: LTCCC Day Health and Housing Model Concept Paper

LONG TERM CARE COORDINATING COUNCIL

Guiding the development of an integrated system of home, community-based, and institutional services for older adults and adults with disabilities

-
- The Long Term Care (LTC) Coordinating Council oversees all implementation activities and delivery system improvements identified in the **Living with Dignity Strategic Plan**.
 - The LTC Coordinating Council will evaluate all issues related to long term care and supportive services, including how different service delivery systems interact. It will make recommendations about how to improve service coordination and system interaction.
-

DAY HEALTH --HOUSING MODEL **CONCEPT PAPER**

May 19, 2005 (a)

The day health-housing model. The day health-housing model discussed in this concept paper consists of apartments in an accessible and affordable residential building that contains a licensed adult day health center on-site.

The current cost over-run problems at Laguna Honda Hospital (LHH) could be resolved, in part, by replacing some of the skilled nursing beds with the day health-housing model. This would include apartments in one or more accessible, affordable residential buildings, on the LHH campus or elsewhere in the community, that also contain a licensed adult day health center.

This day health-housing model is now operating successfully at *Presentation Senior Community*, located at 301 Ellis Street at Taylor. Another day health-housing model, *Mission Creek Senior Community*, is now under construction at Fourth and Berry Streets in Mission Bay. (b)

A. Alternatives to skilled nursing facilities for frail elders & adults with disabilities of all ages

In our field of services for older adults and adults with disabilities, we are quick to talk about capitated managed care, supportive housing, and assisted living. But we also know that these concepts are poorly defined state-wide, and that there is no public money forthcoming at this time to pay for such services for low-income people.

B. Combining congregate housing with adult day health services

Low-income housing and adult day health care are clearly defined, well-known services without-of-county revenue streams available. They have been successfully combined in various ways in San Francisco (b), and are proven to be cost-effective and attractive to clients.

In the model we are discussing, some or all of the apartments are available to frail elderly persons or adults with disabilities only, as determined by a measurable eligibility screen. The apartments are built and managed by a housing developer. An experienced service provider operates a licensed, Medi-Cal-reimbursed adult day health service on the ground floor, providing

all the professional and paraprofessional services of a skilled nursing facility during the day. In-home support workers help participants in their apartments as needed before and after the day health program hours. *Presentation Senior Community* is a good local example of this model. (b)

The Long Term Care Coordinating Council recommends that San Francisco consider developing one or more buildings that combine housing and adult day health care as a substitute for some of the LHH beds for seniors and younger adults with disabilities. This could be done quite rapidly under current circumstances. Here are the factors in favor of such a move:

1. The City already has the land, at Laguna Honda Hospital (LHH) and elsewhere.
2. The City already has construction money in the LHH bonds funding, the Mayor's Office on Housing, and, for some neighborhoods, the San Francisco Redevelopment Agency budget.
3. The state Multifamily Housing Program has specified that its funds can be used for day health-housing projects for adults of all ages. (It would be best not to use HUD construction money, because it takes too long and the eligibility criteria are too restrictive.)
4. In a day health-housing project, each resident would have a little apartment instead of a room, but the construction cost would be about half the projected cost per bed at LHH.
5. Probably some residents would prefer to share an apartment, which would further reduce the cost.
6. The housing segment of a day health-housing project probably will not have to be built according to Residential Care Facility for the Elderly (RCFE) standards and probably will not have to be licensed.
7. Any one of the experienced adult day health care (ADHC) providers in the City, including Laguna Honda Hospitals's own ADHC, could operate the adult day health care program in a new building (or buildings). (Note: The current moratorium on Medi-Cal certification of new adult day health care centers will certainly be lifted within a year or two, and waivers from the moratorium are likely to be allowed.)
8. The minimum age for adult day health care is 18, so younger adults with disabilities can be included.
9. Patients at LHH by definition need to be cared for by the array of professional and paraprofessional staff required in a skilled nursing facility. This is exactly the same staffing required in a licensed adult day health service.
10. Some Civil Service workers now employed at LHH could be transferred to the new adult day health center(s).
11. Although Civil Service staff would cost much more than public sector labor, the per patient day cost for the basic package would be much less than the \$360 per patient per day now spent at LHH. Here's a rough estimate: day health (including main meal) might be about \$120 per day, Section 8 rent about \$50 per day, and four hours of IHSS about \$60 per day, for a total of \$230, most of it coming from outside the City.

12. If extra support is required for dual diagnosis and mental health patients, city mental health or FQHC (federally qualified health center) staff could be used to supplement the day health staffing, with funding coming from outside the county.
13. Or the adult day health care program might be operated directly by an FQHC, with the enhanced funding available from that program. (FQHCs are exempt from the current state-wide moratorium on new day health centers, which is temporary in any case.)
14. Building up census is the biggest hurdle for a new adult day health care program. In this case, the target population is willing and ready, according to the Targeted Case Management (TCM) program, which reported on April 18, 2005 that 755 LHH patients are now on the waiting list for the Medicaid Nursing Facility (NF) Waiver program.
15. Moreover, Medicaid NF (nursing facility) Waiver funding might be utilized for some of the health care and case management costs if the state program is expanded.
16. There is a mechanism (via AB 915) for getting a match from the federal government for city expenditures at an adult day health care service for Medi-Cal-eligible people. This might help cover an additional staffing costs needed in a day health/housing project providing care for people at an advanced level of need.
17. There is over \$600,000 in planning grant funds for the assisted living project at LHH, some portion of which could be used to explore the feasibility of this concept.

This day health-housing concept is being replicated across the country, including here in San Francisco. Mission Creek Senior Community is now under construction at Fourth and Berry. Fifty of the 139 apartments will be reserved for frail and disabled homeless seniors from the shelters, Laguna Honda Hospital, and the marginal housing of the central city. Developed at the behest of the DPH Division of Housing and Urban Health, this new project also will be operated by Mercy Housing, in cooperation with North and South of Market Adult Day Health Care Services. It is due to open early in 2006.

For more information, contact Marie Jobling, 821-1003, or Elizabeth Boardman at 452-1526.

Footnotes:

- (a) *Earlier versions of this paper (April 22, May 3, May 5) have been sent to the members of the Long-term Care Coordinating Council, Marc Trotz, Mitch Katz, the PECC IHSS/Health Task Force, and the controller's consultants at Health Management Associates.*
- (b) *Presentation Senior Community at 301 Ellis (at Taylor) has been operated successfully for over four years by Mercy Services Incorporated. Sixty of the apartments are available only to tenants who have been determined to be frail and disabled. North and South Market Adult Day Health manages the adult day health program there.*

Appendix H: California Home and Community-Based Services Waivers Snapshotⁱ

Information updated March 9, 2005.

Acquired Immune Deficiency Syndrome (AIDS): Provides home and community-based services (HCBS) to persons diagnosed with symptomatic HIV disease or AIDS with symptoms related to HIV disease as an alternative to nursing facility or hospital care.

- Current # Enrollees: 2,315
- Cap on Enrollees: 3,250 - CY 2004 3,330 - CY 2005 3,410 - CY 2006
- Term: 1/1/02 – 12/31/06
- Expiration Date: 12/31/06

Developmentally Disabled (DD): Provides HCBS to mentally retarded and developmentally disabled persons who are regional center clients and reside in the community as an alternative to care provided in an intermediate care facility for the developmentally disabled mentally retarded (ICF/DD/MR).

- Current # Enrollees: 59,719
- Cap on Enrollees: 60,000 - WY 03/04 65,000 - WY 04/05 70,000 - WY 05/06
- Term: 10/1/01 – 9/30/06
- Expiration Date: 9/30/06

In-Home Medical Care (IHMC): Provides HCBS to severely disabled individuals who have a catastrophic illness, may be technology dependent, and have a risk for life-threatening incidences, who would otherwise require care in an acute care hospital for a minimum of 90 days.

- Current # Enrollees: 71
- Cap on Enrollees: 200 - WY 03/04 250 - WY 04/05 300 - WY 05/06 350 - WY 06/07 400 - WY 07/08
- Term: 7/01/03 – 6/30/08
- Expiration Date: 6/30/08

Multipurpose Senior Services Program (MSSP): Provides HCBS to Medi-Cal beneficiaries who are 65 or over and are medically needy. HCBS allow the individuals to live independently in their home, and without this waiver, individuals would require care in a nursing facility.

- Current # Enrollees: 10,459
- Cap on Enrollees: 16,335 for each year of the waiver.
- Term: 7/1/04 – 6/30/09
- Expiration Date: 6/30/09

Nursing Facility A/B (NF A/B): Provides HCBS to physically disabled Medi-Cal beneficiaries, who must meet the NF A or B level of care criteria for 365 consecutive days or greater.

- Current # Enrollees: 670
- Cap on Enrollees: 670 - CY 03/04 780 - CY 04/05 890 - CY 05/06
- Term: 1/01/02 – 12/31/06
- Expiration Date: 12/31/06

Nursing Facility Subacute (NF SA): Provides HCBS to physically disabled Medi-Cal beneficiaries who meet the NF Subacute level of care criteria for 180 consecutive days or greater.

- Current # Enrollees: 570
- Cap on Enrollees: 795 - WY 03/04 905 - WY 04/05
- Term: 4/01/02 – 3/31/05
- Expiration Date: 3/31/05

ⁱ Olmstead Plan Implementation Update. May 2005. Appendix 2: California Medicaid Waivers. California Health and Human Services Agency.

<http://www.chhs.ca.gov/olmstead/PDFs/Appendix%20%20Medicaid%20Waivers.pdf>

Independence Plus A Program for Family or Individual Directed Community Services¹

Program Summary

Independence Plus is based on the experiences and lessons learned from states that have pioneered the philosophy of consumer self-direction. Two national pilot projects demonstrated the success of these approaches – (a) the Self-Determination project in 19 states, focused primarily in the §1915(c) Home and Community-Based Services waiver programs, and (b) the “Cash and Counseling” National Demonstration and Evaluation project in three states, focused on the §1115 demonstration programs. Independence Plus programs afford older persons and persons with disabilities or their families the option to direct the design and delivery of services and supports to avoid unnecessary institutionalization, experience higher levels of satisfaction and maximize the efficient use of community services and supports.

CMS defines an *Independence Plus* self-directed program as “a state Medicaid program that presents individuals with the option to control and direct Medicaid funds identified in an individual budget.” The CMS program requirements for an *Independence Plus* program include:

- Person-centered planning - A process, directed by the participant, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the participant.
- Individual budgeting - The total dollar value of the services and supports, as specified in the plan of care, under the control and direction of the program participant.
- Self-directed services and supports - A system of activities that assist the participant to develop, implement and manage the support services identified in his/her individual budget.
- Quality assurance and quality improvement - The QA/QI model will build on the existing foundation, formally introduced under the CMS Quality Framework, of discovery, remediation and continuous improvement.

CMS has developed two templates under the *Independence Plus* initiative that allow states to choose different self-directed design features to satisfy their unique programs. Use of the templates is optional. For states wishing to create programs that allow Medicaid beneficiaries to manage their cash allowance directly and to hire legally responsible relatives, the §1115 Demonstration Template is available. The §1915(c) Waiver version allows Medicaid beneficiaries to self-direct a wide array of services, so long as these services are required to keep a person from being institutionalized in a hospital, nursing facility or Intermediate Care Facility for the Mentally Retarded.

Background:

On May 9, 2002, Secretary Thompson unveiled the *Independence Plus* template to help states enable elders and persons with disabilities to maximize choice and control of services in their own homes and communities. The electronic templates, for §1915(c) waivers and §1115 demonstrations, provide states needed guidance on how to develop self-directed programs using a streamlined application process, which ultimately results in faster federal approval of state proposals. The templates fulfill just one of the commitments Secretary Thompson made to promote community integration in the March 2002 report, “Delivering on the Promise”.

¹ Provided by CMS July 12, 2005.

The intended purposes of the *Independence Plus* Initiative are to:

- Delay or avoid institutional or other high cost out-of-home placement by strengthening supports to families or individuals.
- Recognize the essential role of the family or individual in the planning and purchasing of health care supports and services by providing family or individual control over an agreed resource amount.
- Encourage cost effective decision-making in the purchase of supports and services.
- Increase family or individual satisfaction through the promotion of self-direction, control and choice – a major theme expressed during the New Freedom Initiative – National Listening Session.
- Promote solutions to the problem of worker availability.
- Provide supports brokerage and financial management services to support and sustain individuals or families as they direct their own services.
- Assist states with meeting their legal obligations under the Americans with Disabilities Act (ADA) and the Supreme Court *Olmstead* decision.
- Provide flexibility for states seeking to increase the opportunities afforded individuals and families in deciding how best to enlist or sustain home and community services.

Current Status

CMS has consolidated the existing *Independence Plus* template and the §1915 (c) waiver application into one soon-to-be web-based § 1915 (c) application with instructions. One streamlined application process enables: the expansion of self-directed options through incremental growth in existing waivers; consistent participant protections across all waiver programs; minimal administrative burden to states; easier amendment process so states may change waivers by modules rather than through a new document; and improved quality by clearly communicating CMS expectations for quality.

12 (12) states currently have thirteen (13) approved *Independence Plus* programs:

- Arkansas (§1115 amendment to Cash and Counseling, approved 10/02/02, effective 1/22/03);
- New Hampshire (§1915 (c) new waiver, approved 12/16/02, effective 1/1/03);
- South Carolina (§1915 (c) new waiver, approved 3/11/03, effective 5/1/03);
- Louisiana (§1915 (c) new waiver, approved 4/24/03, effective 4/24/03);
- North Carolina (§1915 (c) new waiver, approved 12/23/03, effective 1/1/04);
- Florida (§1115 amendment to Cash and Counseling, approved 5/30/03, effective 5/30/03).
- California (§1115 new demonstration, approved 7/30/04, effective 8/1/04);
- Maryland (§1915 (c) new waiver, approved 10/21/04, effective 7/1/05);
- North Carolina (§1915 (b)/(c) new waiver, approved 10/6/04, effective 4/1/05);
- Delaware (§ 1915 (c) new waiver, approved 11/12/04, effective 12/1/04);
- New Jersey (§1115 amendment to Cash and Counseling, approved 12/15/04, effective date pending receipt of Operational Program);
- Connecticut (§1915 (c) new waiver, approved 1/14/05, effective 2/1/05);
- Kentucky (§1915 (c) renewal, approved 6/3/05)

Several additional states are working with CMS on submitting *Independence Plus* applications. Another twelve (12) states were awarded 2003 Systems Change Grants from CMS to develop *Independence Plus* programs by 2006. Finally, the Robert Wood Johnson Foundation, along with ASPE and the AoA, awarded a second round of Cash and Counseling grants to eleven (11) states on October 7, 2004 to develop *Independence Plus* programs using either the §1915 (c) waiver or §1115 demonstration application.

In addition, there are two (2) other states with self-direction demonstrations (OR and CO), and a multitude of states that offer self-directed program options in their §1915 (c) home and community based waiver programs.

Finally, CMS offers states technical assistance to design self-directed options for participants in home and community based services programs. More information is available at <http://www.cms.hhs.gov/independenceplus/>.

Updated: July 12, 2005

Appendix J: Texas Integrated Eligibility Redesign System (TIERS)¹

The Texas Integrated Eligibility Redesign System (TIERS) is an integral part of the Texas Health and Human Services Commission's efforts to modernize its eligibility system. TIERS, which is on schedule and on budget for completion in fiscal year 2005, has issued more than \$159 million in benefits to Texans and will serve as the technological foundation for a more integrated health and human services system.

Cutting-edge technology

TIERS is as modern as today's Internet technology. This browser-based system will integrate the application process for more than 50 Health and Human Services programs. TIERS will replace several outdated systems, including the 25-year-old System of Application, Verification, Eligibility, Review and Referral system (SAVERR), with a single integrated system. SAVERR, which was designed in the '60s and launched in the '70s, is built on technology that is out of date and difficult to service.

- The state began a TIERS pilot in June 2003 in five eligibility offices in Travis and Hays counties. More than 135,000 clients receive their benefits each month through TIERS.
- At a cost of approximately \$296 million, TIERS does more and costs less than similar systems in other large states. For example, California introduced four separate systems with price tags exceeding \$400 million each, and New York's system cost nearly \$330 million. The U.S. Department of Agriculture's Food Nutrition and Consumer Services Division estimates that Texas has one of the lowest per-case implementation costs in the country.
- The TIERS online query system was the first in the nation to receive permission to connect with the Social Security Administration using a secure Internet line. This allows caseworkers to instantly verify information rather than the overnight verification method used with SAVERR.
- TIERS will link to two-dozen government agencies to enhance data collection and save time. These interfaces will allow TIERS to retrieve extensive data, including birth certificates, credit information, number of school-age children in the household, and information indicating if an applicant may have been sanctioned in the past for welfare fraud or may owe child support. The bottom line will be better matching of consumer needs with state programs, less repetitious work for employees – because they will retrieve and enter information just once – and reduced fraud.

¹ Texas Integrated Eligibility Redesign System (TIERS). Texas Health AND Human Services. June 2005. Retrieved July 12, 2005. Available online at: <http://www.hhs.state.tx.us/consolidation/IE/TIERS.shtml>

More logical system for caseworkers

TIERS leads caseworkers through a process that applies the rules consistently across the state. In the current system, applications and eligibility processes vary from one office to another.

- TIERS leads eligibility employees through the intricacies of finding a full menu of services geared for the consumer's needs, based on the information gathered.
- TIERS gives caseworkers immediate feedback if there are data entry errors or conflicting data. That allows them to get immediate feedback from the consumer. SAVERR doesn't show errors till a day later, which adds to the employee's workload and the consumer's frustration.
- TIERS has the ability to work multiple budgets for additional adults in a household – eliminating the need to do cumbersome budget work by hand.
- TIERS allows employees to “point and click” on a screen, as most modern computer users do. There is no need to learn multiple keystrokes, as with SAVERR and its low-tech cousins.

One state employee, who recently began using TIERS said: “TIERS helps new workers. We don't have to have all the answers. The system has the answers. It helps us get organized, not vice versa.”

Appendix K: Project Interview/Interaction Listing*

Linda Anderson

Division Manager, Care Management
Services
Contra Costa County Aging and Adult
Services

Cheryl Austin

Assistant Administrator
Laguna Honda Hospital

Monica Banchero-Hasson, M.D

Chief of Staff
Laguna Honda Hospital

Margaret Baran

President
Coalition of Agencies Serving the
Elderly (CASE)

Lee Blitch

President
San Francisco Chamber of Commerce

Elizabeth Boardman

Program Manager
Presentation Community/Mission Creek

Ken Boyd

Development Staff
CA Tax Credit Allocation Committee

Bob Cabaj, M.D.

Director of Community/Behavioral
Health
San Francisco Department of Public
Health

Donna Calame

Executive Director
SF In-Home Supportive Services Public
Authority

Luis Calderon

Project Coordinator
IHSS Public Authority

Chip Chambers, M.D.

Chief of Infectious Disease
San Francisco General Hospital

Jim Chappel

President
San Francisco Planning and Urban
Research Associates

Ed Chow, M.D.

Health Commissioner

Robert Christmas

Chief Operating Officer
Laguna Honda Hospital

David Counter

Director, MIS
San Francisco Department of Public
Health

Denis Craig

Community Program Specialist II
Area Board 5, State Council on
Developmental Disabilities

Jeff Critchfield, M.D.

Vice-Chief of Medicine
San Francisco General Hospital

Sue Currin

Director of Nursing
San Francisco General Hospital

Robert Edmondson

Executive Director/CEO
On Lok

**This listing may not be inclusive of larger meeting in which others participated*

Honorable Sean Elsbernd
Supervisor
San Francisco Board of Supervisors

Catherine Eng, M.D.
Medical Director, Internal
Medicine/Geriatrics
On Lok Senior Health Services

Lois Escobar
Family Consultant
Family Caregiver Alliance

Larry Funk
Assistant Administrator
Laguna Honda Hospital Replacement
Program

Sue Gallego
Director of Client Services
SF AIDS Foundation

Barbara Garcia
Director, Community Programs
San Francisco Department of Public
Health

Hunter Gatewood
Case Management Program
San Francisco Department of Public
Health

Gayling Gee
Co-Director of Nursing
Laguna Honda Hospital

Lenore Gerard
Health Law Attorney
Legal Assistance to the Elderly

Janet Gillen
Director of Social Services
Laguna Honda Hospital

Nancy Giunta
Project Manager
SF Department of Aging & Adult
Services

Joe Goldenson, M.D.
Medical Director
SF County Jail

Liz Gray
Director of Placement
San Francisco Department of Public
Health

Mary Ruth Gross
Director, Home Care Division
SEIU United Healthcare West

Fusako Hara
SF Controller's Office

Ed Harrington
Controller
City of San Francisco

Bill Haskell
Project Director
SF Department of Aging & Adult
Services

Mauro Hernandez
Doctoral Candidate
UCSF

E. Anne Hinton
Executive Director
Department of Aging and Adult Services

Mivic Hirose
Co-Director of Nursing
Laguna Honda Hospital

Michael Humphrey, M.D.
Former Chief of Nephrology
San Francisco General Hospital

Jim Illig
Health Commissioner

Valerie Inouye
Chief Financial Officer
San Francisco General Hospital and
Laguna Honda Hospital

Paul Isakson, M.D.
Medical Director
Laguna Honda Hospital

Ed Johnson
Manager
CA Tax Credit Allocation Committee

John Kanaley
Executive Administrator
Laguna Honda Hospital

Mitch Katz, M.D.
Director
San Francisco Department of Public
Health

Mike Keys
Community Health Advocacy Project
Bay Area Legal Aid

Ed Kinchley
Health Care Industry Chair
SEIU Local 790

Talmadge King, M.D.
Chief of Medicine
San Francisco General Hospital

John Kosiniski
SEIU United Healthcare West

Anne Kronenberg
Deputy Director of Health
San Francisco Department of Public
Health

Paul Kumar
SEIU United Healthcare West

Eileen Kunz
Director of Policy & Governmental
Relations
On Lok

Sharon Kwong
Chief of Medical Social Services
San Francisco General Hospital

Michael Lane
Program Manager
Laguna Honda Hospital Replacement
Program

Mark Leary, M.D.
Deputy Chief of Psychiatry
San Francisco General Hospital

Nelly Lee
Chief Systems Accountant
SF Department of Public Health

Virginia Leishman
Former Nursing Director
Laguna Honda Hospital

Herb Levine
Executive Director
Independent Living Resource Center of
SF

Lizza Leviste
Senior Systems Accountant
San Francisco Department of Public
Health

Grace Li
Director of Program Operations
On Lok Senior Health Services

Jessie Lorenz

Systems Change Coordinator
Independent Living Resource Center of
SF

John Luce, M.D.

Medical Director for Quality Assurance
San Francisco General Hospital

Yvonne Martinez

SEIU Local 790

Melody McLaughlin

Former Administrator, Dialysis Unit
San Francisco General Hospital

Anson Moon

Director of Information Services
San Francisco General Hospital

Benson Nadell

Program Director
CA Ombudsman Association

Nathan Nayman

Executive Director
Committee on Jobs

Honorable Gavin Newsome

Mayor
City of San Francisco

Gene O'Connell

Executive Administrator
San Francisco General Hospital

Anne Okubo

Deputy Financial Officer
San Francisco Department of Public
Health

Lisa Pascual, M.D.

Chief of Rehabilitation Services
San Francisco General Hospital and
Laguana Honda Hospital

David Pearce, M.D.

Chief of Nephrology
San Francisco General Hospital

Chona Peralta

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Health

Lynne Perry

Executive Director
SF Adult Day Services Network

Honorable Aaron Peskin

President
San Francisco Board of Supervisors

Roland Pickens

Deputy Administrator
San Francisco General Hospital

Jep Poon

Administrator, Dialysis Unit
San Francisco General Hospital

Julian Potter

Policy Director
Office of the Mayor of San Francisco

Charlie Ridgell

Assistant Director, Hospital Division -
Public Sector
SEIU United Healthcare West

Ben Rosenfield

Budget Director
Office of the Mayor of San Francisco

Stan Rosenstein

Deputy Director
Medical Care Services
Department of Health Services

Michelle Ruggels
Director of Operations
San Francisco Department of Public Health
Community & Behavioral Health Services

Gregg Sass
Chief Financial Officer
SF Department of Public Health

Donna Schempp
Program Director
Family Caregiver Alliance

Amy Shin
Health Plan Director
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Appendix L: San Francisco Characteristics

Key Demographic Points Related to Report

San Francisco is certainly a unique community with an abundance of distinguishing characteristics. Demographic points, which have particular meaning to the report include:

- San Francisco's poverty rate is higher among adults 65 years or older (11% in poverty in San Francisco, vs. 8% in California and 10% nationally)
- San Francisco's housing stock is older as 53% of the housing structures were built in 1939 or earlier. This complicates issues related to housing those with special needs.
- San Francisco's housing stock is significantly more expensive than homes in California and the rest of the country. The median San Francisco housing value is approximately four times the price of housing in the rest of the country.
- Similarly, the median rent is substantially higher in San Francisco.
- 44% of people 65 years or older in San Francisco have a disability, vs. 40% Statewide and nationally.

San Francisco Background

The numbers describe San Francisco's residents as more international (especially Asian), more adult, and more educated than the rest of the state and the nation. In addition, the cost of housing in San Francisco is more expensive than almost any other place in the country.

Residents of San Francisco come from all over the world, but especially from Asian countries. In San Francisco, only 64% of residents are native, while 36% are foreign-born; in contrast, 73% of all Californians are native and 88% of Americans are native. San Francisco's ethnic makeup is unique compared to the rest of California and the nation: 33% of San Francisco's population is Asian, compared to 12% Asian in the rest of the State and 4% nationally. There are fewer Hispanics/Latinos in San Francisco compared to the rest of the State (14% Hispanic/Latino in San Francisco, vs. 35% in California) and fewer Whites in San Francisco compared to the rest of the country (43% Whites in San Francisco, vs. 68% nationally).

San Francisco's population includes many more adults per capita than the rest of California. Only 15% of San Francisco's population is under the age of 18, compared to 27% statewide. Of the adults living in San Francisco, a large number remain single: 48% of men and 38% of women in San Francisco have never been married. In comparison, 34% of men and 27% of women in California, and 30% of men and 25% of women nationally, have never been married. Only 45% of San Francisco's households are families (defined as having related persons living together), vs. 68% in California and 67% nationally. In San Francisco, 39% of households are comprised of a person living alone, compared to 24% in California and 27% nationally.

San Francisco's older adult population includes a higher percentage of individuals with disabilities compared to the rest of the state and nation. Almost 14% of San Francisco's population is over 65, compared to 10% statewide. The incidence of disabilities in San Francisco's population is similar to rates statewide and nationally, except for individuals 65 years or older. In San Francisco, 44% of people 65 years or older have a disability, vs. 40% Statewide and nationally.

In general, San Franciscans are better educated than other Californians. In San Francisco, 48% of adults 25 years or older have either a bachelor's, graduate or professional degree. Only 29% of adults in California and 27% of all Americans hold such degrees.

Better health is a correlate of educational attainment, and San Francisco's overall death rate is lower than the statewide average (San Francisco ranks 11th best in California for overall death rates out of 58 counties). San Francisco has comparatively fewer deaths due to motor vehicle crashes, firearm injuries, cancer, coronary heart disease, cerebrovascular disease, and diabetes. However, San Francisco has higher death rates compared to the statewide average in the areas of unintentional injuries, homicide, suicide, and drug-induced deaths. San Francisco also has higher incidences of hepatitis C and chlamydia than the statewide average. San Francisco has the highest incidence of AIDS (among population ages 13 years and over), tuberculosis, syphilis, and measles in all of California.

Income is another correlate of educational attainment, and household incomes in San Francisco are higher than those in the rest of California and nationally. Median household income in San Francisco for 2002 was approximately \$58,000, compared to \$50,000 for the rest of California and \$44,000 nationally.

Higher incomes are a prerequisite to living in San Francisco, because the cost of living—especially the cost of housing—is so high. The nonpartisan California Budget Project (CBP) analyzed the affordability of San Francisco in October 1999. The CBP estimated that it would take a single parent family an hourly wage of \$21.24 to meet basic living expenses in San Francisco (\$44,172 annually), compared to an hourly wage of \$17.68 to meet basic living expenses in Los Angeles (\$36,780 annually).

One important reason for the high cost of living in San Francisco is housing. Despite the fact that housing structures in San Francisco are much older than those in California and nationally (in San Francisco, 53% of housing structures were built in 1939 or earlier, compared to only 10% Statewide and 15% nationally), housing prices here are significantly more expensive. The median home cost in San Francisco is \$597,493, compared to \$334,426 Statewide and \$147,275 nationally. Rents are similarly expensive: San Francisco's median rent is \$1,101, compared to \$890 Statewide and \$679 nationally. Consequently, San Franciscans spend a higher percentage of income on housing compared to the rest of the state. 38% of San Franciscans (vs. 31% Statewide and 22% nationally) spend more than 35% of their incomes on their mortgage payments.

Despite the high cost of living in San Francisco, San Francisco's poverty rate is generally lower than statewide and nationally. Although San Francisco's poverty rate is low (10% of individuals in San Francisco were below poverty, vs. 13% statewide and nationally), the poor primarily include vulnerable populations 24 years or younger and 65 years or older.

Poverty in San Francisco primarily affects youth, with the highest levels among young adults 18-24 (20% in poverty) followed by children under 18 (16% in poverty). Poverty is also higher among adults 65 years or older (11% in poverty in San Francisco, vs. 8% in California and 10% nationally). Single-parent households had much higher poverty rates than married-couple families. Non-families, which in San Francisco constitute more households than families, have poverty rates almost as high as those of non-married couple families. There are disparities in San Francisco's poverty rates by ethnicity, with African American and, Latino, and Asian families experiencing higher poverty rates than Whites.

A very visible sign of poverty in San Francisco has been the homeless. A City-wide count of homeless people on San Francisco's streets, in jails, shelters, rehabilitation centers, or other emergency facilities on January 26, 2005, found 6,248 homeless, down 28% since October 2002 when 8,640 homeless were tallied. Although homelessness is a very prominent issue in San Francisco, the highest rate of homelessness nationally was in New York State, which represented 18% of the U.S. homeless population. The highest rate of homelessness in California was in the City of Los Angeles, which represented 23% of California's homeless population.

San Francisco Demographic Observations:

- *San Francisco's population grows at a slower rate*
Since 1990 San Francisco's population has increased 7.3%, in contrast to a statewide growth increase of 13.9%.¹ San Francisco's growth rate ranked 49th out of 53 California counties (the fastest-growing county, San Benito, saw its population increase 45% between 1990-2000).²
- *San Francisco has many more Asian residents*
San Francisco's ethnic makeup is unique compared to the rest of California and the nation. 33% of San Francisco's population is Asian, compared to 12% in the rest of the State and 4% nationally. There are fewer Hispanics/Latinos in San Francisco compared to the rest of the State (14% in San Francisco, vs. 35% in California) and fewer Whites in San Francisco compared to the rest of the country (43% in San Francisco, vs. 68% nationally).³
- *San Franciscans are better educated*
In San Francisco, 48% of adults 25 years or older have either a bachelor's, graduate

¹ San Francisco Department of Public Health, 2002: Overview of Health Status, p. 5

² CensusScope, California Population Growth Ranking, www.censuscope.org

³ U.S. Census Bureau, American Community Survey, 2003 Data Profile

or professional degree. Only 29% of adults in California and 27% of Americans hold bachelor's, graduate or professional degrees.⁴

- *San Francisco has a large number of single individuals*
48% of men and 38% of women in San Francisco have never been married. In comparison, 34% of men and 27% of women in California, and only 30% of men and 25% of women nationally, have never been married. Only 45% of San Francisco's households are families (defined as having related persons living together), vs. 68% in California and 67% nationally. In San Francisco, 39% of households are comprised of a person living alone, compared to 24% in California and 27% nationally.⁵
- *San Francisco has a large number of foreign-born residents*
In San Francisco, only 64% of residents are native, while 36% are foreign-born. In contrast, 73% of all Californians are native and 88% of Americans are native. Of the foreign-born residents, 59% in San Francisco (vs. 57% Statewide and 51% nationally) have been in this country since at least 1990.⁶
- *San Francisco incomes are generally higher*
Household incomes in San Francisco are higher than those in the rest of California and nationally:

	<u>SF</u>	<u>CA</u>	<u>US</u>
Median household income	\$57,833	\$50,220	\$43,564
Mean household income	\$80,614	\$67,022	\$58,036
Median family income	\$67,809	\$56,530	\$52,273
Mean family income	\$90,771	\$73,826	\$66,920 ⁷
- *San Francisco has a higher cost of living*
San Francisco's high cost of living was analyzed by the nonpartisan California Budget Project (CBP) in October 1999. The study found that San Francisco and the Bay Area is around one-fifth higher than the statewide "modest standard of living" (MSOL) cost.⁸ The CBP estimated that it would take a single parent family an hourly wage of \$21.24 to meet basic living expenses in San Francisco (annual MSOL \$44,172), compared to an hourly wage of \$17.68 to meet basic living expenses in Los Angeles (annual MSOL \$36,780).⁹
- *San Francisco's housing units are significantly older and more expensive*
Housing structures in San Francisco are much older than those in California and nationally. In San Francisco, 53% of housing structures were built in 1939 or earlier

⁴ U.S. Census Bureau, American Community Survey, 2003 Data Profile

⁵ U.S. Census Bureau, American Community Survey, 2003 Data Profile

⁶ U.S. Census Bureau, American Community Survey, 2003 Data Profile

⁷ U.S. Census Bureau, American Community Survey, 2003 Data Profile

⁸ San Francisco Department of Public Health, 2002: Overview of Health Status, p. 12

⁹ The California Budget Project, "Making Ends Meet: How Much Does It Cost to Raise a Family in California?", October 1999

(only 10% Statewide and 15% nationally were built in 1939 or earlier).¹⁰

Despite being older, San Francisco's housing stock is significantly more expensive than homes in the rest of California and the country. The median housing value in San Francisco is \$597,493, compared to \$334,426 Statewide and \$147,275 nationally.¹¹

Rents are similarly expensive: San Francisco's median rent is \$1,101, compared to \$890 Statewide and \$679 nationally.¹²

- *San Franciscans spend a higher percentage of income on housing*
38% of San Franciscans (vs. 31% Statewide and 22% nationally), spend more than 35% of their incomes on their mortgage payments.

However, renters in San Francisco pay less (as a % of income) than do renters Statewide and nationally. Only 33% of San Francisco's renters (vs. 40% Statewide and 35% nationally) pay more than 35% of their household income on rent.¹³

- *San Francisco's population is older*
Only 15% of San Francisco's population is under the age of 18, compared to 27% statewide. Almost 14% of San Francisco's population is over 65, compared to 10% statewide.¹⁴
- *San Francisco's poverty rate is generally lower than statewide and nationally. The poor in San Francisco tend to be young*
Although San Francisco's poverty rate is low (10% of individuals in San Francisco were below poverty, vs. 13% statewide and nationally), **a higher percentage of the poor in San Francisco are 65 years or older (11% in San Francisco, vs. 8% in California and 10% nationally).**¹⁵

Poverty in San Francisco is highest among youth, with the highest levels among young adults 18-24 (20%) followed by children under 18 (16%). Among households, single-parent households had much higher poverty rates than married-couple families. Non-families, which in San Francisco constitute more households than families, have poverty rates almost as high as those of non-married couple families. There are disparities in poverty rates by ethnicity, with African American and, Latino, and Asian families experiencing higher poverty rates than Whites.¹⁶

- *San Franciscans with disabilities tend to be older*
The incidence of disabilities in San Francisco's population is similar to rates

¹⁰ U.S. Census Bureau, American Community Survey, 2003 Data Profile

¹¹ U.S. Census Bureau, American Community Survey, 2003 Data Profile

¹² U.S. Census Bureau, American Community Survey, 2003 Data Profile

¹³ U.S. Census Bureau, American Community Survey, 2003 Data Profile

¹⁴ U.S. Census Bureau, American Community Survey, 2003 Data Profile

¹⁵ U.S. Census Bureau, American Community Survey, 2003 Data Profile

¹⁶ San Francisco Department of Public Health, 2002: Overview of Health Status, p. 10

statewide and nationally, except for individuals 65 years or older. In San Francisco, 44% of people 65 years or older have a disability, vs. 40% Statewide and nationally.¹⁷

- *San Francisco's overall death rate is lower than the Statewide age-adjusted death rate; however, San Francisco's incidence of certain illnesses is the highest in California*

Generally speaking, San Francisco's death rate is lower than the Statewide average (San Francisco is 11th out of 58 counties), and San Francisco has comparatively fewer deaths due to motor vehicle crashes, firearm injuries, cancer, coronary heart disease, cerebrovascular disease, and diabetes.

San Francisco has higher death rates compared to the Statewide average in the areas of unintentional injuries, homicide, suicide, and drug-induced deaths. San Francisco also has higher incidences of hepatitis C and chlamydia than the Statewide average. San Francisco has the highest incidences of AIDS (among population ages 13 years and over), tuberculosis, syphilis, and measles in all of California.¹⁸

- *San Franciscans are trying to address the visible problem of homelessness*
San Francisco's Care Not Cash program began in May 2004, cutting the welfare checks to homeless people from a high of \$410 a month to \$59 a month, giving them either a shelter bed or a permanent room instead. The number of homeless people on welfare since then has dropped 72 percent, from 2,497 to 693 today.¹⁹

A City-wide count of homeless people on San Francisco's streets, in jails, shelters, rehabilitation centers, or other emergency facilities on January 26, 2005, found 6,248 homeless, down 28% since October 2002 when 8,640 homeless were tallied. San Francisco Mayor Gavin Newsom attributed the drop to the Care Not Cash program, which has housed 690 people since last spring; the city's model Direct Access to Housing program, which put 190 homeless people into residences with intensive counseling; and vigorous outreach efforts by city social workers, who are joined one day a month by hundreds of volunteers in the mayor's Project Homeless Connect program.²⁰

According to the U.S. Census Bureau, in 2000 there were 178,638 homeless individuals in emergency and transitional shelters across the country; 27,701 (16%) of the homeless were in California. Within California, 6% of the homeless (1,539) were in San Francisco.²¹ (The highest rate of homelessness nationally was in New York State, which represented 18% of the U.S. homeless population. The highest

¹⁷ U.S. Census Bureau, American Community Survey, 2003 Data Profile

¹⁸ CA Department of Health Services, County Health Status Profiles—2004, April 2004

¹⁹ San Francisco Chronicle, "Fewer Homeless People On Streets of San Francisco," by Kevin Fagan, February 15, 2005

²⁰ San Francisco Chronicle, "Fewer Homeless People On Streets of San Francisco," by Kevin Fagan, February 15, 2005

²¹ U.S. Census Bureau, "Emergency & Transitional Shelter Population: 2000"

rate of homelessness in California was in the City of Los Angeles, represented 23% of California's homeless population.)

Appendix M: Glossary of Abbreviations

AAA	Area Agencies on Aging
ADA	Americans with Disabilities Act
ADHC	Adult Day Health Care
ADL	Activities of Daily Living
ADRC	Aging and Disability Resource Centers
ALTCI	Acute and Long-Term Care Integration
APS	Adult Protective Services
CBO	Congressional Budget Office
BHC	Behavioral Health Center
CEO	Chief Executive Officer
CDLAC	California Debt Limit Allocation Committee
CFR	Code of Federal Regulations
CHN	Community Health Network
CMO	Care Management Organization
CMS	Centers for Medicaid and Medicare Services
COO	Chief Operating Officer
CTCAC	California Tax Credit Allocation Committee
DAAS	Department of Aging and Adult Services
DAHP	Direct Assistance to Housing Program
DHS	Department of Human Services
DOEA	Department of Elder Affairs
DOJ	Department of Justice
DPH	Department of Public Health
ED	Emergency Department
FQHC	Federally Qualified Health Center
HCBS	Home and Community-Based Services
HMA	Health Management Associates
HMO	Health Maintenance Organization

HUD	Housing and Urban Development
ICF/DD	Intermediate Care Facility for persons with Developmental Disabilities
IHDA	Illinois Housing Development Authority
IHSS	In-Home Support Services
IMD	Institutions for Mental Diseases
IRS	Internal Revenue Service
JCAHO	Joint Commission on Accreditation Healthcare Organizations
LIHTC	Low Income Housing Tax Credit
LOC	Level of Care
LHH	Laguna Honda Hospital
LTC	Long-Term Care
LTCCC	Long Term Care Coordinating Council
LTCFS	Long Term Care Functional Screen
MA	Medicare Advantage
MMA	Medicare Modernization Act
MSSP	Multipurpose Senior Service Program
NF	Nursing Facility
OSCAR	Online Survey Certification, and Reporting
PMPM	Per Member Per Month
RCF	Residential Care Facility
RCFE	Residential Care Facility for the Elderly
RFI	Request for Information
SF	San Francisco
SFGH	San Francisco General Hospital
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SPE	Singe Point-of-Entry
SRO	Single Room Occupancy
SSI	Supplemental Security Income
SSP	State Supplementary Payment
STAR+PLUS	State of Texas Access Reform Plus Long-Term Care

TANF	Temporary Assistance to Needy Families
TCM	Targeted Case Management
TIERS	Texas Integrated Eligibility Redesign System
UCSF	University of California, San Francisco
UPL	Upper Payment Limit