San Franciscans for Healthcare, Housing, Jobs and Justice Statement on Sutter Health's Ending Its Provision of Pediatric and Adult Primary Care Services at the Mission Bernal Campus

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Contact: Kung Feng, Jobs with Justice SF, kung@jwjsf.org

Introduction

Sutter Health and its San Francisco affiliate CPMC no longer will operate, as of April 1, the Pediatric and Adult primary care clinics on the newly rebuilt Mission Bernal Campus, the site of the old St. Luke's Hospital. This unilateral decision marks another significant departure from the mission and legacy of St. Luke's Hospital, which for almost 150 years provided direct healthcare services to generations of San Franciscans, especially from low-income neighborhoods in the southeastern part of the city.

The San Francisco Health Commission at its March 16 meeting, in accordance with Proposition Q, will consider whether Sutter's decision to end its operation of the Pediatric and Adult Clinics will have a "detrimental impact" on healthcare services in San Francisco. Such consideration needs to be made in anticipation of long-term consequences for the accessibility and affordability of healthcare services to San Franciscans, not just short-term effects.

Sutter's proposed actions involve transferring the operation of the Pediatric and Adult Clinics to Mission Neighborhood Health Center (MNHC), which is a well-regarded Federally Qualified Health Center (FQHC) that now operates clinics in the Mission and Excelsior Districts and has a strong record of providing quality healthcare services to low-income and diverse patient populations. Sutter promises to provide for five years transitional operating subsidies in support of MNHC's expanded service responsibilities.

The potential impact of this transfer of professional organization and operational responsibilities raises crucial questions about (1) the scope and adequacy of the short-term subsidies proposed; (2) the apparent absence of any contractually enforceable plans for financial and other support from Sutter in the long term; and (3) how this specific decision comports with Sutter's pattern and practice of withdrawing from providing healthcare services to poor and low-income individuals and families, especially from racially and culturally diverse backgrounds, and affects the level and availability of San Francisco healthcare services not just now but over the long run.

DPH's Factual Analysis and the Report's Oversights as of March 2

The Department of Public Health (DPH) staff report (dated February 25, 2021) on Sutter's plan provides scant information regarding the short-term subsidies promised. The report (at p. 4) indicates that the "purpose of the five-year operating grant is to cover any losses MNHC expects to incur as they ramp up the clinics." The report then states that according to Sutter, adult and pediatric services will continue at the Mission Bernal Campus, presumably at the same clinic locations though under the operational control of MNHC, with continuing access for shared patients to additional CPMC hospital services, including women's services. Later, the report (at p. 9) references that the twenty-five Sutter employees staffing the Adult and Pediatrics Clinics have been given the option of applying for positions with MNHC. As of the report date, six physicians, one registered nurse, and a clinic supervisor had been hired by MNHC. The report provides no specific information about the terms and conditions of the agreement between Sutter and MNHC, the amount of cash subsidies and the type of in-kind contributions to be expended by Sutter, and the effects of MNHC's expansion of services and hiring of new personnel on its existing staff deployment, allocation of resources, and patient mix.

In addressing patient mix, the staff report (at pp. 4-7) focuses on the existing composition of patients served by the Adult and Pediatric Clinics, which in 2019 had, respectively, 2,173 and 4,665 patients. Because of the nature of the records available, there is only partial and incomplete information about racial and cultural background. The report provides more precise information regarding payor information. For the Adult Clinic, 37% of the patients had private insurance, and almost all others had coverage through governmental programs— 35.3% Medi-Cal and 27.2% Medicare. For the Pediatrics Clinic, the respective percentages were 43.8% private insurance, 55.7% Medi-Cal, and 0.3% Medicare.

The staff discussion of patient demographics leaves much unaddressed, and the absence of comprehensive information leads to a partial and stilted understanding of the service and financial consequences to be borne by MNHC and other San Francisco healthcare providers in the future. What changes have occurred in who receives services from the two clinics over the last decade? Are there fewer patients now than each year previously? What have been the changes, if any, in the range and level of culturally and linguistically appropriate services utilized at the two clinics over the past ten years? Has the mix of private-insured and government-insured patients changed during this period? If there has been a drop-off in the number of patients, what changes might be expected in patient service demand when the clinics are managed by an organization with deep experience in serving diverse and low-income communities, and what are the financial consequences for MNHC? In terms of serving privately insured patients, what are the likely differences in reimbursement rates when negotiated by a hospital conglomerate like Sutter and

a relatively small provider like MNHC? What is the actual significance comparatively of any offsetting financial advantages MNHC may receive as an FQHC? Depending on who the patients are, what can be expected about which hospitals they will use in the future for in-patient and specialty services, and what are the potential impacts for Zuckerberg San Francisco General Hospital? What promises beyond a five-year period, if any, have been made by Sutter to MNHC regarding subsidies and the rental use of clinic space on the Mission Bernal Campus?

The above questions bear on the adequacy of Sutter's short-term subsidies and rationales. The answers to these inquiries also go to analyzing long-term service and financial consequences resulting from the transfer in management of the two clinics for both MNHC and San Francisco's healthcare system overall.

The DPH staff report nowhere accounts for what service and fiscal issues are likely to be challenging for MNHC after five years, and in what ways Sutter may need to step-up to assure that there are not detrimental effects for healthcare services in San Francisco. Five years pass quickly. It is too short of a timeframe for analyzing the likely effects of a large, revenue rich, healthcare provider no longer offering primary care services. Sutter has the capacity but not the will to absorb the expense and service needs of medical units that lose money. MNHC is not in a comparable position to weather the uncertainties and adversities of a changing and volatile healthcare landscape. To make the case for a Proposition Q finding of no detrimental impact, Sutter has the burden to show that the Adult and Pediatrics Clinics will remain operational well beyond five years without it continuing to provide subsidies and other support.

<u>The Elephant in the Room</u>

Sutter has a long history of trying to walk away and indeed walking away from revenue losing healthcare services in San Francisco.

In proposing the rebuilding of CPMC campuses, Sutter initially wanted to close St. Luke's Hospital because of operational losses mainly due to the large number of Medi-Cal patients treated. Grassroots political pressure resulted in a change of plans that at first set forth a proposal for a likely economically unviable 80-bed replacement hospital on the St. Luke's site and a new regional "tertiary and quaternary" care hospital with 555 beds at Van Ness and Geary. Further political pressure by grassroots groups and the Board of Supervisors led to a final compromise memorialized in a 2013 Development Agreement (DA) between Sutter and San Francisco. Among other provisions including $74 million in negotiated cash community benefits paid by Sutter, the DA provided for the construction of a 120-bed hospital on the St. Luke's site, which opened in August 2018 and is now known as the Mission Bernal Campus, and a 274-bed hospital with shell space for 30 additional beds, which opened in March 2019 and is now known as the Van Ness Campus.

At the Board of Supervisors during the final stages of the land-use permitting for the new hospitals, a high-level Sutter executive stated that a rebuilt St. Luke's hospital would serve a new patient demographic who are better educated, better employed, and better insured. At the Health Commission hearing on March 2 regarding the transfer of the two clinics to MNHC, the lead Sutter representative included in her remarks that it is rare for a "tertiary and quaternary" care hospital to operate primary care clinics. She did not mention that Sutter, which includes within its organizational umbrella various separately incorporated entities, still operates primary care clinics elsewhere in San Francisco. Sutter executives have no reluctance in expressing Sutter's interests in targeting higher income populations and emphasizing exceptionally remunerative, high-end specialty services.

Fully comporting with these expressed interests, Sutter's track record, since the adoption and contrary to the spirit of the Development Agreement, reveals a pattern and practice of eliminating or reducing services primarily utilized by low-income people, particularly those on Medi-Cal. According to the DPH staff slide presentation at the March 2 hearing, Sutter in 2014 closed the 101-bed Skilled Nursing Facility (SNF) at CPMC's then California Campus. In 2017, it closed the St. Luke's 79-bed SNF and subacute care unit. And in 2018, it ceased hosting an Alzheimer's day program and administering an Alzheimer's Residential Care Facility for the Elderly as part of the closing of the California Campus. During this period, Sutter also reduced the professional staffing and the availability of bilingual services at its St. Luke's diabetes clinic. Furthermore, Sutter has contributed minimally to meeting the DA target of 1,500 new Tenderloin Medi-Cal recipients receiving primary care services at Tenderloin clinics, with follow-up hospital services as needed at preferably CPMC's nearby Van Ness Campus. As of mid-2019, fewer than 180 Tenderloin Medi-Cal recipients, as counted under the terms of the DA, have been enrolled in Tenderloin primary care clinics.

As a last example and especially relevant to the case-at-hand, Sutter's ending its administration of the Adult and Pediatrics Clinics directly implicates its obligations under the Development Agreement to establish and operate on the Mission Bernal Campus centers of excellence in senior health and community health. What are the projected short-term and long-term consequences of Sutter no longer operating the two clinics for the patient mix served and the scope, seamlessness, and effectiveness of services provided by these two new centers? The promise was that these centers would focus on neighborhood healthcare needs in southeastern San Francisco and would be innovative and comprehensive.

Sutter's *modus operandi* is to close healthcare units that lose money because the patients served are mainly not privately insured and to obscure the effects by providing limited front-end cash subsidies or other benefits when

viewed as politically necessary. The calculation is that such subsidies and benefits are a relatively small price to pay when compared to the long-term costs of continuing to operate medical units that largely serve low-income populations. Rather than doing its fair share of meeting the healthcare needs of low-income individuals and families, Sutter leaves to others, particularly taxpayer supported facilities and agencies, to deal with the service and financial demands and attendant uncertainties that result from its unilateral decisions to no longer provide or cutback on specific services.

Conclusion

The present determination—whether Sutter's action to transfer operation of the Adult and Pediatrics Clinics to MNHC will have a detrimental impact on healthcare services in San Francisco—needs to be analyzed accounting for long-term as well as short-term consequences and Sutter's pattern and practice of not doing its fair share in meeting citywide healthcare responsibilities for low-income San Franciscans.

The purposes of Proposition Q hearings are to provide the public with information and analysis and to establish a public record of the impacts of healthcare service changes initiated by hospitals. In reaching Proposition Q decisions, the Health Commission is responsible for assuring that decisions made are fully supported by the information and analysis presented. While the Commission has no authority to sanction Sutter if its actions in this instance result in a detrimental impact, the Commission does have the authority to hold the Proposition Q record open until it has all relevant information and a contextually comprehensive analysis.