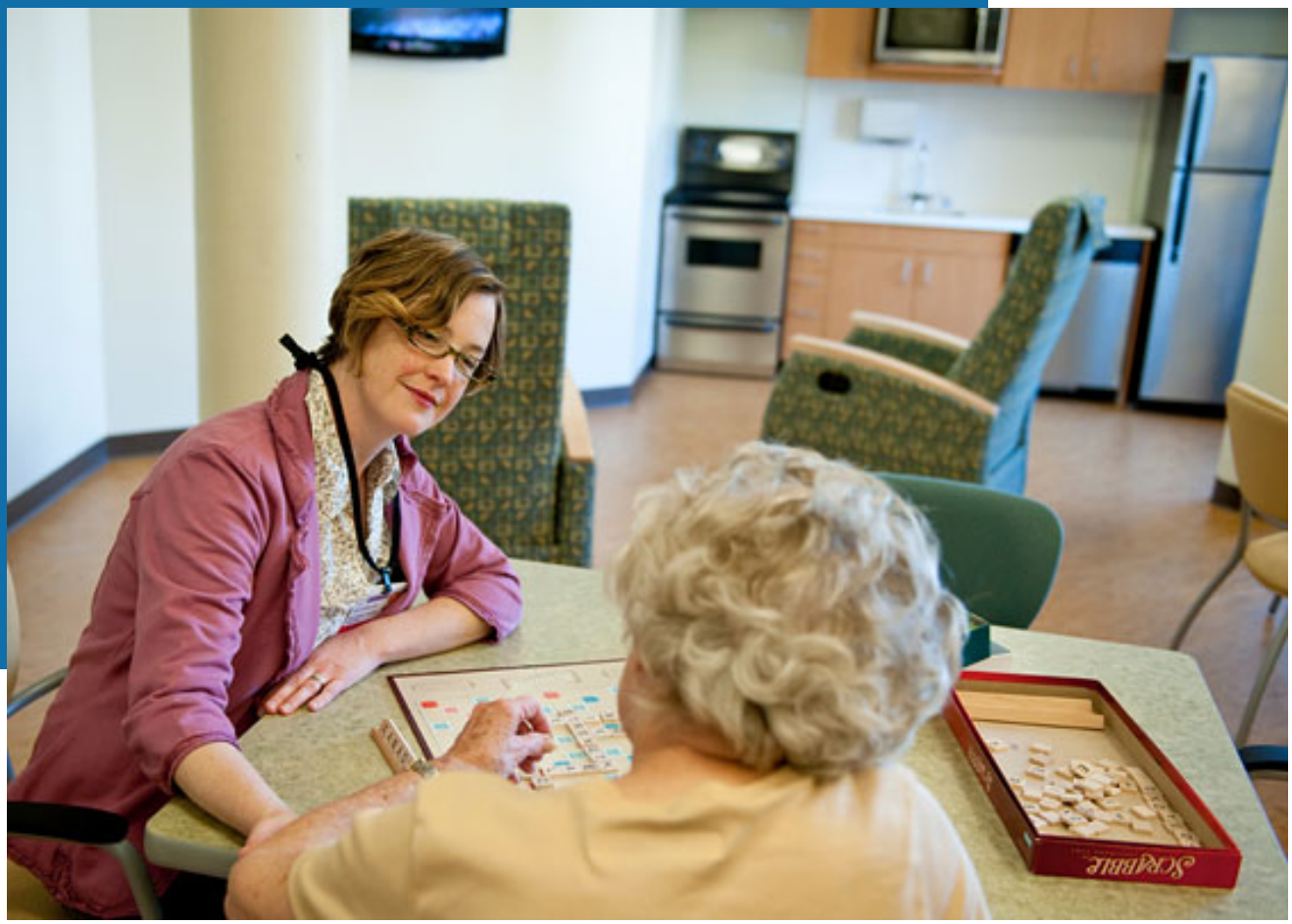


2019 COMMUNITY HEALTH NEEDS ASSESSMENT

SAN FRANCISCO
CAMPUS FOR JEWISH LIVING

Jewish Senior Living Group

302 Silver Avenue • San Francisco, CA • 94112
https://sfcjl.org/

A MESSAGE FROM THE BOARD OF TRUSTEES

On behalf of San Francisco Campus for Jewish Living and its board of trustees, I am proud to share our 2019 Community Health Needs Assessment. The board of trustees unanimously approved this report on 6/26/2019.

We continuously strive to provide excellent care and are always working to improve our efforts. We welcome your ongoing input to help us continue to improve and meet the needs of our community. To provide feedback on this CHNA, please contact Ilana Glaun at iglaun@sfcjl.org.

Sincerely,

Howard F. Fine
Chair, Board of Trustees

ACKNOWLEDGMENTS

San Francisco Campus for Jewish Living acknowledges the following individuals for their contributions to the Community Health Needs Assessment:

Alisa Berkowitz, MSW, RCFE
Program Director/Administrator
Acute Geriatric Psychiatry Hospital
San Francisco Campus for Jewish Living

Brad Crowell, MD
Chief of Inpatient Psychiatry
West-South Bay, The Kaiser Permanente Medical Group

Barbara P. Deleon, RN, MSN, CNS
Clinical Nurse Manager
Acute Geriatric Psychiatry Hospital
San Francisco Campus for Jewish Living

April Ellis, LCSW
Director of Social Services
Acute Geriatric Psychiatry Hospital
San Francisco Campus for Jewish Living

Ilana Glaun
Senior Communications Officer
San Francisco Campus for Jewish Living

Stephen Hall, MD
Associate Medical Director, Psychiatry
Acute Geriatric Psychiatry Hospital
San Francisco Campus for Jewish Living

Mario Lemay, PT, RAC-CT, RCFE-CT
Director of Organizational Effectiveness
San Francisco Campus for Jewish Living

Sonya J. Maeck, LCSW
Program Director/Administrator
Acute Geriatric Psychiatry Hospital
San Francisco Campus for Jewish Living

Craig Nelson, MD
Director of Geriatric Psychiatry
University of California, San Francisco

Lisa Dale O'Donnell, CTRS, RTC
Director of Recreation Therapy
Acute Geriatric Psychiatry Hospital
San Francisco Campus for Jewish Living

Michael Skaff
Chief Operating Officer
Jewish Senior Living Group

Elliott M. Stein, MD
Director of Psychiatry, Medical Director
Acute Geriatric Psychiatry Hospital
San Francisco Campus for Jewish Living

Michael Wiederstein, PsyD
Psychiatric Hospital Consultant

CHNA prepared by

FACENTE CONSULTING
UNDERSTAND • IMPLEMENT • TELL YOUR STORY

TABLE OF CONTENTS

WHO WE ARE

San Francisco Campus for Jewish Living (SFCJL) is a nonprofit facility for older adults committed to providing each resident and patient with quality care of body, mind, and spirit. Situated on an attractive nine-acre campus in San Francisco, we provide our older adults with on-site and off-site opportunities for enhanced living, including a wide range of life enrichment, cultural, intellectual, creative, and religious programs and activities. We are part of Jewish Senior Living Group, a growing regional network of programs, services, and communities that enrich the lives of seniors.

SFCJL's medical services are well-known throughout the Bay Area and beyond for their superb quality. Our services are highly sought after, given the limited resources in Northern California for meeting the needs of populations of older adults with special needs. Our unique and welcoming facility provides comprehensive services delivered by a compassionate, experienced medical, clinical, and allied health staff. We have several on-site specialty clinics and three specialized units:

- Short-Term and Rehabilitation Unit
- Alzheimer's Garden Unit
- Acute Geriatric Psychiatry Hospital (AGPH)

The AGPH is the nonprofit facility for which this Community Health Needs Assessment (CHNA) was conducted, in accordance with IRS Section 501(r)3. The hospital is a licensed 13-bed gero-psychiatric inpatient unit devoted to providing behavioral health services exclusively designed for older adults suffering from acute psychiatric disorders. These patients in acute psychiatric crisis require a safe environment, a structured and supportive social milieu, and an effective treatment program. What sets our hospital apart is the intimacy of the program. We provide intensive, sophisticated team-based care for our patients in a warm and caring environment. This intimacy creates an environment that allows the entire interdisciplinary team to communicate with one other in order to move our patients towards healthier outcomes. We are able to access every different professional and skill group in real time and are thus able to respond rapidly to patients' changing needs. The small size of the program allows us to truly individualize care to support the health and goals of the patient.

The hospital addresses the needs of the whole person, not just their psychiatric or mental illness. We offer:

- 24-hour nursing care and services
- Medical assessment and continuing care by geriatricians
- Physical, occupational and speech therapy evaluations
- Daily appointments with specially trained geriatric psychiatrists for therapeutic intervention, as well as medication management
- Recreation therapy to support emotional wellbeing and coping skills
- Social work services to encourage stability during the patient's stay, as well as their continued care and community connection upon discharge

> "Essentially, my goal is to ensure that older adults have access to the psychiatric and mental health services they need and deserve."
>
> *- Dr. Elliott Stein, Acute Geriatric Psychiatry Medical Director (quoted in Jewish Senior Living magazine, 2018/2019 issue)*

Additionally, the social work team's responsibilities extend beyond the patient, connecting with the patient's family and friends, case manager, and outside medical providers. The social work team gathers the patient's past hospitalization records, medical data, and collateral, so that the interdisciplinary group has the most accurate information. The interdisciplinary team strives to create a warm, home-like environment for wellness, growth and positive change, encouraging each patient's stabilization and return to baseline for discharge, thus enabling them to resume their lives at their optimal level of functioning.

During a patient's stay, the AGPH team collaborates with other community-based providers on a steady basis – from communicating prior to admission with medical professionals and outpatient services received in the past, to making sure patients are discharged with the highest level of services available to them. The social services department connects patients with outpatient services, including (but not limited to) partial hospital programs, intensive outpatient programs, home health services, housing services, medical appointments, psychiatric referrals, therapy services, and transportation services, as well as community programs such as senior centers and socialization programs. In turn, these community-based agencies continually refer eligible individuals to SFCJL's hospital.

WHO WE SERVE

Description of the Overall Target Community

Our Community:
Older adults experiencing mental health disorders

According to a recently published article in *US News and World Report,* "One in four adults ages 65 and older experiences a mental health problem such as depression, anxiety, schizophrenia or dementia, according to the American Psychological Association. And people 85 and older have the highest suicide rate of any age group…according to the National Council on Aging."[1] Eden et al.[2] estimated that 5.6 – 8.0 million U.S adults over age 65 experienced a mental health disorder (including substance use disorders) in 2010, and this number is expected to grow by 80% by 2030. A 2015 study using a nationally representative sample of adults ages 55 and older found that in the prior year, 6.77% experienced a mood disorder, 11.39% an anxiety disorder, and 3.75% a substance use disorder. In addition,14.53% experienced a personality disorder in their lifetime.[3]

Insufficient data exists to develop a scientifically sound estimate of the size of our target community in California. Based on national data, however, it is safe to say that there are at least 1 million older adults in our state with mental health disorders, although only a small subset of those will experience symptoms acute enough to require hospitalization.

Description of Our Patients

Our Patients:
Adults age 55 and older residing in California
requiring assistance for acute psychiatric needs

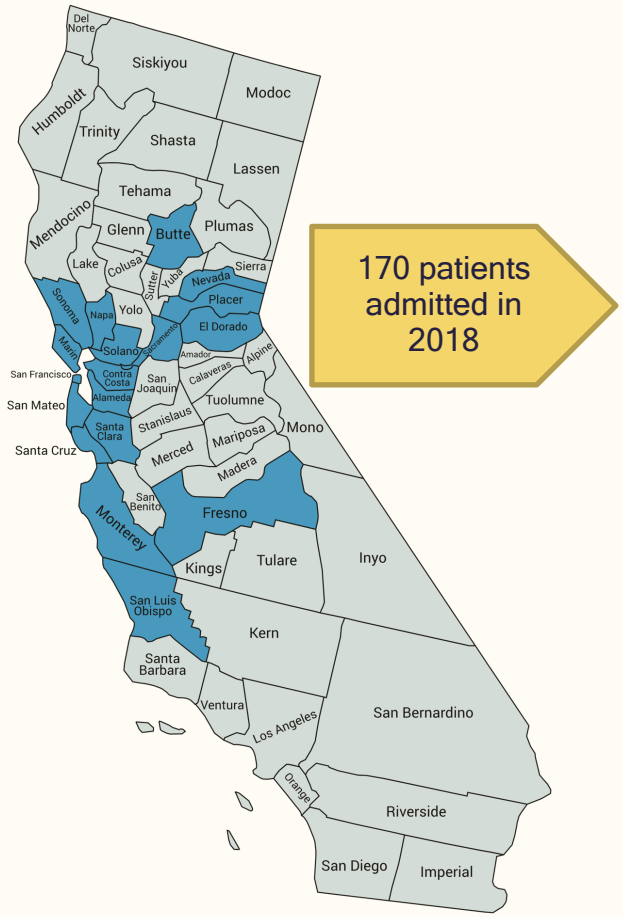
Our program provides treatment and facilitates recovery for adults aged 55 and older residing in California with acute psychiatric needs, including anxiety, depression, mood or behavioral disturbances, impairment in level of functioning, thought or other emotional disturbances, suicidality, assaultive behaviors due to a psychiatric disorder, or who are a threat to others. In 2018, 83% of our patients were admitted as 5150 or 5250 (danger to self or others, or grave disability), 15% were voluntary admissions, and 2% were under conservatorship. Our goal is to stabilize patients and provide them with the tools and resources to be able to return to community-based living.

SFCJL's acute geriatric psychiatry unit staff take pride in correctly identifying and successfully treating each patient's distinct needs, thus enabling them to safely return to their community and able to manage their care with community-based services.

As we are one of the only facilities of its kind in the region, our patients come from all over Northern and Central California. In 2018, we admitted 170 patients from 18 counties. We accept eligible patients of all racial/ethnic identities and genders. Patient demographics are shown in **Figure 1.**

The most common psychiatric diagnoses of our patients are major depressive disorder (63% in 2018), anxiety (25%), and bipolar disorder (20%). Other disorders include schizophrenia, schizoaffective disorder, psychosis, suicidal ideation, suicide attempt, panic disorder, post-traumatic stress disorder (PTSD), and obsessive compulsive disorder (OCD). In addition to having psychiatric needs, our patients are also coping with the traditional diseases of aging, including hypertension (44% in 2018), cardiovascular disease (27%), dementia and related illness (25%), type 2 diabetes (19%), atherosclerosis (16%), COPD (14%), and osteoarthritis (8%).

Figure 1. Patient Demographics and County of Residence, 2018



170 patients admitted in 2018

Demographic Characteristics	n	%
GENDER		
Male	51	31
Female	112	68
Transgender	2	1
AGE		
50-59	9	5
60-69	38	22
70-79	77	45
80-89	41	24
90+	5	3
RACE		
Asian/Pacific Islander	15	9
Black/African American	4	2
Latinx	7	4
Native American	1	<1
White	143	84
EDUCATION		
High school or less	93	55
College degree or more	77	45
INSURANCE		
Public	111	65
Private	59	35

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AND METHODS

Our Approach

The City and County of San Francisco's CHNA is conducted by the health department and overseen by the San Francisco Health Improvement Partnership (SFHIP), a multisector collaboration that includes San Francisco's hospitals. The most recent CHNA was published in May 2019. This CHNA serves as the common basis for all San Francisco's hospital CHNAs, including ours. We have supplemented the SFHIP CHNA with our own assessment of needs, due to the fact that we serve a highly specialized population and many of our patients live outside of San Francisco. The process and methods for both assessments are described below.

San Francisco Health Improvement Partnership CHNA

Process and Methods

The SFHIP CHNA involved three data collection methods:

- **Community health status assessment.** This method examined existing population level health determinant and outcome data, analyzed by age, race/ethnicity, poverty, place, and other relevant variables, in order to identify health disparities.
- **Assessment of prior assessments.** This method involved a review of reports produced by community-based organizations, healthcare service providers, public agencies and task forces. While these reports are generally produced for planning and evaluation purposes, they contain rich data on San Francisco's populations, especially those who are marginalized and vulnerable.
- **Community engagement.** Focus groups with community members and key informants/experts were held to help fill in gaps where quantitative data is sparse.

Additional detail on the process and methods used for the SFHIP CHNA can be found in the final CHNA report.[4]

Collaborators

Numerous institutions and community groups have a stake in the health of San Francisco's populations. Many of these stakeholders have come together under the umbrella of SFHIP. One of SFHIP's key activities is to conduct a CHNA every three years. The CHNA serves multiple purposes: In addition to being the foundation for San Francisco's nonprofit hospital CHNAs, it fulfills the Community Health Assessment requirement for Public Health Accreditation for the health department and it informs San Francisco's Health Care Services Master Plan. Collaborators involved in SFHIP include:

- Hospital Council of Northern and Central California (of which SFCJL and AGPH are members)
- San Francisco Department of Public Health (SFDPH)
- University of California San Francisco (UCSF)
- San Francisco Unified School District (SFUSD)
- African American Community Health Equity Council (AACHEC)
- Asian & Pacific Islander Health Parity Coalition (APIHPC)
- Chicano/Latino/Indigena Health Equity Coalition
- San Francisco Community Clinic Consortium
- San Francisco Interfaith Council
- Funders, the business sector, the Mayor's office, and other key stakeholders

A full list of collaborators can be found in the CHNA report.[4]

Acute Geriatric Psychiatry Hospital CHNA

Process and Methods

To supplement the SFHIP CHNA, AGPH implemented the following methods in June 2019:

- **Review of the literature pertaining to older adults with psychiatric disorders.** Several published book and journal articles, as well as news articles, served as sources for identifying population needs.
- **Key informant interviews with experts.** It was not feasible for us to gather direct input from patients due to the challenges inherent in conducting interviews or focus groups with patients with acute mental health disorders, including patient ability to provide informed consent and be sufficiently stable, both medically and psychiatrically, to participate.[1] In lieu of patient input, we conducted nine key informant interviews with people who represent the broad interests of our population: four geriatric psychiatrists; two geriatric psychiatry hospital program directors/administrators; one nurse manager; one recreation therapist; and one social services director. Six of the key informants were experts from SFCJL, three were from other institutions with reputable geriatric psychiatry programs, and one was an independent psychiatry consultant. Collectively, the interview participants have extensive experience and a long history of serving older adults with mental health disorders across the socioeconomic spectrum, including people of all genders and from all racial/ethnic backgrounds. Data from these interviews was analyzed using basic thematic analysis techniques.

[1] For our next CHNA, we will consider appropriate methods for collecting input directly from patients and community members.

Collaborators

In addition to our collaboration with SFHIP, we engaged Facente Consulting (www.facenteconsulting.com) to assist with the literature review, key informant interviews, and preparation of this CHNA report. Kaiser Permanente and UCSF – two of our referring partners – also collaborated with us on this needs assessment.

PRIORITY HEALTH NEEDS

Process and Criteria for Setting Priorities

The SFHIP CHNA report[4] describes the process used to prioritize health needs. In summary, in October 2018, the SFHIP Steering Committee participated in a structured, facilitated process to identify and prioritize the needs based on a review of the CHNA data. Prior to the meeting, SFHIP identified the following two criteria to screen and prioritize the health needs:

- Health need is confirmed by more than one indicator and/or data source
- Need performs poorly against a defined benchmark

The meeting was facilitated using the Technology of Participation, a method created by the Institute for Cultural Affairs that incorporates "an integrated set of facilitation methods, tools and approaches that foster authentic participation and meaningful collaboration."[5] The process began with small group discussions of the data, followed by re-convening as a large group to list all the needs identified in the small groups, cluster similar needs together, and name each cluster. The result was consensus around five priority health needs (**Figure 2**). **These five needs represent our priority health needs.**

A working group of SFCJL staff, including AGPH clinical and administrative staff, was convened in June 2019 to conduct our supplemental needs assessment, which focused on identifying the specific needs of our population within each of these five priority health needs.

Figure 2: SFHIP and AGPH CHNA Priority Health Needs

*Abbreviated as "Access to Care and Services" in remainder of document

Identified Needs from the Literature Review and Key Informant Interviews

Access to care and services

- **Under-detection and under-diagnosis.** According to interviewees, perhaps the most notable barrier to access to care is the fact that both patients and doctors often fail to acknowledge or recognize the existence of a mental health disorder in older adults. A multitude of clinical, psychosocial, and systems-level factors contribute to this problem. As people get older, health of the mind, brain, and body become much more intertwined, and medical conditions may manifest as psychological or behavioral symptoms and vice versa. When patients present in primary care settings, doctors may fail to recognize mental disorders, or treat only the physical symptoms.[1] In addition, mental health stigma can prevent older adults from seeking care or even believing they have a condition requiring care.[6] Many older adults are residing in isolated living conditions, and unless they reach out, months and years can go by without anyone noticing the person is experiencing a mental disorder. One interview participant characterized this phenomenon as a "donut hole" – patients' mental health needs are often recognized only if they access behavioral health resources, yet the nature of psychiatric illness prevents patients from doing just that. One interviewee described it thusly: "People crash and burn in their homes. So then you see the onset of depression, agoraphobia, hoarding, and all the things you see on TV, but by the time it is recognized they need help, they need help at a higher level than is desirable."

> "People crash and burn in their homes. So then you see the onset of depression, agoraphobia, hoarding, and all the things you see on TV, but by the time it is recognized they need help, they need help at a higher level than is desirable."
>
> *-Key informant*

- **Insufficient psychiatric resources to meet the complex care needs of this growing population.** Both the literature and key informants highlighted the growing concern about the future availability of psychiatrists in general, and geriatric psychiatrists and other geriatric mental health professionals in particular [cite]. With a growing older population and a worsening shortage of providers, it is estimated that by 2030 there will be only 1 geriatric psychiatrist for every 6,000 patients.[1,6] This provider shortage is already acute in some counties. For example, Sonoma County employs only two geriatric psychiatrists each of whom works only one day a week and one of whom does not accept Medicare. Therefore, one county psychiatric nurse is left to absorb 25 new cases each month in addition to their current caseload. Yet the geriatric mental health specialty is essential for successful treatment of this population, according to key informants, due to the complex interactions between medical and psychiatric illnesses and the experience it requires to be

able to effectively manage these patients. It is for this very reason that geriatric psychiatry is one of the few psychiatry subspecialties with certification.

Another complicating factor is the dearth of appropriate facilities for acute psychiatric care. To our knowledge, there are only three acute geriatric psychiatry facilities in Northern California – our hospital (13 beds), Seton Medical Center (20 beds) and Fremont Hospital (16 beds). The census at these facilities is virtually always full. Our facility often has to decline admissions because we are at capacity. Although there are alternatives, they lack many of the specialized services. For example, one interview participant pointed out that general psychiatric units may be able to address psychiatric needs of older patients but are frequently ill-equipped to deal with the complex medical issues that accompany aging. In addition, general psychiatric units do not have the same level of nursing support as a geriatric psychiatric facility, and they may not be able to take patients with walkers/wheelchairs because of the risk of them being used as weapons.

The bottom line, according to interviewees, is that acute geriatric psychiatry facilities are the single most effective place for older patients with mental health disorders to get a full and accurate assessment, diagnosis, and care plan that considers the whole person. The acute inpatient setting presents a rare opportunity to fully assess and treat patients, over the course of weeks and months, giving them a real chance at successful community living post-discharge. In Northern California, only 49 patients at a time have access to this service.

- **Societal and internalized stigma.** Further complicating the picture are individual and societal attitudes and beliefs that compromise access to mental health care for older adults. Societal stigma related to aging and mental illness manifest in beliefs among older adults that prevent them from seeking care.[6] Common beliefs include that people should handle their mental health problems by themselves and that depression is simply an inevitable art of the aging process and not an illness.[2] As a result, a high percentage of people experiencing symptoms of a mental disorder do not perceive a need for services.[2]

  On a systems level, age-related stigma contributes to the paucity of mental health services for this population. One key informant pointed out that the elderly are simply not seen as a priority for resources, the same way that, for example, children and youth are seen as a priority.

- **Financial barriers to care.** Although the Affordable Care Act generally expanded access to health care and required insurers to cover mental health services, covered mental health services are sorely inadequate, often requiring patients to pay high out of pocket costs in the form of co-pays or to seek costly out-of-network care.[2] Even more problematic for elderly patients is that many psychiatrists do not accept Medicare, which several key informants noted as a key barrier to access.

- **Lack of medication adherence support.** Interview participants indicated that patients stopping their psychiatric medications is a very common precursor to a crisis situation resulting in hospitalization. In addition to practical barriers (such as inability to get to the pharmacy), the psychiatric conditions themselves can lead a patient to discontinue their medications. Daily adherence support and continual assessment and removal of barriers to adherence would benefit many patients when they are living in the community setting, and likely prevent many hospitalizations, but the resources available are simply insufficient to meet the needs.

- **Lack of access to transportation.** Key informants and the literature noted lack of transportation as a barrier.[2] Public transit, which seniors rely on, is poor in most of the counties where our patients live. Yet transit is critical for maintaining health. Without transit options, patients are left with fewer options for getting to the doctor and picking up medications. While lack of transportation options is a barrier for many populations, for this population even small barriers can be daunting to deal with, and the consequences of not being able to maintain care and treatment are potentially more severe.

Food security, healthy eating, and active living

- **Insufficient community resources for nutrition/exercise.** In general, according to interviewees, there are insufficient community-based resources to meet the needs of older adults with mental disorders. This also holds true for nutrition and exercise resources. Given the interconnectedness of mind and body in this population, healthy eating and active living are particularly important.

- **Psychological and practical barriers to food access.** Food security is also an issue for some elderly patients with mental disorders. Interviewees stated that psychiatric symptoms can manifest in refusing food, or in an inability to manage simple but important tasks such grocery shopping. Many in this population live on fixed low incomes, thus increasing vulnerability to food insecurity.

Housing security and an end to homelessness

- **Insufficient supply of appropriate housing options.** There are numerous options for senior living: independent living; assisted living; skilled nursing facilities; boarding houses; and other congregate living arrangements. Yet many of these settings in the Bay Area and Northern California, according to interviewees, are already at maximum capacity, and even if they were not, they are not always appropriate for this particular population. Older adults with mental health diagnoses need ongoing daily practical and emotional support – the kind of support that is only available in a supportive housing living arrangement, which is very difficult to find in the Bay Area. AGPH clinical and social work staff noted that in many counties, psychiatric emergency services have become de facto housing; patients

are not supposed to stay longer than 24 hours, but when there is nowhere to discharge them, they end up staying days and sometimes even weeks.

- **Ongoing vulnerability to losing housing.** Elderly patients with mental health disorders are particularly vulnerable to losing their housing. In some cases, this happens because they cannot be discharged to home after an inpatient hospital stay, if it is determined that they would not be able to manage independent living or if there are safety issues. Because housing is in such demand, patients in some congregate living situations who need to be admitted to our hospital risk losing their slot and have to be discharged elsewhere. The high cost of living in California, and in the Bay Area in particular, may also force people out of their homes and into unfamiliar communities where they are likely to become isolated. Conversely, seniors may get "stuck" in a home or apartment because they have been there for decades and it is affordable, but as their family and friends have moved away, they become isolated.

- **Housing situations that foster isolation and psychological and physical deterioration.** One interview participant explained that many seniors, especially in San Francisco, live alone without nearby family, friends, or neighbors to check in on them regularly. This type of isolated living situation can be extremely dangerous for someone with a diagnosed or undiagnosed mental health disorder. It is not uncommon for the full impact of an individual's mental state to be discovered only when Adult Protective Services gets involved and the person is in crisis.

Safety from violence and trauma

- **High rates of suicide.** In 2018, nearly one third (31%) of AGPH's patients were admitted with suicidal ideation or a recent suicide attempt. According to one study, suicide rates increase during the life course and are as high as 48.7/100,000 among older white men in the U.S. – approximately four times the national rate.[7]

- **Unsafe home environments.** As mentioned earlier, home environments may not be safe for some patients, and they cannot be discharged to home. In some cases, safety issues are related to the person's mental health disorder (e.g., living in unsanitary conditions due to hoarding). In other cases, there may be abuse or neglect.

- **Physical vulnerability in inpatient care settings.** When patients needing inpatient acute geriatric psychiatry care cannot get into a specialized facility, they may end up in a general psychiatric unit. This is a vulnerable situation for elderly patients, according to one interviewee, because they are likely to be with younger, stronger people who may act out violently due to their own psychiatric illness.

Social, emotional, and behavioral health

- **High levels of social isolation and emotional distress.** Older adults inevitably experience life circumstances that put them at risk for social isolation and emotional distress. As one interviewee stated, "People often later in life are experiencing a great deal of loss, becoming more and more isolated as their peers die or they have to move away, and they have less support in the community. And less internal resilience to cope with and manage that." Anxiety, depression, and other psychological symptoms can develop in these circumstances. In addition, the risk of death is increased for isolated older adults. One study found that perceived isolation accounts for a 26% increase in mortality in this population.[1]

"People often later in life are experiencing a great deal of loss, becoming more and more isolated as their peers die or they have to move away, and they have less support in the community. And less internal resilience to cope with and manage that."

-Key Informant

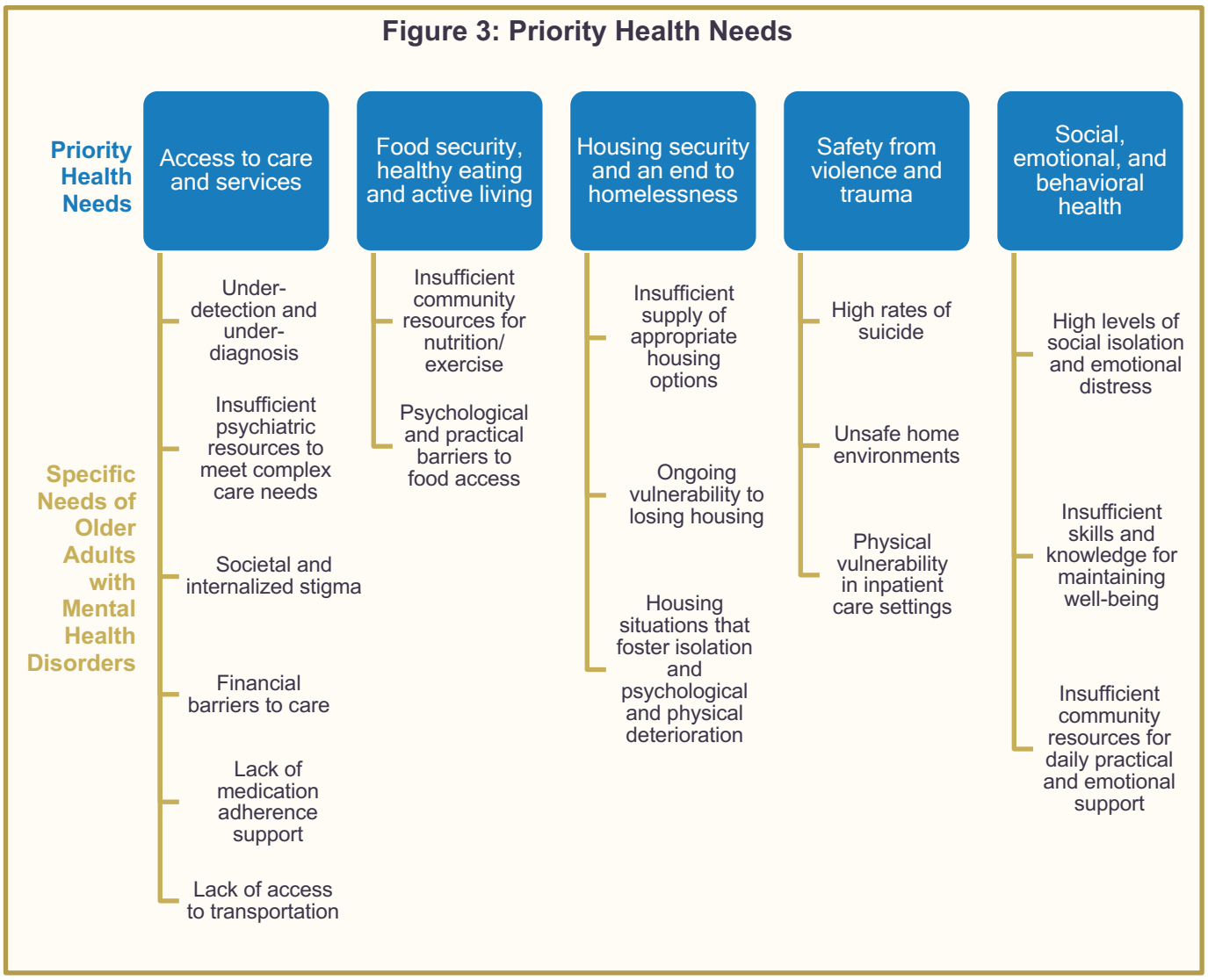
- **Insufficient skills and knowledge for maintaining well-being.** As with any illness, people with psychiatric disorders benefit from some degree of self-management. When patients do not have basic skills for relapse prevention, or knowledge about their diagnosis and medications, they are at risk for an unsuccessful transition back to community living after a hospital stay.

- **Insufficient community resources for daily practical and emotional support.** The one need that nearly all participants highlighted in some way was the insufficient availability of the community supports needed to effectively manage this population outside of a hospital setting. AGPH has nearly 200 referral relationships with community organizations all over Northern California; yet, the one thing that most patients need is daily practical and emotional support, and this is not even close to being universally available. One interview participant gave a hypothetical but representative example of a patient who leaves the hospital armed with a bag of medications, new coping skills, and a follow-up doctor's appointment already scheduled. On the way home, the patient loses his eyeglasses and is therefore unable to read the labels on his medication. He guesses at which medications to take and at what doses, and his mental stability begins to deteriorate. As a result, he cannot go grocery shopping or clean. Not eating further affects his mental state, and the unsanitary conditions put him at risk for infections. Before too long, he is back in the hospital. This situation is preventable, but it requires intensive daily monitoring and support services, which are currently insufficient.

Final Priority Health Needs

Figure 3 shows the five priority health needs, highlighting the specific needs of older adults with mental health disorders derived from our CHNA process.

Figure 3: Priority Health Needs



RESOURCES AVAILABLE TO ADDRESS NEEDS

Resources Available on Campus

We are fortunate to be co-located with numerous clinical and support services on our nine-acre campus. Patients have access to pain management services, care planning, dental care, pharmacy, optometry, audiology, physical rehabilitation, occupational therapy, nutrition counseling (all AGPH patients see a dietician within 72 hours of admission), and a host of social, spiritual, and enrichment opportunities. All these services help to socialize patients and reduce their sense of isolation. We also offer individualized patient education and skills-based groups to strengthen patients' coping skills in preparation for successful post-discharge community living.

Community Resources Available in Patients' Home Counties

In 2018, 57% of our patients were discharged to their home or a family member's home, and 26% were discharged to an assisted living or skilled nursing facility. Patients are also discharged to other hospitals or inpatient facilities, and on rare occasions, to motels or homeless shelters. Given the variety of discharge settings, individual patient needs, and the numerous counties that our patients call home, it is essential that we collaborate with community-based providers on a steady basis from the time a patient is admitted throughout the course of their stay to ensure a successful transition to community living. We maintain collaborations with nearly 200 community-based programs from nearly every county in Northern California. Our social services department uses these resources to develop a tailored discharge plan for each patient. Examples of community-based resources include (but are not limited to):

- Partial hospital programs
- Intensive outpatient programs
- Home health services
- Housing services
- Therapy services
- Transportation services
- Senior centers and other socialization programs

Careful discharge planning and the use of these referrals can help reduce patient isolation post-discharge.

Community Benefits Resources

A commitment to excellence in service to others and providing exceptional care to frail vulnerable seniors, including charitable support, is SFCJL's founding focus and remains key to its mission – to enhance and enrich older adults' quality of life. As such, SFCJL dedicates substantial resources to services, training, research, and other activities that benefit the larger community of older adults in the Bay Area. Many of these resources help to address some of

the needs identified in this assessment. For example, we are in the process of expanding our campus to create the nonresidential, membership-based, community-wide Byer Square, the organization's forthcoming new hub of wellness and activity. We are broadening the continuum of living options, offering independent living, assisted living, and memory care and support for the surging population of seniors, as well as developing senior-oriented services that will address this cohort's changing and unmet needs. This expansion is designed to benefit the entire Bay Area community. Our extensive and close partnerships with numerous organizations have allowed us to help shape and expand the resources and service networks that are so critical for the health and well-being of seniors. In addition, since 2012, the AGPH has served as a training site for future geriatric psychiatrists and provides clinical training and internship opportunities to mitigate the current and future provider shortages.

EVALUATION OF PREVIOUS IMPLEMENTATION STRATEGY

This report represents the first CHNA and implementation strategy in which our hospital conducted assessment, prioritization, and implementation plans beyond SFHIP's activities. SFHIP's 2017 evaluation of its implementation strategy can be found here:

https://sfcjl.org/pdf/SFHIP-Annual-Report.pdf

Our implementation strategy to meet the needs identified in the 2019 CHNA is in development. Some highlights are provided below.

Access to care and services

As stated above, SFCJL is making significant progress with the redevelopment of its campus to serve a significantly broader range and a much larger number of the Bay Area's growing older adult population (as well as their families and caregivers) than it does currently – either on its campus or in individuals' own homes and the community. SFCJL is also actively involved in San Francisco's Post-Acute Care Collaborative, the city-wide advisory board for health care working to develop comprehensive and actionable solutions to the city's urgent post-acute care access and other challenges.

In addition to SFCJL expanding access to our general services, our hospital also addresses access barriers. For example, all patients are discharged with extensive resources for continued success in the greater community, including pre-set initial primary care and psychiatry appointments, and other appointments as warranted. We conduct educational outreach to community facilities and programs to dispel the stigma of psychiatric need as well as to put a human face to the process of inpatient psychiatry. We meet with patients and their family members to decrease the stigma and myths around individual patient's symptomatology and increase success when returning to the community.

To help address the dwindling availability of providers specializing in geriatric mental health, we serve as a training site for future geriatric psychiatrists. Exemplifying this valuable opportunity, SFCJL's geriatric psychiatry department and the University of California, San Francisco's department of psychiatry continue their program of training and medical education for doctors in their fifth year after medical school graduation fulfill part of their specialty training in geriatric medicine and geriatric psychiatry. Additionally, a fourth-year psychiatric resident from CPMC benefited from a six-week training at the campus's psychiatry hospital. Learning opportunities are not limited to the field of geriatric psychiatry, however. The expertise and experience of the acute geriatric psychiatry hospital's staff lends itself to the training of students (from multiple community and regional educational institutions) in the areas of social work and recreational therapy as well. Opportunities to expand SFCJL's

geriatric psychiatry training program to other Bay Area medical teaching institutions continue to be explored.

In order to address financial barriers to care among this frail, elderly population who have very little or no financial resources, our admissions policy facilitates admission to the neediest, regardless of their ability to pay. For fiscal year ending June 30, 2018, 95% of our long-term care residents are financially compromised and/or Medi-Cal recipients, or without the ability to pay the full cost of care. Sixty-nine percent of our long-term care, short-term rehabilitation, and acute geriatric psychiatry patients fall into this category.

Food security, healthy eating, and active living; and Housing insecurity and an end to homelessness

AGPH social services staff continually assess patient needs around food and housing. All hospital patients see a nutritionist within 72 hours of admission. We maintain an extensive database of housing options in the different counties we serve. Our team tailors individualized discharge plans that can increase supports within the home (e.g., in-home supportive services, meal delivery programs). Although only a handful of our patients are homeless, these patients are more likely to relapse; social services staff make special effort to connect all homeless patients to housing and case management services to reduce the chances of readmission. Because we maintain active relationships with housing providers, we rarely have to discharge patients to shelters or motels, which is a significant accomplishment in a region with such an acute housing crisis.

Safety from violence and trauma

A large percentage of our hospital patients have either attempted suicide or experience suicidal ideation. Our hospital provides a haven to support these patients during their crisis, stabilize them, and treat their psychiatric symptoms. Physical safety is promoted by being in a location with other seniors, as opposed to a general psychiatric unit where they may be vulnerable to other younger and stronger patients' violent behavior.

Social, emotional, and behavioral health

AGPH places a particular emphasis on building patient's capacity for resilience. Each patient undergoes an extensive needs evaluation during their stay. The treatment team works with the patient to plan for continued social and emotional well-being upon discharge, including self-care strategies and making linkages to community-based mental health and social programs that best fit their needs and level of function. To inspire healthy living, patients are encouraged to take part in as many groups as appropriate to their medical/psychiatric issues while at the hospital.

CONCLUSION

San Francisco Campus for Jewish Living has been dedicated to improving the lives of Bay Area seniors for nearly 150 years. We are committed to our long tradition of service to the entire community and, in particular, the underserved. This CHNA reveals that older patients with mental health disorders are one of the most underserved groups in our community. We are proud that our Acute Geriatric Psychiatry Hospital plays such a significant role in meeting the clinical and service needs of our patients, while also educating and training the next generation of geriatric psychiatry providers. As the population grows and the demographics shift, the needs of our elderly residents, patients, and community members are continually changing. SFCJL and our hospital are dedicated to meeting the challenges of the future.

REFERENCES

1. Newman K: A look into older adults' state of mind. U.S. News and World Report, October 11, 2017. (https://www.usnews.com/news/best-states/articles/2017-10-11/older-adults-struggle-to-get-adequate-mental-health-care)
2. Committee on the Mental Health Workforce for Geriatric Populations; Board on Health Care Services; Institute of Medicine; Eden J, Maslow K. Le M, et al., editors. The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands? Washington (DC): National Academies Press (US); 2012 Jul 10.
3. Reynolds K, Pietrzak RH, El-Gabalawy R, Mackenzie CS, Sareen J. Prevalence of psychiatric disorders in U.S. older adults: findings from a nationally representative survey. *World Psychiatry*. 2015;14(1):74-81.
4. San Francisco Community Health Needs Assessment 2019. (https://drive.google.com/file/d/1tHNl4BKq7nR4r_TunKaMh9nVFr3NR3FH/view)
5. Institute for Cultural Affairs. Technology of participation (ToP). (http://www.ica-international.org/icas-technology-of-participation-top/)
6. Struble LM. The Challenges of Hospitalized Older Adults with Psychiatric Disorders. J Intensive & Crit Care 2016, 2:1.
7. Conejero I, Olie E, Courtet P, Calate R. Suicide in older adults: current perspectives. *Clin Interv Aging.* 2018;13:691-699.