2022 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 2022 Community Health Needs Assessment.

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 Peggy Cmiel at pcmiel@sfcjl.org.

Sincerely,

David Lowi
Chair, Board of Trustees

ACKNOWLEDGMENTS

San Francisco Campus for Jewish Living acknowledges the following individuals for their contributions to the 2022 Community Health Needs Assessment:

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CHNA prepared by

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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 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 specialized units:

- Short-Term and Rehabilitation Skilled Nursing Units
- Long-Term Care Skilled Nursing Units
- Alzheimer's Garden Unit
- Acute Geriatric Psychiatry Hospital (AGPH)
- Assisted Living
- Memory Care

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 another 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

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.

> **"We are committed to the care and treatment of older adults experiencing a mental health crisis."**
>
> *- Dr. Stephen Hall, Medical Director, Psychiatry; Clinical Professor of Psychiatry, UCSF*

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.

The COVID-19 pandemic has had a profound impact on older adults experiencing mental health disorders and has greatly affected those we serve. A recent article by Hwang et al. stated that the "pandemic has illuminated the pre-existing threat to well-being that older adults frequently experience with social isolation and loneliness."[4] They noted that no aspect of normal societal functioning was spared from COVID-19 and that the measures necessary to prevent COVID-19, such as quarantine and social distancing, also led to elevated levels of loneliness and social isolation, which in turn produced physical and mental health-related repercussions. As a result, older adults, who have experienced an acute, severe sense of social isolation and loneliness have potentially serious mental and physical health consequences. The authors warn that the impact may be disproportionately amplified in those with pre-existing mental illness, who were often suffering from loneliness and social isolation prior to isolation imposed during the COVID-19 pandemic public health measures.

Another recent study of elderly psychiatric patients found that patients with depression, higher psychiatric illness severity, and less social contact were more affected by the current COVID-19 pandemic. Utilization of psychosocial support services decreased during the pandemic despite a high demand for support reported by elderly patients.[5] The authors noted that depression in the elderly is linked to lower resilience, i.e., "a decreased ability to protect one's mental health when confronted with stressors." They speculated, therefore, that patients with depression may be less able to handle isolation, uncertainty, and other demands during the pandemic.

An article by Vahia posited that older adults are also more vulnerable to social isolation and loneliness because 1) they are functionally very dependent on family members or supports by community services, and 2) because they are at a higher risk of negative outcomes from COVID-19, older adults may self-restrict their activities and interactions even beyond the general population.[6] This appears to trigger "increasing isolation and loneliness, disrupting daily routines and activities, and changed access to essential services such as doctor's visits."

Webb states that the management of COVID-19 lockdown presented a perfect storm for mental distress for older people "by enforcing isolation and heightening perceptions of risk of death and illness."[7] Older people will experience social isolation for the longest period because they carry the highest mortality. And finally, Sepúlveda-Loyola and colleagues published a study on the mental and physical effects of social isolation on older people due to COVID-19. Their study found that older people experienced high levels of anxiety, depression, poor sleep quality, and physical inactivity from COVID-19-imposed social distancing.[8]

The mental health impacts from COVID-19 of fear and isolation among older adults, and particularly older adults with psychiatric illnesses, have been widely documented. In addition to experiencing these negative impacts more frequently than younger adults, older adults often have fewer resources to mitigate them. Therefore, each of the priority health needs identified in this CHNA have been exacerbated by COVID-19.

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 2021, 80% of our patients were admitted as 5150 or 5250 (danger to self or others or grave disability), 19% were voluntary admissions, and 1% 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 manage their care with community-based services.

Because there are few geriatric psychiatry hospitals in the region, our patients come from all over Northern and Central California. In 2021, we admitted 205 patients from 21 counties and one from out of state. 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 (57% in 2021), psychosis (12%), and bipolar disorder (24%). Other disorders include paranoid schizophrenia, schizophrenia, schizoaffective disorder, suicidal ideation, suicide attempt, and panic disorder. In addition to having psychiatric needs, our patients are also coping with the traditional diseases of aging, including hypertension, cardiovascular disease, dementia and related illness, type 2 diabetes, atherosclerosis, COPD, and osteoarthritis.

Figure 1. Patient Demographics and County of Residence, 2021

205 patients admitted in 2021

Demographic Characteristics	N=205	%
GENDER		
Male	67	33
Female	138	67
Transgender	0	0
AGE		
50-59	4	2
60-69	33	16
70-79	116	57
80-89	43	21
90+	9	4
RACE		
Asian/Pacific Islander	16	8
Black/African American	11	5
Latinx	13	6
Native American	0	0
White	165	80
INSURANCE		
Public	110	54
Private	95	46

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 City and County of San Francisco CHNA was published in May 2019. This CHNA serves as the common basis for all San Francisco's hospital CHNAs, including ours. In 2019, we 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. And, in June 2022, we updated our CHNA, and the findings are described in this document. The process and methods for the 2019 SFHIP CHNA, our 2019 CHNA, and our 2022 CHNA update 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.[9]

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.[9] SFHIP anticipates it will release their 2022 CHNA later in the year, after the due date for our CHNA; therefore our 2022 supplemental CHNA is still based on the 2019 SFHIP CHNA.

Acute Geriatric Psychiatry Hospital CHNA

Process and Methods

To supplement the SFHIP CHNA, AGPH implemented the following methods in June 2019 and again in June 2022:

- **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. (Of note, in 2019, we were considering creative methods for collecting input directly from patients and community members and had hoped to incorporate the direct community voice in the 2022 CHNA. In early 2020, the COVID-19 pandemic forced us to postpone those plans. We hope to be able to reconsider direct input from patients and community for our next CHNA.) In lieu of patient input, we conducted nine key informant interviews in 2019 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. Key informant interviews with five experts were conducted again in June 2022 to review and confirm the priority

health needs. These key informants included four experts from SFCJL as well as the medical director of another adult psychiatric hospital clinic in San Francisco. 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 racial/ethnic backgrounds. Data from these interviews was analyzed using basic thematic analysis techniques.

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. UCSF, one 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[9] 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."[10] 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.

A working group of SFCJL staff, including AGPH clinical and administrative staff, was initially convened in June 2019 and again in June 2022 to conduct our supplemental needs assessment, which focused on identifying the specific needs of our population within each of the SFHIP-identified health needs. **The five needs in Figure 2 represent AGPH's priority health needs.**

Figure 2: SFHIP and AGPH CHNA Priority Health Needs

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

Impact of COVID-19 on the Acute Geriatric Psychiatry Hospital's patients and staff

Any discussion of the priority health needs faced by older adults with psychiatric disorders must begin by recognizing the profound impact of the COVID-19 pandemic. COVID-19 has caused extraordinary challenges for health care systems across the world including the AGPH. Keeping front line workers and patients safe, securing protective equipment, developing testing protocols, and helping patients and families deal with the isolation needed to stop the spread of the virus all took priority as the pandemic took hold. However, as our medical director, Dr. Stephen Hall, noted, the treatment and prevention of COVID-19 as an infectious disease is in direct conflict with how the mental health needs of our patients should be addressed. Isolation, social distancing, telemedicine, remote meetings, and limits to visits with family and peers, for example, are all needed to address and prevent COVID-19 but are in direct opposition to the standard of care, protocols, and methods to treat mental illness.

> "All of this has been very fatiguing. We're looking forward for a spring day when we don't have to do this. You're trying to communicate with a patient and you're dressed up in multiple layers of PPE. It becomes very difficult to navigate."
>
> *-Key informant*

> "For some patients having remote options is the same as not having options at all. It's disturbing that some of these mental health support programs are now only remote because it means that a large segment of the elderly population are not able to access the programs, so patients are not being helped at all."

Since March of 2020, the AGPH has had to adapt to changing requirements from the San Francisco Department of Public Health in terms of visitor restrictions as well as quarantine and isolation requirements for patients and staff after exposure to or infection with COVID-19. One key informant reported that the AGPH had at least three episodes in a red zone for the unit due to exposure of COVID-19 or positive cases. "We had to change our whole program. We were no longer able to do group meetings, patients had to stay in their rooms and receive individual treatment." For our unique population, COVID-19 policies and procedures were extremely anxiety producing. Group therapy and meetings, recreational and occupational therapy, and other forms exercise or socialization were strictly curtailed. Additionally, the geriatric care workforce has been hard hit by the stresses of COVID-19 and social inequities for themselves and their patients. Our staff were challenged with operating under these sub-optimal conditions and these stressors have led to trauma, anxiety, and grief among our staff and colleagues. Even the necessity of wearing personal protection equipment (PPE), such as masks, made it difficult for some of our elderly patients with vision and hearing impairment to see and understand their providers. While other medical clinics may have been able to pivot to telemedicine options, many elderly patients do not have the technologic ability to navigate

> "What we just talked about sounds really negative, but we are still here …our tight-knit group of staff is dedicated to their work and their patients and, in spite of these extreme challenges, has done an exceptional job to meet our goals and meet the need of the community."
>
> *-Dr. Stephen Hall*

telemedicine or remote visits. Family and peer support to assist patients were also limited due to shelter-in-place requirements or simply from fear of socializing and gathering due to COVID-19 risks. This has had implications for patients while in our care as well as post-discharge when they need home assistance or support from other community services.

Our training programs for psychiatric nurses, medical residents, and interns were also restricted due to COVID-19, creating staff shortages and limited resources and, as a result, more work and stress for the remaining staff. In addition, curtailing the training programs impacted our community benefits goals of knowledge sharing and serving as a training site for future geriatric psychiatrists and nurses. As a result of COVID-19, many of our intended plans, laid out in our 2019 CHNA and 2020 Implementation Strategy, were not able to be started or implemented (see Implementation Strategy Evaluation section later in this document.) Further examples of the impact on COVID-19 on patients, staff, and community partners as they related to the five priority health needs are noted in the following sections. For nearly all of the identified needs, COVID-19 exacerbated the already existing gaps and disparities in care faced by geriatric psychiatric patients. Nevertheless, it is important to emphasize that, in the words of the AGPH medical director Dr. Stephen Hall "…we are still here…our tight-knit group of staff is dedicated to the work and their patients and, in spite of these extreme challenges, has done an exceptional job to accommodate our goals and meet the needs of the community."

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.[11] 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." A 2022 key informant stated that staff had observed deterioration in the cognition of people who were isolated because of fear of COVID-19.

"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. 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.[1,11] This provider shortage is already acute in some counties. 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 due to lack of 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.[11] 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. One key informant noted an unanticipated benefit of COVID-19 in relation to Medicare. There was a change in Medicare coverage to allow for some psychiatric services to be provided in the home (e.g., permission to have telehealth appointments). This opened a door for some patients who did have access to the necessary technology to receive care that they might have otherwise been unable 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. Many patients rely on family members to manage medications including picking up from pharmacies and helping to remind and administer medications at home.

COVID-19 restrictions on visiting and fear of infection or transmission severely limited family support and further exacerbating the lack of medication adherence support available.

- **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 and, with COVID-19, fear of utilizing public transportation even where available also increased. 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. Climate change, rising temperatures, and the wildfires across California have also affected many seniors. People have lost homes and other community resources due to the fires. One of the key informants stated that referrals from Sonoma County have increased for people who have had recent changes in their housing situation as a result of the fires. And seniors, particularly those with limited resources, are highly affected by the heat, often without the means to adequately air condition or access a cooling center. The key informant noted that they have seen more patients acting out behaviorally due to fear and anxiety during periods of extreme heat. Fear of COVID-19 also makes cooling centers less appealing.

Safety from violence and trauma

- **High rates of suicide.** In 2021, over 25% 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.[12]

- **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. Living situations where patients could not distance themselves from roommates or family members who had COVID-19 or had been exposed could cause stress and fear of infection. On the other hand, distancing and

> "For the older adult Asian population in particular who've been targeted in the area, there's been an increased in anxiety because they just don't feel safe going out into the community."
>
> *-Key Informant*

isolation from roommates and family members was also stressful. Another consequence of COVID-19 has been the increase in violence experienced and feared among Asian seniors in the San Francisco Bay Area. One key informant commented on the fear her patients have expressed about leaving their homes and the increased stress and anxiety they feel for their safety.

- **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. The impact of COVID-19 on social isolation is obvious and profound. This already vulnerable population experienced increased isolation during periods of shelter-in-place and when their support systems also isolated. 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. The reliance on telemedicine and other forms of remote access to clinicians, which was successfully implemented in some settings as a response to COVID-19, has proven to be another barrier to care and support

> "One major contributing factor for the mental illness observed was isolation due to COVID."
>
> *-Key Informant*

to older patients with psychiatric disorders in many instances. Many community support systems that successfully transitioned to remote services for COVID-19 have adapted this approach to continue in the future, which will present further barriers to some patients.

- **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. Resources have become even more limited during COVID-19 with some closing permanently and other others cutting back on services. Additionally, some organizations have transitioned to remote services that in effect render them inaccessible to patients without the technical capability to navigate. One key informant specifically mentioned that partial hospitalization programs have largely shut down or have become fully remote. Another 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. Additionally, with COVID-19 restrictions and fear, visits from family members, who often assume these support tasks, have been limited which reduces resources for practical and emotional support even further.

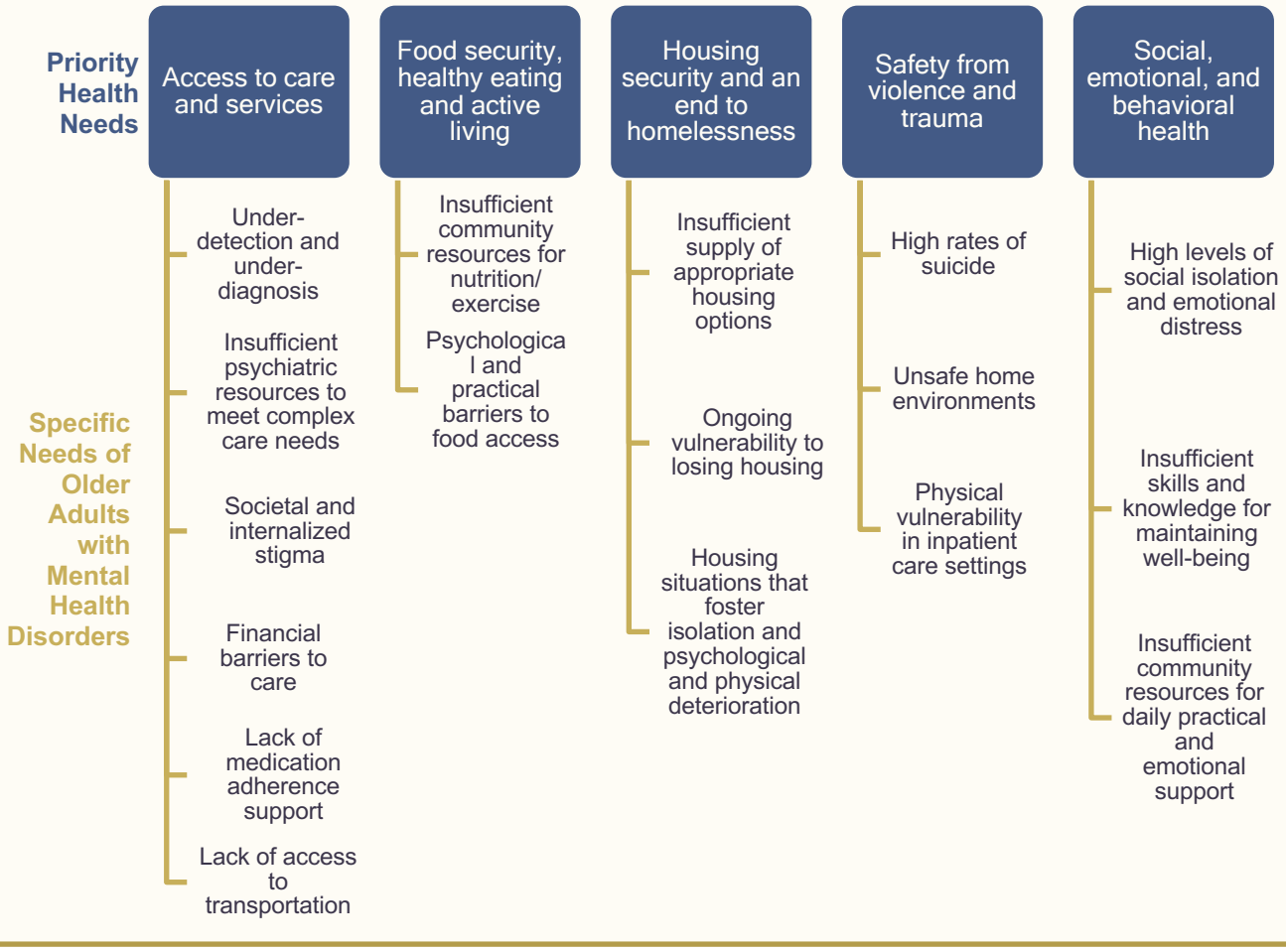
> "It was hard for us to even develop a discharge process for our patients because so many of those outpatient mental health support services were no longer available. COVID has severely impacted their access to care on both ends. We are discharging to the community and trying to get patients access to services or resources that just don't exist anymore or just in little snippets."
>
> *-Key informant*

> "We feel very responsible for our patients when they come to us, and when we're not able to set up adequate plans it's very challenging."

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 2021, 74% of our patients were discharged to their home or a family member's home, 10% to an assisted living facility, 12% to sub-acute residential care, and 2% to a crisis residential unit. 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
- Sub-acute psychiatric residential facilities
- Crisis residential treatment centers (alcohol, drug, and rehabilitation facilities)

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. Prior to COVID-19, we had plans to expand our campus to create the nonresidential, membership-based, community-wide Byer Square, the organization's forthcoming new hub of wellness and activity. Our goal is to revisit these plans as soon as the possible after resources redirected to the pandemic are restored. We plan to broaden the continuum of living options, offer more independent living, assisted living, and memory care and support for the surging population of seniors, as well as develop 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 current 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. Some of these training programs have been put on hold during the pandemic but have been reinstated recently; we look forward to full implementation again as soon as possible.

EVALUATION OF PREVIOUS IMPLEMENTATION STRATEGY

Implementation Strategy Design Process

SFCJL contracted with Conduent Healthy Communities Institute (HCI) to facilitate the Implementation Strategy process. HCI convened the hospital's leaders to review the priority health needs identified during the CHNA process and come to agreement on an Implementation Strategy outline.

Taking into consideration the CHNA findings and its own resources and expertise, SFCJL used an inventory of existing and planned programs to narrow its focus to addressing Access to Care and Services. SFCJL leadership then worked with HCI to complete the report on the implementation strategy.

Implementation Strategy

The Implementation Strategy outlined in the following tables summarizes the strategies and activities that will be taken on by SFCJL and the AGPH to address Access to Care and Services, which was identified as a priority in the CHNA process. The following components are included:

- Actions the hospital intends to take to address the health need identified in the CHNA
- Anticipated impact of these actions
- Outcome measures for each activity – outcomes for each of the three years are provided and represent the evaluation of our strategy
- Resources the hospital plans to commit to each strategy
- Any planned collaboration to support the work described

It should be noted that no one organization can address all the health needs identified in its community. SFCJL and the AGPH are committed to serving the community by adhering to our mission, and using its skills, expertise, and resources to provide a range of community benefit programs to address Access to Care and Services. Due to limited resources and/or expertise, this Implementation Strategy does not include specific plans to address other prioritized health needs including: Food Security, Healthy Eating and Active Living; Housing Security and an End to Homelessness; Safety from Violence and Trauma; Social, Emotional and Behavioral Health.

Of note, some of our community benefit strategies have been temporarily paused or adjusted to comply with current public health guidelines for COVID-19 to ensure the health and safety of those participating.

San Francisco Campus for Jewish Living: Implementation Strategy and Evaluation

The following objectives and strategies support the priority Access to Coordinated, Culturally and Linguistically Appropriate Care and Services. Our goal statement is to: Share knowledge and provide training in support of increasing psychiatric resources for older adults and dispelling the societal stigma associated with psychiatric need.

Objective: By June 30, 2022 train four geriatric psychiatry students

Strategy 1: Serve as a training site for future geriatric psychiatrists

Programs/Activities	Evaluation Measures	Data Source	Baseline	Outcomes Y1 July 2019 – June 2020	Outcomes Y2 July 2020 – June 2021	Outcomes Y3 July 2021 – June 2022
Activity 1.A) Didactic lectures and discussions on relevant patient diagnoses, treatments and medications	# of lectures	Internal	-	2 lectures held	Coronavirus pandemic placed a hold on these lectures	Coronavirus pandemic placed a hold on these lectures
Activity 1.B) Internships	# of students	Internal	-	2 Geriatric Psych Fellows in place until March 2020 - program suspended due to pandemic	Program continued to be suspended due to Covid pandemic	Internships were restarted – 4 geriatric fellows completed the program.
Activity 1.C) Clinical review of patients with geriatric psychiatrists	# of clinical reviews	Internal	-	32 patient reviews conducted	24 patient reviews conducted	28 patient reviews conducted

Anticipated Outcomes: More psychiatric resources available in Northern California

Target Population(s): Third year psychiatry students

Resources: (financial, staff, supplies, in-kind etc.): Staff time to coordinate the program, physician time for classroom education, physician time for on the floor training with patients

Collaboration Partners:

- University of California, SF Department of Psychiatry
- California Pacific Medical Center Residency Program

Objective: By June 30, 2022 implement a nurse internship program and train four nurses

Strategy 2: Develop and implement a nurse internship program

Programs/Activities	**Evaluation Measures**	**Data Source**	**Baseline**	**Outcomes Y1** July 2019 – June 2020	**Outcomes Y2** July 2020 – June 2021	**Outcomes Y3** July 2021 – June 2022
Activity 2.A) Develop internship program outline	Program Developed	Internal	New Program	Developed psychiatric nursing core competencies for current employees that will be incorporated into Nursing Internship program. Placed on hold due to pandemic beginning 3/2020	Updated psychiatric nursing core competencies for current employees to add to nursing internship program. Placed on hold due to pandemic beginning 3/2020	Able to initiate core competency training. 22 nurses successfully completed the program
Activity 2.B) Educate hospital nurses in formalized preceptor program	# of nurses educated	Internal	New Program	Preceptor program developed by Jewish Home & Rehab Center Nursing Education Dept; one Gero-Psychiatric RN attended preceptor program	Preceptor training program on hold due to pandemic	Preceptor training program on hold due to pandemic
Activity 2.C) Outreach and recruitment for possible nurse interns	# of outreach events # of interns	-	New Program	Placed on hold due to pandemic beginning 3/2020	1 nursing student from University of San Francisco, completed clinical rotation from 2/21-3/21	Placed on hold due to pandemic

Anticipated Outcomes: Nurse internship program in place and 4 nurses trained and working in the field of geriatric psychiatry

Target Population(s): Third year nursing students

Resources: (financial, staff, supplies, in-kind etc.)

- Year 1: Staff time to develop, promote and coordinate the program
- Year 2: Classroom training of interns, nurse time for training interns
- Year 3: Classroom training of interns, nurse time for training interns with patients

Collaboration Partners:

- San Francisco State Nursing School
- University of San Francisco

Objective: By June 30, 2022 engage with five community organization to provide ten community outreach activities						
Strategy 3: Provide community outreach to dispel stigma associated with psychiatric need						
Programs/Activities	**Evaluation Measures**	**Data Source**	**Baseline**	**Outcomes Y1** July 2019 – June 2020	**Outcomes Y2** July 2020 – June 2021	**Outcomes Y3** July 2021 – June 2022
Activity 3.A) Research community outreach programs/events for the senior community	Research Completed	-	-	No community outreach activities scheduled for 2020, unable to coordinate due to pandemic beginning March 2020	Placed on hold due to pandemic	Placed on hold due to pandemic
Activity 3.B) Create outreach plan to secure presentation opportunities at public events focused on seniors/their caregivers	Outreach plan in place	-	-	N/A due to pandemic beginning March 2020	Placed on hold due to pandemic	Placed on hold due to pandemic
Activity 3.C) Present educational information	# of presentations # of people reached	-	-	N/A due to pandemic beginning March 2020	Placed on hold due to pandemic	Placed on hold due to pandemic
Anticipated Outcomes: Enhanced relationships with community organizations serving seniors and/or their caregivers, and increased availability of information to help dispel stigma associated with psychiatric need						
Target Population(s): Seniors, their families and senior caregivers						
Resources: (financial, staff, supplies, in-kind etc.) • Year 1: Staff time for research and outreach plan • Year 2: Staff time and materials for presentations and outreach efforts • Year 3: Staff time and materials for presentations and outreach efforts						
Collaboration Partners: • To be determined						

Objective: By June 30, 2022 expand current training options from one Social Worker and one Recreational Therapist to two Social Workers, two Recreational Therapists, and two Occupational Therapists

Strategy 4: Provide training to professionals in the areas of social work, recreational therapy and occupational therapy to increase services for older psychiatric patients

Programs/Activities	**Evaluation Measures**	**Data Source**	**Baseline**	**Outcomes Y1** July 2019 – June 2020	**Outcomes Y2** July 2020 – June 2021	**Outcomes Y3** July 2021 – June 2022
Activity 4.A) Program promotion and outreach	Outreach plan in place					
Activity 4.B) Classroom training	# of students trained /2	Internal		2 social work interns interned for 16 hours each per week from 1/2020-3/2020 on the unit 1 recreational therapist interned from 1/2020 – 3/2020	1 recreational therapy intern interned for 40 hours per week/8weeks from 2/21-4/21 1 University of San Francisco Nursing student completed preceptor program for 30 hours per week/8 weeks from 2/21-3/21	1 recreational therapy intern interned for 40 hours per week/8 weeks from 8/21-10/21 1 Recreational Therapy intern trained for 40 hours per week/8 weeks from 3/22-5/22
Activity 4.C) Floor training	# of students trained/ 2	Internal		SW interns received 2 hours/wk of supervision per intern by APU Director of SS and Program Director Recreational Therapist intern	Recreational Therapist Intern, supervision by Recreational Therapy Director 1 RN preceptor student, supervised by Charge RN/Nurse manager	Recreational Therapist intern, supervision by Recreational Therapy Director

Anticipated Outcomes: 2 social workers, 2 recreational therapists, 2 occupational therapists trained in caring for older psychiatric patients

Target Population(s): Students from community and regional educational institutions in the areas of social work, recreational therapy and occupational therapy

Resources: (financial, staff, supplies, in-kind etc.): Years 1-3: Staff time to promote and coordinate the program; staff/clinician time to train students

Collaboration Partners:

- San Francisco State University

CONCLUSION

San Francisco Campus for Jewish Living has been dedicated to improving the lives of Bay Area seniors for 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.

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