City and County of San Francisco
Department of Public Health

Gavin Newsom
Mayor

Mitchell H. Katz, MD
Director of Health

MEMORANDUM

DATE: June 7, 2005

TO: President Lee Ann Monfredini and
Members, San Francisco Health Commission

FROM: Mitchell H. Katz, MD
Director of Health

RE: **Laguna Honda Hospital Replacement Program**

On May 19th, 2005 Ed Harrington, the San Francisco City & County Controller, released his report the "Laguna Honda Replacement Program: Where do we go from here?" (Attachment 1) The report was prepared at the request of Mayor Newsom to have an independent analysis of the options available to the City.

The two options considered were:

Option 1 - Use all reasonably available funds to complete a 1,200 bed skilled nursing facility at Laguna Honda.

Option 2 - Use most funds to complete three buildings at Laguna Honda with 780 skilled nursing beds and use the remaining funds plus operational savings to purchase other long-term care services in assisted living, supportive housing, home care, or other community based settings. Total people served under this option would exceed 1,800.

Mr. Harrington will be available at the Commission meeting to explain the complicated financial issues involved in the two scenarios.

I want to focus my report on the implications of the report for the Health Department and the Health Commission.

Based on the report, the Health Commission should assume that:

1) There is enough money to build at least 780 beds (plus the 50% contribution to the 140 units of assisted living, and the adult day health center envisioned in the bond).

2) It is possible to use certificates of participation and the tobacco funds to build the entire 1200 beds initially envisioned.

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3) The major policy question for the Health Commission is whether to build the full 1200 beds or use the money saved by building and operating only 780 beds to increase other types of community-based long-term care (e.g., board and care, assisted living, supportive housing, and independent living).

This will be an important decision for the Health Commission. Making this decision will require review of detailed information including, at a minimum:

1) Laguna Honda Hospital (LHH)
   - Available services
   - Census
   - Resident characteristics
   - Where patients are admitted from
   - Where patients are discharged to
   - Ability and preferences of existing residents and residents who would be entering LHH to be cared for in the community
   - Projections of need versus supply of skilled nursing beds for the future
   - Costs (present and future) of operating LHH

2) Community-based long-term care
   - Available services
   - Census of different community providers
   - Client characteristics
   - Costs
   - Obstacles to expansion
   - Projection of needs and supply of services

The Commission will undoubtedly identify other information that it will need to make a decision. The Department will do our best to provide that information.

Process for Citywide Decision-making

Multiple agencies of government will be involved in determining the City's answer as to whether to build the full 1200 beds or 780 beds plus other community-based long-term care.

Clearly the Health Commission, as the governing body over LHH, has a responsibility to hold hearings and render a decision on its recommendation to the Mayor and the Board of Supervisors. The City's Long Term Care Coordinating Council (LTCCC) will also be having hearings on the issue and has already made some preliminary recommendations (Attachment 2).

Ultimately, issuing the certificates of participation to build 1200 beds would require a majority vote by the Board of Supervisors and the Mayor's signature or a super majority of the Board of Supervisors in the case of a Mayor's veto.

Other groups are likely to have opinions as well. Recently, I reconvened with Louise Renne the Laguna Honda Rebuild Committee. The purpose of this committee is to restore the positive feelings about Laguna Honda Hospital that led to the successful Proposition A Campaign. The size of the new LHH was an issue raised at the first meeting. A second meeting is scheduled for June 21, 2005.

We have received correspondence from the Planning for Elders In-home Supportive Services (IHSS) and Health Task Force. They recommend consideration of construction of congregate housing with co-located adult day health services in lieu of rebuilding Laguna Honda Hospital at 1200 beds (Attachment 3).

There may also be further legal action. As explained in Mr. Harrington's report, a recent court order specified that there is no legal requirement that the new LHH be 1200 beds. However, the decision may be appealed and/or other legal action may be taken to attempt to force the City to build 1200 beds or to not build more than 780 beds.

Time of decision

From a programmatic point of view, the City does not need to make an immediate decision about whether to build 780 or 1200 beds. The reason is that the final 420 beds cannot be built until Clarendon Hall is demolished. Clarendon Hall cannot be demolished until the first 3 buildings can be inhabited. The projected date for the start of construction of the last building is 2009.

Although there is no programmatic need for immediate action, there is a financial reason. There is a limited period during which the City can reimburse itself using SB1128 for the costs of construction initially paid for by using certificates of participation. To maximize the repayment using SB1128 a decision to go forward with the 1200 beds should be made by December 2005.

Data for Decision-Making

For today's presentation we begin the process of providing the necessary data. At future meetings we will provide the data that is not yet available.

Services at Laguna Honda Hospital

The services provided at Laguna Honda Hospital are:

- Skilled Nursing Care (including a ward dedicated to the care of persons with AIDS)
- Hospice
- Rehabilitation
- Acute Medical and Rehabilitation
- Senior Nutrition
- Adult Day Health Care

Census of LHH

The maximum census of LHH was 1197 residents in 1997. At that time we had visits from the Department of Justice and State of California Licensing Authority that were critical of the physical set-up of LHH, specifically the lack of private spaces for residents. In response, DPH agreed to lower the census to a maximum of 1065 patients and install large closets as room dividers and to provide residents with private space for their belongings. Recent census is shown below.

Laguna Honda Hospital Average Daily Census 2003-2005												
Average Daily Census												
2003												
Jan-03	Feb-03	Mar-03	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03	Oct-03	Nov-03	Dec-03	Average
1031	1039	1042	1039	1039	1046	1043	1048	1049	1038	1035	1025	1039.5
2004												
Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	Jul-04	Aug-04	Sep-04	Oct-04	Nov-04	Dec-04	Average
1027	1043	1044	1042	1036	1028	1027	1032	1026	1027	1032	1041	1033.8
2005												
Jan-05	Feb-05	Mar-05	Apr-05	Average								
1036	1041	1031	1031	1034.8								

It should be noted that we do not reach 1065 residents for several reasons. The major reason is that the services offered in different wards is not interchangeable. For example, there may be an empty bed in the hospice or a rehabilitation unit, but the only patients waiting for admission need a different type of ward (e.g., long-term care). Second, although some of our wards appropriately have both men and women (e.g., AIDS unit, hospice unit) most of our wards are single sex. This is especially relevant as need for male beds has exceeded supply in recent years.

The sources of admissions to Laguna Honda Hospital in 2003, 2004, and 2005 are shown in Tables 1, 2, and 3 respectively.

Note that the major change over this 3-year period is the percent of admissions coming from San Francisco General Hospital (SFGH). It was 52% in 2003 (prior to our admission policy giving greater priority to SFGH admission), 73% in 2004 (the year of the admission change), and 67% in 2005 (and declining – 58% in the most recent month) as we have returned to our prior admission policy.

Resident characteristics

The race/ethnicity of LHH residents in 1998, 2004, and 2005 is shown in Table 4. The age of LHH residents in the years from 2001 to the present are shown in Table 5.

The 10 most common conditions of residents cared for at LHH are shown in Figure 1 and the 20 commonest conditions are shown in Table 6. (These diagnoses are not mutually exclusive.)

TCM Program

Since March of 2004 the Department has run a Targeted Case Management (TCM Program) to screen, assess, and develop individual service/discharge plans for residents of LHH and patients of SFGH who might be admitted to LHH.

To date all residents at LHH have been screened by the TCM Program and approximately 80% are candidates for being discharged to a community setting. However, this does not mean that these residents wish to be discharged or that the appropriate community resource exists at the current time.

Beyond performing the assessment the TCM group has an active caseload of LHH residents. To date, 120 LHH residents have been accepted to the TCM Program. In April alone 7 LHH residents were discharged from LHH to community settings. A more detailed report of the TCM Program will be presented in the future.

Health Management Associates Management Study

As the Commission is aware, Proposition C allocated 0.1% of the budgets of all City Departments to the Controller to do management studies or audits. The Department asked the Controller to use a portion of our resources to provide us management consultation on LHH, focusing on how to best use our resources to care for residents of LHH. The consultants have had extensive meetings with LHH staff and community leaders and will issue their report in July. We expect that it will be very helpful to us in planning for the future of LHH.

Discharges

A major focus of our attention has been appropriate discharges from LHH. As you can see, in Figures 2 & 3, the total number of discharges and the number of discharges back to the community have increased significantly since 2001. Table 7 shows where people are being discharged to.

Future steps

We are currently compiling the additional information that the Health Commission will be needing to make its decision.

Of note, the Controller's report included an addendum from the Mayor's Office on Disability. The addendum reviewed a number of different community options and costs. We have reviewed the document and believe the costs are in the correct ballpark. Some issues have been raised as to whether the capacities of some of the community providers listed in the document are accurate. We are currently reviewing this information and it will be part of our next presentation on LHH.

Table 1

SOURCES OF NEW SNF ADMISSIONS TO LAGUNA HONDA HOSPITAL*
JANUARY 2003 - DECEMBER 2003

Source of Admission	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	%
Board and Care		3	2	1	2	2				1			11	2%
Cal Pac Acute		2	2	1	2	1	2	3	1	1	3	3	21	4%
Cal Pac SNF	5	3	1	3			2	2		1			17	3%
Chinese Hospital Acute	1			3							2		6	1%
Chinese Hospital SNF			1										1	0%
Home	4	6	6	9	5	10	1	5	5	6	1	5	63	11%
Home Health										1			1	0%
Kaiser Acute		1	1				1	1					4	1%
Other		1	2	3	4			4	1	3	1	2	21	4%
R.K. Davies Acute													0	0%
R.K. Davies SNF													0	0%
SFGH Acute	27	19	29	20	32	20	20	23	24	23	24	29	290	52%
SFGH SNF	3	2	4	2		1				1			13	2%
St. Francis Acute	1	1	1			3	4	2			1	2	15	3%
St. Francis SNF	2	2	2			2	3			3	1	2	17	3%
St. Luke's Acute		1	1	2	2	1	1	1		1	3		13	2%
St. Luke's SNF	1		2		1		2			1	1	1	9	2%
St. Mary's Acute		4	4	2	1	1	1	2		2	2		19	3%
St. Mary's SNF		1	1										2	0%
Seton Acute					1		2	1		1			5	1%
Seton SNF	1												1	0%
UC Med Acute	1	1	1	1	3	5	2	2	3	3	4	2	28	5%
UC Med SNF													0	0%
VA Hospital Acute							1						1	0%
VA Hospital SNF					1			1					2	0%
TOTAL	46	47	60	47	54	46	42	47	34	48	43	46	560	100%

* Excluding admissions from Unit M7

Table 2

SOURCES OF NEW SNF ADMISSIONS TO LAGUNA HONDA HOSPITAL*
JANUARY 2004 - DECEMBER 2004

Source of Admission	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	%
Board and Care					1	1	1						3	0%
Cal Pac Acute		4		2	3	3	1		2	2	1	2	20	3%
Cal Pac SNF												1	1	0%
Chinese Hospital Acute						1	1	1	2	1			6	1%
Chinese Hospital SNF													0	0%
Home	4	7	3	7	8	1	2	6	6	2	5	3	54	9%
Home Health													0	0%
Kaiser Acute	1				1			2		1			5	1%
Other	1	2			1	5	3	3	1				16	3%
Out of County**										1			1	0%
R.K. Davies Acute													0	0%
R.K. Davies SNF													0	0%
SFGH Acute	40	36	64	37	24	35	33	34	31	41	39	42	456	73%
SFGH SNF							1					1	2	0%
St. Francis Acute		1		5	1	1	2	2	1				13	2%
St. Francis SNF						1		1					2	0%
St. Luke's Acute		1				1	2		1	2			7	1%
St. Luke's SNF			1	1									2	0%
St. Mary's Acute	1		3		1	3	5	1	1			2	17	3%
St. Mary's SNF													0	0%
Seton Acute						1		1				1	3	0%
Seton SNF													0	0%
UC Med Acute		5	1		1	2	1		1	3	1		15	2%
UC Med SNF													0	0%
VA Hospital Acute						2							2	0%
VA Hospital SNF													0	0%
TOTAL	47	56	72	52	41	57	52	51	46	53	46	52	625	100%

* Excluding internal transfers

** Out-of-county count begins in October 2004

Table 3

SOURCES OF NEW SNF ADMISSIONS TO LAGUNA HONDA HOSPITAL*
JANUARY 2005 - MAY 2005

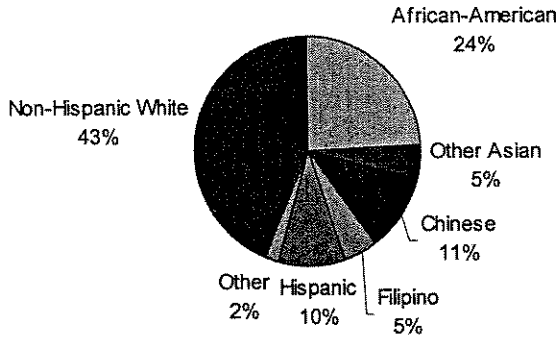
Source of Admission	Jan	%SFGH	Feb	%SFGH	Mar	%SFGH	Apr	%SFGH	May	%SFGH	Total	%
Board and Care			1						1		2	1%
Cal Pac Acute	1		1				1				3	1%
Cal Pac SNF											0	0%
Chinese Hospital Acute			1		1				1		3	1%
Chinese Hospital SNF											0	0%
Home	3		3		5		8		5		24	10%
Home Health											0	0%
Kaiser Acute											0	0%
Other	1		2		2		1		1		7	3%
Out of County**											0	0%
R.K. Davies Acute											0	0%
R.K. Davies SNF											0	0%
SFGH Acute	38	79%	34	68%	38	68%	27	59%	26	58%	163	67%
SFGH SNF	2	4%	1	2%	2	4%	1	2%	1	2%	7	3%
St. Francis Acute			2		1		4		1		8	3%
St. Francis SNF					1				1		2	1%
St. Luke's Acute	1		1		1		1		1		5	2%
St. Luke's SNF			1								1	0%
St. Mary's Acute							1		1		2	1%
St. Mary's SNF											0	0%
Seton Acute					1						1	0%
Seton SNF							1				1	0%
UC Med Acute	2		3		2		1		5		13	5%
UC Med SNF											0	0%
VA Hospital Acute					2				1		3	1%
VA Hospital SNF											0	0%
TOTAL	48	**83%**	50	**70%**	56	**71%**	46	**61%**	45	**60%**	245	100%

* Excluding internal transfers

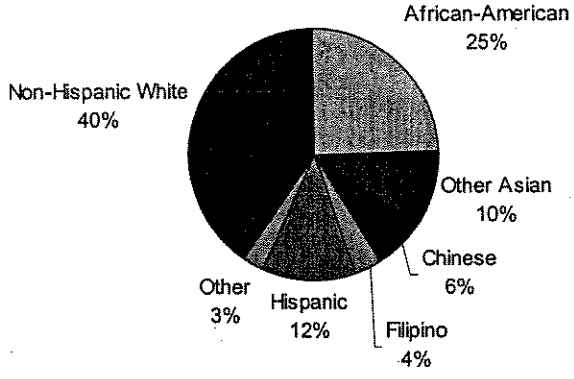
** Out-of-county count began in October 2004

Table 4

Laguna Honda Hospital
Distribution of Residents by Race/Ethnicity as of June 30, 1998 (*n* = 1157)



Laguna Honda Hospital
Distribution of Residents by Race/Ethnicity as of June 30, 2004 (*n* = 1036)



Laguna Honda Hospital
Distribution of Residents by Race/Ethnicity as of March 31, 2005 (*n* = 1045)

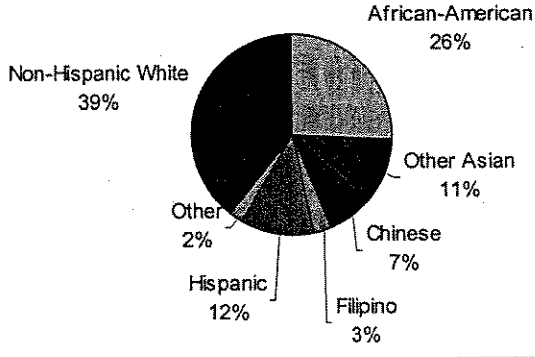
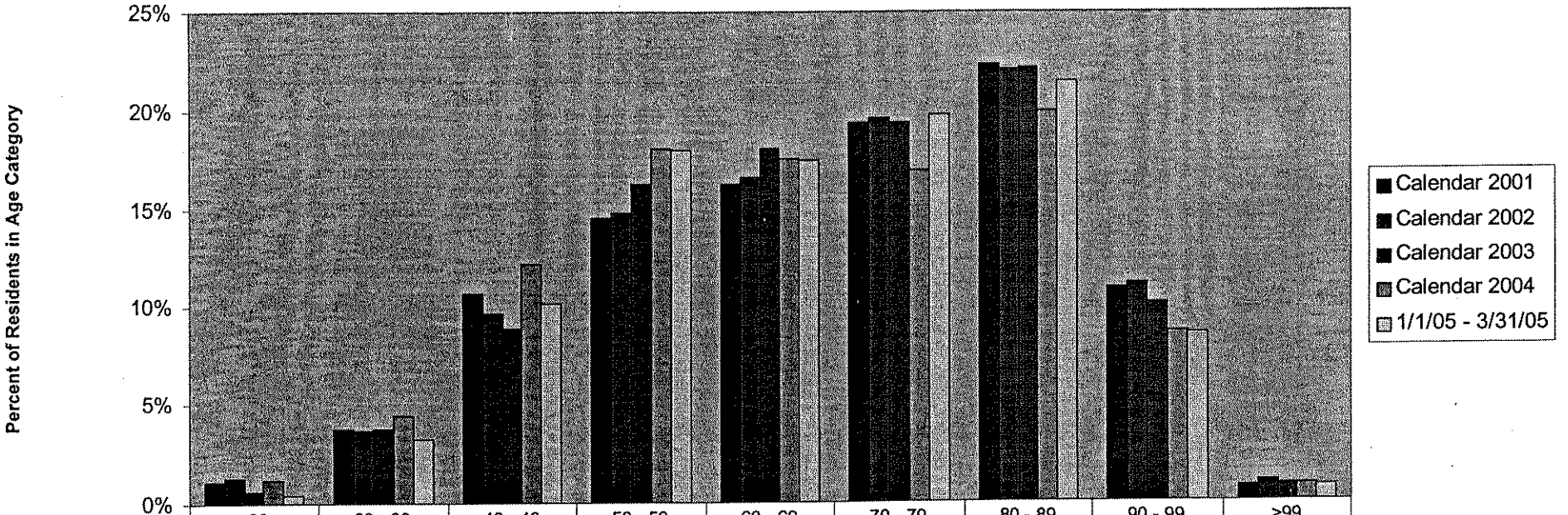


Table 5

Laguna Honda Hospital
All Unique Residents Served
1/1/01 - 3/31/05



	<30	30 - 39	40 - 49	50 - 59	60 - 69	70 - 79	80 - 89	90 - 99	>99
Calendar 2001	1%	4%	11%	15%	16%	19%	22%	11%	1%
Calendar 2002	1%	4%	10%	15%	17%	20%	22%	11%	1%
Calendar 2003	1%	4%	9%	16%	18%	19%	22%	10%	1%
Calendar 2004	1%	4%	12%	18%	18%	17%	20%	9%	1%
1/1/05 - 3/31/05	0%	3%	10%	18%	17%	20%	22%	9%	1%

Table 6

Laguna Honda Hospital
20 Commonest Diagnoses as of March 9, 2004
(Categories Are Not Discrete -- Residents Can Be Assigned Up to 10 ICD-9 Codes)

ICD-9 Code	Description	No. of LHH Residents With This Condition
348.9	Brain condition (not otherwise specified)	433
401.9	Hypertension	401
290.00	Diabetes mellitus, Type II, without mention of complication	185
438.20	Late effects of cerebrovascular disease -- hemiplegia	140
311	Depressive disorder, not elsewhere classified	136
438.0	Late effects of cerebrovascular disease -- cognitive deficits	128
780.39	Convulsions, not elsewhere classified	128
414	Coronary atherosclerosis	101
438.82	Other late effects of cerebrovascular disease -- dysphagia	94
285.9	Anemia (not otherwise specified)	93
715.90	Osteoarthrosis, unspecified	89
496	Chronic airway obstruction (not elsewhere classified)	84
795.5	Nonspecific reaction to tuberculin skin test without active tuberculosis	83
244.9	Hypothyroidism	83
290.40	Arteriosclerotic dementia, uncomplicated	76
331.0	Alzheimer's disease	69
438.11	Late effects of cerebrovascular disease -- aphasia	64
307.9	Other and unspecified special symptoms or syndromes, NEC	57
787.2	Dysphagia	55
733.00	Osteoporosis, not otherwise specified	53

Table 7

LAGUNA HONDA HOSPITAL
JULY 2004 - APRIL 2005
DISCHARGES

Discharge Location	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Total	Average Per Month
EXTERNAL DISCHARGES												
Cal Pac Acute					1						1	0.1
Chinese Hospital Acute				1				1			2	0.2
R.K. Davies Acute											0	0.0
Kaiser Acute						1					1	0.1
Mt. Zion Acute		1		2							3	0.3
St. Francis Acute				1							1	0.1
St. Luke's Acute			1				1	1			3	0.3
St. Mary's Acute	1		1	3	1	2				1	9	0.9
SFGH Acute	16	17	19	21	25	29	26	26	29	27	235	23.5
Seton Acute				1							1	0.1
UC Med Acute	7	10	11	17	12	16	10	12	18	3	116	11.6
VA Hospital Acute											0	0.0
Home	23	26	27	23	24	25	26	28	26	26	254	25.4
Board and Care		2			2	2	2	2			10	1.0
AMA	2	1				3		1		1	8	0.8
AWOL	11	5	4	5	7		8	7	4	3	54	5.4
5150	2	1	1	3	2	3			3	1	16	1.6
Other Misc	2	1	2	2		1	2	1	2	1	14	1.4
Out of County*				1							1	0.1
SUBTOTAL	64	64	66	80	74	82	75	79	82	63	729	72.9
INTERNAL DISCHARGES												
Discharge From M7A to Other Unit	6	6	3	5	6	11	12	7	5	14	75	7.5
Discharge From Other Unit to M7A	10	7	2	10	8	12	15	6	10	17	97	9.7
Discharge From L4A to L4S	2		2	1	2	2	3		1		13	1.3
SUBTOTAL	18	13	7	16	16	25	30	13	16	31	154	15.4
EXPIRED	25	28	17	25	18	14	24	22	28	33	234	23.4
TOTAL	107	105	90	121	108	121	129	114	126	127	1148	95.7

Figure 1

Laguna Honda Hospital
10 Commonest Conditions
September 13, 2004
(*n* = 1026 / Non-discrete Categories)

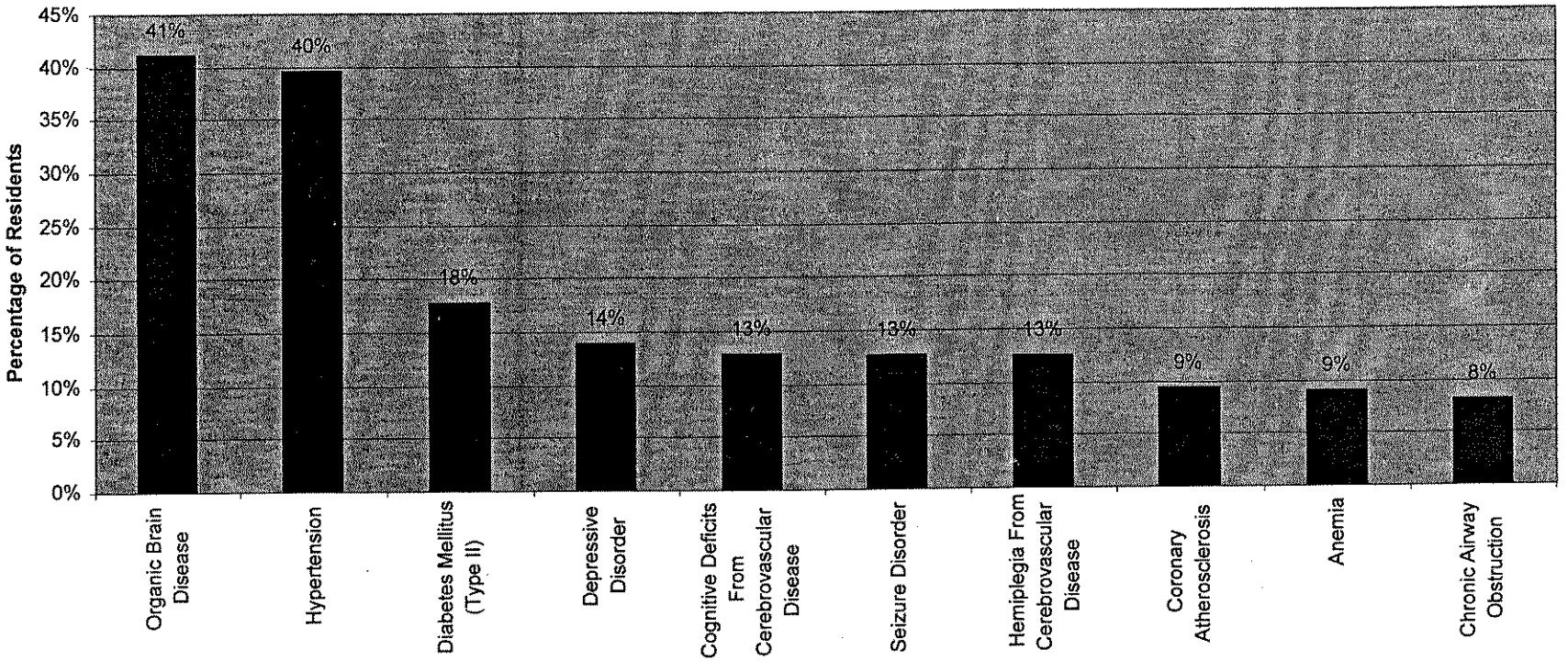


Figure 2

Laguna Honda Hospital
Total Discharges* Per Month in FY 04-05 Versus
Average Per Month in FY 00-01, FY 01-02, FY 02-03 and FY 03-04

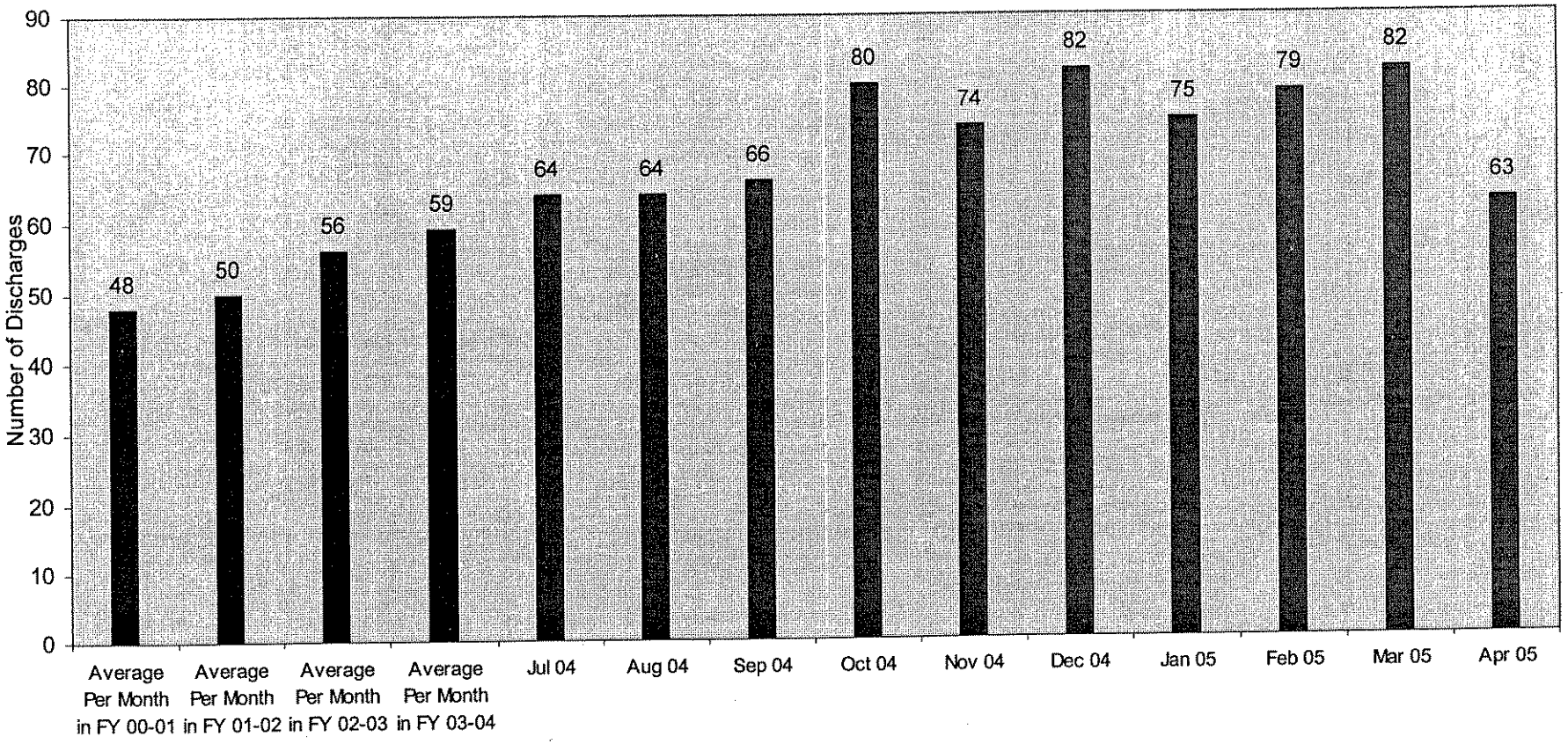
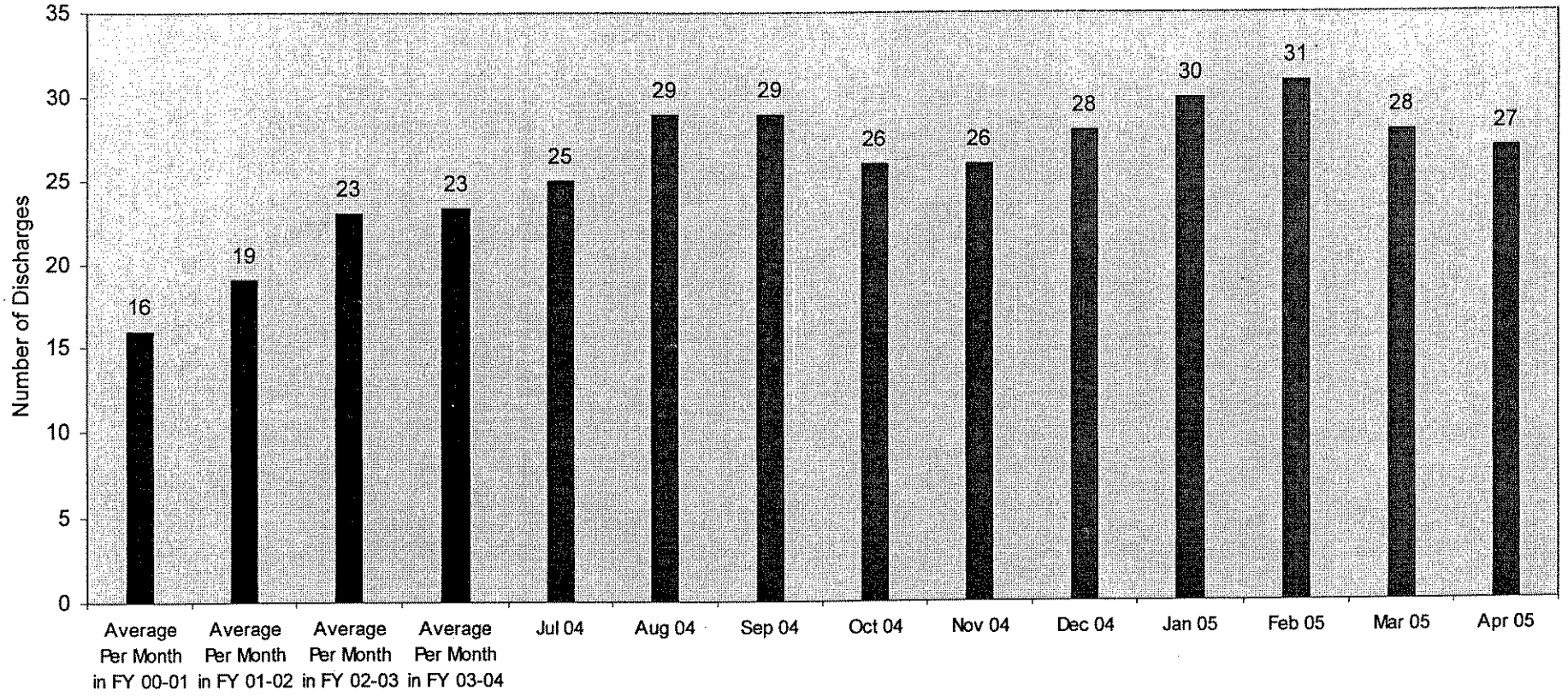


Figure 3

Laguna Honda Hospital
Community Discharges* Per Month in FY 04-05 Versus
Average Per Month in FY 00-01, FY 01-02, FY 02-03 and FY 03-04



Laguna Honda Replacement Program

Where do we go from here?

Ed Harrington
Controller
May 19, 2005

As costs to replace Laguna Honda Hospital have increased, Mayor Gavin Newsom asked the Controller's Office to collect information and prepare an independent analysis of the options that are available to the City. To prepare this report we looked at a variety of possible options, but concluded there are only two options worth considering:

Option 1 – Use all reasonably available funds to complete a 1,200 bed skilled nursing facility at Laguna Honda.

Option 2 – Use most funds to complete three buildings at Laguna Honda with 780 skilled nursing beds and use the remaining funds plus operational savings to purchase other long-term care services in assisted living, supportive housing, home care or other community based settings. Total people served under this option would exceed 1,800.

Background – the Laguna Honda Replacement Project

In 1999 the voters of San Francisco approved a $299 million general obligation bond measure to construct "a health care, assisted living and/or other type of continuing care facility or facilities to replace Laguna Honda Hospital." While the project was planned to have 1,200 skilled nursing facility (SNF) beds--approximately the historic number of beds in the current Laguna Honda Hospital--the number of beds to be built is not included in the bond ordinance. In a recent Court order, Judge James Warren states: "Nothing in the Proposition A 'bond contract' limits the type of facility the City must construct to a 'long-term care facility'. Moreover, nothing in the Proposition A 'bond contract' requires the City to construct a facility of a specific size." Please note that the current census at Laguna Honda is under 1,050 patients.

The original project plan included constructing 1,200 beds in four buildings in the following order:

- 300 beds in the South building
- 60 beds in the Link building
- 420 beds in the North building
- 420 beds in the West building

1,200 beds total

plus 140 assisted living beds on the LHH site (only partially funded at $15 million).

The proposed Laguna Honda replacement facility was estimated to cost $401 million made up of $299 million in bonds, and $102 million from proceeds of a tobacco settlement and interest earnings. In March 2005, bids for the first phases of the project indicated there was a shortfall of $84 million for a new estimated cost of $485 million. In May 2005, additional bid information increased the cost estimate by another $12 million. The cost overruns are attributed to increased construction escalation. The project had budgeted a construction escalation rate of 3.8% per year. In the18 months ending last October, construction escalation had increased by about 55%.

Current estimates for entire project:

If escalation continues at:	**Total project cost:**
• 2.9%/mo (18 month high) (Used for DPH 3/15/05 report)	$747 million
• 2.4%/mo (last 23 months)	$678 million
• 1%/mo (moderate case)	$580-$600 million
• 3.8%/year (future drops to original projection)	$540-$550 million
• **Most probable**	**$600-640 million**

These escalated total costs can be viewed as a per bed cost of approximately:

- SNF Original estimate $322,000
- SNF Current-first three buildings (heavily loaded with infrastructure) $536,000
- SNF Current-last (West) building (no extra food, loading dock, etc.) $350,000

Option 1 would use $629 million in funding to cover the estimated $600 million to $640 million most probable cost estimate for a 1,200 bed skilled nursing facility.

This is possible because other funding streams are now available that were not envisioned when this project was first proposed.

Currently Programmed funds	Original proposal	Current View
General Obligation bonds	$299 million	$299 million
Tobacco Settlement before bonds are issued	$80 million	$92 million
Other—primarily interest	$22 million	$10 million
Sub-total	$401 million	$401 million

New Funding (see explanations on following page)

1. Issue Certificates of Participation (COPs) using the general fund as credit but to actually be repaid using federal revenue made available through SB1128	$120 million
2. Use NEXT $100 million of Tobacco Settlement funds	$100 million
Total funds that could be made available	**$621 million**

1. Issue COPs to be repaid using Federal revenue available through SB1128

This 1999 bill, by State Senator Jackie Speier, allows the City to receive additional Federal funds by billing for the cost of debt service once we build new SNF beds at Laguna Honda that are occupied by Medi-Care sponsored patients. This new stream of revenue can be leveraged through COPs to provide additional funds for the project. Legally, the COPs would be guaranteed by the City's General Fund, but the assumed source for repayment would be the additional Federal reimbursement.

2. Use NEXT $100 million of Tobacco Settlement funds for construction

Proposition A requires that "the first $100,000,000 of available tobacco settlement revenues...shall be applied to...construction [and additional receipts should be applied to debt service]. The proposition also defines available tobacco settlement revenues as tobacco settlement payments the City receives over the term of bonded debt. Since the City has not issued any debt, the tobacco settlement revenues received to date would fall outside this definition. While this interpretation has been challenged, it prevailed in the recent court litigation. Based on this interpretation, instead of spending a total of $100 million in tobacco settlements revenues on Project costs, the City could choose to apply the approximately $92 million of tobacco settlement revenues received before bond issuance **and** the next $100 million received after bond issuance for a total of $192 million from this source.

This would mean that property tax payers would be responsible for an additional $100 million of debt service since the tobacco settlements funds wouldn't be available for this purpose. However, since 1999, tobacco settlement funds have amounted to significantly more than were originally projected and the total cost of borrowing has been reduced by more creative financing techniques. That means that property tax payers would still be projected to pay $189 million less than was originally proposed even if they had to pay the additional $100 million (see table below).

Property Tax effect:

	Bond Repayment Sources		
	Property Tax	Tobacco Settlement	Total
Original 1999 estimate	$315 M	$215 M	$530 M
Current estimates	$26 M	$443 M	$469 M
If $100 million more tobacco settlement used for construction	$126 M	$333 M	$469 M

Note: Original property tax payments of $315 million would drop by $189 million to $126 million under this proposal.

Option 2 would provide a mix of long term care for over 1,800 individuals. The City would use all of the funds identified in Option 1 plus the General Fund share of the operational savings that would occur since fewer SNF beds would be maintained at their relatively high cost. These funds would provide for 1,015 beds on the Laguna Honda campus and pay for the annual cost of care for another 790 individuals in various community-based settings.

Construction costs:

a. Use $482 million--$299 million of the general obligation bonds, plus the $120 million COPs (SB 1128 monies), $10 million in interest and $53 million of tobacco settlement funds--to complete the first three buildings with 780 beds.

b. Use $59 million of tobacco settlement funds to build 235 assisted living and/or supportive housing beds at Laguna Honda (at approximately $250,000 per bed). This could build 5 floors of the West Building with 47 units of assisted living per floor. This would be substantially more than the 140 assisted living beds that were only partially funded in the original plan. These beds added to the 780 SNF beds would provide 1,015 beds at the Laguna Honda campus.

Annual units of service: Attachment A is a paper prepared by the Mayor's Office of Disability that provides examples of how long term non-skilled nursing services might be provided and the number of people who could be served. It conservatively estimates that 100 people could receive long term care in a mix of settings for about $2 million per year. Since the total saved under Option 2 c, d and e amounts to $15.8 million dollars annually, approximately 790 people could be served per year.

c. Use $80 million of previously received tobacco settlement revenues that could be freed up when the general obligation bonds are issued. These funds could be invested in a trust fund and used for other long-term care needs for 25 years until the Laguna Honda bonds are paid off. We estimate this trust fund would generate about $5.4 million per year that could fund the long-term care needs of **270 people** per year. Once the Proposition A bonds are paid off the City would no longer be constrained to use tobacco settlement revenues for any particular purpose; any further receipts could be used to maintain this trust fund or allocated to pay for similar long-term care programs.

d. Use $6.1 million annually of operating savings from the 185 SNF beds not built (West building drops from 420 to 235) to provide assistance to an additional **305 plus people** with long-term care needs. This calculation assumes that the General Fund cost per day of a SNF bed is approximately $100. Most of these costs are staffing, food and similar costs that are not fixed; so we assume that the City would save about $90 per day per bed for each SNF bed that we do not build.

e. Use an additional $4.3 million in savings by having 235 assisted living or supportive housing beds rather than SNF beds to provide assistance to another **215 people**. This calculation assumes that the City could contribute $50 per day

with a Medi-Cal waiver for this lower level of care rather than the $100 per day currently paid for SNF beds.

Using the various levels of institutional and community care offered in Option 2 would presumably be responsive to concerns of the Department of Justice that have been expressed over the past several years.

Terminology: This report uses terms like "beds", "people" or "individuals" somewhat interchangeably for the convenience of the reader. They do not refer to services only available over time to one person, rather they are meant to indicate the availability of services to a total number of people at any one time.

Attachment A

Estimates for Housing, Medical and Supportive Care Costs for People Discharged from LHH

(Excerpts from a report by the Mayor's Office on Disability
Susan Mizner - April, 2005)

Background & Summary

The City is considering adding funding to long-term care needs other than skilled nursing beds. The question presented is what community care could be provided at what price? In short:

Q: How many people, eligible for services at LHH, could be served in the community at service levels similar to Laguna Honda?

A: For each $2 million, 100 people could be served.

Assumptions and Analysis

Of the people able to leave a skilled nursing facility and return to the community, (currently 84% of the LHH residents according to data from TCM), Targeted Case Management staff estimate that 25% would want to live in a Board and Care facility, 50% would want supportive housing, and 25% would want to return to their own home or live in independent housing (with outside supports).[1]

So, for every 100 people discharged from LHH, their preferred living situations would break down as follows:

- 25 Board and Care
- 50 Supported Housing
- 25 Own home or independent unit

Board & Care

For Board and Care residents, the cost to the city would be a straightforward "patch" for the providers, above what they receive from SSI or Social Security.[2] The best numbers available for that patch would be $1600 / month per resident, or, $19,200 per year.

Total cost to county for 25 people in Board and Care = $480,000

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[1] Data from national surveys support this. There is currently a large body of research regarding trends in long-term care use. Seniors are living healthier longer, and staying home longer. The data shows that few seniors want nursing home placement, and the availability of new models of service, such as PACE and assisted living, has helped seniors avoid nursing home placement longer or altogether. Nationally and in California, nursing home bed occupancy rates have steadily decreased, and are currently around 81%.

[2] Charlene Harrington, PhD, testifying at the Mayor's Disability Council, cited a study that found 315 available slots at residential and board and care facilities. Of these, half of the providers said they would be willing to take on more clients with substance abuse, cognitive impairment, or behavioral problems if the reimbursement rates were higher. This patch is the estimated need.

Supportive Housing

Supportive Housing comes in a range of forms. Some supportive housing is in Single Room Occupancy units, others include private units where services can be provided to many people at the same location. Models for seniors are available through HUD's 811 buildings or On Lok.

For people entering Supported Housing, there would be both housing and care costs. The care costs would vary according to need, but would primarily be covered by programs such as IHSS, PACE, Adult Day Health, and waiver programs. To be conservative, these numbers do not include the waiver programs (which are **no** cost to the county).

Population assumptions per 50 people

- 10% of people in supportive housing would need only IHSS services – 5
- 50% would benefit from, and be able to get into, a PACE program – 25
- The remainder, 40% would get services from both IHSS and Adult Day Health – 20
- About a third may also receive one or more home delivered meals per day – 15

The cost breakdown per person to the County for these assumptions would be as follows:

Supportive Housing costs - $42/ day or 15,330 / year.

IHSS costs – Not all clients would need the maximum number of hours of care each month (approximately 9 hours of care a day). However, that maximum is assumed for these cost estimates. County costs for clients range from $21 to $35 / day, or $7665 to $12,775 / year, depending on whether this is the Independent Provider mode or Consortium services. Ave =$10,220/yr
Those who receive only IHSS tend to be relatively stable medically, but have functional limitations that interfere with their ability to dress themselves, cook, clean, etc. Any medical care that they needed would covered by MediCal, through visits to community clinics, etc.

PACE costs – to county are ZERO (This is an all-inclusive program with medical care, support services and meals provided.) This is also a program with 300 slots *currently* available.

Adult Day Health costs – to county are currently zero, MediCal covers all but an average of $15 / day. If the county were to cover that cost, it would amount to $5470 / yr. This is another program with slots *currently* available and with room for expansion.

Cost Totals

SH + IHSS = $15,330 + 10,220 = $25,550 / yr x 5 = $ 127,750
SH + PACE = $15,330 + 0 = $15,330 / yr x 25 = $ 383,250
SH + IHSS + ADH = $15,330 + 10,220 + $5470 = $31,020 / yr x 20 = $ 620,400
+ HDM = $2190 x 15 = $32,850

Total to county for 50 People living in Supportive Housing = $1,164,250

Independent Housing

Like supportive housing, this is a combination of housing costs and service/medical costs. This is the most difficult category to average. Many people would require a one-time expenditure to enable the person to modify or keep their housing. Some would require housing subsidies.

The assumptions are:

- 20%, or 5 of the 25 could return to a home that they own or could live with family. If funds were needed to rehab the home to make it accessible, CHRP funds could be accessed. (This is a little used fund available for a range of home rehabilitation, including access.) Cost to county = 0

- 50%, or 12 of the 25, could return to housing they were previously in, usually government subsidized (e.g. Housing Authority) or section 8 housing. Costs here would include both bridge rent payments, until released from the hospital or rehab, and possible renovations to make accessible, with one-time home modifications ranging from $12K to $42K.

  Cost to county = $30K (average cost) x 12 = $360,000 one-time cost.

- 30% , or 8 of the 24, would want to be placed in independent, affordable housing, or provided a rent subsidy. The rent subsidy could range from $500 to $1500 per month, averaging $1000/ month or $12K / yr.
  Cost to county = $12K x 8 = $96,000 on-going

The medical and support costs would be similar to costs in supportive housing.

Cost Totals for Independent Housing

IHSS = $10,220 / yr x 2 =	$ 20,440
PACE = $0 x 13 =	$ 0
IHSS + ADH = $10,220 + $5470 = $15,690 / yr x 10 =	$ 156,900
+ HDM = $2190 x 10 =	$21,900
Total medical and service, and rent subsidy costs =	$295,240

One-time cost of $360,000 for access changes,
amortized over average life expectancy 5 years = $72,000 / year.

Total cost to county for 25 people living in independent housing = $367,240

Grand total for 100 people leaving LHH and living in the community:

Board & Care =	$480,000
Supportive Housing =	$1,164,250
Independent Housing =	$367,240
Grand total	$2,011,490

Note re: Specific Populations: These calculations do not always factor in the varying needs of the population of LHH. About 40% of the LHH population has a primary psychiatric diagnosis or substance abuse issue and will need some form of community mental health services (including day treatment, counseling, mental health board and care, etc.)

It is important to note that, **the services to meet these unique and different needs can be secured primarily through programs that will cost the county nothing.** Specifically, Home and Community based Waivers can provide additional attendant/home nursing care (Nursing Facility Waiver), case management (Nursing Facility Waiver, MSSP, AIDS Waiver), as well as other incidental services for LHH residents. Waivers are 100% state and federal Medi-Cal funds, and are at no cost to San Francisco. In addition, Proposition 63 will provide $50 million to SF for first year (planning year) and more thereafter to provide community mental health services and supports, including housing options. Proposition 63 funds can be used to drawn down federal matching funds, again, at no increased cost to San Francisco.

LONG TERM CARE COORDINATING COUNCIL

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

Memorandum

To: Julian Potter
Director of Public Policy
Office of the Mayor

Ruby Tourk
Commission Secretary
Office of the Mayor

cc: Renuka George
Policy Aide
Office of the Mayor

From: Margaret Baran
Co-Chair
Long Term Care Coordinating Council

Donna Calame
Co-Chair
Long Term Care Coordinating Council

Date: March 30, 2005

Re: Policy Issues Explored and Recommendations to the Office of the Mayor

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As you know, in November 2004 the Long Term Care Coordinating Council (LTCCC) was appointed by Mayor Gavin Newsom as an official advisory body to the Office of the Mayor.

The LTCCC has been charged to: (1) advise, implement, and monitor community-based long term care planning in San Francisco; and (2) facilitate the improved coordination of home, community-based, and institutional services for older adults and adults with disabilities. Toward this end, the LTCCC has been assigned the responsibility of overseeing all implementation activities identified in the "Living with Dignity" strategic plan to make improvements in San Francisco's community-based long term care and supportive services system.

Since its creation, the LTCCC has been meeting monthly to explore issues related to: (1) making improvements in San Francisco's system of community-based long term care and supportive services; and (2) facilitating the improved coordination of home, community-based, and institutional services. Following is a brief summary of issues explored between December 2004 and March 2005, with recommendations made to the Office of the Mayor in the form of an adopted resolution:

1. **The need for supportive housing and assisted living in San Francisco, and specifically, the need for assisted living as part of the rebuild of Laguna Honda Hospital**

In December 2004 and January 2005, the LTCCC explored issues related to the replacement plans for Laguna Honda Hospital (LHH), the city's long term care facility, and the plans for the development of 140 units of assisted living on the LHH campus. As part of this exploration, the LTCCC undertook research on supportive housing and assisted living.

The LTCCC finds that housing with services is the cornerstone of a continuum of home and community-based long term care services for older adults and adults with disabilities. Many older adults and adults with disabilities, when no longer able to remain in their own housing, may need intermediate level assistance provided in supportive housing and assisted living, and not necessarily the 24-hour skilled care provided in a nursing facility. For this reason, it is anticipated that the growing population of older and adults with disabilities in San Francisco will require the development of additional supportive housing and assisted living.

In February 2005, the following motion was unanimously approved:

> *MOTION: That Resolution No.1-012005, adopting findings and recommendations of the Long Term Care Coordinating Council concerning the need for supportive housing and assisted living in San Francisco, and specifically, the need for assisted living as part of the rebuild of Laguna Honda Hospital, be adopted and forwarded to the Office of the Mayor.*

NOTE: LTCCC Resolution No. 1-012005 is attached for your review.

2. **Proposition 63 – planning for behavioral health innovations**

Proposition 63 is a statewide initiative that will generate over $1 billion for mental health care. Of this amount, San Francisco could receive between $30 to $50 million. The process of planning to obtain this funding was discussed. A 40-member planning committee has been created. Vera Haile will represent the LTCCC on San Francisco's Proposition 63 planning committee, which is called the Behavioral Health Innovations Task Force. Other LTCCC members will serve on several of the nine different subcommittees.

3. **Transition from institutional care to community care**

In January, February and March 2005, the LTCCC learned about: (1) plans being undertaken for the closure of the Agnews Developmental Center, located in Santa Clara County, for the developmental disabilities population; and (2) implications for transitions from institutional to community care for older adults and adults with disabilities in San Francisco.

The comprehensive, effective planning for the closure of the Agnews Developmental Center is one model that can help to address the need for comparable planning for community-based care of older adults and adults with disabilities in San Francisco. In April 2005, the LTCCC will begin to develop a comprehensive plan to improve community placements, which will include barriers to successful transitions from institutional living to community living, and the solutions for such successful transitions.

LONG TERM CARE COORDINATING COUNCIL

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

Adopted February 17, 2005

RESOLUTION NO. 1 - 012005

Resolution adopting findings and recommendations of the San Francisco Long Term Care Coordinating Council concerning the need for supportive housing and assisted living in San Francisco, and specifically the need for assisted living as part of the rebuild of Laguna Honda Hospital.

1. WHEREAS, approximately one-fifth of San Francisco's population (approximately 150,000 people) has a disability: and

2. WHEREAS, it is expected that the total number of adults with disabilities will increase in San Francisco, with older adults comprising an increasingly larger share of the disabled population; and

3. WHEREAS, the "oldest old" population, those over 85, is projected to increase by 10,000 people, from approximately 14,000 in 2005 to 24,000 in 2020; and

4. WHEREAS, San Franciscans face an ever increasing demand for home and community-based long term care services for its older and disabled population; and

5. WHEREAS, the 1999 Olmstead decision of the U. S. Supreme Court determined that communities must provide community-based services for persons with disabilities who would otherwise face institutionalization; and

6. WHEREAS, housing with services is the cornerstone of a continuum of home and community-based long term care services for older adults and adults with disabilities; and

7. WHEREAS, many older adults and adults with disabilities, when no longer able to remain in their own housing, may need intermediate level assistance and not necessarily the 24-hour skilled care provided in a nursing facility; and

8. WHEREAS, as recognized in the City's Housing Impediments Report*, available, accessible, and affordable housing is key to enabling older adults and adults with disabilities to remain living in the community; and

9. WHEREAS, the 2000 Consolidated Housing Plan, developed by the Mayor's Office of Housing, states that the City must develop 940 additional supportive housing units (i.e., affordable housing that provides a broad range of on-site and off-site services) for older adults and adults with disabilities who require long-term care; and

10. WHEREAS, even if all 940 units of supportive housing were developed, they would not address all of the demand for such housing needed for older adults and adults with disabilities; and

11. WHEREAS, the 1999 Laguna Honda Hospital bond measure included $15 million to construct a minimum of 140 units of assisted living as well as the reconstruction of a new skilled nursing facility; and

12. WHEREAS, the Board of Supervisors adopted a resolution (No. 336-99) supporting the development of alternatives to
institutional care for seniors and adults with disabilities, including the need for 6,500 more supportive housing units by 2020; now, therefore, be it

RESOLVED, That the Mayor and the City's policy makers:

1. Continue and expand efforts to increase the amount of accessible, affordable supportive housing and assisted living for adults with disabilities and seniors in San Francisco;

2. Provide assurances that the commitment to include 140 units of assisted living at Laguna Honda Hospital, as specified in the bond measure implementation plan, will not be compromised as plans for the replacement of Laguna Honda Hospital are finalized;

3. Explore ways to move up the scheduled construction date of the assisted living units on-site at Laguna Honda Hospital; and

BE IT FURTHER RESOLVED that the Long Term Care Coordinating Council will work to ensure that there is a successful implementation of these policy recommendations.

* Analysis of Impediments to Fair Housing, Appendix B: Housing Impediments/Disability, Mayor's Office of Housing, December 2003.

Planning for Elders

Advocacy
Organizing
Problem-solving
A Catalyst for Change

6 May 2005

The Honorable Gavin Newsom
Mayor, San Francisco
1 Dr. Carlton B. Goodlett Place, Room 200
San Francisco, CA 94102

CC: Margaret Baran & Donna Calame, Co-Chairs, Long Term Care Coordinating Council
Edward M. Harrington, Controller of the City and County of San Francisco
Mitchell H. Katz, MD, City and County of San Francisco Director of Health

Dear Mayor Newsom:

Planning for Elders In-Home Supportive Services (IHSS) & Health Task Force is writing to ask that San Francisco explore resolving the construction cost over-run problems at Laguna Honda by replacing some of the beds with units in an affordable, accessible housing building that includes a licensed adult day health center on site, as proposed by Elizabeth Boardman and Marie Jobling in their memo to you dated May 5, 2005.

The IHSS & Health Task Force is an on-going group that brings all of the stakeholders together to work for improvements in the IHSS Program and in other home and community based services. The Task Force has the long-held position that services provided in home and community based settings are generally most appropriate for seniors and people with disabilities who require supports. Activities have focused on improved wages and benefits for homecare workers, better services to consumers, and more outreach and advocacy to assure those who need assistance receive it. The Task Force also works to support community-based long term care services and developing creative models for housing with supportive services. Our initial planning and feasibility work for the "day health housing project", led to Presentation Senior Community, opened in 2001 at 301 Ellis Street.

Ms. Boardman and Ms. Jobling have provided a detailed list of potential benefits to the City and County in constructing congregate housing with co-located adult day health services in lieu of rebuilding Laguna Honda at 1200 beds. We urge the city to initiate a cost analysis of constructing and operating a housing complex with day health versus a Skilled Nursing Facility like Laguna Honda. We would like to hear back from you on your opinion of this idea and its feasibility, and the results of any cost analysis you perform. Thank you for your consideration.

Sincerely,

Vera Haile
Co-Chair, IHSS and Health Task Force

Norma Satten
Co-Chair, IHSS and Health Task Force

afl-cio-opeiu3/ac

1370 Mission Street, 3rd Floor, San Francisco, CA 94103
Phone: (415) 703-0188 Fax: (415) 703-0186 Email: info@planningfor elders www.seniorsurvivalschool.org www.planningforelders.org

Mission Creek Day Health Development Project

191 Chilton Avenue
San Francisco CA 94131

MEMO

TO **Mayor Gavin Newsom**
FROM Marie Jobling and Elizabeth Boardman
DATE **May 5, 2005 Upgrade** (A)

RE **DAY HEALTH -- HOUSING MODEL**

Could the cost over-run problems at Laguna Honda be resolved by replacing some of the beds with units in a senior housing building that includes a licensed adult day health center on site, as modeled by Presentation and Mission Creek? (B)

A. Various alternatives to skilled nursing facilities for frail elders and disabled adults of all ages

We are all quick to talk about capitated managed care, supportive housing, and assisted living. But we also know that these concepts are poorly defined state-wide, and that there is no money forthcoming at this time to pay for them. (AB 469 has died in process.) Perhaps some time in the future.....

B. Combining congregate housing with adult day health services

Low-income housing and adult day health are clearly defined, known services with revenue streams available. They have been successfully combined in various ways in our town (A), and are proven to be cost effective and attractive to clients.

We'd like to see the Long-term Care Coordinating Council recommend that the city develop one or more buildings which combine housing and day health as a substitute for some of the Laguna Honda beds. It could be done quite rapidly under the current circumstances. Here are the factors in favor of such a move.

1. The city already has the land, at Laguna Honda and elsewhere
2. The city already has construction money, in the LHH bonds pot, the Mayor's Office on Housing, and, for some neighborhoods, the SF Redevelopment Agency budgets.
3. The state Multifamily Housing Program has specified that their funds can be used for day health/housing projects for adults of all ages. (It would be best not to use HUD construction money, because it takes too long and the eligibility criteria are too restrictive.)
4. In a day health/housing project, the resident would have a little apartment instead of a room, but the construction cost would be about half the projected cost per bed at LHH
5. Probably some patients would prefer to share an apartment, which would further reduce the cost.
6. The housing segment of a day health/housing project probably will not have to be built according to RCFE standards and probably will not have to be licensed

7. Any one of the experienced adult day health providers in the city, including Laguna Honda's own, could operate the adult day health program in a new building (or buildings). (Note: The current moratorium on MediCal certification of new adult day health centers will certainly be lifted within a year or two, and waivers from the moratorium are likely to be allowed.)
8. The minimum age for adult day health care is 18, so younger disabled adults can be included.
9. Patients at LHH by definition need to be cared for by the array of professional and paraprofessional staff required in a skilled nursing facility. This is exactly the same staffing required in a licensed adult day health service.
10. Some civil service workers now employed at LHH could be transferred to the new day health center(s).
11. Although civil service staff would cost much more than public sector labor, the per patient day cost for the basic package would be much less than the $360 ppd now spent at LHH. Here's a rough estimate: day health (including main meal) might be about $120 per day, Section 8 rent about $50 per day, and four hours of IHSS about $60 per day, for a total of $230, most of it coming from outside the city.
12. If extra support is required for dual diagnosis and mental health patients, city mental health or FQHC (federally qualified health center) staff could be used to supplement the day health staffing, with funding coming from outside the county.
13. Building up census is the biggest hurdle for a new adult day health care program. In this case, the target population is willing and ready, according to the TCM program, which reported on 4/18/05 that 755 LHH patients are now on the waiting list for the Nursing Facility Waiver program.
14. Moreover, NF Waiver funding might be utilized for some of the health care and case management costs if the state program is expanded.
15. There is a mechanism (via AB 915) for getting a match from the federal government for city expenditures at an adult day health service. This might help cover an additional staffing costs needed in a day health/housing project providing care for people at an advanced level of need.

(A) Earlier versions of this paper (April 22, May 3) have been sent to the members of the Long-term Care Coordinating Council, Mark Trotz, Mitch Katz, the PECC IHSS/Health Task Force, and the controller's consultants at Health Management Associates. It has been accepted favorably so far.

(B) Presentation Senior Community at 301 Ellis (at Taylor) has been operated successfully for over four years by Mercy Services Incorporated. Sixty of the apartments are available only to tenants who have been determined to be frail and disabled. North and South Market Adult Day Health manages the adult day health program there.

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

5.31 *For more information, contact Elizabeth Boardman, 452-1526.*