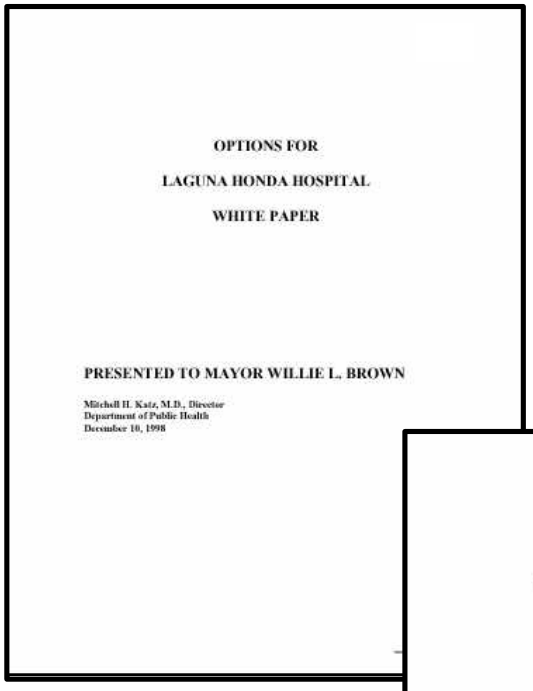
Committee to Save Laguna Honda Hospital and Rehabilitation Center

This report is available on-line at **www.stopLHHdownsize.com**

Committee to Save LHH *Report*

Downsizing of Laguna Honda Hospital and Rehabilitation Center's Replacement Facility:

Irresponsible Proposal to Eliminate One-Third of LHH's 1,200 Skilled Nursing Beds Is Driven by Politics — and Flawed Data



OPTIONS FOR

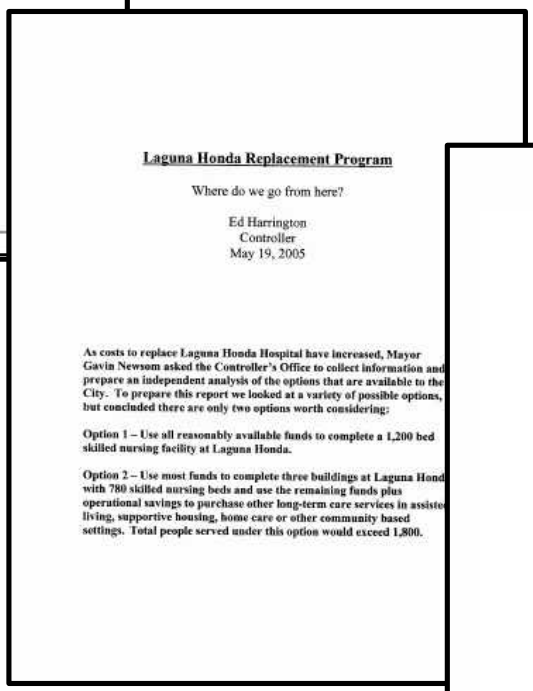
LAGUNA HONDA HOSPITAL

WHITE PAPER

PRESENTED TO MAYOR WILLIE L. BROWN

Mitchell H. Katz, M.D., Director
Department of Public Health
December 10, 1998

Options for Laguna Honda Hospital White Paper; December 10, 1998; 29 pages.
Author:
Mitch Katz, MD, Director of Public Health



Laguna Honda Replacement Program

Where do we go from here?

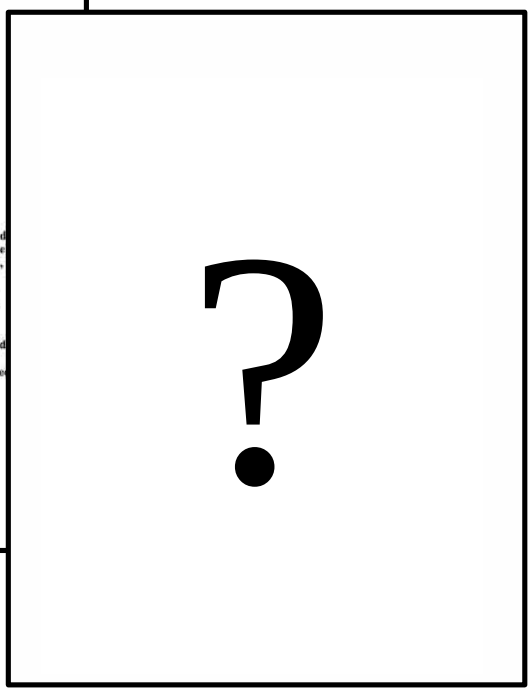
Ed Harrington
Controller
May 19, 2005

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 Hond with 780 skilled nursing beds and use the remaining funds plus operational savings to purchase other long-term care services in assiste living, supportive housing, home care or other community based settings. Total people served under this option would exceed 1,800.

Laguna Honda Replacement Program — Where do we go from here?; May 19, 2005; four-and-a-quarter pages
Author:
Ed Harrington, City Controller



Nearly 90 days after Health Commission President Lee Ann Monfredini ordered on March 15, 2005 a new "White Paper" on options for Rebuilding Laguna Honda Hospital, Mitch Katz, MD, Director of Public Health delivered on June 7, 2005 a four-and-a-half page report, not a White Paper.

July 23, 2005
Final Version

Downsizing Laguna Honda Hospital: Fulfilling the Politician's — Not the People's — Vision

"Let's stop playing politics with our most vulnerable citizens."

— Board of Supervisors Proponent's Argument in Favor of Proposition A in 1999

Hint: The politician known as former City Attorney Louise Renne, — who admitted on June 1, 2005 that it was she who had authored "Proposition A" in 1999 [which used really vague language tricking voters into believing what they would actually be voting on], and who on Friday May 20, 2005 single-handedly convinced the Laguna Honda Foundation to suspend its operations — should pay particular attention to the admonition to get politicians out of the affairs of LHH. The LHH Foundation, a non-profit organization that Renne set up, lacked a Memorandum of Understanding with either Laguna Honda Hospital or the City and County of San Francisco. The Foundation's Fall 2004 newsletter, *Voices of Laguna Honda*, carried a front-page story entitled "The New Laguna Honda: Fulfilling the People's Vision." The news story might better have been entitled "The Downsized Laguna Honda: Fulfilling the Politician's Vision," since that lead article claimed, most probably guided by Renne's editorial pen, that ***the replacement facility for LHH would "move Laguna Honda from a traditional medical model to a social residential model of care"*** in order to please Renne's political puppet-masters. During a June 1, 2005 meeting with select members of the 1999 Planning Committee for the LHH Rebuild, Renne wept crocodile tears, staging a performance worthy of an Academy Award over her angst that LHH's reputation was being adversely affected by "negative publicity." If she only had the courage, Renne would acknowledge that the negative publicity is largely of her own, and other politician's, doing as a direct result of the now 16-month dispute regarding the LHH admissions policy.

This change in the model of care coincides with the current social rehabilitation grant being implemented as a pilot program at LHH that will eventually be implemented on all 40 wards, which involves replacing the skilled nursing model of care for the elderly with a self-care model of care for younger patients, instead. Despite the Mayor's order to return LHH's admission policy and patient population mix to its pre-March 2004 composition serving San Francisco's frail elderly who need the skilled nursing model of care, Renne's vision for a "social rehabilitation model of care" is intended under the social rehab grant to serve a younger patient population, who are ***theoretically*** now not to be admitted to LHH.

It's time to ask this particular politician — and others — to stop playing politics with our frail elderly and disabled citizens ***who need Laguna Honda's skilled nursing model of care***.

Stop Playing Politics With LHH's Vulnerable Residents!

Contents

Front Matter

Board of Supervisors and Health Commission Found Talk in 1999 "Irresponsible"

In the 1999 Voter Guide, prominent City Officials said talk of rebuilding a smaller Laguna Honda Hospital was "irresponsible:

"Talk of utilizing 'community-based long-term care providers' is irresponsible, since San Francisco already faces a severe shortage of long-term care beds. … Let's stop playing politics with our most vulnerable citizens."

— **Board of Supervisors**[1]

"Talk of a 'smaller Laguna Honda' by Proposition A opponents is irresponsible for many reasons:

- San Francisco already faces a severe shortage of long-term care nursing care beds.
- The shortage will worsen as San Francisco's population ages.
- The total cost to taxpayers of building other, smaller facilities throughout the city to meet current and future needs would be much, much greater — if appropriate sites could even be found."

— **Health Commission President Lee Ann Mondfredini**, and Other Health Commissioners[2]

How Supervisors Voted to Place Proposition A on the Ballot on June 21, 1999:

- Supervisors Ammiano, Becerril, Bierman, Brown, Katz, Leno, Teng, Yaki, and Yee voted "Yes."
- Supervisors Kaufman and ***Newsom voted "No."***

How Supervisors Voted to Submit the Proponents' Argument on August 16, 1999:

- Supervisors Ammiano, Becerril, Bierman, Brown, Katz, Leno, Yaki, and Yee voted "Yes."
- Supervisors Kaufman and ***Newsom voted "No."***
- Supervisor Teng was absent.

How Supervisors Voted to Submit the Proponents' Rebuttal (to Opponent's Argument) on August 23, 1999:

- Supervisors Ammiano, Becerril, Bierman, Brown, Katz, Leno, Teng, Yaki, and Yee voted "Yes."
- Supervisors Kaufman and ***Newsom voted "No."***

[1] 1999 San Francisco Voter Guide, page 35.
[2] Ibid., page 43.

Extract of Board of Supervisors Proponent's Argument[3] in Favor of 1999 Proposition A

- Since 1866 San Francisco has cared for our **elderly and disabled** at Laguna Honda Hospital. Proposition A enables us to continue fulfilling this moral obligation into the next century. From both healthcare and financial standpoints, Proposition A prevents a catastrophe we cannot afford.
- ***Thousands*** of San Francisco families have depended on Laguna Honda Hospital to provide compassionate **medical care** for **elderly and disabled** family members whose needs cannot be met at home
- As San Francisco's **elderly** population increases, the need for Laguna Honda will be even greater.
- While the majority of Laguna Honda residents are **elderly**, many are people of all ages — born with **disabilities**, survivors of debilitating illnesses or severely injured in accidents.
- If Laguna Honda closed, with San Francisco's **severe shortage of nursing home beds**, many patients would fail at home, requiring them to seek expensive emergency room treatment and acute care in hospitals such as San Francisco General.
- This **long-term care** hospital is the last resort for **disabled and senior** San Franciscans who can't afford other facilities. If it closes, they have nowhere to go.
- Painstaking analysis by healthcare, finance and social service experts shows that rebuilding Laguna Honda Hospital is the least expensive way to provide quality healthcare to the greatest number of San Francisco's **elderly and disabled**.
- Yes, rebuilding Laguna Honda is expensive, but other alternatives serving the same number of people would be far more costly. ***Talk of utilizing "community-based long-term care providers" is irresponsible***, since San Francisco already faces a severe **shortage of long-term care beds**. The situation will only get worse as San Francisco's Baby Boomer population ages. Laguna Honda Provides extensive 24 hour, 7 day a week care unavailable in community settings.
- Dispersing Laguna Honda's population to smaller public facilities would require wasteful duplication of costly medical equipment. And where would these facilities by located? … Commercial areas are inappropriate as the home for **frail elderly and disabled** San Franciscans.
- ***Let's stop playing politics with our most vulnerable citizens***.

[3] Ibid., pages 34–35.

Executive Summary[4]

The long-awaited audit of Laguna Honda Hospital has been released, and it's worse than previously expected. Rather than losing up to one-third of Laguna Honda's skilled nursing (SNF) beds, the Chicago auditing firm, Health Management Associates (HMA), has weighed in[5], and are recommending the City reconsider the LHH rebuild plan, and possibly build only three 200-bed buildings on the LHH campus — and they're not saying what kind of beds should be included in the 600-bed recommendation, nor what kind of patients will be served in such a configuration.

HMA is also recommending that the City consider that "special hard-to-place populations" be given priority for beds on the LHH replacement campus. In the end, San Francisco may loose up to 740 skilled nursing beds in one fell swoop — leaving only 150 SNF beds, if we're lucky.

This report examines four of the six documents involved in the house of cards illustrated in Figure 1 [the shaded reports]. The remaining two reports will be examined in a separate *Committee to Save LHH* report.

Notably, HMA based its report, in part (despite advanced warning), on dubious Targeted Case Management data that even Dr. Katz doubts.

Figure 1:
LHH Rebuild Is Based on a Flawed House of Cards

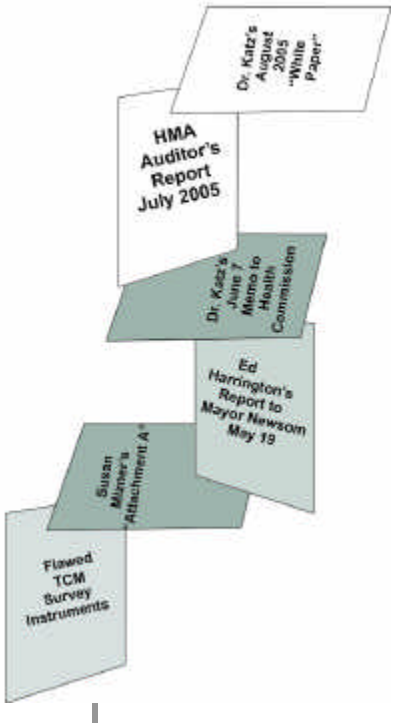


Table 1: LHH's Skilled Nursing Beds May Be Cut from 890 to 150

	Current LHH Capacity	City Controller's "Option 2"	HMA Auditor's July 2005 Recommendation †
Rehabilitation Unit	26	60	60
AIDS Unit	30	60	60
Hospice	26	30	30
Acute Hospital	26	15	0
Locked Units	67	300	300
Medical Specialty Subtotal	**175**	**465**	**450**
SNF Beds	890	315	150
Total Beds at LHH	**1,065**	**780**	**600**
Assisted Living Beds		235	?
Planned Total Beds at LHH		**1,015**	**600**

† The Chicago auditors, Health Management Associates has not stratified what kind of beds should be built, nor which medical specialty units should receive how many beds. They have only recommended that The City re-consider building only three 200-bed buildings on the LHH campus. This table seeks to illustrate that LHH may lose 740 SNF beds in one fell swoop if the auditors recommendations are implemented and the current promises to the medical specialty units are honored, not gutted. Note the acute beds loss.

4 The Executive Summary does not include references; please refer to the body of this report for citations.

5 Health Management Associates (2005, July). *The San Francisco Department of Public Health: Its Effectiveness as an Integrated Health Care Delivery System and Provider of a Continuum of Long Term Care Services.*

Data presented in 2005 by Benson Nadell, San Francisco's Long-Term Care Ombudsman, before the Board of Supervisors reported that there are only 2,658 Medi-Cal eligible beds in San Francisco (about half at LHH and half in private nursing homes.

The 967-bed difference between Dr. Katz's and Nadell's data is significant, for it suggests San Francisco may face a critical shortage of 3,767 skilled nursing beds — not the 2,380 that Katz reported in his 1998 White Paper — if Laguna Honda's skilled nursing beds are cut by 420 beds as recommended by City Controller Ed Harrington on May 19, 2005. The shortage of 3,767 skilled nursing beds in the City will occur at the same time that San Francisco will have an additional 15,091 people over the age of 65 who have mobility and/or self-care limitations, many of whom may need skilled nursing care.

Adjusting for the possible error in Katz's 1998 projections of how many SNF beds in San Francisco accept Medi-Cal reimbursement, and the projected downsizing of LHH's SNF beds, San Francisco may be short a total of 3,767 SNF beds ***just for those over the age of 65*** by the year 2020, or 1,387 more than Katz's 1998 estimate.

This is no time to be considering eliminating one-third (or more) of LHH's SNF beds!

If the decision is made to cut 420 SNF beds at LHH, San Francisco will lose more SNF beds in one fell swoop than it has lost between 1992 and 2005, exacerbating the loss of SNF beds since 1992 from 300, to a total of 720. And if the Health Management Associates recommendations are implemented and LHH loses 740 SNF beds in one fell swoop, San Francisco will have lost over 1,000 SNF beds during a short, 13-year period.

This will pose a severe crisis in San Francisco, particularly if additional closures of nursing home or board-and-care facilities occur in the near future!

Had there been no cost overruns, the LHH replacement project team would be moving full steam ahead building ***all*** of Laguna Honda's 1,200 beds. There would have been no need to go back to re-debating whether or not to proceed, as the rebuild would have already begun. And we wouldn't now be repeating the same discussion that we had six years ago, when 73% of the voters expressed their will by approving bond financing and tobacco settlement funds to build a ***replacement*** facility for Laguna Honda Hospital. Most people understand the term "replace" to mean a 1:1 replacement; when people talk of replacing an 18-wheel semi, they don't settle for a four-wheel jeep. Voters approved ***replacing*** a 1,200-bed skilled nursing facility, and that's exactly what they expect to get.

And it is completely irresponsible of the Mayor to now suggest that tobacco settlement revenues approved in 1999 to rebuild LHH should be used for "housing," instead. Voters were led into believing they were approving bond financing to build 1,200 skilled nursing beds — not housing — and any other outcome for the Laguna Honda Replacement Facility will be irresponsible meddling by politicians.

Mayor Newsom isn't trying to "frame community discussion," he's trying to divert the tobacco settlement funds voters approved for use in reconstructing LHH to his pet project — solving homelessness — by creatively reinterpreting the will of the voters, and promises made in 1999, instead.

So what will happen to the LHH rebuild? Well, if Herb Levine, Executive Director of the Independent Living Resource Center, gets his way, San Francisco will not even get the 780 beds that City Controller Ed Harrington recommended as "Option 2" to Mayor Newsom on May 19. That will be because Mr. Levine noted during a community forum regarding the LHH replacement project that was held On Lok's Adult Day Health Center on June 29 that the disability rights movement does not believe that the City has ***only*** two options regarding the LHH replacement project, and that his organization believes that there are many more options than just two which should be considered.

Hang on to your seats, folks. The "public policy debate" Mayor Newsom has called for is now back to square one, and Harrington's two options are off of the table, at least as far as Mr. Levine is concerned.. LHH's future is just beginning to be debated again ... and the outcome won't be determined for months, or years.

The First Four Flawed Reports: Constructing a Shaky House of Cards

The public policy debate that is occurring over how to proceed with the rebuild of Laguna Honda Hospital is all based on wildly inaccurate data "estimated" by the Targeted Case Management (TCM) team that is led by DPH's Director of Placement, Liz Gray. Rather than mining several DPH databases, most notably the MDS system (Minimum Data Set), the TCM staff surveyed LHH residents and concluded that 84% of LHH's residents could live independently in the community. Despite the fact that this wild assertion has been denounced as completely inaccurate by some LHH medical staff, the claim has made its way into the first four reports, and was also cited in the fifth report (the Health Management Associates "audit," which will be examined in a separate analysis).

Shaky Foundation: Liz Gray's Targeted Case Management Survey Instrument

A partial answer to how the TCM staff — most probably Liz Gray, advising Mizner — arrived at the "estimate" that 84% of LHH's residents are able to reside outside of a skilled nursing facility such as LHH lies with a single question posed to LHH's residents. The "estimate" was arrived at by asking LHH residents a simple — and irresponsibly simplistic single — question: "Do you want to reside in the community?" Residents who responded "yes" were included in the 84%. ***This is not scientific research; this is pseudo-science at its worst,*** as is often the case with data from Nursing staff not rigorously trained in data analysis**.** And this percentage does not accurately reflect that 84% ***can*** reside in the community; at best it only demonstrates that 84% may ***want*** to live in the community. As such, the 84% figure is little more than an anecdotal report, ***not*** evidence-based practice.

- Liz Gray asserts in her June presentation that 86% of 1,303 patients ***screened*** are eligible for the TCM program. Mizner, however, asserted that 84% — not 86% — of LHH residents are able to leave LHH's skilled nursing facility.
- Of the those Gray's TCM team ***screened*** and reportedly found eligible, fully 66% expressed their preference to be placed in a nursing home. You can't have 84% of LHH's residents "able" to leave LHH when 66% of them have expressed their preference to remain in a nursing home, the overwhelming majority of whom will need nursing homes that accept Medi-Cal. Those who may have expressed such preference are not "able" to leave LHH, since on another slide, Gray notes that 67% expressed their preference ***not*** to return to the community.
- Gray reports that 324 (29%) of those assessed are "severely" cognitively impaired, and another 414 (37%) have "moderate" cognitive impairments. Between "severe" and "moderate," cognitive functional ability, fully 66% of Gray's sample of LHH residents have cognitive impairments. It is extremely unlikely that ***severely*** cognitively impaired people can live ***safely*** in the community without a lot of 24/7 care, given their diminished capacity for safety awareness.
- Gray reports that 47% of her assessments were female, and 53% male. This contrasts sharply with data on the LHH Replacement Project web site that indicates that 56% of LHH residents in 1998–1999 were women, and only 44% were men. In just six short years, the gender demographics of LHH residents have completely swapped. Statistically, this could not possibly have occurred through attrition or changing healthcare needs, particularly since women are the fastest growing segment of those over the age of 85 and those over the age of 65. Instead, ever since the introduction of seven "psychosocial" wards at LHH in 2001 — which displaced hundreds of frail elderly residents — a concerted effort has been underway to socially reengineer the demographics of people being admitted to LHH by favoring men with "behavior" problems over frail elderly women.
- Gray reports that only 12% of those assessed have a support person who are positive about the prospects for discharge. If 88% of the support people are opposed to discharge planing of those residents they are trying to protect, Mizner and the Mayor must be completely miscalculating the level of support among voters in the community who want LHH preserved as a long-term care skilled nursing facility.

In fact, in the year that the TCM program has been in place, only one briefing has been supplied by the TCM Director of Placement to LHH staff, during which meeting handouts of data were not provided, because of a fear they would be misinterpreted without staff being guided through the reading. Despite concerns raised by LHH clinicians during that meeting that the TCM documentation was not being integrated into LHH residents' medical charts, more than 12 months into the TCM project, the TCM "screening" tool, the full TCM "assessment," and progress notes by TCM social workers are still not (as of this writing) being integrated into LHH medical charts, let alone being shared with LHH's staff. So LHH staff are

not being told what the TCM staff is doing, and there is no opportunity for LHH staff to provide independent clinical oversight into what the TCM case managers are doing for LHH residents.

Shaky Subflooring: Susan Mizner's "Attachment A"

Mizner's first assumption is that "currently 84% of the LHH residents" are able to leave a skilled nursing facility, according to [flawed] data obtained from the Targeted Case Management program.

Mizner's second flawed assumption is that "about 40% of LHH's residents have a "primary psychiatric diagnosis or substance abuse issue." Patients need a primary medical diagnosis to be eligible for LHH's SNF level of care, and LHH is not permitted to accept patients whose primary diagnosis is psychiatric.

Neither assumption is true, as they rely of the flawed, substantial problems with the TCM data. But that doesn't stop Susan Mizner, the director of the Mayor's Office of Disability, from indicating that TCM staff have ***estimated*** that 25% of LHH' residents would *prefer* to go to a B&C, 50% would *prefer* supportive housing, and 25% would *prefer* home or independent living, with additional supports. If the *SF GetCare* database was anywhere near accurate, why would anyone need an "estimate"; wouldn't the database be capable of accurately reporting real, actual numbers of ***needs***, not estimates of ***preferences***?

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Mizner's second flawed assumption is that "about 40% of LHH's residents have a "primary psychiatric diagnosis or substance abuse issue." Patients need a primary medical diagnosis to be eligible for LHH's SNF level of care, and LHH is not permitted to accept patients whose primary diagnosis is psychiatric.

Neither assumption is true.

The first version of Mizner's report obtained under the Sunshine Ordinance is a four-and-two-thirds-page document, which — when Harrington subsequently claimed was an "extract" — shrank to four-and-a-quarter-page "Attachment A," containing almost the same information as the first version. ***As such, "Attachment A" was merely a* revision *of Mizner's original report,* not *an extract.*** The record obtained under Sunshine was described as being "in its original form." So it is also instructive to compare the original report to its subsequent incarnation as an "extract."

The first change is that the subtitle in the original report — "What $6 Million Can Buy in the Community" — was removed from Attachment A. The only other changes were in the section "Background and Summary" (which change is discussed below), and a "Conclusion" section that appeared in the original report, but which was inexplicably removed from the version "Attachment A."

Using revisionist history straight out of the box, Mizner's revised Attachment A included in Harrington's May19 report to the Mayor stated:

> "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?"

Nothing could be further from the truth! The City did ***not*** set out to consider adding funding for home- and community-based long-term services, it set out to consider and explore how to finance the rebuild of ***all*** 1,200 beds at Laguna Honda. Because in truth, that is ***precisely*** what Mizner's opening sentence in the "original report" had indicated — that the City had set out to explore adding additional funding to ensure LHH would be rebuilt as promised (bold italics in the quote below highlights original text that was subsequently deleted from the Attachment A "revision"):

> "The City is considering ***using an additional $90 million to $100 million to increase the number of skilled nursing beds that could be re-built at Laguna Honda Hospital***. The question presented is what community care could be provided ***if that same amount of money were to be put in a trust, with approximately $6 million in interest available for community services***."

It is significant that by revising Mizner's opening sentence, clearly someone wanted to downplay the fact that a plan was being hatched to create a second trust fund — to be endowed using $100 million from the first tobacco settlement revenue account that is also a trust fund — to be used ***for a completely different purpose*** than what voters had approved when Proposition A was passed in 1999 … without first obtaining voter approval to create a second trust fund.

The key difference between the two versions of Mizner's opening sentence is that the focus shifted from taking $100 million out of tobacco settlement revenues (since the City is now estimating it will receive $820 million in TSR's) for rebuilding LHH by depositing the same $100 million into a new trust fund.

Notably, by the time Harrington wrote his May 19 financing recommendations two weeks after Mizner's original report, the $100 million proposed for a new trust fund had mysteriously shrunk to only $80 million — representing a 20% decline. But more mysteriously, the amount of estimated interest generated annually from a possible new trust fund had dropped from $6 million to Harrington's "***about***" $5.4 million — representing a 10% decline in expected interest earnings. Did Harrington know that interest rates were higher than lawyer Mizner's knowledge of interest rates? Or is this more like ***the miracle of the fish and loaves*** reported in chapter Mark 8 of Bible, despite our separation of church and state? ***Can a 20% decline in the size of a second endowed trust fund* really *yield only a 10% decline in projected interest earnings?***

Neither the folks at TCM nor Mizner stratify the age cohorts of the purported 84% who can be discharged from LHH. This is important, because the "E" in "PACE" stands for "Elderly," defined as those over age 55. Clearly, many of the purported 84% are below age of 55, and therefore, don't meet PACE (Programs of All-inclusive Care for of the Elderly) eligibility requirements.

In discussing various community-based alternatives to care at LHH, Mizner discusses board ad care facilities. Both versions of Mizner's report claim that the cost to San Francisco would be a "straightforward 'patch' " to owners of board and care facilities to provide the ***difference*** between a resident's SSI or Social Security income and the cost of the B&C bed.

B&C facilities (most probably to limit their risk, under risk-management programs), carefully screen referrals, and only accept those who require minimal assistance. Many B&C's, will not accept resident's who are incontinent, many patients who have physical limitations are precluded from residing in a B&C. Most B&C's provide minimal services (meals, bed, laundry), and rarely provide transportation. Activities at B&C are usually limited to a television, as compared to the Activity Therapy program at LHH, which is rich with activities to stimulate LHH residents, including trips into the community. Non-ambulatory residents at B&C's are rarely involved with community activities outside of the actual B&C facility, so they would be condemned to a small mom-and-pop, family operated, three- to four-bedroom home, with an in-law unit where the operator lives. Many of the B&C's are small, darkened environments, with the shades perpetually pulled drawn, with tenants sitting silently alone or propped in front of a television all day to baby sit them. ***Is this really how we want elderly San Franciscans discharged from LHH treated, and is this what we call an improvement over institutionalization*****?**

Mizner's second footnote is troubling because it claims there are currently 315 slots available at residential- or board-and-care facilities. This is problematic for several reasons: First, Benson Nadell provided data documenting that of the City's B&C's that accept SSI, the occupancy rate is 96%; it is unclear how many of the 315 slots claimed are available will actually take SSI patients. Second, Mizner and the TCM staff offer no explanation about how many of the 40% of LHH they claim have primary psychiatric diagnoses are receiving SSI ***and who*** have manageable behaviors that could be safely cared for in any of the purported 315 slots, if any of the B&C's are licensed for psychiatric patients. Third, because many of the B&C are "mom-and-pop" shops, it is unclear how many of them are equipped to accept patients with behavioral issues.

Mitch Katz, Director of Public Health, was forced to acknowledge Mizner's inaccuracies to the Health Commission on June 7:

> "Some issues have been raised as to whether the capacities of some of the community providers listed in [Mizner's] document are accurate."

It is in the "Supportive Housing" section of the two versions of Mizner's report that contain the most irresponsible and serious flaws. She indicates supportive housing comes in a range of forms, including HUD housing. However, HUD buildings are not considered "Supportive Housing," as Mizner claimed. These buildings are considered independent housing, HUD does not fund supportive services, and eligibility requirements are completely different for supportive vs. independent housing.

For the 50 people she "estimated" would chose supportive housing, Mizner's report does not explain, let alone fully, how service needs for the "estimated" 50 people were determined. Obviously each batch of 50, and those within each batch of 50, are going to have quite varying levels of ***actual and individual*** care needs, but all Mizner presents are average costs, with no breakout of the level of acuity or the varying care needs for these 50 people.

Although Mizner claims that healthcare costs for people in supportive housing ***might*** be paid for through waiver programs, she does not discuss that "waiver programs" are relatively new and not much used. Nor does she mention:

- Waivers do not provide 24-hour services.
- A resident can only sign up for one waiver (i.e., if a resident signs up for MSSP, that resident is not eligible for the HCBS waiver).
- A resident needs to remain cost neutral in order to be eligible for waivers. If the cost of services provided in the community using waivers costs more than care in a SNF facility, Medi-Cal will only cover the SNF-level of services.
- Waivers are not the ultimate solution, because once an individual utilizes services available in the community, the amount of services the waiver can provide is reduced.

She then makes unfounded assumptions about Supportive Housing utilization.

IHSS Costs (In Home Support Services):

- Of the 50 people needing supportive housing, Mizner claims only 5 would need IHSS services. However, there is no proof — only estimates — that not all 50 would need IHSS assistance, possibly at greater cost than Mizner estimates.
- Mizner neglects to note that of 50+ discharges from LHH last year, IHSS only granted the maximum number of *extended* hours per month to just one person. Additionally, over the past two years, IHSS has been decreasing the number of approved hours, and has increased the waiting period for the start of home-based care.
- She notes that "any medical care needed would be covered by Medi-Cal, through visits to community clinics, etc.," but she fails to note that a) DPH's

clinic system is running at full capacity, some clinics are being threatened with regulatory closure, or are facing the possibility of funding cuts, and b)

- Mizner ignores that the IHSS system is unable to carry the current level of discharges from LHH and is limiting services to LHH dischargees, and/or increasing the wait for the start of care.

PACE Program:

- Mizner claims that there is a "program with 300 [PACE] slots currently available." This single unsupportable exaggeration is what Dr. Katz was referring to in his June 7 memo to the Health Commission noting questions have been raised whether some of the capacity statements claimed in Mizner's report(s) "are accurate." Indeed, just nine days after Katz's June 7 memo, the Long-Term Care Coordinating Council released a report on June 16 indicating that only 130 – not 300 — PACE slots are currently available, yet Ed Harrington's report to the Mayor on May 19 was based on Mizner's grossly over-estimated, flawed data.
- First, a resident needs to receive several interviews with PACE program staff for a thorough medical and psychiatric evaluation prior to being admitted to the program. ***Historically, residents who are medically complex can be denied admission to a PACE program.*** Residents may also not qualify for the program after the evaluation if they are deemed too close to needing SNF-level of care. Yet neither Mizner nor the TCM staff ackowledge that multiple of LHH's many wards are, in fact, dedicated to medically-complex patients who will most certainly be denied eligibility for a PACE slot.
- During the June 7, 2005 Health Commission meeting, one expert describing the PACE slots noted eligibility rules to PACE programs require the applicant to give up their primary care physician, as most managed care health insurance plans do. Many residents do not want — and refuse — to leave their primary care physician, and are thus ineligible for PACE programs.
- Eligibility rules for PACE slots may prevent many of LHH's residents from qualifying. For instance, the eligibility guidelines for On Lok's PACE program ***excludes*** people who:
  - Are on dialysis.
  - Have a psychiatric disorder requiring intensive intervention
  - Are presently homeless
  - Actively abuse substances
  - Lives in an unsafe place (for themselves and/or the providers)
  - Have dangerous behavior(s)
- Mizner does not stratify what percentage of the purported 84% of LHH residents the TCM program claims could be discharged to the community have one or more of the exclusion criteria that would ***prevent*** them from being accepted into a PACE program.

- Because the platform for PACE slots are ADHC programs, many of LHH's residents have a higher acuity level than most ADHC's will accept, disqualifying them for the PACE slot.

ADHC (Adult Day Health Care) Programs:

- As noted, San Francisco's ADHC network is now operating at full capacity, and the waiting lists for ADHC programs are usually three- to six-months, or longer. Currently, there is only one ADHC (the Institute On Aging's Golden Gate Center) in the Tenderloin that has only a three- to six-month waiting list. Each ADHC has its catchment area, and usually does not accept participants from other catchment areas, unless they are nearby and they obtain a waiver from the ADHC of their catchment area.
- ADHC's require a higher level of physical functional ability than many of LHH's residents have. For example, ADHC's often will not accept patients who can only be transferred using Hoyer lifts.

Independent Housing:

Mizner wisely notes in the opening paragraph of this section that estimating costs for independent housing "is the most difficult category to ***average***." But it is not *average* costs that need to be addressed, but ***actual*** costs, since there is virtually no independent housing to be had in the City, particularly since this category involves housing costs, personal services costs, and medical costs.

The most glaring problem with this section is that completely missing from Mizner's analysis is any discussion about patients who rely on Medi-Cal, which does ***not*** pay costs for independent housing — or for any other form of housing. And though she admits that "some" of the 25 who have ostensibly indicated that this is their "preference," she estimates a raw number of "8" would probably want a subsidy.

- 50% (12) of the 25 "could return to housing they were previously in, usually government subsidized (e.g., Housing Authority) or to Section 8 housing," there would be additional costs to the County for home modifications. But there are problems with this: a) There's a question about whether San Francisco is allowed to modify Section 8 housing to make it "accessible," and — much more glaringly problematic — b) There are no long-term care residents at LHH who have access to Section 8 housing. Mizner's claims, therefore, have to be viewed as purely hypothetical, not reality-based.
- Section 8 is currently ***not*** accepting applications, and hasn't accepted applications for years, since that waiting list has been closed for several years. Further, the current Section 8 waiting list is expected to last anywhere from five to eight years before people will even be offered Section 8 ***applications***.

While she wrote a "Conclusion" section on May 5, political forces appear to have determined that conclusions Mizner had already reached needed to be censored

from widespread public view. Her conclusions were, therefore, surgically excised from Harrington's "Attachment A" May 19 report to the Mayor.

Other issues Mizner's report does not even begin to address, or cost out, include:

- Home delivered-meals are not as readily available as Mizner assumes. Currently, the Meals on Wheels program to deliver food to home-bound seniors now has a waiting list, and often does, with estimated wait times of weeks to months depending on demand. The Health at Home meals program through the Salvation Army provides home delivered meals only in the Tenderloin and South of Market areas. All home delivered food programs, including Project Open Hand's, are limited to one meal per day; some programs deliver only five days a week, while others cover all seven days. Unfortunately, some programs deliver only bagged peanut-butter-and-jelly sandwiches. Few programs have nutritionists who can assess and develop diets for individual clients who need specialized feeding plans.
- Eliminating 420 SNF beds from LHH will lead to fewer discharge locations for SFGH's acute care patients, exacerbating the very "diversion" to other Bay Area acute hospitals that Katz claims is of such a concern to DPH.
- Those patients with an "NG" or "G" tube for feeding, which patients many B&C facilities refuse to accept for admission, due to their acuity level(s).
- Undocumented residents with SNF-level only Medi-Cal coverage.
- Diabetics who are incapable of managing gluco checks and insulin injections.
- Those who are at risk of elopement and wandering.
- Mizner's report does not take into consideration residents who are not straight Medi-Cal. Residents may have Medi-Cal ***Share of Cost*** or additional medical expenses — including prescription medications — that they have to pay out of pocket if they are not straight Medi-Cal.
- Community placement can be too isolating for some patients with severe cognitive impairments or who have extensive nursing care needs.
- In a report first presented on June 16, additional costs that would need to be factored in to a cost/benefit analysis of whether community-based care would be more expensive than care at LHH, the following needs for a "so-called "Community Living Fund" (the second "endowed" trust fund using $100 million in tobacco settlement revenue) were presented. But to date, neither Mizner nor Harrington have released any costing information for these additional services:
  - Housing for caregivers/family members.
  - Transitional living training.
  - Money management services.
  - Transportation services.
  - Availability of 24-hour supervision.
  - Citywide, coordinated case management.

Shaky Framing: Ed Harrington's May 19 Recommendations to the Mayor

Harrington's May 19 financing options to rebuild LHH is premised entirely on Attachment A, a three-and-a-quarter-page set of flawed estimates excerpted from a report prepared by Susan Mizner in the Mayor's Office of Disability.

The most serious flaws in the glass of Harrington's report are contained in its Attachment A, since its flawed data is used throughout Harrington's skimpy four-and-a-quarter-page "report" as the basis for arguing that Option 2 — to eliminate 420 of LHH's SNF beds — should be considered in a new public policy debate.

Patrick Monette-Shaw's lawsuit alleged that the 1999 Voter Guide's Ballot Simplification Committee's "digest" had promised voters that "all available settlement monies" would be used for the replacement program or to pay down interest on the bonds authorized by Proposition A. In the Superior Court case, City Attorneys argued that ***all*** of the tobacco settlement money did ***not*** have to be used for the rebuild, and the Superior Court judge ruled in favor of the City.

After the judge's ruling, with the political coast partly clear, Harrington now proposes using ***all available funding***, but he is not completely honest about how much tobacco settlement revenue funds will actually become available. ***That amount is $820 million!***

It is interesting to note that the push is on to pit how many ***people*** will be served between the two options. But nowhere in Harrington's' skimpy writing does he acknowledge that the 1,200 ***beds*** at Laguna Honda serve far more than 1,200 ***people*** annually. LHH's turnover — through discharges and deaths in-house — is approximately one-third, year in and year out; somewhere between 1,600 and 1,800 ***people*** are served at LHH each year, and it is ***irresponsible*** of Harrington for not noting that fact in his report. After all, how are you going to have a public policy debate without honestly admitting how many ***people*** are served annually at Laguna Honda?

Harrington notes LHH's "current census … is under 1,050 patients," as if to imply that building 1,200 beds is unnecessary because of current "demand." What Harrington irresponsibly neglects to inform his readers is that at least two of LHH's current wards, totaling 60 beds, are temporarily closed (one being renovated after a behaviorally-disturbed patient set a fire that was ruled to be arson, and the other that is kept open to shuffle wards in and out of while other wards are also being remodeled). Additionally, in part due to State citations against Laguna Honda for inappropriate staffing levels, and in part due to keeping the staffing levels vacant in order to obtain so-called budgetary "salary savings," the census at LHH is kept ***artificially*** under full capacity. Demand for LHH's 1,200 beds exists, but to claim the current census of 1,050 is a rationale to downsize the facility to less than 1,200 beds is both irresponsible and spurious.

Harrington's analysis of the source of funding for Option 1 is remarkable. First, nowhere does he acknowledge that over the life of the general obligation bonds, the City projects it will now receive a total of over $820 million in tobacco settlement revenue (TSR). The closest Harrington gets to acknowledging the amount of TSR funds that will become available is by combining the "$92 million of tobacco settlement *before* the bonds are issued" plus "$443 million in tobacco settlement funds currently estimated to repay the bonded debt," totaling $535 million; Harrington does not discuss the projected influx of $820 million in TSR's.

Astoundingly, Harrington admits for the first time that SB 1128, a 1999 bill sponsored by State Senator Jackie Spier, ***will generate $120 million*** in Federal reimbursement earmarked for new skilled nursing beds after the facility is completed. The City should have been able to estimate that it would receive $120 million ever since Proposition A was passed in November 1999, the same year in which Spier introduced her bill, but instead, for the past six years, the City has painted the amount of Federal funding that would be received as insignificant. A cash cow of $120 million is a significant amount of funding that has been irresponsibly withheld from public knowledge until May 2005.

Since May 19 when Harrington released his report to the Mayor, community observers have recognized that if LHH's SNF beds are cut by one-third, so too will be the City's receipt of $120 million in funding under SB1128. Harrington acknowledged during the June 7, 2005 Health Commission meeting that SB1128 funds can only be used to recover the costs of building ***skilled nursing beds***. If LHH's beds are cut by one third, the City will only receive $80M, not $120 million; both options Harrington presented to the Mayor would then be short $40 million!

Harrington suggested using an additional "next" $100 million in TSR's (after the first $100 million authorized by Proposition A) to finance Option 1. Harrington claims the additional $100 million can be used, since the "proposition" had discussed "over the term of bonded debt," and as of the date of his report (May 19, 2005) the "City had not issued any debt." ***This is patently untrue!*** Surely Harrington should have remembered that nine days earlier, ***the City had, in fact, issued the lion's share of the bonds in part one of the bond sales.***

Harrington notes that taxpayers will be responsible for the second $100 million that should have been applied to reduce the property tax burden from $315 million to only $26 million, and use of the second $100 million will require property tax payers to foot $126 million, which is still $189 million lower than the 1999 original estimate of $315 million. What property owners should do is demand the City ***responsibly*** report the ***true*** amount ($820 million) of TSR's projected to be received over the next 25 years, and demand both that all 1,200 beds be built as promised, ***and*** that property taxes be reduced (to close to nothing) ***by using all available TSR's***, not just the amount Harrington — or his politician boss, the Mayor — wants to spend on LHH.

There's more flaws in the glass of Option 2, the most glaring of which is that Option 2 claims it will use "all of the funds identified in Option 1 …", including the first $92 million and the additional $100 million. Incredibly, in Option 2-c, Harrington claims an additional "80 million in ***previously received*** tobacco

settlement revenues could then be freed up when the general obligation bonds are issued." Putting aside, again, the fact that when Harrington issued his report on May 19 the bonds had already been issued for nine days, he appears to be double counting — or double spending — the amount of TSR's already received. He says Option 1 will include $92 million in TSR's received before the bonds were issued, and then wants to use for Option 2 both ***all*** of the Option 1 funds ***and*** a separate amount of $80 million received before the bonds were issued, for ***a presumed total of $172 million in TSR's that had been received*** **before** ***the bonds were issued***, but in fact, $172 million had ***not*** been received prior to the bond sale on May 10, 2005.

Harrington, potentially irresponsibly, claims in Option 2-c that $5.4 million — presumably "interest" earned from a second trust fund — could be generated annually "that could fund the long-term care needs of 270 people per year." But Harrington does not explain how $5.4 million could be earned annually, after having noted on page 4 of his report that only $10 million in interest is the "current view" of ***all*** interest to be earned on (presumably) ***all*** TSR's to be received over 25 years. This is the first of ***the miracle of the fish and loaves logic*** presented in Harrington's and Mizner's reports**.**

The most important flaw in the entire rationale for Option 2 is that it would provide for both 1,015 beds at Laguna Honda (780 SNF beds + 235 assisted living beds) ***and*** "care for another 790 individuals in various community-based settings." Once again, Harrington appears to be double-counting his numbers: He includes the 235 assisted living beds in the 1,015 total, and then in Option 2-e counts the 215 people, ostensibly as part of the additional 790 "individuals." One is left wondering whether to reach the 1,015 beds + the 790 individuals, he may have considered putting in bunk beds in order to serve two people in each of the 235 assisted living beds. In other words, Harrington's math, once again, does not quite add up when he double-counts both millions in pre-bond TSR's and double-counts the people who will use the assisted living beds.

Harrington's skimpy four-and-a-quarter-page report — particularly Option 2 — was premised on its Attachment "A", titled *Estimates for Housing, Medical and Supportive Care Costs for People Discharged from LHH*. "Attachment "A" is an excerpt from a report prepared by Susan Mizner, director of the Mayor's Office on Disability, in April 2005. Harrington acknowledged Attachment A provides "examples of how long-term ***non-skilled nursing*** services ***might*** be provided and the number of people who could be served" [emphasis added]. ***But he never estimates how skilled nursing will actually be provided in the community, nor how community-based skilled nursing will be funded.***

But Harrington ignores that many of the people who will be displaced from Laguna Honda if 420 SNF beds are eliminated from the rebuild project, as he proposes, actually ***need*** skilled nursing, ***not*** non-skilled nursing care.

Nobody — certainly not Liz Gray, Herb Levine, Susan Mizner, Ed Harrington, Mitchell Katz, nor Pat Terrell from HMA, in their rush to shut down Laguna Honda Hospital — has weighed in on how skilled nursing services will ***actually***

be provided in the community. ***Will we have a roving band of public health nurses providing home-based skilled nursing care?*** It is highly unlikely that we will, but nobody wants to talk about it openly.

Since Dr. Katz keeps trying to eliminate public health nurses from DPH's budget year in and year out, this question is pertinent. And not even the unions (SEIU 790–Nurses, Teamsters 856, nor United Healthcare Worker's –West) are talking openly yet about how *skilled nursing services* ***might be*** provided if LHH is completely gutted of its traditional mission to provide long-term care to frail elderly, elderly, and disabled San Franciscans.

Shaky Walls: Mitch Katz's June 7 Memo to Health Commission

On March 15, 2005, Dr. Katz agreed with the Health Commission's suggestion to author a new White Paper, indicating 60 days in which to do so was reasonable. He indicated such a report "would mesh nicely" with the financing options Mayor Newsom had asked City Controller Ed Harrington to prepare and recommend. Harrington issued that report right on target on May 19, two-and-a-half months ago, and we're still waiting four months later for Dr. Katz to get around to releasing his new White Paper.

As of today, it has now been 130 days (not 60 days) since the Health Commission's March 15 hearing. Dr. Katz's delay in releasing the requested new White Paper is irresponsible, given that this additional four-month delay will contribute to driving up the costs to replace LHH, just like each day of delay escalated costs of the Bay Bridge retrofit.

Katz did not present a new, let alone updated, White Paper on June 7, 2005 at the Health Commission meeting. Instead, he presented a four-page ***memo*** (albeit, with ten pages of attached tables and charts, the significance of which were largely left unexplained). It contained nearly as many irresponsibly glaring flaws as did Mizner's "Attachment A". Katz indicated that in mid-July, he will receive data from Health Management Associates that will address comparative data from other jurisdictions, and that he may finally present a "White Paper" during the Health Commission's August 16 meeting.

Katz's June 7 memo claims to focus on so-called "implications" for the Department of Public Health and the Health Commission. Damnably, he does not set out — or ever bother — to consider "implications" for elderly, frail San Franciscans relying on Laguna Honda Hospital. After all, to Katz, the issue is all about money ... not about the skilled nursing needs of thousands of people served at LHH annually, or the many thousands more who will need skilled nursing care in the decades to come.

Katz noted, wryly, "This will be an important decision for the Health Commission." Katz irresponsibly and falsely claims that as the governing body over LHH, the Health Commission has a responsibility to hold new hearings, but Katz ignores the *elephant in the room* again by ***not*** noting that the Health

Commission has a responsibility to carry out the will of the voters, as do the Mayor and the Board of Supervisors. ***None of these appointed or elected public servants have any authority to change the will of the voters!***

Katz notes that the "City's Long-Term Care Coordinating Council (LTCCC) will also be having hearings on the issue." The LTCCC is not a City agency; it is a policy advisory body to the Mayor (which seeks to avoid open accountability under the Sunshine Ordinance by calling itself a "passive meeting body, despite the fact that they have issued a flurry of policy recommendations to the Mayor).

The LTCCC's membership is troublesome, since it contains no representatives from the City's single long-term care facility (LHH). Despite three nominations made to the Mayor in late 2004 recommending LHH's Medical Director, Chief of Rehabilitation Services, or Rehabilitation Coordinator for membership on this body, politics was played, and no LHH staff were appointed to the LTCCC. It is not clear whether the LTCCC's membership includes a nurse with ***experience in*** long-term skilled nursing care. *More troubling, the LTCCC does not have the authority to set policy for LHH,* ***nor do they have authority to change the will of the 1999 voters!***

However, Katz does not note that Harrington's financing recommendations noted that Option 2 would use the same funding as outlined for Options 1 — meaning that the Certificates of Participation (COP's) would need to be issued for both options. Obviously, if Option 2 relies on the COP's, it would be foolhardy, when not likely, for the Board of Supervisors to vote against issuing them, and more unlikely that the Mayor would veto such an action by the Board, so Katz's observation is moot.

Katz then claims he reconvened, with Louise Renne, the membership of the 1999 Laguna Honda Rebuild Committee, noting the "size of the new LHH was an issue raised during the first meeting." Katz is being disingenuous: The size of the replacement facility was a ***contentious*** issue during the first meeting of the reconvened Rebuild Committee when Katz indicated the best LHH would get would be 780 skilled nursing beds, since many of the members of the committee worked hard during 1998 and 1999 to ensure LHH would be replaced with ***all*** 1,200 beds.

During the second meeting of the Rebuild Committee on June 22, Katz floated an idea for consideration: Build 1,500 beds — not 1,200 — but build only 500 skilled nursing beds, with the remainder a variety of supportive housing and assisted living beds. The idea would be to have the other 1,000 residents housed on the LHH campus in a greatly expanded Adult Day Health Center (ADHC). One problem with this is that yet more "change orders" would have to be issued to redesign the facility, since the square footage for each type of room is different than for skilled nursing beds. And such a plan may have to obtain yet another Environmental Impact Review, ***since the density at Laguna Honda may increase by another 300 residents***.

Another problem is that the current ADHC at LHH has a case load of 110 — 125 clients. To accommodate 1,000 clients, the ADHC would have to expand ten fold!

Obviously, Katz's claim that we don't have enough money to build all 1,200 skilled nursing beds, but we have plenty of money to build 1,500 beds of varying types, is more of ***the miracle of the fish and loaves***.

Katz informed the Health Commission:

> " ... the Planning for Elders In-home Supportive Services (IHSS) and Health Task Force ... [recommended considering] ... construction of congregate housing with co-located adult day health services ***in lieu of*** building Laguna Honda Hospital with 1,200 beds."

Attachments 2 and 3 to Katz's June 7 memo to the Health Commission propose just that: ***In lieu of*** rebuilding LHH's skilled nursing beds, ***replace*** them with an ADHC model of care, instead. But an ADHC to replace LHH is not what voters were promised in Proposition A.

There's a lesson to be learned from the recent closure of an AIDS ADHC in San Francisco. Continuum's Board of Directors and Executive Director announced the closure of its ADHC program effective on May 27, 2005. The program for low income and homeless people living with HIV/ AIDS based in San Francisco's Tenderloin district closed due to:

> "... inadequate Medi-Cal reimbursements, loss of Ryan White CARE Act funding, City and County of San Francisco General Fund cuts due to the failure of [ballot measure] Propositions J and K, as well as barriers to accessing other government reimbursement sources."

Clearly, if Medi-Cal and other sources of government funding were unable to prevent the closure of Continuum's adult day health program, proposing to replace LHH with adult day health programming is ***completely irresponsible***, and may well place frail elderly and disabled San Franciscans at equal risk for eventual program closure.

What should be required of Dr. Katz, and DPH, is that all data to be considered by the Health Commission and others during this new "public policy debate" on the future of LHH must ***uniformly*** include data dating back to 1995 in order to gauge how historical utilization prior to passage of Proposition A in 1999 has changed. The data Dr. Katz presented in his June 7 memo between 2001 and 2005 does not accurately reflect the demographics of the population served at LHH ***before*** the introduction of "psychosocial programming" in 2001, just two short years after voters passed Proposition A.

Other problems with Katz's June 7 memo include:

- ***Interestingly, Katz does not stratify data to report accurately the number of people who were homeless at the time of admission to LHH.***
- Admissions from Bay Area acute and SNF hospitals are significantly lower than in 2003; admissions from other acute hospitals have dropped by 5% and admissions from other SNF's are 7.2% lower than in 2003.
- Admits to LHH from Board and Care facilities are 50% lower than in 2003.
- Dr. Katz claims there has only been one admission from an out-of-county facility in this two-and-a-half year period. But staff at LHH who process Medi-Cal treatment authorization requests (TAR's) have noted that at least ten out-of-county TAR's in 2005 alone have been denied payment, because the ten patients had Medi-Cal ID numbers issued by other counties. LHH's Rehabilitation Services Department commonly has admissions from SFGH from San Mateo General Hospital for trauma care.

As with so much of the data coming from DPH, there is no explanation why the number of admissions in 2004 was reported differently at different times. Aren't they collecting this data from a ***single*** database, and shouldn't the data from one report to another match?

In Katz's Table 5, he indicated two age cohorts had only experienced a 2% decline for both those aged 70-79 and those aged 80-89 between 2003 and 2004. But the data obtained from a public records request showed a decline by 27.9% of admissions of people between 70-79 and a decline of 7.6% for people between 80-89 between 2003 and 2004 (see Table 8 on the next page). Even considering the discrepancy of the 30 additional admissions in 2004 between the two data sources, there is no way to explain why the age distribution of admissions varies so wildly between the public records request and Dr. Katz's Table 5.

Additional observations about Katz's June 7 memo include:

- Fully 53.2% of discharges from LHH are to acute hospitals (the percentage of acute discharges drops to only 40.3% when those who expired in-house are accounted for). Yet neither Harrington nor Mizner factored into their respective analyses costs to the proposed "Community Living Fund" that will result from acute hospitalizations; in particular, costs related to acute admissions to SFGH when LHH residents discharged to the community fail at home and require re-hospitalization were not estimated.
- While 38.3% of LHH discharges were to "the community," adjusting for in-house deaths drops the community-based discharges to only 29%. Given that less than one-third of LHH's discharges are to the community, is there really a high enough demand for community placement that justifies eliminating 420 of LHH's SNF beds, particularly since San Francisco can expect that as the Baby Boomer's age, there will be even greater need for those same beds?

- When deaths are factored in, only 1% of LHH discharges in the reporting period were placed in board-and-care facilities. Discharges to "miscellaneous" locations — presumably assisted living or supportive housing, though since "miscellaneous" is not defined, we may be being overly-generous here in assuming assisted or supportive housing locations — represented only 1.5% of the discharges. Notably, Mizner claims many of LHH's residents can be discharged to community-based alternatives. Given that only 2.5% of LHH discharges during this reporting period were to community locations other than previous housing, several of Mizner's hypothesis about the need for non-home community alternatives seems irresponsibly out of touch.
- ***The number of deaths in-house at LHH — 24.3% of total turnover during the nine-month reporting period in Table 10 — nearly equals the number of discharges to the community.*** In addition, many of the discharges to acute facilities result in additional deaths at the receiving facility, which data has not been made public. Discharging people to the "community" en mass from LHH may result in even more deaths, some prematurely, than may have occurred with conserved 24-hour skilled nursing care at LHH.

It should be noted that the sharp decline in the number of people aged 70 and over admitted to LHH in 2004 may have affected the number of LHH residents who are totally dependent for ADL's, which may largely explain the decline in total dependence in Table 11. However, those who need 1- or 2-person assistance has risen sharply for each of the five ADL's; this may be indicative of a younger patient population from SFGH who were given priority for admission to LHH during the 2004 "Flow Project," while the decline in those totally dependent may be indicative that elderly over the age of 70 (see Table 9, above) were differentially denied admission during the Flow Project resulting in a sharp decrease in the number of elderly residents, possibly those totally dependent. ***Readers should note that the IHSS waivers proposed for community-based alternatives to LHH do not provide for multiple caregivers in order to perform two-person assistance with ADL's.***

Table 12 in this report shows a number of key changes between 1998 and 2005:

- The percentage of LHH residents who are bedfast has quadrupled.
- The percentage of LHH residents who ambulate independently has declined.
- The percentage of LHH residents who ambulate with assistance, or with assistive devices has doubled.
- The percentage of LHH residents having contractures has increased sharply. This may be due, in part, to a lessening of basic skilled nursing attention in assisting residents with range-of-motion exercises to prevent the onset of muscular contractures. Just as bed sores are preventable, so too are the onset of contractures post-admission. Due to the time spent "managing" the increased aggression of patients with "behavioral problems" that resulted

from the changing demographics of admissions to LHH under the revised admissions policy during the 2004 Flow Project, LHH's nursing staff may not have focused on providing nursing interventions to prevent the onset of contractures and bed sores post-admission.

A transcript of a KPFA radio debate illustrates, in part, that Herb Levine appears ***not*** to be concerned about the frail elderly (those over age 85).

What Herb Levine refuses to admit — and hopes everyone won't notice — is that while Laguna Honda Hospital provides nearly ***half*** of all nursing home beds in San Francisco that continue to accept medically-indigent Medi-Cal clients (according to Benson Nadell), only ***one-third*** of Medi-Cal funds coming to San Francisco goes to LHH.

A better question Mr. Levine should be asking — in his role as an accountability activist for the clients he represents — is: ***"If Laguna Honda Hospital is providing* one-half *of the SNF beds accepting Medi-Cal clients and is doing so with only* one-third *of Medi-Cal dollars flowing to San Francisco, where are the remaining* two-thirds *of Medi-Cal funds going?"*** If he is truly concerned about limited dollars, this is an important, unanswered question that he has failed to ask.

Unless, of course, he prefers to ignore both the **elephant in the room**, and the ***miracle of the fish and the loaves*** phenomena.

Indeed, the Mayor's Disability Council voted prematurely to Support Ed Harrington's Option 2 without knowing that the Independent Living Resource Center and its director, Herb Levine, were poised to take a position against Option 2. During a June 29 forum sponsored in part by the Long-term Care Coordinating Council (LTCCC) held at On Lok's ADHC, that's exactly what Levine did: He rejected the notion that there are only two viable options, indicating Harrington's Option 2 unacceptable.

On June 29, a member of the public suggested to Mr. Levine that both sides could work together. Patrick Monette-Shaw suggested splitting the $820 million in tobacco settlement revenues (TSR's) between advocates for preserving Laguna Honda's skilled nursing beds and advocates seeking funding for community based alternatives. Monette-Shaw noted that LHH's supporters only need $320 million of the TSR's to see LHH rebuilt with all 1,200 beds, and are willing to see the remaining $500 million in TSR's used to fund community-based alternatives. Collaborative use of the TSR's was rejected outright by Herb Levine, without a moment of reflection; his immediate response was "No, Patrick, because there is no price on civil rights." What Levine fails to note is that the civil rights of people who ***willingly choose*** nursing home placement are also being violated by those hell-bent preventing the rebuild of ***any*** beds at Laguna Honda Hospital.

Other advisory bodies — including the LTCCC, the Human Services Network, and the Department of Aging and Adult Services — are all racing to weigh in with recommendations about how to proceed with the LHH replacement project. In the end, both Option 1 and Option 2 will be rejected by these advisory bodies. In that regard, a public policy debate is occurring, but the general public and

voters have not been told, and have no idea about, what the real "options" are that are being considered.

The problem is, these advisory bodies are collectively ignoring the flawed data provided by the TCM program and Dr. Katz's Department of Public Health upon which the house of cards contained in the first four reports is being built.

What has happened at Laguna Honda Hospital over the course of the past year-and-a-half, and what is now happening with the project to finance and replace LHH, is no laughing matter to most people … particularly ***not*** to those who reside at LHH, call it home, and want it to be a safe-haven environment in which to live.

But when two Laguna Honda nurses — who were formerly psychiatric nurses at San Francisco's Mental Health Rehabilitation Facility (MHRF) who lost their jobs when Dr. Katz re-configured the MHRF — were asked on June 20, 2005 whether the San Francisco Health Commission might consider offering an employee-of-the-month award to a group of LHH staff who had valiantly struggled for over a year to overturn the LHH admission policy granting first priority to SFGH patients with behavioral problems, the pair of former psych nurses inappropriately burst out laughing, even before the rest of the question could be posed.

And that question was: Should those brave LHH staff who opposed the changes to LHH's admissions policy deserve the employee-of-the-month award for having ***prevented*** additional elder abuse at LHH , and for having ***prevented*** additional State citations against LHH? Callously, this pair of nurses appear not to care — given their inappropriate laughter to a seriously-posed question — about preventing State citations for elder abuse. Laughter may be this pair's best medicine, but it may not be the best medicine residents of LHH deserve to receive from LHH's nursing leadership.

But moving on, it's likely no accident that three months after Mayor Newsom took office in January 2004, that Mitch Katz, San Francisco's Director of Public Health, unilaterally changed Laguna Honda Hospital and Rehabilitation Center's admissions policy in March 2004. Nope. No accident there.

After all, Newsom was swept into office promising homeless reform, his signature campaign promise based on a phenomena called "Care Not Cash" to rid from the streets of San Francisco any vestige of homeless people. It's bad for business, and bad for tourism.

Ironically, in order to implement the "care" part of his equation, Newsom seems determined to eliminate care to elderly (those over 65), frail elderly (those over 85), and younger disabled San Franciscans who have relied on Laguna Honda for generations for healthcare in order to accomplish his political agenda on his way to higher elected political office. And Katz, who serves at the political pleasure of the Mayor, appears all too willing to have changed LHH's admission policy in order to help his political puppet master, The Gavin.

Laughably, Dr. Katz claimed on June 18, 2005 that "Nobody is sorrier than I" over the failure of the "Flow Project" which resulted from his unilateral change of LHH's admission policy. Give us a break, Dr. Katz! All of the frail elderly who could not gain admission to LHH outnumber how sorry you may be in hindsight by a factor of hundreds to one. Then there are the courageous clinicians at LHH who risked their professional careers to object to the flawed and dangerous admission policy Katz repeatedly insisted could save the City $1.7 million annually, but which has cost the City nearly ***twice that amount*** (over $2 million has already been expended to correct the safety and discharge problems at LHH, and that does not include counting increased City expenditures of increased admissions to SFGH's emergency room and acute care beds resulting from the inability of frail San Franciscans to gain direct admission to LHH).

This paper explores the completely flawed, when not completely contradictory, data on which a new "public policy debate" is being premised to determine the size and fate of Laguna Honda Hospital as a long-term care skilled nursing facility. A key issue is that City officials — including the Mayor — have a ***mandatory ministerial duty*** to implement the will of the voters who passed Proposition A in 1999. Those ministerial duties preclude opening up a new debate about what kind of beds should be built to "replace" Laguna Honda Hospital.

This paper explores the completely flawed, when not completely contradictory, data on which a new "public policy debate" is being premised to determine the size and fate of Laguna Honda Hospital as a long-term care skilled nursing facility.

The debate was held, and resolved, in 1999. Now it up to the City to carry out the will of the voters, not to launch into a new "debate."

The problem is, various advisory bodies are collectively ignoring the flawed data provided by the TCM program and Dr. Katz's Department of Public Health upon which the house of cards contained in the first four reports is being built.

Disturbingly, none of the advisory bodies are demanding that the flawed TCM premises be corrected prior to racing into a fatal embrace of Option 2.

Introduction

Had the cost overruns for the replacement project not skyrocketed, San Francisco would not now in 2005 be bitterly feuding like the Hatfield's and McCoy's over whether to rebuild all 1,200 skilled nursing (SNF) beds at Laguna Honda Hospital.

Had there been no cost overruns, the LHH replacement project team would be moving full steam ahead building ***all*** of Laguna Honda's 1,200 beds. There would have been no need to go back to re-debating whether or not to proceed, as the rebuild would have already begun. And we wouldn't now be repeating the same discussion that we had six years ago, when 73% of the voters expressed their will by approving bond financing and tobacco settlement funds to build a ***replacement*** facility for Laguna Honda Hospital. Most people understand the term "replace" to mean a 1:1 replacement; when people talk of replacing an 18-wheel semi, they don't settle for a four-wheel jeep. Voters approved ***replacing*** a 1,200-bed skilled nursing facility, and that's exactly what they expect to get.

"Do we want to use the Tobacco Settlement for Laguna Honda, for [other] health care, for **housing***?," Newsom framed community discussion.*

But not if Mayor Newsom gets his way. Newsom wants to use every last penny he can get his hands on for housing to solve the "homeless problem" he made campaign promises to voters in 2003, and he doesn't care if LHH is built as promised voters in 1999. When news stories appeared covering the City Controller's anemic four-and-a-quarter page report to Newsom outlining only two options to finance the LHH rebuild, Newsom was quoted as saying:

> "Do we want to use the Tobacco Settlement for Laguna Honda, for [other] health care, for ***housing***?," Newsom framed community discussion[6].

Newsom isn't trying to "frame community discussion," he's trying to divert the tobacco settlement funds voters approved for use in reconstructing LHH to his pet project - solving homelessness - by creatively reinterpreting the will of the voters, and promises made in 1999, instead.

During 1998, there was intense debate among City leaders — politicians, Health Department officials, and the Health Commission, among others — and healthcare advocates throughout the City over how best to proceed with the rebuild of LHH to prudently plan for the future healthcare needs of elderly (those over 65), frail elderly (those over 85), and other disabled San Franciscans.

Had there been no cost overruns, the LHH replacement project team would be moving full steam ahead building **all** *of Laguna Honda's 1,200 beds. There would have been no need to go back to re-debating whether or not to proceed, as the rebuild would have already begun. And we wouldn't now be repeating the same discussion that we had six years ago ...*

[6] "Harrington proposes two options," *San Francisco Sentinel.com* web site, by Pat Murphy; viewed on the Internet on June 11, 2005 at www.sanfranciscosentinel.com/id383.htm

In an analysis written in 1998 by Mitch Katz, MD — the then and current Director of Public Health — he examined ten options for rebuilding Laguna Honda Hospital. Katz's 1998 White Paper resulted in the City deciding to place a bond measure on the 1999 November ballot seeking voter approval to rebuild LHH with 1,200 beds (although the actual language of Proposition A was cleverly crafted by the City Attorney in such vague terms that it failed to mention either the number of skilled nursing beds, or the number of assisted living beds, voters were actually voting on). Publicity materials, and paid arguments in favor of the ballot measure that appeared in the voter guide, lead reasonable people to believe LHH would be ***replaced*** with all 1,200 SNF beds.

By the time the MHRF was reconfigured just seven short years after opening, it was left with only 47 psychiatric SNF beds even though the $26 million price tag for the MHRF cost $553,191 per bed.

Despite opposition from some quarters of the disability rights movement, Proposition A was passed by over 73% of the voters, who indicated their dedication to preserving Laguna Honda as a skilled nursing home for elder and disabled San Franciscans.

Recent History of Mismanaged General Obligation Bonds

The history of mismanaged bond financing in San Francisco is riddled with irresponsibility, most of it irresponsible behavior on the part of City politicians.

First, there was a bond passed to rebuild City Hall and to also renovate both the War Memorial building and the headquarters of the Department of Public Health at 101 Grove Street. All of that bond financing was used to make Willie Brown's City Hall a jewel, but none of that bond financing was ever used to remodel either the War Memorial Building or 101 Grove.

Then, in 1987, voters were asked to approve $26 million in bond financing to build a 147-bed Mental Health Rehabilitation Facility (MHRF) on the campus of San Francisco General Hospital. The then Director of Public Health, David Werdergar, said in the 1987 voter guide that the MHRF would pay for itself. Werdergar should have told voters that Medi-Cal only reimburses skilled nursing facilities with no more than 16 beds, and that the MHRF would not be cost neutral. Although the MHRF was built, it is not now the psychiatric skilled nursing facility voters were led to believe they were getting; it now has three separate licenses for three separate "mixed uses."

The MHRF opened in 1996, nine years after city voters approved the 1997 bond measure to build the MHRF in response to problems created when the state began closing mental hospitals. ***By the time the MHRF was reconfigured just seven short years after opening, it was left with only 47 psychiatric SNF beds even though the $26 million price tag for the MHRF cost $553,191 per bed.***

The MHRF was intended to be a 147-bed sub-acute care skilled nursing facility to serve patients with mental health problems and to eventually re-integrate them back into the community once they were stabilized. The MHRF had been designed to serve people with severe depression, psychosis, or schizophrenia, as well as people who were unable to handle independent living or even supportive living in the community.

Discussion notes from the February 12, 2003 meeting of San Francisco's Mental Health Board, reveal that SEIU 790's Ed Warshauer testified:

> "We prefer to focus at this point on maintaining the MHRF and want to see that the promise made to the voters who built it is kept[7]."

An at-the-time Mental Health Board member, Dr. Del Zotto, stated during the same meeting:

> "We're encouraging the Health Commission to just say no. Just say no to the Mayor [Brown]. Let the Mayor make the cuts. Let us go to him and hold him accountable. ***It's like he wants us to make a political decision so he will have cover. We think there shouldn't be cover***[8]. [emphasis added]"

However, following the outcome of a so-called Blue Ribbon Committee formed to determine the fate of the MHRF, the MHRF was reprogrammed in 2003, and became a residential care facility (RCF). Today, only 47 of the original 147 beds are licensed for psychiatric rehabilitation; the remaining beds are so-called "step-down" beds, the majority of which are board-and-care beds.

When the MHRF closed in 2003, the City had to transfer some patients to out-of-county psychiatric facilities, paying between $50 and $100 per day in supplementary "patch" payments to other counties for care of San Francisco residents. Some MHRF residents lost their SSI eligibility as a result. And some patients who should have been treated at the MHRF were sent to Laguna Honda, instead, despite the fact that LHH does not have a psychiatric license.

The history of mismanagement of the MHRF's bond financing is being repeated again at LHH. There are plans afoot to create multiple "mixed uses" at LHH, too, rather than building a long-term care facility with bond financing, as voters were promised in 1999.

The history of mismanagement of the MHRF's bond financing is being repeated again at LHH. There are plans afoot to create multiple "mixed uses" at LHH, too, rather than building a long-term care facility with bond financing, as voters were promised in 1999.

[7] Discussion Notes. (2003, February 12). Mental Health Board.. Viewed on the Internet on June 11, 2005 at www.ci.sf.ca.us/site/mental_health_page.asp?id=18379

[8] Ibid.

Now the Laguna Honda Hospital replacement bond money is being used against the will of the voters, who were lead to believe that they were financing a long-term care facility for the elderly and disabled. Unless the community demands that the bond money be used as promised to build all 1,200 skilled nursing beds as Ed Harrington proposed as his "Option 1," the voters will again have been misled by bond financing gone amuck.

The day following release of Harrington's May 19 report to the Mayor, the *San Francisco Examiner* ran a story[9] regarding Harrington's recommendations. In that story, Mayor Newsom was quoted that "It's [now] a great opportunity to have an interesting discussion ..." about how to proceed with the Laguna Honda rebuild.

In the same story Supervisor Sean Elsbernd was quoted that he expects to see a "major public dialogue" at Health Commission and Board of Supervisors hearings over how to proceed with the replacement project.

It is irresponsible for the Mayor and Supervisor Elsbernd to think that the discussion and dialogue that had occurred in 1999 and which lured voters into approving Proposition A in 1999, now needs to be revisited. And it is completely irresponsible of the Mayor to now suggest that tobacco settlement revenues approved in 1999 to rebuild LHH should be used for "housing," instead. Voters were led into believing they were approving bond financing to build 1,200 skilled nursing beds - not housing - and any other outcome for the Laguna Honda Replacement Facility will be irresponsible meddling by politicians.

Unless the community demands that the bond money be used as promised to build all 1,200 skilled nursing beds as Ed Harrington proposed as his "Option 1," the voters will again have been misled by bond financing gone amuck.

In his first year in office, Newsom attempted to place a bond measure on the November 2004 ballot to finance new housing in San Francisco. San Franciscans roundly rejected his ballot proposal to levy new "taxes" on property owners in order to create new housing. Now, to "get even" with voters, Newsom appears to be all too willing to use general obligation bonds approved in a prior election cycle for purposes other than what voters approved at the time, possibly in order to obtain the hundreds of millions he needs to create housing voters deprived him of in November 2004. And he's doing this only to "save face," since voters in 2004 said they wanted nothing to do with his housing "financing" plans. If Newsom persists in trying to raid the LHH rebuild project, his polling numbers are going to plummet rapidly.

It's time to make our politicians stop playing politics with the people's vision for our beloved Laguna Honda Hospital!

[9] Stanley, J. , Staff Writer. (2005, May 20). "Laguna Honda costs skyrocket to more than $600M." *San Francisco Examiner*.

Historical Background

The need for Laguna Honda Hospital was well documented in a 1998 29-page "White Paper" authored by Dr. Katz. Reviewing Dr. Katz's data from 1998 is instructive, because on March 15, 2005 Health Commission President Lee Ann Monfredini ordered Katz to re-write and update a new version of his 1998 White Paper within 60 days. Katz's new paper will likely just be revisionist spin control.

In 1998, Katz noted that San Francisco is projected to have an additional 65,901 people over the age of 65, ***including an additional 9,114 people over age 85***, by the year 2020, (Table 1, below).

Although he did not comment explicitly on it, Katz presented data (Table 2, below) that shows San Francisco will see a ***decrease*** of 2,500 persons age 64 and younger by the year 2020 who will have mobility or self-care limitations, ***and a concurrent increase of 15,000 people over the age of 65*** with mobility and self-care limitations, many of whom will need care in a skilled nursing facility (SNF).

However, the shortage of skilled nursing beds in San Francisco remains in dispute. In Katz's 1998 White Paper, he projected that San Francisco has a projected supply of 3,625 SNF[10] beds, but he did not elaborate on, or stratify, whether all of the projected supply of SNF beds accept Medi-Cal clients. This is important precisely because the vast majority of LHH residents rely on Medi-Cal for their skilled nursing reimbursement. Data presented in 2005 by Benson Nadell, San Francisco's Long-Term Care Ombudsman, before the Board of Supervisors reported that there are only 2,658 Medi-Cal eligible beds in San Francisco (about half at LHH and half in private nursing homes; Table 5 below).

The 967-bed difference between Katz and Nadell's data is significant, for it suggests San Francisco may face a critical shortage of 3,767 skilled nursing beds — not the 2,380 that Katz reported in his 1998 White Paper — if Laguna Honda's skilled nursing beds are cut by 420 beds as recommended by City Controller Ed Harrington on May 19 2005. The shortage of 3,767 skilled nursing beds in the City will occur at the same time that San Francisco will have an ***additional*** 15,091 people over the age of 65 who may have mobility and/or self-care limitations, many of whom may need skilled nursing care. ***This is no time to be considering eliminating one-third (or more) of LHH's SNF beds!***

The shortage of 3,767 skilled nursing beds in the City will occur at the same time that San Francisco will have an **additional** *15,091 people over the age of 65 who may have mobility and/or self-care limitations, many of whom may need skilled nursing care.*

This is no time to be considering eliminating one-third (or more) of LHH's SNF beds!

[10] "Options for Laguna Honda Hospital White Paper," Mitch Katz, MD, Director, Department of Public Health, December 10, 1998, Table 2, page 10.

1998 Department of Public Health White Paper: Options to Rebuild LHH

In 1998, Mitch Katz, MD, Director of Public Health, presented a report to then Mayor Willie Brown regarding options to rebuild Laguna Honda Hospital. In the Executive Summary, Dr. Katz informed the Mayor:

> "The need for long-term care (both community-based and hospital-based) will grow over the next two decades. An estimated 6% of San Franciscans aged 18–64 and 23% of San Franciscans over the age of 65 have mobility problems or limitations in caring for themselves. This translates to approximately 57,000 lives in the year 2000. Some of these individuals can be cared for in their homes or in less intensive settings while others will require skilled nursing in institutions such as LHH. ... LHH is a critical component of San Francisco's long-term care delivery system[11]."

Katz indicated that many of the ten options he evaluated in 1998 were ... "not advantageous, because they might result in an unacceptable reduction in the number of skilled nursing beds, or are more costly."

Katz indicated that many of the ten options he evaluated in 1998 were:

> "... not advantageous, because they might result in an unacceptable reduction in the number of skilled nursing beds [available throughout the City], or are more costly."

In a section projecting the need for long-term care in San Francisco, Katz noted in narrative form[12] that the aging of the "baby boom" generation will markedly increase the number of people over the age of 65 (presented here as a table):

Table 2: Projected Increase of San Franciscans Over Age 65 by Year 2020[13]

				Increase	
San Franciscans …	**2000**	**2010**	**2020**	**Raw**	**Percent**
Age 65 and over	116,080	129,787	181,981	65,901	57%
Age 75 and over	59,523	66,483	75,346	15,823	26%
Age 85 and over	17,718	23,958	26,832	9,114	50%

[11] Ibid., page 3.
[12] Ibid., page 8–9.
[13] Footnote 12 was written based on the 1990 U.S. Census data.

In further discussing the projected need for long-term care services in San Francisco, Katz presented data from the 1990 U.S. census (U.S. Census Bureau) estimating that 6% of persons 18 to 64 and 22.9% of persons 65 and over have mobility or self-care limitations (an indicator of possible need for skilled nursing facility level of care). He included a table extrapolating the projections of San Franciscans who will have self-care limitations[14]:

Table 3: Projected People With Mobility or Self-Care Limitations

	Persons 18–64		Persons 65 and Over		Total
Year	Number	With Mobility or Self-Care Limitations (@ 6.0%)	Number	With Mobility or Self-Care Limitations (@ 22.9%)	With Mobility or Self-Care Limitations
2000	506,588	30,395	116,080	26,582	56,977
2010	494,877	29,693	129,787	29,721	59,414
2020	464,962	27,898	181,981	41,673	69,571
Change 2000 – 2020	(41,626)	(2,497)	65,901	15,091	12,594

Notably, while San Francisco will see a decrease of 2,500 persons age 64 and younger by the year 2020 who will have mobility or self-care limitations, ***there will be a concurrent increase of 15,000 people over the age of 65*** with mobility and self-care limitations, many of whom will need skilled nursing care. If all 15,000 will need skilled nursing care, at the rate of 33 SNF beds per 1,000 residents, that indicates an increased demand for 495 additional skilled nursing beds, not a reduction in SNF beds.

Notably, while San Francisco will see a decrease of 2,500 persons age 64 and younger by the year 2020 who will have mobility or self-care limitations, **there will be a concurrent increase of 15,000 people over the age of 65** *with mobility and self-care limitations, many of whom will need skilled nursing care. If all 15,000 will need skilled nursing care, at the rate of 33 SNF beds per 1,000 residents, that indicates an increased demand for 495 additional skilled nursing beds, not a reduction in SNF beds.*

In a section discussing the projected demand, projected supply, and resulting shortage of skilled nursing facility (SNF) beds, Katz's 1998 White Paper projected that if San Francisco is unable to reduce the number of SNF beds from 33 per 1,000 persons over the age of 65, the City would be short 2,380 SNF beds by the year 2020[15]. Katz speculated that if San Francisco could reduce it's need for SNF beds to the State of Oregon's rate of 27 SNF beds per 1,000 (and our needs did not increase to the State of Washington's SNF bed rate of 45 beds per 1,000), he projected San Francisco would be short by the year 2020 of at least

[14] Ibid., Table 1, page 9.
[15] Ibid., Table 1, page 10.

1,288 SNF beds. Both assumptions were based on not reducing Laguna Honda's beds by 420, as Option 2 of the City Controller's May 19, 2005 report to Mayor Newsom now proposes. Both of Katz's 1998 estimates assumed that San Francisco's projected supply of SNF beds stood at 3,625. However, Katz's projected supply of available SNF beds may have been off by nearly 1,000, since other data suggests that San Francisco only has 2,658 SNF beds that accept Medi-Cal reimbursement (see Table 5, below). Adjusting for the possible error in Katz's 1998 projections of how many SNF beds in San Francisco accept Medi-Cal reimbursement, and the projected downsizing of LHH's SNF beds, San Francisco may be short a total of 3,767 SNF beds ***just for those over the age of 65*** by the year 2020, or 1,387 more than Katz's 1998 estimate.

Adjusting for the possible error in Katz's 1998 projections of how many SNF beds in San Francisco accept Medi-Cal reimbursement, and the projected downsizing of LHH's SNF beds, San Francisco may be short a total of 3,767 SNF beds **just for those over the age of 65** *by the year 2020, or 1,387 more than Katz's 1998 estimate.*

Table 4: Potential Shortage of Skilled Nursing Beds in San Francisco

Rate of SNF Beds Per 1,000 For Persons Age 65 and Older …	Katz's 1998 White Paper SNF Bed Shortage	Disputed Projected Supply of SNF Beds Accepting Medi-Cal [16]	Proposal to Cut SNF Beds at LHH[17]	Adjusted Shortage of SNF Beds
33 Per 1,000 (San Francisco)	(2,380)	(967)	(420)	(3,767)
27 Per 1,000 (Oregon Model)	(1,288)	(967)	(420)	(2,675)

In exploring various options to rebuild LHH in his 1998 White Paper, Katz presented as Option 1 consideration to decrease the number of residents (the census) at LHH, noting that it would "cause a severe shortage of SNF beds in San Francisco," would result in San Francisco acute care hospitals being unable to discharge patients to a lower level of care in SNF facilities, and would result in patients failing at home without the alternative of placement at a SNF[18].

[16] The 967-bed difference between Dr. Katz's and Benson Nadell's data is discussed on page 27 of this report.

[17] "Laguna Honda Replacement Program Where Do We Go From Here," Ed Harrington, San Francisco Controller, May 15, 2005.

[18] Katz, (1998), op. cit., page 11.

Option 4 that Katz explored in 1998 considered building several smaller facilities throughout the City. Option 4 was rejected because a 1994 Bond report projected that the cost of building 12 ninety-nine bed SNF's ***would cost $171 million more*** than the economy of scale of building a single 1,200-bed facility on LHH's existing campus[19]. Additionally, Katz noted Option 4 was not feasible because the City would also face obstacles identifying available land throughout the City on which to build smaller facilities, and that each smaller facility might not qualify for the State's "distinct part SNF" reimbursement rates, since they would each have to have acute care beds in order to qualify, leading to a loss of revenue to the City.

In Option 7 Katz considered in 1998 — to increase use of community-based long-term care options — he noted that community-based long-term care providers had suggested there might be a "substantial number of LHH residents" who could be cared for at a less institutionalized facility. Katz reported:

> "... the Department [of Public Health] comprehensively evaluated over 700 of the highest functioning residents of LHH. ... Less than 100 residents were considered candidates for discharge. ... However none [of 25 of the 100 who were candidates for a PACE model discharge] for whom this was an option wished this placement. ... Another group of residents (35) [ostensibly of the 100 candidates for discharge] were felt to be candidates for medical or psychiatric board and care facilities, which are in extremely short supply. ***At the conclusion of the process, of all of the patients evaluated, only five were discharged***[20]." [emphasis added]

Katz concluded that Option 7 may be inappropriate, since "community-based alternatives are not as successful for the most vulnerably ill persons with long-term care needs[21]."

In Option 9, having the City and County of San Francisco "phase itself out of the "long-term care business," Katz recommended that the Department of Public Health not consider this option, because when San Francisco's elderly, substance abuse, mental illness, and homeless populations "develop medical illnesses, they cannot usually be handled by free-standing SNF's, and instead require a facility like LHH" [22] and would require the City to "patch" Medicaid payments under a long-term commitment to providing operating subsidies to private facilities.

Option 4 was rejected because a 1994 Bond report projected that the cost of building 12 ninety-nine bed SNF's **would cost $171 million more** *than the economy of scale of building a single 1,200-bed facility on LHH's existing campus.*

[19] Ibid., page 15.
[20] Ibid., page 17.
[21] Ibid., page 20.
[22] Ibid., page 21.

In Option 10 to rebuild LHH at the current Forest Hills site, Katz noted in 1998 that LHH had instituted a moratorium on admissions in a compromise reached with the federal Health Care Financing Administration to limit LHH's census to 1,080 patients, and that the moratorium had created both a hardship for seniors failing at home who were unable to be admitted to LHH, and problems for local acute care hospitals unable to discharge their patients to LHH[23].

Katz noted discussing the pros and cons for Option 10 that "The projections show that San Francisco will need at least 1,200 NF beds at LHH," and that "an 800-bed facility would not meet the City's needs for SNF beds over the next two decades[24]."

Katz noted discussing the pros and cons for Option 10 that "The projections show that San Francisco will need at least 1,200 NF beds at LHH," and that "an 800-bed facility would not meet the City's needs for SNF beds over the next two decades."

2005 Data From San Francisco's Long-Term Care Ombudsman

In February 2005 Benson Nadell, San Francisco's Long-Term Care Ombudsman, delivered testimony to the Board of Supervisors about the need for long-term care beds in San Francisco. Tables 5 and 6 below are based on Nadell's testimony[25].

Table 5: Number of Medi-Cal Eligible Nursing Home Beds in San Francisco

Possible Maximum LHH beds for low-income Medi-Cal eligible residents (if all 1,200 built at LHH are rebuilt)	1,215 [26]
Medi-Cal eligible beds in private nursing homes [assuming no further loss]	1,443
Total Medi-Cal Eligible LTC Beds in San Francisco	**2,658**
Revised Maximum LHH beds for low-income Medi-Cal eligible residents if only 780 beds are rebuilt at LHH	780
Medi-Cal eligible beds in private nursing homes [assuming no further loss]	1,443
Total Medi-Cal Eligible LTC Beds in San Francisco	**2,223**

If the City decides to eliminate 420 beds from Laguna Honda's current approximate 1,215 skilled nursing beds, the number of beds available for low-income Medi-Cal eligible San Franciscans may drop to only 2,223 such beds (Table 5, above). And if the HMA recommendations are implemented, eliminating 740 SNF beds from LHH's current 1,200 SNF beds, the shortage of low-income Medi-Cal eligible SNF beds will shoot up to almost 3,000.

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[23] Ibid., page 22.

[24] Ibid., page 23–24.

[25] Testimony presented to Board of Supervisors Government Audits and Oversight Committee, Benson Nadell, San Francisco Long-Term Care Ombudsman Program, February 28, 2005..

[26] LHH's total current beds have dropped from 1,215 to only 1,065, and then to 1,035, due to recent problems with Federal and state regulatory agency oversight rulings.

Table 6: Number of Medi-Cal Eligible Nursing Home Beds in San Francisco

Number of Medi-Cal beds lost in San Francisco since 1992 due to nursing home closures	– 300
Number of Board-and-Care beds lost in San Francisco since 1987	– 951
New assisted living beds built in San Francisco since 1992	+ 1,693
Average assisted living monthly rates (graduated fees for supportive services are additional and not included)	$4,000
Number of Nursing Homes in San Francisco	20
Number of Nursing Homes in San Francisco Accepting Medi-Cal	11
Occupancy Rate of San Francisco Nursing Homes Accepting Medi-Cal	95%
Current number of remaining small Board-and-Care homes in San Francisco	33
Number of small Board-and-Care remaining that take SSI clients	200
Current occupancy rate of Board-and-Care taking SSI clients	96%

Given the high occupancy rate and low turnover in nursing homes and board-and-care facilities accepting Medic-Cal clients, the increase of 1,693 assisted living beds built in San Francisco since 1992 is encouraging. However, it is not reasonable to expect that Medi-Cal clients can afford an average of $4,000 per month for assisted living "rent," and expect them to afford additional graduated fees for supportive services not included in the assisted living fees.

There is no discussion in Katz's 1998 White Paper about the cost of maintaining assisted living beds. Indeed, although the LHH Replacement Facility set aside $15 million to renovate existing LHH facilities to provide 140 assisted living beds, no source of funding has yet been identified to pay for ongoing, annual operating costs to maintain these proposed beds.

However, it is not reasonable to expect that Medi-Cal clients can afford an average of $4,000 per month for assisted living "rent," and expect them to afford additional graduated fees for supportive services not included in the assisted living fees.

If the decision is made to cut 420 SNF beds at LHH, San Francisco will lose more SNF beds in one fell swoop than it has lost between 1992 and 2005, ***exacerbating the loss of SNF beds since 1992 from 300, to a total of 720***. And if the HMA recommendations are implemented and LHH loses 740 SNF beds in one fell swoop, San Francisco will have lost over 1,000 SNF beds during a short, 13-year period.

This will pose a severe crisis in San Francisco, particularly if additional closures of nursing home or board-and-care facilities occur in the near future!

Why Is a "Major Public Policy Debate" Being Premised on Flaws in the Glass?

As noted earlier in this report, both Mayor Newsom and Supervisor Sean Elsbernd are saying that the new debate over Laguna Honda Hospital — which new debate is being held ***only*** due the cost overruns of the LHH replacement project, and which debate was already held in 1998–1999 — provides a new opportunity for a major public policy debate. This report submits that setting public policy based on seriously flawed data, much of it unsubstantiated "estimates," is completely irresponsible and, therefore, poor planning for future needs of San Francisco's rapidly aging population.

This report submits that setting public policy based on completely flawed data, much of it unsubstantiated "estimates," is completely irresponsible and, therefore, poor planning for future needs of San Francisco's rapidly aging population.

Flaws in Susan Mizner's "Attachment A" Examined in Detail

The community must evaluate this Committee to Save LHH report fairly, because public policy is being developed based on flawed, and wildly exaggerated, Targeted Case Management (TCM) data. In addition to criticisms of Mizner's "Attachment A" noted on page 70 made by Dr. Tim Skovrinski at the LHH-Joint Conference Committee meeting on May 23, Mizner's report has received so much widespread criticism by LHH clinicians and others that Mitch Katz, Director of Public Health, was forced to acknowledge Mizner's inaccuracies to the Health Commission, which bears repeating:

> "Some issues have been raised as to whether the capacities of some of the community providers listed in [Mizner's] document are accurate[27]."

Katz was merely using a diplomatic way of saying that the ***inaccurate*** Mizner data analysis is riddled with flaws. But LHH clinicians and other staff who have closely read Mizner's "Attachment A" analysis have not been as kind in their criticism, suggesting that the vague details Mizner included shows a desperate rush job in trying to justify the raid of funds intended to be used to rebuild Laguna Honda by irresponsibly using sloppy data, unsupportable assumptions, and tenuous "estimates."

Version Control

There are two versions of Susan Mizner's "report." The second version completely changed the "question being presented," and also deleted entirely the "Conclusions" section contained in the first version. ***Both changes were deliberate, and significantly important.***

[27] Katz, M. (2005, June 7). "Laguna Honda Hospital Replacement Program." Memo to President Lee Ann Monfredini and Members of the San Francisco Health Commission.

On June 10, a public records request was placed by a private citizen to obtain the "complete copy, including exhibits, of Susan Mizner's April 2005 report *Estimates for Housing, Medical and Supportive Care Costs for People Discharged from Laguna Honda Hospital*[28]. [**Note**: It is instructive to read this footnote, and the following footnote.] Like most people, the requestor believed that the version of Attachment A attached to Harrington's May 19 report, which was subtitled an "extract," was just that — an extract from a larger report.

Not so. The first version of Mizner's report obtained under the Sunshine Ordinance is a four-and-two-thirds-page document, which — when Harrington subsequently claimed was an "extract" — shrank to four-and-a-quarter-page "Attachment A," containing almost the same information as the first version. ***As such, "Attachment A" was merely a* revision *of Mizner's original report,* not *an extract.*** The record obtained under Sunshine was described as being "in its original form." So it is also instructive to compare the original report to its subsequent incarnation as an "extract."

As such, "Attachment A" was merely a *revision* of Mizner's original report, *not* an extract.

The first change is that the subtitle in the original report — "What $6 Million Can Buy in the Community" — was removed from Attachment A. The only other changes were in the section "Background and Summary" (which change is discussed below), and a "Conclusion" section that appeared in the original report, but which was inexplicably removed from the version "Attachment A." The missing conclusions are also discussed below.

What is unknown is whether it was Mizner herself who ***revised*** the original report (first created on May 5), possibly at the request of the Department of Public Health, or whether it was revised by the City Controller (for use in his May 19 report to the Mayor).

Another unanswered question is whether Mizner's revised document is merely ***version*** control, or ***spin*** control .... ***for purely political purposes***!

Another unanswered question is whether Mizner's revised document is merely **version** *control, or* **spin** *control ...* **for purely political purposes***!*

[28] Mizner, S. (2005, May 5). "Estimates for Housing, Medical and Support Care for People Discharged From LHH — What $6 Million Can Buy in the Community." This report was inappropriately later referred to as an "April 2005 report," but the electronic document shows it was created on May 5, not in April 2005, revised seven times, and worked on a skimpy 193 minutes (or just over 3 hours to write, edit, and revise).

Mizner's Background and Summary

Using revisionist history straight out of the box, Mizner's revised Attachment A included in Harrington's May19 report to the Mayor stated:

> "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?[29]"

Nothing could be further from the truth! The City did ***not*** set out to consider adding funding for home- and community-based long-term services, it set out to consider and explore how to finance the rebuild of ***all*** 1,200 beds at Laguna Honda. Because in truth, that is ***precisely*** what Mizner's opening sentence in the "original report" had indicated — that the City had set out to explore adding additional funding to ensure LHH would be rebuilt as promised (bold italics in the quote below highlights original text that was subsequently deleted from the Attachment A "revision"):

Nothing could be further from the truth! The City did **not** *set out to consider adding funding for home- and community-based long-term services, it set out to consider and explore how to finance the rebuild of* **all** *1,200 beds at Laguna Honda.*

> "The City is considering ***using an additional $90 million to $100 million to increase the number of skilled nursing beds that could be re-built at Laguna Honda Hospital***. The question presented is what community care could be provided ***if that same amount of money were to be put in a trust, with approximately $6 million in interest available for community services***[30]."

It is significant that by revising Mizner's opening sentence, clearly someone wanted to downplay the fact that a plan was being hatched to create a second trust fund — to be endowed using $100 million from the first tobacco settlement revenue account that is also a trust fund — to be used ***for a completely different purpose*** than what voters had approved when Proposition A was passed in 1999 … without first obtaining voter approval to create a second trust fund.

It is significant that by revising Mizner's opening sentence, clearly someone wanted to downplay a plan was being hatched to create a second trust fund — to be endowed using $100 million from the first tobacco settlement revenue account that is also a trust fund — to be used **for a completely different purpose** *than what voters had approved when Proposition A was passed in 1999 … without first obtaining voter approval to create a second trust fund.*

The key difference between the two versions of Mizner's opening sentence is that the focus shifted from taking $100 million out of tobacco settlement revenues (since the City is now estimating it will receive $820 million in TSR's) for rebuilding LHH by depositing the same $100 million into a new trust fund.

[29] Mizner, S. (2005, May 19). "Estimates for Housing, Medical and Support Care for People Discharged From LHH — Excerpts From a report by the Mayor's Office on Disability," page 1. This is the revised "report" — not an excerpt from the original report.

[30] Mizner, (2005, May 5), op cit., page 1.

Notably, by the time Harrington wrote his May 19 financing recommendations two weeks after Mizner's original report, the $100 million proposed for a new trust fund had mysteriously shrunk to only $80 million — representing a 20% decline. But more mysteriously, the amount of estimated interest generated annually from a possible new trust fund had dropped from $6 million to Harrington's "***about***" $5.4 million — representing a 10% decline in expected interest earnings. Did Harrington know that interest rates were higher than lawyer Mizner's knowledge of interest rates? Or is this more like ***the miracle of the fish and loaves*** reported in chapter Mark 8 of Bible, despite our separation of church and state? ***Can a 20% decline in the size of a second endowed trust fund* really *yield only a 10% decline in projected interest earnings?***

Can a 20% decline in the size of a second endowed trust fund *really* yield only a 10% decline in projected interest earnings?

And the revised "Background and Summary" section of Mizner's report clearly shows that discussion had begun, at least by May 5, with the City Controller about creating a new trust fund, despite the fact that the tobacco settlement revenue account is already a trust account that is generating nowhere near $6 million annually in interest, by Harrington's own admission (see previous discussion on page 68).

As noted earlier in this report, had there been no cost overruns on the LHH replacement program, we would ***not*** be having the discussion about whether to build all 1,200 skilled nursing beds versus funding services in the community. Instead, we would be implementing the will of the voters, who passed proposition A in 1999 with the expectation that the LHH bond financing would give voters a complete 1,200-bed replacement facility at LHH, and construction of 1,200 beds would be well under way. Irresponsibly, during the six years which have passed since Prop A was approved by voters City officials have not even begun to consider seeking additional funding for home- and community-based beds, despite the clear need for ***both*** LHH's beds, ***and*** community-based beds. Mizner, and her various allies, appear to have been unable to get that conversation started during the past six years, nor have City politicians and the Health Commission been willing to initiate any such discussion independent of being prodded to do so.

So the new "public policy debate" Supervisor Elsbernd and the Mayor are now advancing can only be seen as robbing Peter to Pay Paul. After all, rather than having sought ***additional*** sources of funding for community-based long-term care services, San Francisco politicians are now merely cost shifting funds intended to rebuild LHH to other purposes, that the voters had ***not*** approved instead.

So the new "public policy debate" Supervisor Elsbernd and the Mayor are now advancing, can only be seen as robbing Peter to Pay Paul. After all, rather than having sought **additional** *sources of funding for community-based long-term care services, San Francisco politicians are now merely cost shifting funds intended to rebuild LHH to other purposes that voters had* **not** *approved, instead.*

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In her "Background and Summary," a skimpy two-sentence paragraph, lawyer Susan Mizner states "The question presented is what community care could be provided [and] at what price." She then poses an FAQ-style Q&A. The question posed in both Attachment A and the original report was:

> "**Q:** How many people, eligible for services at LHH, could be served in the community at service levels ***similar to*** [services provided at] Laguna Honda?"[31] [emphasis added].

Nowhere in the remainder of her poorly drafted Attachment A "analysis", nor in the "original" document, does Mizner ever get to the point of discussing whether her grossly over-estimated "assumptions" will ***adequately*** provide ***similar*** service levels of care that are provided at LHH.

Her sanitized answer in the Attachment A revision was "**A.** For each $2 million, 100 people could be served." The $2 million she cites is problematic for its simplistic, reductionist logic. But her answer in the original report was:

> "**A:** With $6 million alone, 300 people could be served. If the operating dollars for beds NOT re-built at LHH were included, an additional 525 people could be served, for **a total of 825 people**?"[32] [emphasis in original].

Once again, possibly in order to keep from alarming San Franciscans who passed Proposition A by a 73% landslide, the May 19 version (Attachment A), has been dumbed down and censored from its May 5 "April" incarnation, and does not notify voters that the plan is to eliminate, at minimum, 300 SNF beds from the LHH replacement project (as she suggested in the "Conclusions" section of her "April" report that was subsequently eliminated from the May 19 "Attachment A" version). That appears to have been the Mayor's plan all along.

But as we will see in the "Conclusions" section below, there's more to ***the miracle of the fish and loaves*** story, since the additional 825 people Mizner claimed in her May 5 original paper could be served in the community shrinks to only 790 people in Ed Harrington's report (for a net loss of 35 people to be served) despite a decrease of only $1 million dollars. This should have resulted in 50 fewer people being served, not 35 fewer, based on Mizner's logic that for each $2 million, 100 people could be served. Half of $1 million is 50 people, not 35.

[31] Mizner, (2005, May 5), op cit., page 1, and Mizner, (2005, May 19), op cit., page 1.
[32] Mizner, (2005, May 19), op cit., page 1.

Assumptions and Analysis

Mizner's principal premise asserts that according to TCM (Targeted Case Management) data, 84% of LHH's residents "are able to leave a skilled nursing facility [SNF] and return to the community[33]." One wonders whether she is referring to the many of LHH's residents who are there because they have end-stage renal disease, those with end-stage cancer, or just those with dementia brought on by Alzheimer's and AIDS. It is irresponsible and unbelievable that she asserts that only 16% of LHH's residents actually need long-term skilled nursing care.

Notably, few of the nine TCM staff members performing assessments appear to be trained, or licensed, to assess the *skilled nursing needs* of LHH residents. TCM is a hastily-implemented new agency that has been in operation for a little over a year, which has shown dismal performance results to date..

Clearly, several key questions need to be asked:

- How was it determined that 84% of LHH patients could receive adequate care outside the hospital?
- What *clinical* experience did the assessors have in addressing the skilled nursing care needs of dependent adults?
- How much *experience* does TCM staff have in assessing long-term skilled nursing needs?

Underscoring Mizner's lack of credibility, there is ***nothing*** in either "Attachment A" or her original report that answers either question. What *is* known is that the TCM staff is comprised of one coordinator, seven social workers and one program aide, potentially a "Healthcare Worker III." ***Notably, few of the nine TCM staff members performing assessments appear to be trained, or licensed, to assess the* skilled nursing needs *of LHH residents. TCM is a hastily-implemented new agency that has been in operation for a little over a year, which has shown dismal performance results to date.*** TCM's eight staff members discharged only 16 patients during its first year, compared to a single LHH medical social worker who discharged more than that in the first four months of this year.

The data coming from the TCM[34] program is known to be fraught with errors. The TCM program relies on an Internet-based database known as *SF GetCare*,

[33] Same as footnote 17.

[34] The TCM program was implemented as part of the Court-ordered settlement of the Davis case, in which independent living advocates in San Francisco sued the City and County of San Francisco over institutionalizing people in Laguna Honda Hospital and San Francisco General Hospital. The Davis settlement specified that San Francisco's Health Department would be required to aggressively screen patients at both LHH and SFGH to help facilitate community placement options prior to admission to LHH. But in May 2005, the TCM program advised LHH that it would no longer screen — or assist — SFGH patients who were denied admission to LHH. In other words, the TCM program staff unilaterally determined that it would only screen, and work with, patients admitted to LHH from SFGH, despite the Court's order that the TCM staff should also assist SFGH patients in locating community placements to prevent them from ever getting into LHH. But the TCM

which is known to be poorly designed. Aggregate data from SF *GetCare* that was supposed to have been made available to LHH staff for data analysis to improve and strengthen discharge planning at LHH, has not been provided.

In fact, in the year that the TCM program has been in place, only one briefing has been supplied by the TCM Director of Placement to LHH staff, during which meeting handouts of data were not provided, because of a fear they would be misinterpreted without staff being guided through the reading. Despite concerns raised by LHH clinicians during that meeting that the TCM documentation was not being integrated into LHH residents' medical charts, more than 12 months into the TCM project, the TCM "screening" tool, the full TCM "assessment," and progress notes by TCM social workers are still not (as of this writing) being integrated into LHH medical charts, let alone being shared with LHH's staff. So LHH staff are not being told what the TCM staff is doing, and there is no opportunity for LHH staff to provide independent clinical oversight into what the TCM case managers are doing for LHH residents.

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Reading either version of Mizner's report is even more troubling, because it sets the stage that LHH residents, some of whom are cognitively impaired, may have expressed ideal-world ***preferred*** living situations in the community assuming community supports are ***actually*** available and in place. Some residents may not have understood the conversation was not about the ideal world, but the real world where those community supports are currently ***not*** available or in place because of the severe shortage of service providers' current capacity (which even Dr. Katz acknowledged on June 7). Because the TCM assessment instruments have not been shared with LHH staff, it is not clear whether LHH residents are being asked their ideal-world preferences, or their real-world preferences.

program managers have now decided, possibly without the Court's knowledge, that it will only work with patients who are admitted to LHH, and that those SFGH patients inappropriate for LHH admission — those who do not need skilled nursing care, or those with behavioral problems making them unsafe at LHH — will not get help from the TCM program in finding community alternatives.

A partial answer to how the TCM staff — most probably Liz Gray, advising Mizner — arrived at the "estimate" that 84% of LHH's residents are able to reside outside of a skilled nursing facility such as LHH lies with a single question posed to LHH's residents. The "estimate" was arrived at by asking LHH residents a simple — and irresponsibly simplistic single — question: "Do you want to reside in the community?" Residents who responded "yes" were included in the 84%. ***This is not scientific research; this is pseudo-science at its worst,*** as is often the case with data from Nursing staff not rigorously trained in data analysis**.** And this percentage does not accurately reflect that 84% ***can*** reside in the community; at best it only demonstrates that 84% may ***want*** to live in the community. As such, the 84% figure is little more than an anecdotal report, ***not*** evidence-based practice.

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Obviously, asking someone an open-ended question of "Do you ***want*** to reside in the community?," followed, ***possibly***, by asking "Is your preferred living situation a board-and-care facility, supportive housing, or your own home," (an ideal world question reportedly not even asked), is quite different from asking someone pointed questions like "Since board-and-care facilities accepting Medi-Cal clients are running at 96% occupancy, would you prefer to go there, or stay here?," or "Since the waiting list for an independent-living Section 8 apartment will take at least eight years to obtain, would you prefer to go there, or stay here?," or "If a waiver could be obtained to provide you with no more than 9 hours a day of nursing assistance in your home after the waiting list clears up two years from now, would you prefer to go there, or stay here?" (the latter three are real-world fully-informed consent questions). And the TCM folks aren't telling us, let alone LHH's residents, whether they're asking ideal- or real-world hypotheticals, or whether they're actually providing complete, accurate information on which LHH residents can base truly informed consents.

And this percentage does not accurately reflect that 84% **can** *reside in the community; at best it only demonstrates that 84% may* **want** *to live in the community. As such, the 84% figure is little more than an anecdotal report,* **not** *evidence-based practice.*

Preferences (wants), obviously, are not the same thing as reality-based actual needs. And the TCM staff are not telling anyone whether a LHH resident's preferences have been disproved by their treating clinicians as medically infeasible, when not simply wishful thinking on the part of a resident with cognitive impairments.

That doesn't stop Mizner from indicating that TCM staff have ***estimated*** that 25% of LHH' residents would *prefer* to go to a B&C, 50% would *prefer* supportive housing, and 25% would *prefer* home or independent living, with additional supports. If the *SF GetCare* database was anywhere near accurate, why would anyone need an "estimate," wouldn't the database be capable of accurately reporting real, actual numbers of ***needs***, not estimates of ***preferences***?

More troubling, the footnote to the first paragraph of both versions of Mizner's "Assumptions and Analysis" section contains yet more flawed logic. The footnote reads, in part:

> "... 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%***[35]**"** [emphasis added].

First of all, this is an apple-to-orange comparison. Everybody knows that nobody ***wants*** long-term care placement in a nursing home, but the fact is, for some people, they simply ***need*** the level of long-term care that only a skilled nursing home can provide. **Skilled nursing facilities should be available for those who need, or prefer, them**. And nobody would argue that despite not ***wanting*** to be in a nursing home, most people would rather be in one than to not receive the appropriate level of care that they ***need*** outside of a nursing home. Often, the only appropriate level of care for some patients ***is in*** a nursing home, whether they ***want*** to be there or not.

And the TCM staff are ***not*** honestly asking LHH residents "Would you want to reside in the community if you knew you'd have to wait *months* to obtain medical appointments?" TCM staff are also ***not*** asking LHH's current residents "Would you want to live in the community if you knew you would not receive the same level of care that you are receiving at LHH?"

TCM staff are also **not** *asking LHH's current residents "Would you want to live in the community if you knew you would not receive the same level of care that you are receiving at LHH?"*

Second, the term "longer" in the footnote implies that there is a population of seniors who will need LTC placement at some point, and the implication needs to be acknowledged for what it is: an admission of the need for nursing homes for patients requiring that level of care.

Third, PACE slots and assisted living arrangements should ***not*** be used as a dumping ground for patients who truly need long-term care placement in a skilled nursing facility.

Fourth, neither the folks at TCM nor Mizner stratify the age cohorts of the purported 84% who can be discharged from LHH. This is important, because the "E" in "PACE" stands for "Elderly," defined as those over age 55. Clearly, many of the purported 84% are below age of 55, and therefore, don't meet PACE-slot eligibility requirements. There goes one of Mizner's assumptions!

[35] Same as footnote 17; see Mizner's footnote 1.

Fifth, if it were true that 84% of LHH residents could leave the facility and receive ***similar*** services currently available in the community, why isn't LHH seeing a mass exodus of its residents? To date, the TCM program has discharged a small percentage of those people discharged from LHH; some reports are that only seven discharges have been accomplished by the nine TCM employees.

Fifth, if it were true that 84% of LHH residents could leave the facility and receive **similar** *services currently available in the community, why isn't LHH seeing a mass exodus of its residents?*

Finally, Mizner's endnotes claims nursing home occupancy rates have declined to an average of 81%, disproving the TCM claim that 84% of LHH residents could safely leave the facility. In reality, LHH's occupancy rate is closer to 100%, or it wouldn't often have a waiting list for admissions to the facility. Most disturbing is that the 81% occupancy rate data is not stratified between those who can afford private facilities and those who are relying on Medi-Cal. Nor is data presented that details the occupancy rates of publicly-supported SNF's, which most likely have a greater demand and need than private nursing homes.

Board and Care (B&C)

Both versions of Mizner's report claim that the cost to San Francisco would be a "straightforward 'patch' " to owners of Board and Care facilities to provide the ***difference*** between a resident's SSI or Social Security income and the cost of the B&C bed. Mizner estimates that amount would be $1,600/month, or $19,200 per year per resident. Were 25 such patients to be transferred from Laguna Honda to B&C facilities, it would cost the City nearly half a million ($480,000) in ***new*** patch funding annually from the General fund. Given the past several years of the City's deficits, finding another half-million is problematic.

Mizner's data is based on her second footnote:

> "... 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***. ***The patch is the estimated need***[36]." [emphasis added].

Again, first there is the problem of how many residential, or board-and-care, facilities are actually licensed for psychiatric and substance-abuse patients.

Second, how many of these facilities are accessible for non-ambulatory people? Mizner doesn't even begin to estimate the capital costs it might take to make these types of facilities accessible for LHH's non-ambulatory patients.

[36] Same as footnote 17; see Mizner's footnote 2.

Third, data presented in 2005 to the Board of Supervisor's by San Francisco's long-term care Ombudsman, Benson Nadell, indicates that the percentage of SSI-rate B&C facilities in San Francisco is shrinking.

Fourth, there are even fewer B&C facilities that provide services in languages other than English. Mizner and the TCM staff did not stratify how many of the 84% of potential discharges from LHH speak a language other than English. She presented no data on the cost of translators, provided translators could even be found at the appropriate time who would be willing to travel between B&C facilities to assist residents requiring translation services.

Mizner doesn't even begin to estimate the capital costs it might take to make these types of facilities accessible for LHH's non-ambulatory patients.

Fifth, Mizner presents absolutely no data on the need for higher patch fees, or the amount of funding required, for those who need psychiatric or substance-abuse services in a B&C environment, nor whether that would involve additional outpatient services. In an unnumbered footnote[37], Mizner notes that about 40% of LHH's population has "a primary psychiatric diagnosis or substance abuse issue, and will need some form of community mental health services (including ... mental health board-and-care)," but neither she nor TCM staff indicated whether the new half-million in B&C patch funds from the General Fund includes both those with special B&C needs ***and*** those without special needs. It is unclear whether the half-million in "patch" funds would need to increase for those with special needs.

Sixth, B&C facilities (most probably to limit their risk, under risk-management programs), carefully screen referrals, and only accept those who require minimal assistance.

Sixth, B&C facilities (most probably to limit their risk, under risk-management programs), carefully screen referrals, and only accept those who require minimal assistance. Many B&C's, will not accept resident's who are incontinent, many patients who have physical limitations are precluded from residing in a B&C. Most B&C's provide minimal services (meals, bed, laundry), and rarely provide transportation. Activities at B&C are usually limited to a television, as compared to the Activity Therapy program at LHH, which is rich with activities to stimulate LHH residents, including trips into the community. Non-ambulatory residents at B&C's are rarely involved with community activities outside of the actual B&C facility, so they would be condemned to a small mom-and-pop, family operated, three- to four-bedroom home, with an in-law unit where the operator lives. Many of the B&C's are small, darkened environments, with the shades perpetually pulled drawn, with tenants sitting silently alone or propped in front of a television all day to baby sit them. ***Is this really how we want elderly San Franciscans discharged from LHH treated, and is this what we call an improvement over institutionalization*?**

Is this really how we want elderly San Franciscans discharged from LHH treated, and is this what we call an improvement over institutionalization?

[37] Same as footnote 17; note on last page of both versions of Mizner's report.

Seventh, Mizner's second footnote is troubling because it claims there are currently 315 slots available at residential- or board-and-care facilities. This is problematic for several reasons: First, Benson Nadell provided data documenting that of the City's B&C's that accept SSI, the occupancy rate is 96%; it is unclear how many of the 315 slots claimed are available will actually take SSI patients. Second, Mizner and the TCM staff offer no explanation about how many of the 40% of LHH they claim have primary psychiatric diagnoses are receiving SSI ***and who*** have manageable behaviors that could be safely cared for in any of the purported 315 slots, if any of the B&C's are licensed for psychiatric patients. Third, because many of the B&C are "mom-and-pop" shops, it is unclear how many of them are equipped to accept patients with behavioral issues. And fourth, surely some B&C and residential providers must have indicated an acceptable reimbursement rate that would entice them into accepting patients with behavioral issues, but neither Charlene Harrington nor Ed Harrington nor Mizner included the higher reimbursement rate in order to estimate the increased expenses to the City's General Fund.

It is not known whether Charlene Harrington's claim that 315 B&C slots are "currently available" is part of Katz's concerns about inflated estimates of provider capacity.

Finally, as noted elsewhere, on June 7 Dr. Katz noted that questions had been raised about the claims Mizner raised about capacity of some of the providers. It is not known whether Charlene Harrington's claim that the 315 B&C slots are "currently available" is part of Katz's concerns about inflated estimates of provider capacity.

Supportive Housing

It is in the "Supportive Housing" section of the two versions of Mizner's report that contain the most irresponsible and serious flaws. She begins:

> "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.[38]. [emphasis added]

Where does one begin analyzing this information, and all that is left out of it?

First, HUD buildings are not considered "Supportive Housing," as Mizner claimed. These buildings are considered independent housing, HUD does not fund supportive services, and eligibility requirements are completely different for supportive vs. independent housing. Moreover, not all HUD buildings are wheelchair accessible.

Second, HUD buildings have a very limited number of beds available, as do the SRO's, and neither type of facility could absorb massive discharges from LHH without severely impacting service to other segments of the community (non-LHH residents).

[38] Same as footnote 17; page 2.

Third, the SRO's are also severely limited, because the current priority is to place Care Not Cash program clients into SRO's first.

Fourth, due to current demand, SRO's have six-month to one-year waiting lists, which neither Mizner nor the TCM folks include in their analyses.

Mizner goes on to write:

> "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. ...[39]

For the 50 people she "estimated" would chose supportive housing, Mizner's report does not explain, let alone fully, how service needs for the "estimated" 50 people were determined. Obviously each batch of 50, and those within each batch of 50, are going to have quite varying levels of ***actual and individual*** care needs, but all Mizner presents are average costs, with no breakout of the level of acuity or the varying care needs for these 50 people. And because the TCM staff have for over a year failed to integrate their discharge planning progress notes into the medical records of LHH's residents and make that information available to LHH clinicians, it is unknown what level of "care costs" are being discussed, or whether the "estimates" for care costs are anywhere near reasonably accurate based on ***actual and individual*** care needs.

Fourth, due to current demand, SRO's have six-month to one-year waiting lists, which neither Mizner nor the TCM folks include in their analyses.

Although Mizner claims that healthcare costs for people in supportive housing ***might*** be paid for through waiver programs, she does not discuss that "waiver programs" are relatively new and not much used. Nor does she mention:

- Waivers do not provide 24-hour services.
- A resident can only sign up for one waiver (i.e., if a resident signs up for MSSP, that resident is not eligible for the HCBS waiver).
- A resident needs to remain cost neutral in order to be eligible for waivers. If the cost of services provided in the community using waivers costs more than care in a SNF facility, Medi-Cal will only cover the SNF-level of services.
- Waivers are not the ultimate solution, because once an individual utilizes services available in the community, the amount of services the waiver can provide is reduced.

[39] Ibid.

During the June 7, 2005 Health Commission meeting, Dr. Katz noted the State has a waiting list for NF (nursing facility) waivers, and that the City is placing people on **that** waiting list to document the need for the NF waiver programs, in the hope of exerting pressure on the State to increase the number of NF waiver slots. It is important to note ***these waiver slots are not currently available***.

This bears repeating: Mizner ignores that for many Medi-Cal waiver programs, if the cost of community placement exceeds what Medi-Cal would reimburse for SNF-level of care, Medi-Cal will only approve "aid" codes for skilled nursing facility care.

This bears repeating: Mizner ignores that for many Medi-Cal waiver programs, if the cost of community placement exceeds what Medi-Cal would reimburse for SNF-level of care, Medi-Cal will only approve "aid' codes for skilled nursing facility care..

Finally, it remains to be seen whether current funding would allow waiver programs to absorb residents discharged from LHH without sacrificing other waiver needs for people who are currently in home- and community-based facilities who may also be competing for the waiver slots.

She then makes unfounded assumptions about Supportive Housing utilization:

IHSS Costs (In-Home Support Services)

- Of the 50 people needing supportive housing, Mizner claims only 5 would need IHSS services. However, there is no proof — only estimates — that not all 50 would need IHSS assistance, possibly at greater cost than Mizner estimates.
- She indicates that "not all clients would need the maximum number of hours of care each months (approximately 9 hours of care a day)." While Mizner estimates a cost to the City and County of San Francisco of an "average" of $10,220/year for each of the 5 people needing IHSS (for a total of $51,100). However, if Mizner is wrong, and all 50 people choosing supportive housing needed IHSS asistance in which to do so, that amount could climb to an annual cost to the City of $511,000, substantially more than her estimate. Moreover, depending on accuity level, IHSS provides up to 389 hours per month, or about 13 hours per day for patients with a higher risk or a higher acuity. Assuming that the costs are based on the $35/day rate, and not an average, for 5 higher acuity patients the annual cost would be $63,000, not the $51,100 average. And if all 50 residents had the higher acuity level requiring the extended IHSS hours of care, the additional annual cost to the City and County for IHSS would be $630,000, not $511,000, a significant under-estimation.

And if all 50 residents had the higher acuity level requiring the extended IHSS hours of care, the annual additional cost to the City and County for IHSS would be $630,000, not $511,000, a significant under-estimation.

- Mizner neglects to note that of 50+ discharges from LHH last year, IHSS only granted the maximum number of *extended* hours per month to just one person. Additionally, over the past two years, IHSS has been decreasing the number of approved hours, and has increased the waiting period for the start of home-based care.
- She notes that "any medical care needed would be covered by Medi-Cal, through visits to community clinics, etc.," but she fails to note that a) DPH's clinic system is running at full capacity, some clinics are being threatened with regulatory closure, or are facing the possibility of funding cuts, and b) waiting times for appointments at City clinics takes months and months. For instance, if a patient needed a renal ultrasound, it could take up to seven months to get such an appointment. A patient who needs an appointment for a sigmoidoscopy may have to wait up to 16 months to obtain one. Clients with high acuity levels obviously cannot wait for months for appointments, and may likely end up at SFGH's Emergency Room, which is also stressed to the max, and which E.R./acute-care costs are not even considered in Mizner's analysis.

Mizner neglects to note that of 50+ discharges from LHH last year, IHSS only granted the maximum number of **extended** *hours per month to just one person. Additionally, over the past two years, IHSS has been decreasing the number of approved hours, and has increased the waiting period for the start of home-based care.*

- Mizner ignores that the IHSS system is unable to carry the current level of discharges from LHH and is limiting services to LHH dischargees, and/or increasing the wait for the start of care.
- Mizner makes no mention that California's governor is actively attempting to further reduce funding to IHSS, in particular by lowering the hourly wage to IHSS employees, which will only drive those employees from the labor pool, driving up scarcity of home-based healthcare workers and increasing waiting lists.
- Mizner fails to mention that no single-standard-of-care requirement exists for IHSS programs. This issue is further explored in the **Quality Assurance and Oversight** section of this report.

PACE Program

- Mizner claims that there is a "program with 300 [PACE] slots currently available." This single unsupportable exaggeration is most likely what Dr. Katz was referring to in his June 7 memo to the Health Commission noting questions have been raised whether capacity statements claimed in Mizner's report(s) "are accurate." Indeed, just nine days after Katz's June 7 memo, the Long-Term Care Coordinating Council released a report on June 16 indicating that only 130 – not 300 — PACE slots are currently available, yet Ed Harrington's report to the Mayor on May 19 was based on Mizner's grossly over-estimated, flawed data.

Indeed, just nine days after Katz's June 7 memo, the Long-Term Care Coordinating Council released a report on June 16 indicating that only 130 – not 300 — PACE slots are currently available, yet Ed Harrington's report to the Mayor on May 19 was based on Mizner's grossly over-estimated, flawed data.

- First, a resident needs to receive several interviews with PACE program staff for a thorough medical and psychiatric evaluation prior to being admitted to the program. ***Historically, residents who are medically complex can be denied admission to a PACE program.*** Residents may also not qualify for the program after the evaluation if they are deemed too close to needing SNF-level of care. Yet neither Mizner nor the TCM staff ackowledge that multiple of LHH's many wards are, in fact, dedicated to medically-complex patients who will most certainly be denied eligibility for a PACE slot.
- During the June 7, 2005 Health Commission meeting, one expert describing the PACE slots noted eligibility rules to PACE programs require the applicant to give up their primary care physician, as most managed care health insurance plans do. Many residents do not want — and refuse — to leave their primary care physician, and are thus ineligible for PACE programs.

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- Eligibility rules for PACE slots may prevent many of LHH's residents from qualifying. For instance, the eligibility guidelines for On Lok's PACE program ***excludes*** people who:
  - Are on dialysis.
  - Have a psychiatric disorder requiring intensive intervention
  - Are presently homeless
  - Actively abuse substances
  - Lives in an unsafe place (for themselves and/or the providers)
  - Have dangerous behavior(s)

- Mizner does not stratify what percentage of the purported 84% of LHH residents the TCM program claims could be discharged to the community have one or more of the exclusion criteria that would ***prevent*** them from being accepted into a PACE program.
- Because the platform for PACE slots are ADHC programs, many of LHH's residents have a higher acuity level than most ADHC's will accept, disqualifying them for the PACE slot.

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ADHC (Adult Day Health Care) Programs

- As noted, San Francisco's ADHC network is now operating at full capacity, and the waiting lists for ADHC programs are usually three- to six-months, or longer. Currently, there is only one ADHC (the Institute On Aging's Golden Gate Center) in the Tenderloin that has only a three- to six-month waiting list. Each ADHC has its catchment area, and usually does not accept participants from other catchment areas, unless they are nearby and they obtain a waiver from the ADHC of their catchment area. This is due, in part, to State regulations limiting bus rides to a one-hour maxium. The paratransit vehicle provided carries 10 to 15 passengers. Therefore, the first one picked up starts the one-hour-time-limit clock ticking. If the van goes outside the catchment area, it increases the ride time.
- ADHC's require a higher level of physical functional ability than many of LHH's residents have. For example, ADHC's often will not accept patients who can only be transferred using Hoyer lifts.

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Independent Housing

Mizner wisely notes in the opening paragraph of this section that estimating costs for independent housing "is the most difficult category to ***average***." But it is not *average* costs that need to be addressed, but ***actual*** costs, since there is virtually no independent housing to be had in the City, particularly since this category involves housing costs, personal services costs, and medical costs.

The most glaring problem with this section is that completely missing from Mizner's analysis is any discussion about patients who rely on Medi-Cal, which does ***not*** pay costs for independent housing — or for any other form of housing. And though she admits that "some" of the 25 who have ostensibly indicated that this is their "preference," she estimates a raw number of "8" would probably want a subsidy. (It is indicative of just one of the many problems with *SF GetCare* database on which the TCM program relies, that it can't accurately report the number who would ***actually*** require a housing subsidy, and what payor source would fund the housing subsidy.) To her credit, Mizner notes it would be an on-going cost to the City and County of San Francisco. But if her ***estimate*** of eight subsidies is inaccurate, and all 25 would need housing subsidies, the nearly $100,00 annual cost to the City would triple to $300,000.

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Among Mizner's "assumptions" for Independent Housing are:

- 20% (5) of the 25 desiring "Independent Housing" could return to "a home that they own" or could live in a family member's home (which may not be the same thing as their "previous home"), if "little-used funds" from the CHRP[40] pot of money were utilized to rehab homes to make them accessible. Nonetheless, a reasonable question to ask is: If these funds are little used, how available are they, really? Unanswered is whether family members would be willing, or are able, to take in relatives who had not previously lived with them, and if they are capable of providing supportive care. Also unaswered is whether improvements can only be made to a resident's home, not to their relative's home.

[40] Mizner did not define the CHRP acronym;.it stands for "Community Housing Rehabilitation Program." And Mizner did not note that one of the reasons that it is a "little used" program is because it is a "single family rehabilitation program" that provides "low-income homeowners of single family and two-unit homes" with low-interest, and possibly deferred rehabilitation ***loans*** for remodeling of homes to make them accessible, but which may be limited to widening doorways, lowering cabinets, adding a chair lift, and/or a ramp. The home must be owner-occupied, which may exclude landlords who *might* be willing to rent units to disabled persons if the owner is not occupying one of the two units. Given that the overwhelming percentage of LHH residents are Medi-Cal recipients who do not own property, the chances that CHRP funds can actually assist LHH residents is at question.

- 50% (12) of the 25 "could return to housing they were previously in, usually government subsidized (e.g., Housing Authority) or to Section 8 housing[41]," there would be additional costs to the County for home modifications. There are problems with this: a) There's a question about whether San Francisco is allowed to modify Section 8 housing to make it "accessible," and — much more glaringly problematic — b) There are no long-term care residents at LHH who have access to Section 8 housing. Mizner's claims, therefore, have to be viewed as purely hypothetical, not reality-based.
- Section 8 is currently ***not*** accepting applications, and hasn't accepted applications for years, since that waiting list has been closed for several years. Further, the current Section 8 waiting list is expected to last anywhere from five to eight years before people will even be offered Section 8 ***applications***. Moreover, the federal government is trying to severely cut back on Section 8 housing in San Francisco, and nationwide. Mizner's "estimate" that some of these 12 applicants can be placed into Section 8 housing is simply wishful thinking, irresponsibly divorced from any shred of reality.
- Mizner claims that 30% (8) of the 24 who would prefer Independent Housing would want affordable housing, or a rent subsidy. When she then claims the average subsidy would average $1,000 per month, she's using round numbers that are basically unreliable. If the high end of the "range" being discussed ***actually costs*** $1,500 per month for each of the 8 people, the cost to the County would not be $96,000 annually (at $1,000/per month for each of the 8), it would be $144,000, showing Mizner's estimates would be off by at least $48,000. If the goal is to place 300, not 100, of LHH residents back into the community, providing 24 people (of 72 people potentially wanting a housing subsidy) Mizner would be off by ***another*** $144,000.

There are no long-term care residents at LHH who have access to Section 8 housing. Mizner's claims, therefore, have to be viewed as purely hypothetical, not reality-based.

[41] Same as footnote 17; page 3.

Mizner's May 5th "Conclusions" Vanish From Report to the Mayor

While she wrote a "Conclusion" section on May 5, political forces appear to have determined that conclusions Mizner had already reached needed to be censored from widespread public view. Her conclusions were, therefore, surgically excised from Harrington's "Attachment A" May 19 report to the Mayor. The May 5 version of Mizner's "original" report stated in the Conclusion section:

> "With $6 million a year from a trust fund, 300 people could live in the community with ***similar*** levels of needed support [that are currently provided at LHH][42]." [emphasis added]

Nowhere in either of Mizner's analyses was it proved that ***similar*** levels of service provided at LHH ***could*** actually be provided in the community. But the "conclusion" she reached — which was subsequently censored by removal from the subsequent version of her report — that a $6 million trust fund could provide the ***same level of services*** to 300 people "in the community" shows that she is desperately trying to make preconceived conclusions fit the facts.

Mizner claims "***not*** building 300 beds [at LHH] would free up $10.8 million [from operating funds financed from the General Fund] that could be used for 'community housing and care,' allowing an additional 535 people to live in the community." Her "conclusion" claims 825 additional people could be served in the community from savings of not building 300 beds, plus savings from operating funds, for a combined savings of $16.8 million.

While she wrote a "Conclusion" section on May 5, political forces appear to have determined that conclusions Mizner had already reached needed to be censored from widespread public view. Her conclusions were, therefore, surgically excised from Harrington's "Attachment A" May 19 report to the Mayor.

But when Harrington analyzed the same so-called "facts," he concluded that only 790 people could be served using $15.8 million, a one million dollar variance over Mizner's data. Since Mizner had claimed for each $2 million in "savings" an additional 100 people could be served, it is odd that the one million difference between Harrington's $15.8 million and Mizner's $16.8 million has resulted in only 35, not 50, fewer patients who could potentially be served.

Isn't this more of ***the miracle of the fish and loaves?***

[42] Mizner, (2005, May 5), op cit., page 4.

Mizner's End-Notes Gaffes

In her end notes, Mizner claims:

- "Specifically, Home and Community based Waivers can provide ***additional*** attendant/home nursing care," but this implies these services are ***already*** in place. However, in many cases, they ***are*** not in place and not readily available.
- "In addition, Proposition 63 will provide $50 million to San Francisco] for first year (planing year) and more thereafter to provide community mental health services and supports, including housing options," Mizner writes. She continues, "Proposition 63 funds can be used to drawn (sic) down federal matching funds, again, at no increased cost to San Francisco." But as Dr. Katz noted during the June 7 Health Commission meeting, the best San Francisco can expect from Prop 63 funding this year is a total of $5.5 million, not $50 million, as Mizner wrongly claims — leaving Ed Harrington's May 19 report to the Mayor with another $44.5 million problem.
- Combining the Prop 63 $44.5 million error in Mizner's "Attachment A" (of which she should have been aware), with the potential for losing $40 million of the SB1128 funding if all 1,200 ***SNF*** beds are ***not*** built at LHH (see discussion on page 65), Harrington's financing options may be off by a cool $84.5 million. ***Given the enormity of such an error, this is no way to be conducting a "major public policy debate"!***
- Other observers have noted that Prop 63 funds will ***not*** draw down additional, matching, Federal funds. Besides, these services are ***not*** available at this time, and to suggest that they ***are*** in place and ready to support Mizner's claims 84% of LHH's residents could be moved to the community, is completely unrealistic, when not irresponsible.
- As a United Healthcare Workers—West shop steward, noted during public testimony on June 18[43], Proposition 63 funds cannot be used for either skilled nursing facilities or for long-term care. Therefore, if Prop 63 funds cannot be used to provide the ***same level of care as currently provided at LHH***, Mizner irresponsibly included this recommendation to the Mayor.

Combining the Prop 63 $44.5 million error in Mizner's "Attachment A" with the potential for losing $40 million of the SB1128 funding if all 1,200 **SNF** *beds are* **not** *built at LHH, Harrington's financing options may be off by a cool $84.5 million.* **Given the enormity of such an error, this is no way to be conducting a "major public policy debate"!**.

Therefore, if Prop 63 funds cannot be used to provide the **same level of care as currently provided at LHH**, *Mizner irresponsibly included this recommendation to the Mayor.*

[43] Bevan, Larry. (2005, June18). Public testimony during *Joint Hearing on Laguna Honda Hospital*.

Information TCM Staff Failed to Tell Mizner and Harrington, and Don't Want You to Know

- Given the fact that the TCM assessments, screening tool, and progress notes are not incorporated in the medical records of LHH residents, it is impossible for an independent analysis of the veracity of TCM data.
- It is believed that the TCM assessment instrument is not considering behavioral, psychiatric, and substance abuse issues and personality disorders that may affect community placement, nor is the instrument considering skills in coping with change and life management.
- No information has been forthcoming about the outcomes of residents who have been discharged under the TCM program, including no information about the number of re-admissions to acute-care hospitals or to LHH, and the costs of such re-admissions.
- During the June 7, 2005 Health Commission meeting, Liz Gray, DPH's "Director of Placement," testified that the TCM program has submitted 747 housing applications and/or nursing home waivers. Gray stated on June 7:

  > "If we feel the residents can be discharged, we file the waiver and housing applications[44]."

This is problematic for several reasons:

- First, monthly TCM reports that were obtained from a public records request show that in many months 63% to 74% of LHH residents being "case managed" by the TCM program declined having housing applications submitted of their behalf, because they have chosen to remain at Laguna Honda. *Therefore, how the TCM program could have submitted 747 housing and waiver applications for such a large percentage of LHH residents* ***who declined having housing applications submitted*** *is unknown; this may be grossly confounding and over-estimating the number of LHH residents who wish to be discharged to the community.*
- Second, assuming that some of the 84% of LHH residents the TCM program estimate do not need to be placed at LHH have mental health problems and cognitive impairments, where are the surrogate consent approvals to have had such a high number of housing and waiver applications submitted?

Therefore, how the TCM program could have submitted 747 housing and waiver applications for such a large percentage of LHH residents **who declined having housing applications submitted** *is unknown; this may be grossly confounding and over-estimating the number of LHH residents who wish to be discharged to the community.*

[44] Monette-Shaw, P. (2005, June 7). Health Commission meeting notes.

New TCM Report Disproves Its Own Claim 84% of LHH Residents Can Be Discharged

The Department of Public Health staff member in charge of the Targeted Case Management Program — Elizabeth Gray, RN, Director of Placement — presented a document in early June 2005[45] completely contradicting data presented in Susan Mizner's "Attachment A" that Ed Harrington relied on in his recommendations for financing the rebuild of Laguna Honda to Mayor Newsom on May 19. Imagine that: Completely contradictory data. Contradictory data between the two "reports" include:

You can't have 84% of LHH's residents "able" to leave LHH when 66% of them have expressed their preference to remain in a nursing home, the overwhelming majority of whom will need a nursing home that accepts Medi-Cal.

- Liz Gray asserts in her June presentation that 86% of 1,303 patients ***screened*** are eligible for the TCM program. Mizner, however, asserted that 84% — not 86% — of LHH residents are able to leave LHH's skilled nursing facility.
- The ***screening*** assessment tool does not adequately assess whether those screened are really capable of living in the community.
- Of the 1,303 screened, only 1,045 were actually assessed using the RAI-HC (Resident Assessment Instrument–Home Care) tool. At an average of 1.5 hours needed to complete a single RAI-HC assessment, the TCM staff would have had to spend 4.9 person-months to complete the actual assessments. ***Where did TCM's staff of eight find 1,567 hours in which to complete the RAI-HC assessments, given their additional discharge planning duties?***
- Of the those Gray's TCM team ***screened*** and reportedly found eligible, fully 66% expressed their preference to be placed in a nursing home. You can't have 84% of LHH's residents "able" to leave LHH when 66% of them have expressed their preference to remain in a nursing home, the overwhelming majority of whom will need nursing homes that accept Medi-Cal. Those who may have expressed such preference are not "able" to leave LHH, since on another slide, Gray notes that 67% expressed their preference ***not*** to return to the community.
- Gray asserts that only 20% of those surveyed prefer to live at home ***with*** supportive services. Mizner, however, estimates that for every 100 people discharged from LHH, 50 people would prefer supportive housing. Fifty of each 100 residents represents a 50% rate, not 20%.
- Gray reports that only 12% of those assessed have a support person who are positive about the prospects for discharge. If 88% of the support people are opposed to discharge planing of those residents they are trying to protect, Mizner and the Mayor must be completely miscalculating the level of support among voters in the community who want LHH preserved as a long-term care skilled nursing facility.

[45] Gray, V.E. (2005, June). "Targeted Case Management Assessment Outcomes April 2004–May 2005."

- Gray reports that 324 (29%) of those assessed are "severely" cognitively impaired, and another 414 (37%) have "moderate" cognitive impairments. Between "severe" and "moderate," cognitive functional ability, fully 66% of Gray's sample of LHH residents have cognitive impairments. It is extremely unlikely that ***severely*** cognitively impaired people can live ***safely*** in the community without a lot of 24/7 care, given their diminished capacity for safety awareness.
- Gray reports on only two activities of daily living (ADL): "Dressing," and "Personal Hygiene," the latter of which is not a standard ADL term. There are at least five standard terms used to describe ADL's (bathing, dressing, transferring, toilet use, and eating). That she omits reporting on three of the ADL's, which must have been part of the assessment tool, and misnames the fourth measure, is suspicious. Of the two she did report on, 61% to 67% of those survey are totally dependent on care, or require "extensive" assistance. Yet neither Mizner nor Ed Harrington provide cost estimates of what providing either "extensive" or "total" assistance in community-based settings, rather than at LHH, will cost.
- Gray reports 45% of those surveyed have a "suspected presence" of developmental delay or mental illness. But Mizner does not indicate in the "Attachment A" to Ed Harrington's two-option recommendation to the mayor that fully 45% of the 84% she claims could be discharged to the community would require mental health services, and Mizner fails to provide a cost estimate of what those services will cost in community-based settings, let alone how to pay for them. After all, Prop 63 funds can only be used for new mental health services, not to replace funding for mental health services already in place at LHH.
- Gray reports that 47% of her assessments were female, and 53% male. This contrasts sharply with data on the LHH Replacement Project web site that indicates that 56% of LHH residents in 1998–1999 were women, and only 44% were men. In just six short years, the gender demographics of LHH residents have completely swapped. Statistically, this could not possibly have occurred through attrition or changing healthcare needs, particularly since women are the fastest growing segment of those over the age of 85 and those over the age of 65. Instead, ever since the introduction of seven "psychosocial" wards at LHH in 2001 — which displaced hundreds of frail elderly residents — a concerted effort has been underway to socially reengineer the demographics of people being admitted to LHH by favoring men with "behavior" problems over frail elderly women.

Between "severe" and "moderate" cognitive functional ability, fully 66% of Gray's sample of LHH residents have cognitive impairments. It is extremely unlikely that **severely** *cognitively impaired people can live* **safely** *in the community without a lot of 24/7 care, given their diminished capacity for safety awareness.*

- Gray reports that 69% of her study population have been at LHH for over a year; this indicates a clear need for long-term care ***beds*** to serve ***people*** with long-term care needs. Of the remaining 31% who have been at LHH less than a year, Gray chose to ***not*** report on the number of people who had expired in-house within their first year. And for the one-third of LHH residents who do expire in-house annually at LHH, neither Gray nor Mizner stratify the length of stay prior to dying.

Gray reports that 69% of her study population have been at LHH for over a year; this indicates a clear need for long-term care **beds** *to serve* **people** *with long-term care needs.*

Issues Mizner Failed to Even Consider and Harrington Didn't Cost Out

Other issues Mizner's report does not even begin to address include:

- Home delivered-meals are not as readily available as Mizner assumes. Currently, the Meals on Wheels program to deliver food to home-bound seniors now has a waiting list, and often does, with estimated wait times of weeks to months depending on demand. The Health at Home meals program through the Salvation Army provides home delivered meals only in the Tenderloin and South of Market areas. All home delivered food programs, including Project Open Hand's, are limited to one meal per day; some programs deliver only five days a week, while others cover all seven days. Unfortunately, some programs deliver only bagged peanut-butter-and-jelly sandwiches. Few programs have nutritionists who can assess and develop diets for individual clients who need specialized feeding plans.
- Traditionally, the City has a limited number of Medi-Cal SNF beds. If the City eliminates up to 420 SNF beds from the LHH replacement project, we can reasonably project that Medi-Cal residents will have to wait in acute care hospitals for discharge to a lower level of care, or be asked to transfer out of the county. As noted in this report, the City already faces a critical shortage of Medi-Cal SNF beds.
- Eliminating 420 SNF beds from LHH will lead to fewer discharge locations for SFGH's acute care patients, exacerbating the very "diversion" to other Bay Area acute hospitals that Katz claims is of such a concern to DPH.
- Per Mizner's report, there are currently multiple resources to support residents in the community, but the City has no plans to add additional resource capacity. ***The current resources are not adequate to support the complex medical and psychosocial needs of LHH residents***, or they would have already been considered for discharge.
- Those who need 24/7 safety supervision, for instance, patients who have a traumatic, or acquired, brain injury resulting in cognitive impairments that require closer supervision than "community placement" can provide.
- Those patients with an "NG" or "G" tube for feeding, which patients many B&C facilities refuse to accept for admission, due to their acuity level(s).

- Those who have families unable, or who are unwilling, to provide care.
- The severely limited supply of non-ambulatory board-and-care, assisted living, and independent living facilities in San Francisco. This is important because many of these facilities have no devices other than single-point canes for non-ambulatory patients, limiting their ability to safely exit the facility without assistance during an emergency.
- Undocumented residents with SNF-level only Medi-Cal coverage.
- Diabetics who are incapable of managing gluco checks and insulin injections.
- Those who are at risk of elopement and wandering.
- The fact that San Francisco has more elderly living alone, particularly those people over the age of 85.
- While undocumented clients may receive some Medi-Cal coverage while in a skilled nursing home, undocumented individuals do not qualify for benefits or many community-based services.
- Younger patients transferred to LHH from SFGH are subsuming elderly admissions, and at what cost.
- By adding in costs of other support services besides IHSS, and rent, food, transport to appointments, day care, etc. are they ***really*** actually ***less*** than the costs to care for the same patients at LHH who need SNF care?
- How will acute care hospitals be able to discharge patients to SNF level-of-care if the total number of SNF beds at LHH are slashed by one-third, and at what cost?
- If the City builds smaller SNF facilities throughout the City, or awards contracts to other service providers, will they be able to qualify for the "distinct part SNF" rate, and if not, what increased costs will the City face?
- Are all of the costs for "treating" patients in the community really limited to just staffing, food and other costs, as Ed Harrington asserted, or should the costs of Section 8 housing, housing subsidies, medical care, and other costs be factored in to the ***true*** cost of placing patients in the community?
- Is the City just cost shifting between LHH care, and community-based care?
- How many LHH patients need non-nursing, as opposed to full-nursing, level of care?
- Mizner's report does not take into consideration residents who are not straight Medi-Cal. Residents may have Medi-Cal ***Share of Cost*** or additional medical expenses — including prescription medications — that they have to pay out of pocket if they are not straight Medi-Cal.
- Community placement can be too isolating for some patients with severe cognitive impairments or who have extensive nursing care needs.

- Most importantly, neither Harrington nor Mizner address the increasing demographics of the "frail elderly" (those over age 85) in San Francisco. Increasingly, there are more frail elderly living alone in San Francisco who are experiencing a decline in their ability to live independently, and who will need care that can only be provided in a skilled nursing home. In their rush to simply eliminate SNF beds from the LHH replacement project, neither Mizner nor Harrington discuss the number of skilled nursing beds needed to accommodate the increasing number of elderly and frail eldery San Franciscans.

In their rush to simply eliminate SNF beds from the LHH replacement project, neither Mizner nor Harrington address the number of skilled nursing beds that will be needed to accommodate the increasing number of elderly and frail elderly San Franciscans.

- Will LHH residents who are dumped into the community be, in any real way, more independent than when residing in their community of peers at LHH, or will they simply become isolated?

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- In a report first presented on June 16[46], additional costs that would need to be factored in to a cost/benefit analysis of whether community-based care would be more expensive than care at LHH, the following needs for a "so-called "Community Living Fund" (the second "endowed" trust fund using $100 million in tobacco settlement revenue) were presented. But to date, neither Mizner nor Harrington have released any costing information for these additional services:
  - **Housing for caregivers/family members**. Since many people discharged from LHH would require a 24-hour caregiver, two-bedroom units would need to be found that are accessible for people with disabilities. This would be a significant additional expense, which expense has not been financially estimated.
  - **Transitional living training** to prepare people for community living.
  - **Money management services** are insufficient, and there are long wait lists and limited money management personnel.
  - **Transportation services** is noted to be a problem in the community.
  - **Availability of 24-hour supervision** for some high-need, high-risk individuals needing intermittent care. Ironically, nobody is mentioning that the 24-hour services at LHH may well be the most appropriate, and most integrated, and possibly the least expensive, setting for some LHH residents needing 24/7 skilled nursing care and supervision.

[46] "Community Placement Plan," San Francisco Long-Term Care Coordinating Council (a policy advisory body to Mayor Newsom), June 16, 2005. This plan is to another "rush" report to provide "safe and healthful transitions from LHH and other institutional settings for successful placements in the community." This report comes with its own set of errors.

– **Citywide, coordinated case management** for some individuals who will need intensive case management. It should be noted that the salaries for the seven TCM social workers is budgeted at approximately $627,445, including fringe benefits. The additional two TCM staff are probably budgeted for another $170,000, bring the cost of the TCM program to approximately $800,000 — just for personnel expenses. The significant expenses for ***additional*** case managers for the Community Living Fund (in addition to the TCM staff) have ***not*** been estimated by Harrington or Mizner.

And Mizner, Gray, and Harrington aren't (yet) talking.

The significant expenses for **additional** *case managers for the Community Living Fund (in addition to the TCM staff) have* **not** *been estimated by either Harrington or Mizner.*

Flaws in the Glass: City Controller's May 2005 Financing Options to Rebuild LHH

On the cover page of his report — in which he rhetorically asks "Where do we go from here?" — concerning the LHH replacement project, City Controller Harrington notes that Mayor Gavin Newsom asked the Controller's Office to collect information and to prepare an "independent"[47] analysis of the options the City has to replace Laguna Honda Hospital.

Unfortunately, Harrington is anything ***but*** a disinterested or independent observer. In most jurisdictions, City Controller's are elected. Harrington, because he is not an elected official, is therefore beholden to his political masters, since as the department head of the Controller's Office, Harrington serves at the pleasure of his boss, a politician known as Mayor Newsom, as does Director of Public Health, Mitch Katz, MD. Both men serve the ***political pleasure*** of Newsom, and both men are seeking to fulfill the politician's vision, not the people's vision for LHH. And both men are playing politics with San Francisco's most vulnerable citizens — our elderly and disabled who need Laguna Honda. Mayor Newsom has been playing an active game of political football involving safety at LHH for the last 16 months. Actually, Newsom has played political football with LHH for over six years, since he did not support placing Proposition A to rebuild LHH on the 1999 ballot. Newsom has gone from playing politics with Laguna Honda as a supervisor to playing politics with Laguna Honda as mayor.

Harrington's May 19 financing options to rebuild LHH is premised entirely on Attachment A, a three-and-a-quarter-page set of flawed estimates excerpted from a report prepared by Susan Mizner in the Mayor's Office of Disability. Mizner, like Harrington, is not an "independent observer." Mizner is a lawyer, not a healthcare professional nor an financing expert, and her office focuses on civil rights issues, not healthcare. She, too, most likely serves at the pleasure of the Mayor, and Attachment "A" to Harrington's report was written to help the Mayor play politics with LHH.

Mayor Newsom has been playing an active game of political football involving safety at LHH for the last 16 months. Actually, Newsom has played political football with LHH for over six years, since he did not support placing Proposition A to rebuild LHH on the 1999 ballot. Newsom has gone from playing politics with Laguna Honda as a supervisor to playing politics with Laguna Honda as mayor.

The most serious flaws in the glass of Harrington's report are contained in its Attachment A, since its flawed data is used throughout Harrington's skimpy four-and-a-quarter-page "report" as the basis for arguing that Option 2 — to eliminate 420 of LHH's SNF beds — should be considered in a new public policy debate. But errors in Harrington's report actually begin on its cover page.

[47] Harrington, (2005), op. cit., cover page (misnumbered page 1).

Errors in a Skimpy Four-Page Financial Analysis: Option 1

> **Option 1:** Use ***all*** reasonably available funds to complete a 1,200 bed skilled nursing facility at Laguna Honda[48]. [emphasis added]

Interestingly, Harrington uses the key word "all" referring to available funding. The term "all" was the focus of a taxpayer-citizen's lawsuit filed by Patrick Monette-Shaw in Superior Court in 2004, seeking to have $25 million misappropriated from the tobacco settlement revenue (TSR) that had been intended for the LHH rebuild project returned to the project. Monette-Shaw's lawsuit alleged that the 1999 Voter Guide's Ballot Simplification Committee's "digest" had promised voters that "all available settlement monies[49]" would be used for the replacement program or to pay down interest on the bonds authorized by Proposition A. In the Superior Court case, City Attorneys argued that ***all*** of the tobacco settlement revenue did ***not*** have to be used for the rebuild, and the Superior Court judge ruled in favor of the City.

After the judge's ruling, and the political coast partly clear, Harrington now proposes using **all available funding**, *but he is not completely honest about how much TSR funds will actually become available.* **That amount is $820 million!**

After the judge's ruling, with the political coast partly clear, Harrington now proposes using ***all available funding***, but he is not completely honest about how much TSR funds will actually become available. ***That amount is $820 million!***

> **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**[50]. [emphasis added]

It is interesting to note that the push is on to pit how many ***people*** will be served between the two options. But nowhere in Harrington's' skimpy writing does he acknowledge that the 1,200 ***beds*** at Laguna Honda serve far more than 1,200 ***people*** annually. LHH's turnover — through discharges and deaths in-house — is approximately one-third, year in and year out; somewhere between 1,600 and 1,800 ***people*** are served at LHH each year, and it is ***irresponsible*** of Harrington for not noting that fact in his report. After all, how are you going to have a public policy debate without honestly admitting how many ***people*** are served annually at Laguna Honda? Everyone — including Herb Levine, the Executive Director of the Independent Living Resource Center,

LHH's turnover — through discharges and deaths in-house — is approximately one-third, year in and year out; somewhere between 1,600 and 1,800 **people** *are served at LHH each year, and it is* **irresponsible** *of Harrington for not noting that fact in his report.*

[48] Ibid., cover page.
[49] 1999 San Francisco Voter Guide, "Digest" by Ballot Simplification Committee, page 33.
[50] Harrington (2005), op. cit., cover page.

which organization undoubtedly helped Mizner write Harrington's flawed Attachment A — keeps talking about the number of beds at Laguna Honda, without mentioning the number of ***people*** served at LHH.

Harrington then moves into background information for the LHH replacement project. Interestingly, in his opening paragraph, Harrington claims that the ***bond ordinance*** did not indicate that the voters would be getting 1,200 beds. As noted, Louise Renne's pen was at work in ensuring that the bond ordinance was so vaguely written in 1999 that the City could later do what it wanted with the bond financing in the future.

Then, when the bond measure passes, the governing board says that it was the provisions of the bond ordinance *which the voters passed, not, the provisions of the* ***ballot proposal*** *or question put to the voters in the voters pamphlet and the voting booth; so that by this bait-and-switch, back-door politics can continue as usual.*

And in his opening paragraph, Harrington cites the Superior Court order against Monette-Shaw as proof that the "bond contract"[51] [ordinance] does not bind the City, noting Judge Warren's ruling indicated Proposition A did not limit the type of facility the City must construct.

Although Harrington may have been aware the Monette-Shaw case had been placed on appeal with the Appeals Court, he did not know one of the principal arguments being put forth in the appeal:

> **IV. The Respondents hew to the erroneous claim that the *bond ordinance* (at Page 55 of the Voters Pamphlet), supersedes the contrary provisions in the *ballot proposal* and in the Digest of the measure, (at Page 33 of the Voters Pamphlet).**
>
> Approval by the Court of this Respondents' claim would put the judicial seal of approval on what is essentially a bait-and-switch, in which municipalities would be given the judicial go-ahead to first enact a bond ordinance which places a bond measure on the ballot; then draft a **ballot proposal** which has salutary language to persuade the voters to pass the measure; but which *bond ordinance* has completely contradictory wording which would nullify the salutary provisions of the ballot proposal. Then, when the bond measure passes, the governing board says that it was the provisions of the *bond ordinance* which the voters passed, not, the provisions of the **ballot proposal** or question put to the voters in the voters pamphlet and the voting booth; so that by this bait-and-switch, back-door politics can continue as usual.
>
> In this respect the Respondents have been unable to come up with a single case decision which holds that, where a municipality puts Language X in a bond ordinance, but, obtains passage of the measure by using a **ballot proposal** and a **Digest** of the measure which says Language Y, that the municipality can enforce the measure on the basis that Language X, which the voters did not approve, applies, and that Language Y, which the voters did approve by marking "Yes" to the **ballot proposal** in the ballot booth, does not apply [52].

[51] Ibid., page 2 (Harrington mistakenly counts the cover page as page 1).
[52] Writ of Mandamus Sought Against the Superior Court, filed in Appeals Court, June 2005.

Harrington continues to use the irresponsible logic that the City can get away with a bait-and-switch using contradictory language between the bond *ordinance* and the ballot *proposal*. And Harrington is unaware that in Monette-Shaw's appeal, the Appeals Court is being asked to set aside Judge Warren's improper ruling:

> The petitioner submits that the Superior Court answered each of these pivotal questions erroneously, and therein acted in excess of and without jurisdiction, and in gross abuse of discretion, in denying petitioner's motion for peremptory writ of mandamus …[53]

If Monette-Shaw wins on appeal, will Ed Harrington then have to re-write his opening, inappropriate first paragraph?

Harrington then notes LHH's "current census … is under 1,050 patients," as if to imply that building 1,200 beds is unnecessary because of current "demand." What Harrington irresponsibly neglects to inform his readers is that at least two of LHH's current wards, totaling 60 beds, are temporarily closed (one being renovated after a behaviorally-disturbed patient set a fire that was ruled to be arson, and the other that is kept open to shuffle wards in and out of while other wards are also being remodeled). Additionally, in part due to State citations against Laguna Honda for inappropriate staffing levels, and in part due to keeping the staffing levels vacant in order to obtain so-called budgetary "salary savings," the census at LHH is kept ***artificially*** under full capacity. Demand for LHH's 1,200 beds exists, but to claim the current census of 1,050 is a rationale to downsize the facility to less than 1,200 beds is both irresponsible and spurious.

The petitioner submits that the Superior Court answered each of these pivotal questions erroneously, and therein acted in excess of and without jurisdiction, and in gross abuse of discretion, in denying petitioner's motion for peremptory writ of mandamus …

In Harrington's report, he lists the total number of beds that were supposed to be built in each of four buildings for a total of 1,200 beds, but he mistakenly refers to one of the buildings as the "North" building, when in fact all along the replacement project team has called that residential tower the "West" building.

Harrington's analysis of the source of funding for Option 1 is remarkable. First, nowhere does he acknowledge that over the life of the general obligation bonds, the City projects it will now receive a total of over $820 million in tobacco settlement revenue (TSR). The closest Harrington gets to acknowledging the amount of TSR funds that will become available is by combining the "$92 million of tobacco settlement *before* the bonds are issued" plus "$443 million in tobacco settlement funds currently estimated to repay the bonded debt[54]," totaling $535 million; Harrington does not discuss the projected influx of $820 million in TSR's.

[53] Verified Petition for Writ of Mandamus filed in Appeals Court, June 2005.
[54] Harrington, (2005), op. cit., in two unnumbered tables on pages 3 and 4.

Indeed, the City stalled issuing the Proposition A-approved general obligation bonds until May 2005 for the express purpose of trying to creatively reinterpret how the tobacco settlement funds could be used.

Astoundingly, Harrington admits for the first time that SB 1128, a 1999 bill sponsored by State Senator Jackie Spier, ***will generate $120 million*** in Federal reimbursement earmarked for new skilled nursing beds after the facility is completed[55]. The City should have been able to estimate that it would receive $120 million ever since Proposition A was passed in November 1999, the same year in which Spier introduced her bill, but instead, for the past six years, the City has painted the amount of Federal funding that would be received as insignificant. A cash cow of $120 million is a significant amount of funding that has been irresponsibly withheld from public knowledge until May 2005.

Indeed, if $120 million in Federal funding for the project could have been reasonably estimated was available, voters should have been asked to approve only $179 million in general obligation bonds, not the $299 million they approved in 1999, **after having been irresponsibly deceived**.

And Harrington says that until the $120 million is received at the end of the project, the City will in the interim issue Certificates of Participation (COP) temporarily, which will be "guaranteed" from the General Fund. ***The COP's are a form of new bonded debt, no matter what term is used to justify the creative accounting scheme***, and San Francisco's voters approved no such financing plan when they approved Proposition A in 1999. Indeed, if $120 million in Federal funding for the project could have been reasonably estimated was available, voters should have been asked to approve only $179 million in general obligation bonds, not the $299 million they approved in 1999, ***after having been irresponsibly deceived***.

Since May 19 when Harrington released his report to the Mayor, community observers have recognized that if LHH's SNF beds are cut by one-third, so too will be the City's receipt of $120 million in funding under SB1128. Harrington acknowledged during the June 7, 2005 Health Commission meeting that SB1128 funds can only be used to recover the costs of building ***skilled nursing beds***[56]. If LHH's beds are cut by one third, the City will only receive $80M, not $120 million; both options Harrington presented to the Mayor would then be short $40 million!

Harrington suggested using an additional "next" $100 million in TSR's (after the first $100 million authorized by Proposition A) to finance Option 1. Harrington claims the additional $100 million can be used, since the "proposition" had discussed "over the term of bonded debt," and as of the date of his report (May 19, 2005) the "City had not issued any debt[57]." ***This is patently untrue!***

[55] Ibid., page 4, paragraph 1.
[56] Ibid., page 4, paragraph 1.
[57] Audio tape of June 7, 2005 Health Commission meeting.

Surely Harrington should have remembered that nine days earlier, ***the City had, in fact, issued the lion's share of the bonds in part one of the bond sales***[58]:

> "SAN FRANCISCO--(BUSINESS WIRE)--May 3, 2005--Fitch rates the City and County of San Francisco, CA's $110,000,000 general obligation bonds (Laguna Honda Hospital, 1999) series 2005A. **The bonds will be sold competitively on May 10**." [emphasis added]

Since the bonds *had already been issued* prior to Harrington's report, he can not now claim that the ***second*** $100 million are an option and can be used. Harrington's report has not been approved by the Health Commission, nor has it had a full public discussion about whether voters are prepared to spend the second $100 million as he presents in Option 1. Harrington again claims that the City can pick and choose between Language X (in the bond ordinance) rather Language Y (used in the ballot proposal or the ballot digest), choosing to use whichever contradictory language best suits his purpose for any given argument.

Harrington notes that the City is now poised to use a "total of $192 million from this source" [i.e., TSR's], when for months the City argued it could only use $100 million when it wanted to claim it could only build a much smaller replacement facility, and before public pressure was brought to bear on irresponsible politicians. Harrington goes on to note that "since 1999, tobacco settlement funds have amounted to significantly more than originally projected," but again, he does not inform his readers that the City is expecting to receive over $820 million and that it can ***all*** be used to replace Laguna Honda Hospital at the full 1,200-bed original scope of the project.

Harrington notes that taxpayers will be responsible for the second $100 million that should have been applied to reduce the property tax burden from $315 million to only $26 million, and use of the second $100 million will require property tax payers to foot $126 million, which is still $189 million lower than the 1999 original estimate of $315 million. What property owners should do is demand the City ***responsibly*** report the ***true*** amount ($820 million) of TSR's projected to be received over the next 25 years, and demand both that all 1,200 beds be built as promised, ***and*** that property taxes be reduced (to close to nothing) ***by using all available TSR's***, not just the amount Harrington — or his politician boss, the Mayor — wants to spend on LHH.

What property owners should do is demand the City **responsibly** *report the* **true** *amount ($820 million) of TSR's projected to be received over the next 25 years, and demand both that all 1,200 beds be built as promised,* **and** *that property taxes be reduced (to close to nothing)* **by using all available TSR's**, *not just the amount Harrington — or his politician boss, the Mayor — wants to spend on LHH.*

[58] *Business Wire*, May 3, 2005.

… Yet More Errors: Option 2

Harrington then examines Option 2, to provide 780 skilled nursing beds and 234 assisted living beds on LHH's campus, and other long-term care services using community-based providers.

Harrington appears not to have consulted the 1999 Voter Guide, in which the Board of Supervisors acknowledged:

> "***Talk of utilizing 'community-based long-term care providers' is irresponsible***, since San Francisco already faces a severe shortage of long-term care beds[59]."

Indeed, nowhere in his skimpy four-and-a-quarter-page "analysis" does Harrington even stop to consider that ***not*** building all 1,200 beds will exacerbate the shortage of skilled nursing beds available in San Francisco, nor does he consider the financial impact to the City when acute care hospitals will have fewer discharge locations for their patients needing skilled nursing beds, or the increased costs of treating people at San Francisco General Hospital in an acute setting who cannot get into skilled nursing beds at a much smaller Laguna Honda Hospital.

Putting aside, again, the fact that when Harrington issued his report on May 19 the bonds had already been issued for nine days, he appears to be double counting — or double spending — the amount of TSR's already received.

There's more flaws in the glass of Option 2, the most glaring of which is that Option 2 claims it will use "all of the funds identified in Option 1 …[60]", including the first $92 million and the additional $100 million. Incredibly, in Option 2-c, Harrington claims an additional "80 million in ***previously received*** tobacco settlement revenues could then be freed up when the general obligation bonds are issued." Putting aside, again, the fact that when Harrington issued his report on May 19 the bonds had already been issued for nine days, he appears to be double counting — or double spending — the amount of TSR's already received. He says Option 1 will include $92 million in TSR's received before the bonds were issued, and then wants to use for Option 2 both ***all*** of the Option 1 funds ***and*** a separate amount of $80 million received before the bonds were issued, for ***a presumed total of $172 million in TSR's that had been received*** **before** ***the bonds were issued***, but in fact, $172 million had ***not*** been received prior to the bond sale on May 10, 2005.

In discussing "annual units of service" on page 5, Harrington indicates that an additional 790 people could be served per year by pursuing Option 2. But his math is quesitonable.

First, he claims the City should place the $80 million in a new "trust fund." [Note: the tobacco settlement funds are ***already*** in an interest-bearing trust fund, but the City won't readily admit that, and Harrington doesn't offer any explanation of why a second trust fund would really be necessary.]

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[59] 1999 San Francisco Voter Guide, page 35.

[60] Harrington, (2005), op. cit., page 5.

Harrington, potentially irresponsibly, claims in Option 2-c that $5.4 million — presumably "interest" earned from a second trust fund — could be generated annually "that could fund the long-term care needs of 270 people per year." But Harrington does not explain how $5.4 million could be earned annually, after having noted in his report that only $10 million in interest is the "current view" of ***all*** interest to be earned on (presumably) ***all*** TSR's to be received over 25 years. This is the first of ***the miracle of the fish and loaves logic*** presented in Harrington's and Mizner's reports**.**

But Harrington does not explain how $5.4 million could be earned annually, after having noted on page 4 of his report that only $10 million in interest is the "current view" of **all** *interest to be earned on (presumably)* **all** *TSR's to be received over 25 years. This is the first of* **the miracle of the fish and loaves logic** *presented in Harrington's and Mizner's reports***.**

He then notes that once the Proposition A bonds are paid off — 25 years from now, in the year 2030 — the City could use any further TSR receipts to "maintain" the second trust fund or pay for similar long-term care programs. Harrington ***assumes*** that the City will continue receiving tobacco settlement revenues beyond 2030. But Harrington neglects to note to his readers that even former City Attorney Louise Renne has expressed concerns that the tobacco settlement money could dry up long before then if the tobacco companies file for bankruptcy protection, as they have threatened to do. With the recent $1 billion judgment against Big Tobacco, that possibility remains a concern.

In Option 2-d, Harrington claims another 305 people could be served with the difference in operating expenses that currently are funded from the General Fund that would be "saved" by not building 185 of the SNF beds in the planned West tower at LHH. The West building would be cut from 420 skilled nursing beds to 235 assisted living beds, and the 185 difference is estimated to generate $6.1 million in operating expense savings. While Harrington claims between $90 and $100 per day would be saved for each SNF bed not built, he claims most of the costs are for staffing, food and "similar" costs. Foremost, he does not factor in the costs to the City for the patients who will ***not*** be served in the skilled nursing beds who will wind up in acute care beds or at the emergency room at SFGH. Nor does he discuss that there are housing costs that will accrue to the City for many of the indigent people who will not have access to the lost 185 SNF beds. Option 2-d is riddled with "assumptions" that may or may not be true.

Option 2-e indicates an additional $4.3 million in savings can assist another 215 people, with a $50 per day City contribution to assisted living expenses, rather than the $100 per day for the SNF beds. Harrington makes no mention of why the 235 assisted living ***beds*** will serve only 215 ***people,*** despite his lame explanation on page 6 of his report that the terms "beds," "people," and "individuals" can be used interchangeably. By funding each of the 235 beds with $18,250 annually (the $4.3 million), the City calculates it can move these patients to a lower level of care in assisted living using Medi-Cal waivers, but Harrington neglects to mention to his readers that there's a waiting list for these waivers. How long people will end up languishing on this waiting list is unknown.

Notably Option 2-d and Option 2-e, show a total ***savings*** of only $10.4 million. Option 2-c hopes to ***earn*** $5.4 million in interest, which Harrington refers to as "savings" when he notes on page 5 that a total of $15.8 million could be ***saved*** annually. Only a Controller would consider "earnings" as "savings"!

Once again, Harrington appears to be double-counting his numbers: He includes the 235 assisted living beds in the 1,015 total, and then in Option 2-e counts the 215 people, ostensibly as part of the additional 790 "individuals." One is left wondering whether to reach the 1,015 beds + the 790 individuals, he may have considered putting in bunk beds in order to serve two people in each of the 235 assisted living beds.

But the most important flaw in the entire rationale for Option 2 is that it would provide for both 1,015 beds at Laguna Honda (780 SNF beds + 235 assisted living beds) ***and*** "care for another 790 individuals in various community-based settings[61]." Once again, Harrington appears to be double-counting his numbers: He includes the 235 assisted living beds in the 1,015 total, and then in Option 2-e counts the 215 people, ostensibly as part of the additional 790 "individuals." One is left wondering whether to reach the 1,015 beds + the 790 individuals, he may have considered putting in bunk beds in order to serve two people in each of the 235 assisted living beds. In other words, Harrington's math, once again, does not quite add up when he double-counts both millions in pre-bond TSR's and double-counts the people who will use the assisted living beds.

And remarkably, while Harrington claims the $4.3 million in Option 2-e will fund operating costs for the extra 215 people, he does not discuss operating expenses for the 235 assisted living beds that are included in the 1,015 total. Are we to conclude that the operating costs for the ***first counting*** of the 235 beds included in the 1,015 total will continue to funded by the General Fund? If so, Harrington should be required to tell us what that annual cost will be.

Flawed "Attachment A" Fed Harrington's Spurious Recommendations

Harrington's skimpy four-and-a-quarter-page report — particularly Option 2 — was premised on its Attachment "A", titled *Estimates for Housing, Medical and Supportive Care Costs for People Discharged from LHH*. "Attachment "A" is an excerpt from a report prepared by Susan Mizner, director of the Mayor's Office on Disability, in April 2005. Harrington acknowledged Attachment A provides "examples of how long-term ***non-skilled nursing*** services ***might*** be provided and the number of people who could be served[62]" [emphasis added]. ***But he never estimates how skilled nursing will actually be provided in the community, nor how community-based skilled nursing will be funded.***

But Harrington ignores that many of the people who will be displaced from Laguna Honda if 420 SNF beds are eliminated from the rebuild project, as he proposes, actually ***need*** skilled nursing, ***not*** non-skilled nursing care.

[61] Ibid., page 5.
[62] Ibid., page 5.

Mizner also poses a rhetorical question: "How many people eligible for services at LHH could be served in the community at service levels ***similar to*** Laguna Honda[63]." She then bases her report on completely flawed assumptions.

Mizner's first assumption is that "currently 84% of the LHH residents" are able to leave a skilled nursing facility, according to [flawed] data obtained from the Targeted Case Management program.

Mizner's second flawed assumption is that "about 40% of LHH's residents have a "primary psychiatric diagnosis or substance abuse issue." Patients need a primary medical diagnosis to be eligible for LHH's SNF level of care, and LHH is not permitted to accept patients whose primary diagnosis is psychiatric.

But Harrington ignores that many of the people who will be displaced from Laguna Honda if 420 SNF beds are eliminated from the rebuild project, as he proposes, actually **need** *skilled nursing care,* **not** *non-skilled nursing care.*

Neither assumption is true, but if they were, the U.S. Department of Justice would not be pleased that potential fraud may have occurred by admitting people who don't need to be there, or because LHH does not have a license to operate a psychiatric facility.

Notably, just four days after Harrington released his recommendations to the Mayor on May 19, the then Co-Medical Director of LHH, Timothy Skovrinski, MD, stated during the Laguna Honda Hospital Joint Conference Committee (a committee comprised of the Executive Committee of LHH and Health Commissioners Jim Illig and Edward Chow, MD) that Mizner's Attachment "A" was full of inaccuracies and glaring errors, and was "grossly overestimated[64]. Health Commissioners Chow and Illig agreed with Skovrinski that Mizner's Attachment A was inaccurate.

Notably, just four days after Harrington released his recommendations to the Mayor on May 19, the then Co-Medical Director of LHH, Timothy Skovrinski, MD, stated during the Laguna Honda Hospital Joint Conference Committee … that Mizner's Attachment "A" was full of inaccuracies and glaring errors, and was "grossly overestimated."

Even Dr. Katz acknowledged on June 7 that "Some issues have been raised as to whether the capacities of some of the community [-based service] providers listed in the document [Susan Mizner's "Attachment A"] are accurate[65]."

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63 Ibid., page 5.

64 Meeting notes of Patrick Monette-Shaw, May 23, 2005. It will be interesting to see if the Health Commission includes Dr. Skovrinski's remarks accurately and objectively, or whether the Health Commission will creatively "edit" Skovrinski's blistering criticism of Mizner's inflated rhetoric.

65 "Laguna Honda Hospital Replacement Program," memo from Mitch Katz, Director of Public Health, to the Health Commission, June 7, 2005.

June 2005 Department of Public Health "White Paper" Recommendations for LHH Rebuild

On March 15, 2005, during a full Health Commission meeting[66] held at Laguna Honda Hospital, Health Commission President Lee Ann Monfredini — who was also the President of the Health Commission at the time of the 1999 "Proposition A" ballot measure drive — requested that a revised "White Paper" be written by Director of Public Health Mitch Katz outlining the need for skilled nursing beds, and appropriate staffing levels, at LHH[67].

Given Katz's 1998 rejection of Option 9 to consider whether the City should "phase itself out of the "long-term care business," it is irresponsible of Monfredini to have forgotten that ***that*** *<u>ridiculous</u> idea was rejected as untenable in 1998 while she served as President of the Health Commission.*

During the March 15 meeting, Health Commissioner Guy indicated that in order to prepare for when the Health Commission will take action regarding the LHH replacement facility, that it would be "helpful" for Katz to update his 1998 White Paper to carefully re-examine the available options and consequences in order to help the public, staff, and other decision makers understand relevant factors. Monfredini noted that all options should be explored before deciding on the most appropriate way to proceed with the LHH rebuild. Among the options for Laguna Honda that Monfredini specifically asked to have analyzed:

- Is it economically feasible for the City to operate LHH in terms of operating expenses versus reimbursement rates, and how many beds could, or should, be supported by the City?
- Can DPH justify the number of beds in the proposal delivered on March 15 by LHH Project Manager Michael Lane, given costs per bed?
- Is it financially viable for the Department of Public Health to stay in the long-term care business?
- What is the feasibility of partnerships with private or non-profit organizations to develop on the Laguna Honda campus as an independent/assisted living facility, with a smaller SNF on the campus? [Note: Implicit in this request, Monfredini is questioning whether the replacement facility should be staffed by City employees, or by non-profit sector employees.]

Given Katz's 1998 rejection of Option 9 to consider whether the City should "phase itself out of the "long-term care business," it is irresponsible of Monfredini to have forgotten that ***that*** <u>ridiculous</u> idea was rejected as untenable in 1998 while she served as President of the Health Commission.

[66] Minutes of the San Francisco Health Commission, March 15, 2005.
[67] Ibid.

Health Commissioner Chow requested that demographics of the patient population to be served at LHH be included in the new White Paper, as well as an analysis of whether there is a mix of services that are ***not*** needed at LHH.

The Health Commission asked Katz to prepare a White Paper on the various options and present them to the Health Commission within 60 days, but all they got from Dr. Katz 90 days later on June 7 was a four-page "memo."

The Delay of Dr. Katz's New "White Paper" is Irresponsible

On March 15, 2005, Dr. Katz agreed with the Health Commission's suggestion to author a new White Paper, indicating 60 days in which to do so was reasonable. He indicated such a report "would mesh nicely" with the financing options Mayor Newsom had asked City Controller Ed Harrington to prepare and recommend.

As of today, it has now been 130 days (not 60 days) since the Health Commission's March 15 hearing. Dr. Katz's delay in releasing the requested new White Paper is irresponsible, given that this additional four-month delay will contribute to driving up the costs to replace LHH, just like each day of delay escalated costs of the Bay Bridge retrofit.

Katz did not present a new, let alone updated, White Paper on June 7, 2005 at the Health Commission meeting. Instead, he presented a four-page ***memo*** (albeit, with ten pages of attached tables and charts, the significance of which were largely left unexplained). It contained nearly as many irresponsibly glaring flaws as did Mizner's "Attachment A". Katz indicated that in mid-July, he will receive data from Health Management Associates that will address comparative data from other jurisdictions, and that he may finally present a "White Paper" during the Health Commission's August 16 meeting.

And given the fact that both Supervisor Sean Elsbernd and Mayor Newsom called for a public policy debate to determine the fate of Laguna Honda Hospital, it is **irresponsible** *of Dr. Katz to have already told consummate politician Renne, among others on June 1[1] — before the Health Commission held its first public policy debate on the LHH rebuild issue on June 7 — that LHH will be rebuilt with only 780 long-term care skilled nursing beds.*

It is not yet known whether Katz will ***fairly consider*** with an open mind both options to rebuild LHH that Controller Harrington recommended to the Mayor.

What ***is*** known is that on June 1, Dr. Katz indicated during a private meeting attended by former City Attorney Louise Renne and other members of the 1998 LHH Replacement Planning Committee, that the best deal the public is going to get is 780 new SNF beds at LHH, indicating Katz's early endorsement of Harrington's "Option 2" recommendation.

And given the fact that both Supervisor Sean Elsbernd and Mayor Newsom called for a public policy debate to determine the fate of Laguna Honda Hospital, it is ***irresponsible*** of Dr. Katz to have already told consummate politician Renne,

among others on June 1[68] — before the Health Commission held its first public policy debate on the LHH rebuild issue on June 7 — that LHH will be rebuilt with only 780 long-term care skilled nursing beds.

The Mayor and Supervisor Elsbernd have it wrong. San Francisco's voting public are not prepared to permit politicians to again misappropriate tobacco settlement revenues intended to rebuild LHH for use to develop other housing for the Mayor's "Care Not Cash" program.

After all, Newsom was handed an embarrassing defeat in November 2004 over a mayoral-backed general obligation bond measure designed to finance various levels of housing in San Francisco. That measure was roundly defeated. The same voters do not now expect Newsom will use general obligation bond and tobacco settlement funds approved in 1999 to rebuild LHH for use financing "housing" in 2005, instead.

The Mayor and Supervisor Elsbernd have it wrong. San Francisco's voting public are not prepared to permit politicians to again misappropriate tobacco settlement revenues intended to rebuild LHH for use to develop other housing for the Mayor's "Care Not Cash" program.

Voters in 1999 expected the City would honor its commitment to replace ***all*** of LHH's skilled nursing beds on a 1:1 ***replacement*** basis. They also expect that politicians will immediately stop playing politics with the City's vulnerable elderly and disabled residents.

After all, San Francisco's voters have very long memories of what happens with bond financing, and the replacement project for San Francisco General Hospital is just beginning. If Katz and Newsom want the SFGH bond measure to pass, they should prudently be very sensitive to making sure LHH is rebuilt on a 1:1 replacement basis, with 1,200 SNF beds, as voters were promised.

Katz's Misguided Praise of the Targeted Case Management Program

Issues the Targeted Case Program Must Be Required to Track

Outcomes the TCM program should track, but is not currently tracking, include:

- How many times have clients discharged from LHH by the TCM program called 911 for emergency help after being discharged from LHH?
- How many clients have been re-hospitalized at acute care hospitals or have been re-admitted to LHH due to illness, injury, or inability to get adequate care? "Recividism" rates are an important quality indicator, and any program worth its salt tracks recidivism (re-admissions).

[68] Anonymous notes from the Laguna Honda Rebuild Committee meeting, June 1, 2005.

- How many people placed in community-based alternative settings have been evicted, or had support services terminated, due to behavioral issues or break-downs in other areas of their safety net?
- How many former LHH residents have expired since discharge from LHH and "placement" in the community, and what were their cause(s) of death and what length of time elapsed between discharge and death?
- How many former LHH residents who were discharged to the community by the TCM program experienced a fall at home — resulting in either a traumatic brain injury, or a fracture, particularly hip fractures, as a result of falling — that led to re-hospitalization?

Additional criticisms of the TCM program that Dr. Katz appears to be ignoring in his rush to praise the program include:

- There are reports that the TCM program is counting discharges of people who left LHH in an AWOL status as a "discharge," despite the unplanned nature of the AWOL (absent without leave), simply because the resident who went AWOL was a prospective TCM client. Similarly, other anecdotal reports suggest that the TCM program takes credit for the discharge of a prospective TCM client — even if it was an LHH medical social worker who actually accomplished the discharge. There needs to be an independent audit of all discharges to ensure that the TCM staff are accurately and fairly reporting the program's so-called accomplishments.

There are conflicting anecdotal reports that the TCM staff have only discharged seven LHH residents (not 16), compared to approximately 70 discharges made by non-TCM social workers at LHH.

The TCM program — and San Francisco — is not getting a very good bang for its bucks.

- Additionally, for the approximate $800,000 in salaries for TCM staff, they have not made a significant contribution to discharges from LHH. There are conflicting anecdotal reports that the TCM staff have only discharged seven LHH residents (not 16), compared to approximately 70 discharges made by non-TCM social workers at LHH. ***The TCM program — and San Francisco — is not getting a very good bang for its bucks (budget).***
- The TCM program claims a survey of LHH residents shows 84% do not need to be in a skilled nursing facility. The TCM program should be required to stratify the number of respondents to the survey instrument by admitting source and age; clearly, many of the inappropriate admissions to LHH during the one-year "flow project" involved younger patients placed into LHH who were inappropriate for long-term skilled nursing care. Of the 84% the TCM claims should not be at LHH, the public has a right to know how many of survey respondents involved younger patients from SFGH, who may have skewed results of the TCM "survey."

Vignettes of Potentially Inappropriate TCM Discharges

Laguna Honda Hospital and other skilled nursing facilities are able to care for people with organic brain diseases who are not able to independently accomplish routine activities of daily living. Community alternatives to nursing facilities often cannot provide adequate assistance for people with complex skilled nursing needs related to organic brain disease for a variety of factors, including the lack of adequate supports, and the close observation and supervision these clients require. Some examples[69] of potentially inappropriate discharges from LHH that the TCM staff had considered include:

- An elderly man was discharged under the TCM program. He died in the community several weeks after discharge. It is unclear whether the man elected to be discharged knowing he would soon die, as he may not have wanted to die in a nursing home setting.
- The TCM staff assessed a woman as severely cognitively impaired and, therefore, not able to live in the community independently. However, she actually had a mild dementia, and her main barrier to independent living was the result of schizophrenia. LHH staff had assessed her as unable to live independently in the community because of cognitive impairments related to her schizophrenia. This resident may have been able to be placed in a supportive mental health facility or in a psychiatric board and care setting, but was an inappropriate candidate for an independent living environment. This calls into question whether the TCM staff has an adequate and appropriate level of training to recognize the difference between cognitive impairments and impairments related to mental illnesses like schizophrenia.
- Another female resident of LHH had been discharged four times to the community; she failed each placement. Following her fourth discharge, which only lasted 45 days, she was re-admitted to an acute hospital and subsequently transferred back to LHH. The TCM staff picked up this resident and wanted to discharge her to an independent living setting. LHH staff, however, had assessed the resident's ability to live safely in the community, and had concluded that due to severe memory impairments, her inability to independently manage her medications, and her inability to navigate the community, she should have been considered for a supportive housing setting, not an independent living setting. Again, the TCM's inappropriate recommendation for placement location calls into question whether the experience and level of training TCM discharge planners receive are adequate for the needs of the medically complex skilled nursing patients who reside at Laguna Honda Hospital.

This calls into question whether the TCM staff has an adequate and appropriate level of training to recognize the difference between cognitive impairments and impairments related to mental illnesses like schizophrenia.

[69] Austin, B. (2005, June 27). Public testimony presented during an LHH-JCC meeting.

In addition to the three vignettes presented to Health Commissioners during the June LHH-JCC meeting, there are other -disturbing anecdotal reports that illustrate glaring problems with the TCM program:

- After years of severe behavioral problems at LHH, the TCM staff discharged a quadraplegic to a SRO hotel. Within months of discharge, the former LHH resident was suddenly evicted from the SRO due to illegal activities. The patient was re-admitted to SFGH, which is now planning to transfer him to a higher level of care — a locked psychiatric facility — rather than to a lower level of care. This illustrates that TCM staff may not be conducting adequate psychiatric evaluations during discharge planning. It also illustrates that recividism resulting in re-admission to SFGH for weeks of acute level of care will result in overburdening San Francisco's acute facilities at great expense.

- The TCM staff was considering discharging a resident with mental illness and dementia despite the objections of the resident's family, conservator, psychiatrist, and the patient's interdisciplinary care team, who had collaboratively agreed the patient was ***not*** a candidate for discharge. The TCM worker, however, persisted and reestablished contact a few months later with a family member of the patient. The family member was told the patient could be placed at an "RCF," without an explanation of the acronym. The family member assumed "RCF" meant a recreational program, and also assumed the patient would remain at LHH but attend a recreational program during the day. When the family member eventually learned "RCF" meant Residential Care Facility and, therefore, discharge from LHH, they reaffirmed the family's objection to the planned discharge. Notably, the TCM worker — despite having known the patient for several months — appeared completely unaware of the patient's degree of cognitive impairment, and the level of cueing and assistance required for the resident to be able to perform tasks involving activities of daily living.

The TCM staff was considering discharging a resident with mental illness and dementia despite the objections of the resident's family, conservator, psychiatrist, and the patient's interdisciplinary care team, who had collaboratively agreed the patient was **not** *a candidate for discharge.*

- Another example illustrates that LHH residents are not adequately prepared for discharge to the community. One resident was not shown an apartment arranged during discharge planning, nor were family members informed about the proposed discharge location, as the TCM worker had not established contact with the resident's family members. The TCM worker had also not established a working relationship with the resident. On the day of discharge, the resident was brought to the apartment. He had an anxiety attack, 911 was called, and he was admitted to CPMC. The following day, he was transferred back to LHH. Now the resident refuses to be discharged. Although the TCM staff was responsible for and had coordinated the discharge, they blamed LHH for the failed discharge.

There are other planned discharges under the TCM program that LHH clinicians believe are inappropriate. They include:

- A resident in their late 40's with spinal cord injury who is a recent quadriplegic diagnosed with end-stage renal disease. The resident requires dialysis three times per week. This residents' medically complex conditions include polysubstance abuse, hypertension, hepatitis C, insulin-dependent diabetes mellitus, and depression. This resident requires mechanical lift transfers between wheelchair and bed, and requires extensive assistance with activities of daily living, gluco-checks, insulin injections, and medication management for a complex medication regimen, including methadone maintenance.
- Another resident in their mid-60's has had multiple cerebrovascular accidents. Diagnosed with dementia and hemiparesis (weakness on one side), this resident has very poor, to no, short-term memory; has psychiatric and personality issues; and is wheelchair dependent. Reports from previous case managers indicate this patient is very vulnerable in the community because the resident is very agreeable, easily manipulated, and often taken advantage of. The TCM staff wants to discharge this resident to a Board and Care (B&C) facility, but B&C's in San Francisco who accept non-ambulatory patients on SSI are very scarce, when not non-existent. The few B&C's who accept non-ambulatory patients on SSI are located out-of-county, in Solano and Alameda counties.

The ethical challenge for the TCM program is that honest outcome information has not been made available. If the TCM program is really making appropriate discharges that are safe and patients have truly been provided an opportunity for informed consent about the risks and benefits of discharge to the community, that is one thing. But given a number of vignettes as those illustrated above, it appears this may not be happening, and certainly not happening consistently. Without collecting and ***honestly*** reporting on outcomes information, there is no way to evaluate whether the TCM program is safely placing LHH residents into community settings at the most appropriate level of care.

Without collecting and **honestly** *reporting on outcomes information, there is no way to evaluate whether the TCM program is safely placing LHH residents into community settings at the most appropriate level of care.*

At question is what percentage of the TCM discharges made to date include disturbing stories like these eight vignettes?

Analysis of Dr. Katz's June 7, 2005 "Memo" on LHH Rebuild Options

On June 7, Dr. Katz did not deliver the "white paper" he had been ordered to write 90 days earlier. Instead, he delivered a skeletally-thin, four- page ***memo*** addressing the LHH replacement program.

Policy Decision Implications for the Health Commission

Katz's memo claims to focus on so-called "implications" for the Department of Public Health and the Health Commission. Damnably, he does not set out — or ever bother — to consider "implications" for elderly, frail San Franciscans relying on Laguna Honda Hospital. After all, to Katz, the issue is all about money ... not about the skilled nursing needs of thousands of people served at LHH annually, or the many thousands more who will need skilled nursing care in the decades to come.

Katz's memo irresponsibly continues to ignore the "elephant in the room," as if not acknowledging it means there must be no elephant there. Information Katz presented was supposed to contribute to the "major public policy debate" underway, but the obfuscation's he presented show he is desperately ignoring the elephant, hoping it will go away on its own accord.

Both statements demonstrate Katz is ignoring the elephant in the room!
The Monette-Shaw Superior Court lawsuit has alleged all along that the City **does** *have sufficient funds in the tobacco settlement revenue account to build* **all** *1,200 beds. Katz has finally been forced to acknowledge that Harrington's report shows that the City* **does** *have sufficient funds to re-build* **all** *1,200 beds promised to San Francisco voters in 1999!*

First, Katz acknowledges:

> "It is possible to use certificates of participation and the tobacco funds to build the entire 1,200 beds initially envisioned[70]."

He then notes:

> "The major policy question for the Health Commission is whether to build the full 1,200 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[71]."

Both statements demonstrate Katz is ignoring the elephant in the room!
The Monette-Shaw Superior Court lawsuit has alleged all along that the City ***does*** have sufficient funds in the tobacco settlement revenue account to build ***all*** 1,200 beds. Katz has finally been forced to acknowledge that Harrington's report shows that the City ***does*** have sufficient funds to re-build ***all*** 1,200 beds promised to San Francisco voters in 1999!

[70] Katz, (2005, June 7), op cit., page 1.
[71] Katz, (2005, June 7), op cit., page 2.

Remarkably, the new "public policy debate" regarding how to proceed with the LHH replacement program began when the City claimed it did ***not have*** sufficient funds to build all 1,200 beds due to the cost-over-runs. Now that the City has to acknowledge that it ***does have*** the funding necessary, the debate on how to proceed should stop, and the City should go back to implementing the will of the voters who approved bond financing to replace a 1,200-bed skilled nursing facility on a 1:1 basis! Having a new public policy debate was premised on ***not*** having sufficient funding for all 1,200 beds; now that funding has been shown to exist, there is no need for further debate. The debate was settled in 1999 when 73% of San Franciscans cast their ballots. The bond financing and the tobacco settlement funds were approved by voters expecting a 1,200-bed replacement facility. We should not let Mayor Newsom conduct a new "policy decision" debate on "let's build housing, instead."

Having a new public policy debate was premised on **not** *having sufficient funding for all 1,200 beds; now that funding has been shown to exist, there is no need for further debate. The debate was settled in 1999 when 73% of San Franciscans cast their ballots.*

The Health Commission's "Mandatory Ministerial Duties" Precludes Debate

Regarding public facilities, Courts have held that a municipality's selection and adoption of a plan (like San Francisco's plan for the LHH replacement project) may initially be "discretionary," but as soon as the municipality begins to carry out that plan, it begins acting "ministerially." Because the LHH replacement project has involved architects developing, and carrying out, plans to replace LHH with a 1,200-bed skilled nursing facility — which planning has been underway to carry this out for fully six years — San Francisco public officials have a ***mandatory ministerial duty*** to defend and implement 1999's Proposition A. Precisely so, because the Courts have long held that local officials may be compelled to undertake "ministerial" duties comparable to defending a duly adopted initiative (ballot measure) such as Proposition A.

This constitutionally-based duty to defend enacted ***initiatives*** is consistent with the general duty of public officials to defend enacted ***legislation***. Indeed, Deukmejian v. Brown held that the same reasoning may apply here. To allow San Francisco City officials, including the Health Commission, to avoid implementing Proposition A would, in effect, nullify the voters' decisions when they adopted Proposition A.

This constitutionally-based duty to defend enacted **initiatives** *is consistent with the general duty of public officials to defend enacted* **legislation**.. *Indeed, Deukmejian v. Brown held that the same reasoning may apply here. To allow San Francisco City officials, including the Health Commission, to avoid implementing Proposition A would, in effect, nullify the voters' decisions when they adopted Proposition A. Implementing Proposition A is not subject to the* **discretion** *of a governing body like San Francisco's Health Commission. Instead, the Health Commission has a* **mandatory ministerial duty** *to* **implement** *Proposition A.*

Implementing Proposition A is not subject to the ***discretion*** of a governing body like San Francisco's Health Commission. Instead, the Health Commission has a ***mandatory ministerial duty*** to ***implement*** Proposition A. Since the 1999 voter

guide ballot "Digest" indicated that ***all*** available tobacco settlement revenue funds should be used to rebuild LHH, and the "compact" (which compact resulted from the voter guide arguments put forth by various City officials) between the City and its electorate implied that ***all*** of LHH's 1,200 SNF beds would be re-built, the Health Commission has a mandatory ministerial duty to support the rebuild of LHH with 1,200 long-term care skilled nursing beds for San Francisco's elderly and disabled. That duty precludes the Health Commission from now holding a new "discretionary" public policy debate on how to proceed with the LHH replacement project.

Citywide Decision-making Process

Given the mandatory ministerial duties imposed on the Health Commission and the Board of Supervisors to implement Prop A, Katz incorrectly notes that other agencies of the City should be involved in new recommendations that will, in effect, nullify Proposition A. In his memo, Katz notes:

> "Multiple agencies of government will be involved in determining the City's answer as to whether to build the full 1,200 beds or 780 beds plus other community-based long-term care[72]."

and:

> "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[73]."

Katz noted, wryly, "This will be an important decision for the Health Commission." Katz irresponsibly and falsely claims that as the governing body over LHH, the Health Commission has a responsibility to hold new hearings, but Katz ignores the *elephant in the room* again by ***not*** noting that the Health Commission has a responsibility to carry out the will of the voters, as do the Mayor and the Board of Supervisors. ***None of these appointed or elected public servants have any authority to change the will of the voters!***

Katz notes that the "City's Long-Term Care Coordinating Council (LTCCC) will also be having hearings on the issue." The LTCCC is not a City agency; it is a policy advisory body to the Mayor (which seeks to avoid open accountability under the Sunshine Ordinance by calling itself a "passive meeting body, despite the fact that they have issued a flurry of policy recommendations to the Mayor).

Katz irresponsibly and falsely claims that as the governing body over LHH, the Health Commission has a responsibility to hold new hearings, but Katz ignores the elephant in the room *again by* **not** *noting that the Health Commission has a responsibility to carry out the will of the voters, as do the Mayor and the Board of Supervisors.*
None of these appointed or elected public servants have any authority to change the will of the voters!

[72] Ibid.
[73] Ibid.

The LTCCC's membership is troublesome, since it contains no representatives from the City's single long-term care facility (LHH). Despite three nominations made to the Mayor in late 2004 recommending LHH's Medical Director, Chief of Rehabilitation Services, or Rehabilitation Coordinator for membership on this body, politics was played, and no LHH staff were appointed to the LTCCC. It is not clear whether the LTCCC's membership includes a nurse with ***experience in*** long-term skilled nursing care. *More troubling, the LTCCC does not have the authority to set policy for LHH,* ***nor do they have authority to change the will of the 1999 voters!***

Other Gaffes in Katz's June 7 "Memo"

Katz makes other errors in his memo:

> "Ultimately, issuing the certificates of participation to build 1,200 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[74]." [Two commas added.]

However, Katz does not note that Harrington's financing recommendations noted that Option 2 would use the same funding as outlined for Options 1 — meaning that the Certificates of Participation (COP's) would need to be issued for both options. Obviously, if Option 2 relies on the COP's, it would be foolhardy, when not likely, for the Board of Supervisors to vote against issuing them, and more unlikely that the Mayor would veto such an action by the Board, so Katz's observation is moot.

Katz is being disingenuous: The size of the replacement facility was a **contentious** *issue during the first meeting of the reconvened Rebuild Committee when Katz indicated the* **best** *LHH would get would be 780 skilled nursing beds, since many of the members of the committee worked hard during 1998 and 1999 to ensure LHH would be replaced with* **all** *1,200 beds.*

Katz then claims he reconvened, with Louise Renne, the membership of the 1999 Laguna Honda Rebuild Committee, noting the "size of the new LHH was an issue raised during the first meeting[75]." Katz is being disingenuous: The size of the replacement facility was a ***contentious*** issue during the first meeting of the reconvened Rebuild Committee when Katz indicated the best LHH would get would be 780 skilled nursing beds[76], since many of the members of the committee worked hard during 1998 and 1999 to ensure LHH would be replaced with ***all*** 1,200 beds.

[74] Ibid.
[75] Ibid.
[76] Same as footnote 53.

During the second meeting of the Rebuild Committee on June 22[77], Katz floated an idea for consideration: Build 1,500 beds — not 1,200 — but build only 500 skilled nursing beds, with the remainder a variety of supportive housing and assisted living beds. The idea would be to have the other 1,000 residents housed on the LHH campus in a greatly expanded Adult Day Health Center (ADHC). One problem with this is that yet more "change orders" would have to be issued to redesign the facility, since the square footage for each type of room is different than for skilled nursing beds. And such a plan may have to obtain yet another Environmental Impact Review, since the density at Laguna Honda may increase by another 300 residents. Another problem is that the current ADHC at LHH has a case load of 110 — 125 clients. To accommodate 1,000 clients, the ADHC would have to expand ten fold!

During the second meeting of the Rebuild Committee on June 22, Katz floated an idea for consideration: Build 1,500 beds — not 1,200 — but build only 500 skilled nursing beds, with the remainder a variety of supportive housing and assisted living beds. The idea would be to have the other 1,000 residents housed on the LHH campus in a greatly expanded Adult Day Health Center.

Obviously, Katz's claim that we don't have enough money to build all 1,200 skilled nursing beds, but we have plenty of money to build 1,500 beds of varying types, is more of ***the miracle of the fish and loaves***.

Katz informed the Health Commission:

> " ... the Planning for Elders In-home Supportive Services (IHSS) and Health Task Force ... [recommended considering] ... construction of congregate housing with co-located adult day health services ***in lieu of*** building Laguna Honda Hospital with 1,200 beds[78]." [emphasis added]

Attachments 2 and 3 to Katz's June 7 memo to the Health Commission propose just that: ***In lieu of*** rebuilding LHH's skilled nursing beds, ***replace*** them with an ADHC model of care, instead. But an ADHC to replace LHH is not what voters were promised in Proposition A.

Attachments 2 and 3 to Katz's June 7 memo to the Health Commission propose just that: **In lieu of** *rebuilding LHH's skilled nursing beds,* **replace** *them with an ADHC model of care, instead.*

There's a lesson to be learned from the recent closure of an AIDS ADHC in San Francisco. Continuum's Board of Directors and Executive Director announced the closure of its ADHC program effective on May 27, 2005. The program for low income and homeless people living with HIV/ AIDS based in San Francisco's Tenderloin district closed due to:

> "... inadequate Medi-Cal reimbursements, loss of Ryan White CARE Act funding, City and County of San Francisco General Fund cuts due to the failure of [ballot measure] Propositions J and K, as well as barriers to accessing other government reimbursement sources[79]."

[77] Anonymous notes from the Laguna Honda Rebuild Committee meeting, June 22, 2005.
[78] Katz, (2005, June 7), op cit., page 3.
[79] Continuum press release. (2005, May 11). "Continuum Announces Closure of Ground-Breaking AIDS Program."

Clearly, if Medi-Cal and other sources of government funding were unable to prevent the closure of Continuum's adult day health program, proposing to replace LHH with adult day health programming is ***completely irresponsible***, and may well place frail elderly and disabled San Franciscans at equal risk for eventual program closure.

Clearly, if Medi-Cal and other sources of government funding were unable to prevent the closure of Continuum's adult day health program, proposing to replace LHH with adult day health programming is **completely irresponsible**, *and may well place frail elderly and disabled San Franciscans at equal risk for eventual program closure.*

Katz was again being disingenuous when he wrote in his June 7 memo:

> "Although there is no programmatic need for immediate action [by the Health Commission], there is a financial reason[80]."

Katz discussed funds from SB1128 that Ed Harrington presented as part of his recommendation Option 1 that is expected to draw down $120 million in federal financing, and that a decision needs to be made by December 2005. However, during the June 7 Health Commission meeting, Harrington testified that he would prefer that the Health Commission make a decision of which option to accept by mid-August. During that meeting, Harrington acknowledged that SB1128 funds ***can only be used to build skilled nursing beds***[81], and if other types of beds are built, San Francisco will see a decrease in the amount of funds received under SB 1128. Notably, Harrington's acknowledgement that SB1128 funds could only be used for skilled nursing beds was censored from, and not included in, the minutes of the June 7 Health Commission meeting[82].

Katz included in the body of his memo a table showing the monthly census of residents at LHH. He notes that the yearly average, which hovers at 1,033 patients, is slightly less than the maximum of 1,065. He attempts to infer that because LHH's census is currently below maximum, that is a reason to **not** *build all of LHH's 1,200 beds. Katz's reasoning is patently absurd.*

Another problem with Katz's June 7 memo to the Health Commission include neglecting to mention that among the services provided at LHH are long-term care and a respite program.

Katz included in the body of his memo a table showing the monthly census of residents at LHH. He notes that the yearly average, which hovers at 1,033 patients, is slightly less than the maximum of 1,065[83]. He attempts to infer that because LHH's census is currently below maximum, that is a reason to ***not*** build all of LHH's 1,200 beds.

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80 Katz, (2005, June 7), op cit., page 3.

81 Monette-Shaw, P. (2005, June 7), op cit.; Health Commission meeting notes.

82 Minutes of the June 7, 2005 Health Commission meeting.

83 LHH is licensed for approximately 1,400 skilled nursing beds. However, in a deal reached with the U.S. Department of Justice, the City agreed to lower LHH's census to a maximum of 1,065 beds until the proposed replacement facility is completed and opened.

Katz's reasoning is patently absurd. He claims the "major reason" the census is not reached is because "services offered in different wards is [sic] not interchangeable" and that some wards are dedicated to a single sex [sic]. It must be noted that the single-**gender** wards approach had not stopped him from intermingling male with female patients on single-gender wards that had traditionally served only female patients with dementia when it suited his purposes. While both of his arguments may be true, this is ***not*** the major reason LHH is not operating at its maximum census.

The ***actual*** reason LHH's census has not been reached is a combination of three factors: **First**, an arson fire at LHH closed down one 30-bed ward in March 2004, and has not been opened since, with a great loss of revenue during the ensuing 15 months to date. **Second**, in order to create so-called budgetary "salary savings," staffing on wards has been constrained, leading to insufficient staffing for the appropriate level of resident care. **Third**, in a classic Catch 22 situation, as a direct result of LHH's internal decision to reduce its staffing, California's Department of Health Services' Licensing and Certification Branch subsequently required LHH to reduce its patient census to levels the reduced staff can safely manage and care for. All three factors artificially lower LHH's census, not the reasons Katz misguidedly claims.

Katz's June 7 memo claims that a Health Management Associates (HMA) study scheduled to be delivered to him in July 2005 — which is now several months overdue, in addition to HMA's failure to deliver a mid-contract preliminary report as part of contract deliverables — is based on "extensive meetings with LHH staff." It is widely known that the HMA "auditors" had ***not*** met ***once*** with either the Medical Staff of LHH, with LHH's Chief of Rehabilitation Services, nor with other staff members of LHH's Rehabilitation Services department before June 28, 2005. While HMA ***had*** deigned to meet with the LHH Medical Executive Committee, it is disturbing HMA had ***not*** seen fit to meet with LHH's ***entire*** Medical Staff prior to June 28. How HMA will be able to present ***believable*** recommendations — in the absence of meetings with staff of key departments at LHH — is unknown, if not laughable. It appears that Dr. Katz has expanded the scope of the contract with HMA by asking for comparative information from other jurisdictions, which had not been part of the contract awarded to HMA by the City Controller's office. Katz plans to use the expanded "scope" with HMA to justify future recommendations he may make to the Health Commission, despite the fact that HMA has not been willing to meet with key stakeholders of LHH's staff.

It is widely known that the HMA "auditors" had **not** *met* **once** *with either the Medical Staff of LHH, with LHH's Chief of Rehabilitation Services, nor with other staff members of LHH's Rehabilitation Services department before June 28, 2005. While HMA* **had** *deigned to meet with the LHH Medical Executive Committee, it is disturbing HMA had* **not** *seen fit to meet with LHH's* **entire** *Medical Staff prior to June 28. How HMA will be able to present* **believable** *recommendations — in the absence of meetings with staff of key departments at LHH — is unknown, if not laughable.*

A Preliminary Look at Tables and Graphs

Typical of Katz's presentation of data, the table below summarizes data points he presented on June 7. Note the various starting and ending dates of his data.

Table7: Data Sets Presented in Dr. Katz's June 7 "Memo"

Figure	Chart Type	Title	From (Or On)	To
Table 1	Table	Sources of SNF Admissions to LHH	January 03	December 03
Table 2	Table	Sources of SNF Admissions to LHH	January 04	December 04
Table 3	Table	Sources of SNF Admissions to LHH	January 05	May 05
Table 4	Three Pie Charts	Distribution of Residents by Race/Ethnicity	On June 30, 1998	
		Distribution of Residents by Race/Ethnicity	On June 30, 2004	
		Distribution of Residents by Race/Ethnicity	On March 31, 2005	
Table 5	Bar Chart	All Unique Residents Served (By Age Group)	Calendar Years 2001, 2002, 2003, 2004, and January '05–March '05	
Table 6	Table	20 Commonest Diaganoses	On March 9, 2004	
Table 7	Table	Discharges (Types of Discharge Location)	July 2004	March 2005
Figure 1	Bar Chart	10 Commonest Conditions	September 13, 2004	
Figure 2	Bar Chart	Total Discharges* per Month in FY 04-05 vs. Average Per Month in FY 00-01, FY 01-02, FY 02-03, and FY 03-04 (Note: No Footnote to define asterisk)		
Figure 3	Bar Chart	Community Discharges* per Month in FY 04-05 vs. Average Per Month in FY 00-01, FY 01-02, FY 02-03, and FY 03-04 (Note: No Footnote to define asterisk)		

As shown in Table 7 above, few of the tables compare similar periods in time. It is interesting to note, for example, that while Katz lists the 20 most common diagnoses for a single day — March 31, 2004 — he later then summarizes the same information for the 10 most common diagnoses for a single day nearly six months later on September 13, 2004.

What should be required of Dr. Katz, and DPH, is that all data to be considered by the Health Commission and others during this new "public policy debate" on the future of LHH must **uniformly** *include data dating back to 1995 in order to gauge how historical utilization prior to passage of Proposition A in 1999 has changed.*

What should be required of Dr. Katz, and DPH, is that all data to be considered by the Health Commission and others during this new "public policy debate" on the future of LHH must ***uniformly*** include data dating back to 1995 in order to gauge how historical utilization prior to passage of Proposition A in 1999 has changed. The data Dr. Katz presented in his June 7 memo between 2001 and 2005 does not accurately reflect the demographics of the population served at LHH ***before*** the introduction of "psychosocial programming" in 2001, just two short years after voters passed Proposition A.

Problems With Specific Tables and Graphs

The Trouble With Dr. Katz's Tables 1 Through 3

Dr. Katz presented three pages that included the sources of ***monthly*** admissions to LHH from Bay Area referring hospitals over a three-year period. It is very difficult to spot trends across the three pages Dr. Katz presented. Table 7 below aggregates ***annual*** data, and groups the referring hospitals by type of facility.

Table 8: A More Nuanced Look at the LHH Admission Sources

	1/03–'12/03*		01/04–12/04**		01/05–5/05**	
Admitting Source	**Raw**	**% Mix**	**Raw**	**% Mix**	**Raw**	**% Mix**
SFGH (Acute + SNF) Subtotal	**303**	**54.1%**	**458**	**73.3%**	**170**	**69.4%**
UC Med Acute	**28**	**5.0%**	**15**	**2.4%**	**13**	**5.3%**
Bay Area Acute Hospitals Subtotal	**84**	**15.0%**	**73**	**11.7%**	**25**	**10.2%**
Bay Area SNF Hospitals Subtotal	**49**	**8.8%**	**5**	**0.8%**	**4**	**1.6%**
Board and Care	11	2.0%	3	0.5%	2	0.8%
Home	63	11.3%	54	8.6%	24	9.8%
Home Health	1	0.2%	0	0.0%	0	0.0%
Other	21	3.8%	16	2.6%	7	2.9%
Out-of-County***		0.0%	1	0.2%	0	0.0%
Miscellaneous Subtotal	**96**	**17.1%**	**74**	**11.8%**	**33**	**13.5%**
Total	**560**		**625**		**245**	

* Excluding admissions from Unit M7
** Excluding internal transfers
*** Out-of-county count begins in October 2004

Table 8 above reveals important information:

- Although Dr. Katz's Table 3 — for admissions in the first five months of 2005 — attempts to portray that now that the LHH admissions policy has been partially restored to its pre-March 2004 version, the percentage of admissions to LHH from SFGH is beginning to return to its former level of 53%. However, Table 8 above shows that compared to calendar year 2003, admissions from SFGH in 2005 stand at 69% of all admissions, which is 15% higher than in 2003.
- The number of admissions from UCSF Medical Center (acute only) remain stabilized at 5.3%.
- ***Interestingly, Katz does not stratify data to report accurately the number of people who were homeless at the time of admission to LHH.***

Interestingly, Katz does not stratify data to report accurately the number of people who were homeless at the time of admission to LHH.

- Admissions from Bay Area acute and SNF hospitals are significantly lower than in 2003; admissions from other acute hospitals have dropped by 5% and admissions from other SNF's are 7.2% lower than in 2003.
- Admits to LHH from Board and Care facilities are 50% lower than in 2003.
- Dr. Katz claims there has only been one admission from an out-of-county facility in this two-and-a-half year period. But staff at LHH who process Medi-Cal treatment authorization requests (TAR's) have noted that at least ten out-of-county TAR's in 2005 alone have been denied payment, because the ten patients had Medi-Cal ID numbers issued by other counties. LHH's Rehabilitation Services Department commonly has admissions from SFGH from San Mateo General Hospital for trauma care.

Age Distribution in Dr. Katz's Table 5 in Question

"Table 5" in Katz's June 7 memo shows "All Unique Residents Served at LHH between calendar year 2001 and March 31, 2005." Raw numbers are not presented; instead percentages are shown for each age group. Katz reported in his Table 1 that there were 560 admissions to LHH during 2003, and in his Table 2 he reported there were a total of that there were a total of 625 admissions. However, a public records request revealed that there were 561 admissions in 2003 (1 more), and only 595 admissions in 2004 (30 fewer).

As with so much of the data coming from DPH[84], there is no explanation why the number of admissions in 2004 was reported differently at different times. Aren't they collecting this data from a ***single*** database, and shouldn't the data from one report to another match?

Even considering the discrepancy of the 30 additional admissions in 2004 between the two data sources, there is no way to explain why the age distribution of admissions varies so wildly between the public records request and Dr. Katz's Table 5.

In Katz's Table 5, he indicated two age cohorts had only experienced a 2% decline for both those aged 70-79 and those aged 80-89 between 2003 and 2004. But the data obtained from a public records request showed a decline by 27.9% of admissions of people between 70-79 and a decline of 7.6% for people between 80-89 between 2003 and 2004 (see Table 8 on the next page). Even considering the discrepancy of the 30 additional admissions in 2004 between the two data sources, there is no way to explain why the age distribution of admissions varies so wildly between the public records request and Dr. Katz's Table 5.

Table 9 below is based on data obtained under a public records request; it was not included in Dr. Katz's June 7 memo. Data from the public records request shows a sharp decline in the number of people over the age of 70 who were admitted to

[84] In the recent past, Health Commissioners who sit on the Health Commission's LHH-Joint Conference Committee have noted during subcommittee meetings discrepancies between data in various tables and graphs contained within a single report, or across reports presented on the same date.

LHH in 2004, challenging the veracity of Katz's data. Katz's "Table 5" showed those aged 70-79 represented 19% of LHH's residents in 2003, while the table below shows that number was 18.2%. Katz's Table 5 showed those between 80-89 represented 22% of LHH's residents in 2003, but the table below ***shows that number was only 16.6%***. As noted on the previous page, the discrepancy of a single admission in 2003 can not account for the variance in the percentages. During the current "public policy debate," the credibility of Dr. Katz's data sets needs to be ascertained.

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Table 9: The Decline in Admissions of People Over Age 70

	2003		2004		
Gender	**n =**	**% Mix of Total**	**n =**	**% Mix of Total**	**Absolute Change**
Male	309	55.0%	366	61.50%	18.4%
Female	252	45.0%	229	38.50%	-9.1%
TOTAL	561	100.0%	595	100%	

	2003		2004		
Age Group	**n =**	**% Mix of Total**	**n =**	**% Mix of Total**	**Absolute Change**
Under 30	7	1.2%	15	2.5%	114.3%
30-39	25	4.5%	44	7.4%	76.0%
Subtotal	32	5.7%	59	9.9%	84.4%
40-49	74	13.2%	111	18.7%	50.0%
50-59	104	18.5%	145	24.4%	39.4%
Subtotal	178	31.7%	256	43.0%	43.8%
60-64	67	11.9%	47	7.9%	-29.9%
65-69	48	8.6%	50	8.4%	4.2%
Subtotal	115	20.5%	97	16.3%	-15.7%
70-79	104	18.5%	75	12.6%	-27.9%
80-89	92	16.4%	85	14.3%	-7.6%
Above 90	40	7.1%	23	3.9%	-42.5%
Subtotal	236	42.1%	183	30.8%	-22.5%
TOTAL	**561**	**100.0%**	**595**	**100.0%**	

Age Group Summary:					
Under Age 40	32	5.7%	59	9.9%	84.4%
Under Age 50	106	18.9%	170	28.6%	60.4%
Under Age 65	277	49.4%	362	60.8%	30.7%
70 and Over	236	42.1%	183	30.8%	-22.5%

Source: Analysis of New Admissions to LHH by Gender and Age, Department of Public Health data supplied February 11, 2005 in response to a public records request under the Sunshine Ordinance.

The Many Troubles With Dr. Katz's Table 7

Ironically, "Table 7" in Katz's June 7, 2005 memo[85] to the Health Commission illustrates the need for LHH's SNF beds. But that table included both discharges from Laguna Honda, and various "internal" discharges to various units within LHH, inflating total discharges. (**Note**: Table 10 below, a modified version of Katz's Table 7, excludes "internal discharges" that Katz had included in his totals.)

Table 10: External Discharges from Laguna Honda Hospital (July 2004-April 2005)

External Discharge Location	Raw	Percent of Total Discharges		Percent of Grand Total	
Acute Hospitals Other Than SFGH	137	18.8%		14.2%	
SFGH Acute	235	32.2%		24.4%	
Discharged to Pysch Facility (5150's)	16	2.2%		1.7%	
Discharges to Acute Care Facilities	**388**		**53.2%**		**40.3%**
Discharged Home	254	34.8%		26.4%	
Discharged to Board and Care Facilities	10	1.4%		1.0%	
Discharged to Miscellaneous Locations	14	1.9%		1.5%	
Discharged Out-of-County	1	0.1%		0.1%	
Discharges to Community	**279**		**38.3%**		**29.0%**
Discharged Against Medical Advice	8	1.1%		0.8%	
AWOL (Absent Without Leave)	54	7.4%		5.6%	
Unplanned Discharges	**62**		**8.5%**		**6.4%**
Total Discharges	**729**				
Expired In-House at LHH	234			24.3%	
Grand Total	**963**	**100.0%**		**100.0%**	

Several points should be acknowledged:

- Fully 53.2% of discharges from LHH are to acute hospitals (the percentage of acute discharges drops to only 40.3% when those who expired in-house are accounted for). Yet neither Harrington nor Mizner factored into their respective analyses costs to the proposed "Community Living Fund" that will result from acute hospitalizations; in particular, costs related to acute admissions to SFGH when LHH residents discharged to the community fail at home and require re-hospitalization were not estimated.

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[85] Katz, M. (2005, June 7), op cit., Table 7.

- There are reports that LHH's "ADL" computer system (an acronym not to be confused with Activities of Daily Living) is littered with cases of people who were admitted as "homeless" who were subsequently reported as being discharged to "previous home." An independent audit should be performed to determine just how many of LHH's discharges reported as "to home" involved discharges to previous homelessness, since anecdotal reports indicate a large percentage of people reported as homeless at the time of LHH admission are later reported as discharged to home.

There are reports that LHH's "ADL" computer system is littered with cases of people who were admitted as "homeless" who were subsequently reported as being discharged to "previous home." An independent audit should be performed to determine just how many of LHH's discharges reported as "to home" involved discharges to previous homelessness, since anecdotal reports indicate a large percentage of people reported as homeless at the time of LHH admission are later reported as discharged to home.

- While 38.3% of LHH discharges were to "the community," adjusting for in-house deaths drops the community-based discharges to only 29%. Given that less than one-third of LHH's discharges are to the community, is there really a high enough demand for community placement that justifies eliminating 420 of LHH's SNF beds, particularly since San Francisco can expect that as the Baby Boomer's age, there will be even greater need for those same beds?
- When deaths are factored in, only 1% of LHH discharges in the reporting period were placed in board-and-care facilities. Discharges to "miscellaneous" locations — presumably assisted living or supportive housing, though since "miscellaneous" is not defined, we may be being overly-generous here in assuming assisted or supportive housing locations — represented only 1.5% of the discharges. Notably, Mizner claims many of LHH's residents can be discharged to community-based alternatives. Given that only 2.5% of LHH discharges during this reporting period were to community locations other than previous housing, several of Mizner's hypothesis about the need for non-home community alternatives seems irresponsibly out of touch.
- ***The number of deaths in-house at LHH — 24.3% of total turnover during the nine-month reporting period in Table 10 — nearly equals the number of discharges to the community***. In addition, many of the discharges to acute facilities result in additional deaths at the receiving facility, which data has not been made public. Discharging people to the "community" en mass from LHH may result in even more deaths, some prematurely, than may have occurred with conserved 24-hour skilled nursing care at LHH.

The number of deaths in-house at LHH — 24.3% of total turnover during the nine-month reporting period in Table 9 — nearly equals the number of discharges to the community.

- In the "internal discharges" section of Katz's Table 7, there are an additional 97 who were discharged (i.e., temporarily transferred) to LHH's acute ward, M-7; those discharges are not included in the 963 discharges in Table 10 above. It is notable that LHH's in-house acute ward was able to ***prevent*** more costly discharges to other acute-care facilities.

- Also in the "internal discharges" section of Katz's Table 7, discharges from LHH's acute rehabilitation unit to its SNF-level rehab unit is presented, but Katz failed to include data indicating how many of the discharges from either the acute rehab, or the SNF-level rehab units were made to long-term care units within LHH, nor did he stratify how many of the rehabilitation patients at LHH are actually discharged back to the community. Without that data being made public knowledge, a "public policy debate" would be held without having complete information about the discharge locations of patients sent to LHH for physical rehabilitation.

Readers should note that the IHSS waivers proposed for community-based alternatives to LHH do not provide for multiple caregivers in order to perform two-person assistance with ADL's.

- In his June 7 memo to the Health Commission, Katz does not include a table of re-admissions to LHH, including a stratification of the source of re-admission which occurred (i.e., from home, psychiatric facility, acute hospital, etc.), nor a breakout of the reasons for re-admission. All of this is salient to the public policy discussion at hand.

Data Readily Available Is Missing From Dr. Katz's June 7 Memo

During the 1998-1999 campaign to convince voters to rebuild LHH, the Department of Public Health compiled data describing the level of acuity of LHH's residents, and their mobility limitations and self-care limitations. That data for 2005 was readily available to Dr. Katz, but he chose not to include it in his June 7 memo to the Health Commission. As shown in Table 11 below, LHH's residents continue to have severe limitations with their ability to perform activities of daily living (ADL's).

Table 11: Ability of LHH Residents to Perform Activities of Daily Living

	1- to 2-Person Assistance		Totally Dependent	
Activity of Daily Living	1998†	2005††	1998†	2005††
Bathing	29.0%	44.7%	68.0%	46.8%
Dressing	33.0%	55.8%	57.0%	30.4%
Transferring	26.0%	36.5%	50.0%	33.8%
Toilet Use	22.0%	41.5%	58.0%	37.4%
Eating	28.0%	33.9%	32.0%	20.8%

† http://www.dph.sf.ca.us/LHHReplace/PreBondRpts/Pressummary.pdf

†† Centers for Medicare and Medicaid Services, "Resident Census and Conditions of Residents," Form CMS 672, dated March 15, 2005.

It should be noted that the sharp decline in the number of people aged 70 and over admitted to LHH in 2004 may have affected the number of LHH residents who are totally dependent for ADL's, which may largely explain the decline in total dependence in Table 11. However, those who need 1- or 2-person assistance has risen sharply for each of the five ADL's; this may be indicative of a younger patient population from SFGH who were given priority for admission to LHH

during the 2004 "Flow Project," while the decline in those totally dependent may be indicative that elderly over the age of 70 (see Table 9, above) were differentially denied admission during the Flow Project resulting in a sharp decrease in the number of elderly residents, possibly those totally dependent. ***Readers should note that the IHSS waivers proposed for community-based alternatives to LHH do not provide for multiple caregivers in order to perform two-person assistance with ADL's.***

Table 12: Mobility Status of LHH Residents

Mobility Status	1998†	2005††
Bedfast all or most of the time	1.0%	4.2%
In chair all or most of the time	61.0%	33.7%
Independently ambulatory	17.0%	16.2%
Ambulate with assistance/devices	15.0%	29.3%
Have contractures	34.0%	46.4%
Have pressure sores (Excluding Stage I)	Unknown	11.0%

† http://www.dph.sf.ca.us/LHHReplace/PreBondRpts/Pressummary.pdf

†† Centers for Medicare and Medicaid Services, "Resident Census and Conditions of Residents," Form CMS 672, dated March 15, 2005.

Table 12 above shows a number of key changes between 1998 and 2005:

- The percentage of LHH residents who are bedfast has quadrupled.
- The percentage of LHH residents who ambulate independently has declined.
- The percentage of LHH residents who ambulate with assistance, or with assistive devices has doubled.
- The percentage of LHH residents having contractures has increased sharply. This may be due, in part, to a lessening of basic skilled nursing attention in assisting residents with range-of-motion exercises to prevent the onset of muscular contractures. Just as bed sores are preventable, so too are the onset of contractures post-admission. Due to the time spent "managing" the increased aggression of patients with "behavioral problems" that resulted from the changing demographics of admissions to LHH under the revised admissions policy during the 2004 Flow Project, LHH's nursing staff may not have focused on providing nursing interventions to prevent the onset of contractures and bed sores post-admission.

Due to the time spent "managing" the increased aggression of patients with "behavioral problems" that resulted from the changing demographics of admissions to LHH under the revised admissions policy during the 2004 Flow Project, LHH's nursing staff may not have focused on providing nursing interventions to prevent the onset of contractures and bed sores post-admission.

Tables 11 and 12 above also contain data different than data presented in June 2005 by the TCM program director. A TCM document[86] shows that of 1,045 residents assessed for discharge under the TCM program:

- 32% were totally dependent for dressing, higher than the 30% reported on the CMS Form 672 dated March 15, 2005.
- 12% were judged by the TCM staff to be "Independent" for "Personal Hygiene." However, "personal hygiene" is not a recognized category of ADL's. Industry-standard assessment instruments used to evaluate ADL's differentiate between "bathing" and "toilet use," but it is not clear what the TCM staff means by "personal hygiene." If the TCM staff meant "Bathing," the 12% who are ostensibly independent contrasts sharply with, and is significantly different from, the 8.5% that LHH administration reported on the CMS Form 672 dated March 15, 2005.

Various Advisory Bodies Rush to Weigh In — Ignoring Flawed Data

On June 17, 2005, the Mayor's Disability Council (MDC) took a vote regarding Ed Harrington's two options to rebuild LHH. Without having adequate and accurate data at their disposal — and ignoring all of the flaws in the glass contained in the House of cards based on the inaccurate TCM data that Mizner's incorporated into her "Attachment A," that Harrington continued to incorporate in his May 19 recommendations to the Mayor, and that Katz continued to incorporate in his June 7 memo to the Health Commission — the MDC voted 8–to–1 in favor of supporting Harrington's Option 2 to build only 780 beds at Laguna Honda Hospital. Sadly, the single "No" vote (to preserve LHH's 1,200 skilled nursing beds) was cast by the only LHH resident on the MDC.

Indeed, the MDC voted prematurely to Support Harrington's Option 2 without knowing that the Independent Living Resource Center and its director, Herb Levine, were poised to take a position against Option 2. During a June 29 forum sponsored in part by the Long-term Care Coordinating Council (LTCCC) held at On Lok's ADHC, that's exactly what Levine did: He rejected the notion that there are only two viable options, indicating Harrington's Option 2 unacceptable.

Monette-Shaw noted that LHH's supporters only need $320 million of the TSR's to see LHH rebuilt with all 1,200 beds, and are willing to see the remaining $500 million in TSR's used to fund community-based alternatives. Collaborative use of the TSR's was rejected outright by Herb Levine, without a moment of reflection; his immediate response was "No, Patrick, because there is no price on civil rights."

On June 29, a member of the public suggested to Mr. Levine that both sides could work together. Patrick Monette-Shaw suggested splitting the $820 million in tobacco settlement revenues (TSR's) between advocates for preserving Laguna Honda's skilled nursing beds and advocates seeking funding for community based alternatives. Monette-Shaw noted that LHH's supporters only need $320 million of the TSR's to see LHH rebuilt with all 1,200 beds, and are willing to see the remaining $500 million in TSR's used to fund community-based alternatives.

[86] Gray, (2005, June); op. cit.

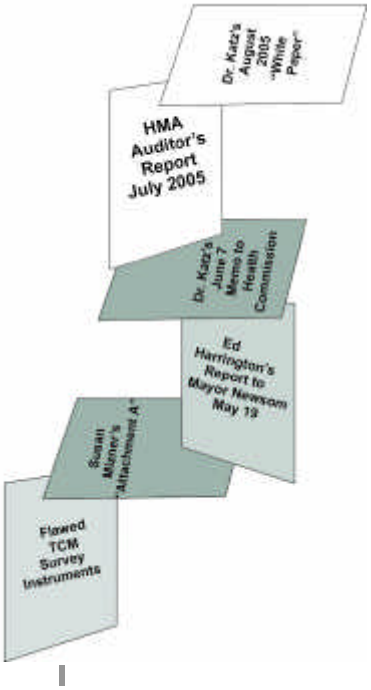
Collaborative use of the TSR's was rejected outright by Herb Levine, without a moment of reflection; his immediate response was "No, Patrick, because there is no price on civil rights[87]." What Levine fails to note is that the civil rights of people who ***willingly choose*** nursing home placement are also being violated by those hell-bent preventing the rebuild of ***any*** beds[88] at Laguna Honda Hospital.

What Levine fails to note is that the civil rights of people who **willingly choose** *nursing home placement are also being violated by those hell-bent on preventing the rebuild of* **any** *beds at Laguna Honda Hospital.*

Other advisory bodies — including the LTCCC, the Human Services Network, and the Department of Aging and Adult Services — are all racing to weigh in with recommendations about how to proceed with the LHH replacement project. In the end, both Option 1 and Option 2 will be rejected by these advisory bodies. In that regard, a public policy debate is occurring, but the general public and voters have not been told, and have no idea about, what the real "options" are that are being considered.

The problem is, these advisory bodies are collectively ignoring the flawed data provided by the TCM program and Dr. Katz's Department of Public Health upon which the house of cards contained in the first four reports is being built.

Disturbingly, none of the advisory bodies are demanding that the flawed TCM premises be corrected prior to racing into a fatal embrace of Option 2.



[87] Levine, H, (2005, June 29). During community forum about LHH held at On Lok's ADHC.

[88] Levine, H, (2004, September 9). Private communication following a meeting of the Mayor's Disability Council, Mr. Levine noted to Patrick Monette-Shaw that "If the right community supports were in place to provide community-based alternatives to LHH, ***there would be a need for zero beds at Laguna Honda Hospital***." That conversation was witnessed by another healthcare advocate and member of the San Francisco chapter of Gray Panthers.

Quality Assurance and Oversight Considerations

To date, nobody — notably not Mizner, Katz, or Ed Harrington — is talking about regulatory oversight by government agencies to ensure quality and accountability of home- and community-based long-term care services.

There are no standards of care for IHSS services, and it is not known whether there is a single standard of care for board and care facilities, so-called "supportive" and "assisted" living facilities, or for agencies providing long-term care services in the community. Because IHSS is not regulated in the way long-term care skilled nursing facilities are, it is up to individual service providers to set standards of care. And there is no mechanism for accountability and oversight of what individual service providers choose to implement for quality-of-care.

Others have noted that there is an "overwhelming failure due to a lack of adherence to, and enforcement of, professional standards of clinical practice, and laws designed to ensure adequate and appropriate care." Guidelines designed to oversee and enforce occupational safety for home-based healthcare workers to ensure fair and appropriate working conditions, and laws designed to protect patients from abuse, harm, and neglect are virtually non-existent.

Lacking such guidelines, oversight, and enforcement, the potential for elder abuse is of paramount concern. The residents and staff of Laguna Honda are provided with oversight by State regulatory and licensing agencies, and when deficiencies are found, efforts are made to address them.

But in unregulated community-based settings, there will be no oversight or outcomes analysis to ensure that our elderly and disabled are being cared for safely and appropriately.

And the costs of implementing quality assurance programs for community-based providers are also not factored in to the Mizner or Harrington recommendations to Mayor Newsom.

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KPFA Radio Debate Regarding LHH

Several out-takes from a debate about LHH provides additional data about San Francisco's rapidly aging population who will need skilled nursing care is presented below. The KPFA radio debate[89] occurred in March 2005 and featured Palmer, MD, a former geriatrician and shop steward for the doctor's union, UAPD, at LHH; Sal Rosselli, the president of United Healthcare Workers, West (formerly SEIU 250); and Herb Levine, executive director of the Independent Living Resource Center.

The transcript illustrates, in part, that Herb Levine appears ***not*** to be concerned about the frail elderly (those over age 85).

(The full transcript is available at www.stoplhhdownsize.com/05-03-21KPFA_LHH)

We're looking at current occupancy rates, the need for thousands [of] more beds in San Francisco than we have now, even if by [the year] 2020 with the most enlightened funding, we can cut those occupancy rates by 50% or even by 75%, there still will not be enough nursing home beds, **and that's just for people over [age] 85**. *We're not even talking about people over [age] 65, or disabled people …*

Demographic Information About Those Over Age 85

Lewis — OK. And Theresa, I want to give you a chance to respond to [what] Herb Levine was saying, that in terms of the folks at the Independent Living Resource Center, that you're describing people there who you're saying need to be in bed. So can you respond to that?

Palmer — "Well, the people that most notably fill nursing home beds nationally are disproportionately older, female, poorer, and people of color. There's no doubt that with more enlightened policies, we can lower the bed ... the number of people absolutely that need nursing home beds. And, in fact, the number of people in the nation as whole that need nursing home beds is very slowly going down. But there are subsets, where the absolute numbers are increasing because of the aging of the population. We've got a huge Baby Boom curve going forward. There's estimated to be a 57% increase in people over 65 in San Francisco between 2000 and 2020; so we've got 100,000 going to 160,000 people over 65. In 2000 there were 14,000 people over 85; a disproportionate number of that increase will be over [age] 85 in [by the year] 2020, because of the aging ... the moving curve of the Baby Boom. Right now, 60% of people over 85 will spend some time in a nursing home, and, in fact, nationally 20% of people over 85 ***are*** in nursing homes. Now I agree with Mr. Levine that this is egregious. If there's any way we can help people age in place ... [and] we can put people in a less institutional environment ... we should do that. And in fact, the Olmstead Act, and the other regulatory moves ***have*** served to turn nursing homes into more of a rehab-and-discharge type of facility, and less of a custodial-care, end-of-life facility, but there still is a significant number of people that will need years of custodial care, and will need end-of-life

[89] Transcript of a KPFA 94.1 FM Radio Debate on is "Morning Show," Andrea Lewis, host (2005, March 21).

	care in a nursing home facility. We have very good — in San Francisco — outpatient hospice organizations, but the hospice at Laguna Honda — the inpatient hospice — is always full. There are people that, for various reasons, cannot get what they need outside of a nursing home. And the numbers are really staggering. We're looking at current occupancy rates, the need for thousands [of] more beds in San Francisco than we have now, even if by [the year] 2020 with the most enlightened funding, we can cut those occupancy rates by 50% or even by 75%, there still will not be enough nursing home beds, ***and that's just for people over 85***. We're not even talking about people over 65, or disabled people with things like multiple sclerosis and degenerative diseases [for those] under 65."
...	[Later in the debate ...]
Palmer	And this needs assessment process has resulted in almost ***no*** discharges [from LHH]. One of the problems is that people who require the type of care that a skilled nursing home facility provides in general cannot get that care outside of a skilled nursing home unless they are very well off financially. And, in fact, the statistics that we're talking about, which includes the 2000 census, shows that the number of people who are over [age] 85 who are incontinent, cognitively impaired, immobile, and need to be fed, are a significant percentage. In San Francisco ...
Lewis	Of the residents at Laguna Honda, you're saying?
Palmer	Of residents in ***any*** nursing home ... in San Francisco, two-thirds of the population are renters, one-third of the population over [age] 65 lives alone. To say that even under the most enlightened circumstances these people can be cared for without nursing home beds, is not rational.
...	[Later in the debate ...]
Levine	Yes. I think that the needs assessment is showing some different things. First of all, a statement that folks who are there really need to be there is insulting to our staff and Board of Directors [of the Independent Living Resource Center], many of whom fit the profile of current residents at Laguna Honda.
Palmer	How many [of your Board of Directors fit the profile of people at LHH who] are over 85?
Levine	Ah. We're not talking about ***that***. We're ... how many of the people at Laguna Honda actually need to be there ***if*** there were appropriate community services? So we're not arguing that there might not be appropriate community services at this moment. Charlene Harrington, who is [a] noted expert on long-term care ... she works at UCSF ... has stated that ***if*** San Francisco improved its utilization of existing home- and community-based services, and expanded community services and waiver programs, the need for Laguna Honda beds could be reduced by 30% to 50%. So the Department of Justice ... [**Editorial Aside:** This exchange illustrates Levine is both unwilling, and avoids, the debate of the issue of those over age 85 who need services provided at Laguna Honda Hospital.]

LHH Advocates Attempt Collaboration; Community Providers Insist It's"Either/Or" ["Us" vs. "Them"]

Rosselli	Sure. If I could just first add that, you know, our Union supports the mission of the Independent Living [Resource] Center, and it's not an "either/or" situation here. ...
...	
Lewis	So, not an "either/or" situation?
Palmer	No, it's not "either/or," and it all [both skilled nursing homes and community-based alternatives] needs to be funded.
...	
Lewis	Final thoughts from you, Herb Levine?
Levine	Yes. I think unfortunately, given the reality of limited dollars, it ***is*** "either/or." One-third of San Francisco's Medi-Cal monies go to a nursing home. That ... that kind of makes it an "either/or" issue.

What Herb Levine refuses to admit — and hopes everyone won't notice — is that while Laguna Honda Hospital provides nearly ***half*** of all nursing home beds in San Francisco that continue to accept medically-indigent Medi-Cal clients (according to Benson Nadell), only ***one-third*** of Medi-Cal funds coming to San Francisco goes to LHH.

A better question Mr. Levine should be asking — in his role as an accountability activist for the clients he represents — is: ***"If Laguna Honda Hospital is providing* one-half *of the SNF beds accepting Medi-Cal clients and is doing so with only* one-third *of Medi-Cal dollars flowing to San Francisco, where are the remaining* two-thirds *of Medi-Cal funds going?"*** If he is truly concerned about limited dollars, this is an important, unanswered question that he has failed to ask.

Unless, of course, he prefers to ignore both the **elephant in the room**, and the ***miracle of the fish and the loaves*** phenomena.

A better question Mr. Levine should be asking — in his role as an accountability activist for the clients he represents — is:
"If Laguna Honda Hospital is providing *one-half* of the SNF beds accepting Medi-Cal clients and is doing so with only *one-third* of Medi-Cal dollars flowing to San Francisco, where are the remaining *two-thirds* of Medi-Cal funds going?"

If he is truly concerned about limited dollars, this is an important, unanswered question that he has failed to ask.