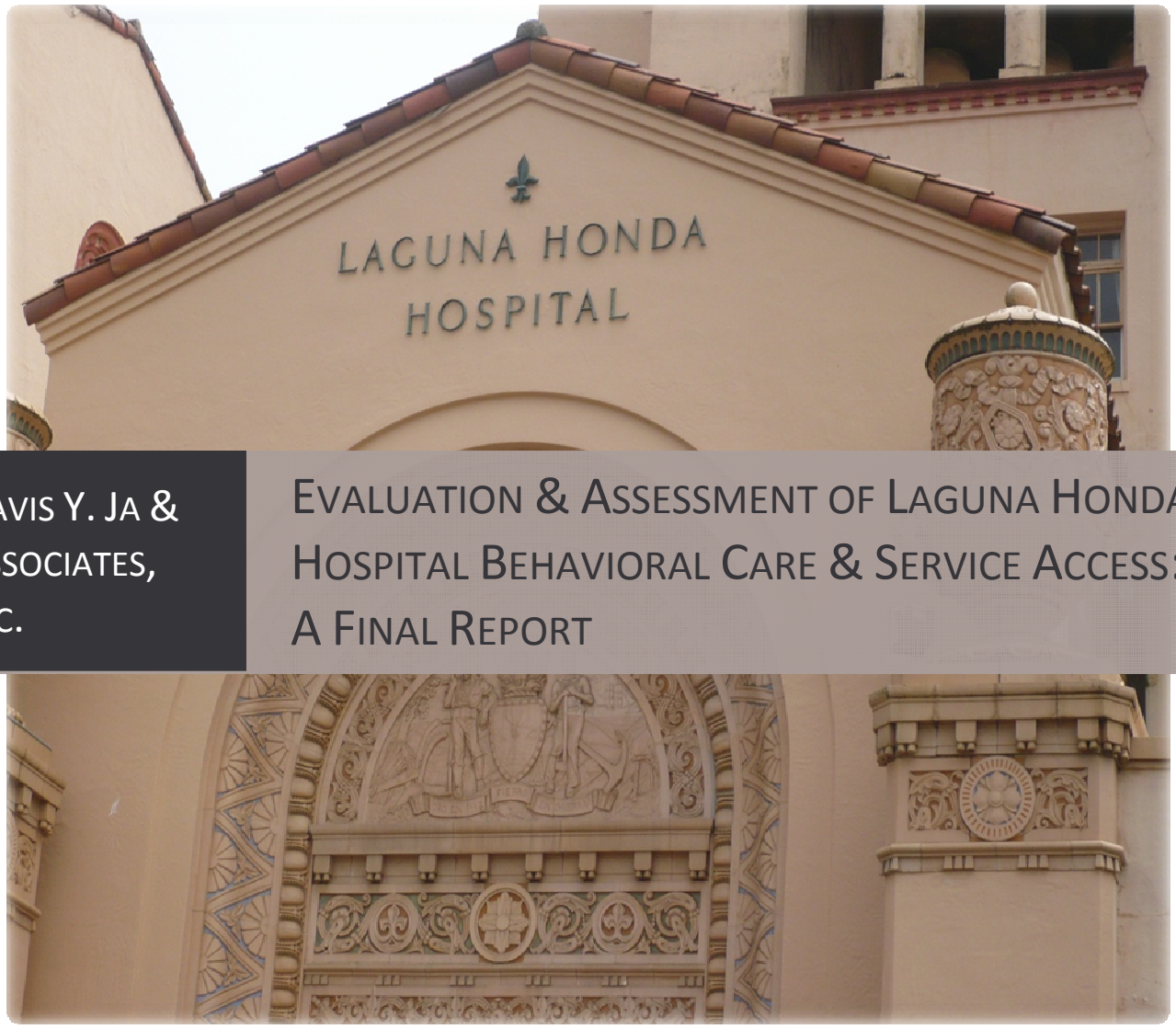

DAVIS Y. JA & ASSOCIATES, INC.

EVALUATION & ASSESSMENT OF LAGUNA HONDA HOSPITAL BEHAVIORAL CARE & SERVICE ACCESS: A FINAL REPORT

Prepared & Submitted to San Francisco Department of Public Health,
Community Behavioral Health Services (BPO#BPHM09000038)

July 2009

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EXECUTIVE SUMMARY

During FY 2008-09, Davis Y. Ja and Associates, Inc. (DYJ) was contracted by the San Francisco Department of Public Health (DPH), Community Behavioral Health Services (CBHS) to conduct an evaluation and assessment of Behavioral Health Services and Service Access at Laguna Honda Hospital (LHH). Four strategies were used in this evaluation: (1) a review and analysis of the existing LHH behavioral health patients and of the patient flow; (2) interviews with staff within and external to LHH; (3) an analysis of the demographic characteristics and of the delivery of mental health and/or substance abuse services to behavioral health patients versus a comparison group; and (4) a review of a random sample of behavioral health patient charts.

RESULTS

Review of Current LHH Behavioral Health Patient Flow Operations: This review resulted in a comprehensive description of the current admission and discharge process at LHH, which is detailed in the body of the report.

Staff Interviews: Interviews were conducted with 40 staff from LHH, CBHS, the TCM Team, representatives from the Department of Aging, and attorneys from Disability Rights of California (with the permission of the City Attorney's Office). The interviews revealed that TCM was a major facilitator to discharge, as were various LHH services which act as positive facilitators for discharge. However, the interviewees also identified the following barriers to successful patient rehabilitation and discharge:

- ► Complex and differing philosophies of patient care
- ► Staffing and training issues
- ► Structure and infrastructure issues
- ► Various discharge complexities

Demographic and Treatment Data: Marked differences in the demographics, survival statistics and disposition data for each of the two groups are detailed in the report.

Random Sample Chart Reviews: A random sample population of 50 patients with behavioral health problems within a six-month study time frame was reviewed for treatment for these concerns. Medical chart documentation review for behavioral health services was extremely time-consuming and made difficult by a complex and somewhat unorganized structure. Findings from this review included the following:

► 85.0% of the treatment recommendations had documentation of a subsequent treatment within the six-month time frame.

► 12.1% of the recommendations were not matched with a subsequent documentation of treatment.

► 12 of the 50 random sample patients had received a severe mental health diagnosis, such as paranoid schizophrenia or manic depression. Three of these were excluded from analysis and of the 9 remaining patients, 5 patients had no documentation of any type of psychiatric evaluation or service in their charts. All five, however were receiving psychotropic medication by their primary care physicians.

The percentage of treatment recommendations matched with subsequent treatments varied considerably by recommendation type.

► Medication recommendations were fulfilled 98.6% of the time, group mental health recommendations were fulfilled 100% of the time, individual mental health recommendations were fulfilled 75% of the time, group substance abuse recommendations were fulfilled 69.2% of the time, and individual substance abuse recommendations were fulfilled 60% of the time.

► Average elapsed time from treatment recommendation to treatment was 5.7 days.

► Average elapsed time varied by type and followed the same pattern as above with the shortest time for medication and the longest time for individual substance abuse.

RECOMMENDATIONS

The recommendations focus on the enhancement of current systems and processes and avoid new initiatives that might add to the workload of staff or the burden on patients.

DPH System Level Recommendation: The Directors of Community Programs, Community Behavioral Health Services and the Executive Administrator of Laguna Honda Hospital convene a system level administrative group to review and integrate behavioral health policies, services and facilitate coordination and communication regarding the assessment, treatment and discharge of behavioral health clients of Laguna Honda Hospital.

LHH Policy Level Recommendations: The Executive Administrator of LHH convene an internal group to prepare and make the policy changes necessary to implement the decisions specified by the system level group. The major tasks for this group will be to:

► Review the LHH Mission statement for conformance with the results of the system level work.

► Develop a standardized assessment, treatment and discharge model for behavioral health patients in LHH. This treatment model will guide the development of the operational processes necessary to carry out the policies and should include the following items:

1. Role of each of the clinical disciplines in the assessment, treatment and discharge of the behavioral health clients at LHH.
2. Chain of responsibility and authority for implementation of the overall service model and each disciplinary component.
3. Implementation of a meaningful participative management system.
4. Development of a culture change model.
5. Role of Quality Management in measuring fidelity to the model and outcomes and overseeing necessary plans of correction.

LHH Operational Level Recommendations: All of the operational level recommendations should be completed based on the policy guidance provided by treatment model and should address at least the following major areas:

1. Use of the Interdisciplinary Teams in the implementation of the treatment model.
2. Development of transitional and specialized behavioral health units.
3. Increase behavioral health staff levels necessary to implement the treatment model.
4. Expansion of current training activities to develop a comprehensive behavioral health training program.
5. Development of better external and internal communication systems.
6. Development of a more effective medical charting system for the short term as well as long term.
7. Resolution of the current disconnection between the LHH care delivery and discharge timelines and the Medicare/Medi-Cal reimbursement requirements.

I. INTRODUCTION

Davis Y. Ja and Associates, Inc. (DYJ) was contracted by the San Francisco Department of Public Health, Community Behavioral Health Services to conduct an evaluation and assessment of behavioral health services at LHH. This evaluation was one of the requirements of the Chambers Settlement Agreement (Chambers, et.al. v. CCSF, Settlement Agreement) as filed with the U.S. District.

Upon DPH's approval of the evaluation contract in late October 2008, DYJ immediately began conducting interviews with LHH staff and administrators. The first site visit occurred on October 31, 2008 and included a tour of the LHH wards and introduction to key administrators and staff. DYJ shared the evaluation procedures with LHH administration and received substantial support, cooperation and documentation throughout this study of LHH's behavioral health functioning.

Following the initial review and interview process, DYJ submitted a revised evaluation design to accommodate: (1) the complex size and scope of LHH staff and infrastructure and (2) the complexities involved in defining the patient class for the evaluation. This revision was approved by the Project Officer and the CBHS Director in January 2009. Following this approval, data collection for the chart review and case study began in March 2009 and culminated in a final report prepared in June 2009.

During the time of this data collection, substantial changes occurred within the LHH system including an extensive and unprecedented turnover of the top administrators of Laguna Honda Hospital. Subsequently, much of the findings and recommendations must be made with this process (and opportunity) in mind. As this report was being finalized, behavioral health changes by the new administrators were being made and plans for additional changes were being implemented.

II. EVALUATION SCOPE

This evaluation was commissioned to satisfy the requirement described in the Chambers settlement agreement. In order to satisfy that requirement, the scope of this evaluation was designed to accomplish the following goals:

1. Conduct an assessment of the mental health and substance abuse services needed, provided and available to LHH residents.
2. Determine the level of community expertise available to promote better discharges and linkages of class members to CBHS mental health and substance abuse services.
3. Make recommendations regarding mental health and substance abuse services provided at LHH in order to promote and support discharge so that LHH residents who can benefit from either on-site or community-based mental health/substance abuse services are provided with those services in a timely manner.

To accomplish these goals, the evaluation was implemented in nine phases:

Phase I: Assemble the DYJ evaluation team and acquire and review all relevant documentation.

Phase II: Interviews with CBHS and LHH staff and administrators, the TCM Team, Department of Aging and Adult Services (DASS) staff, and attorneys from Disability Rights of California (with the permission of the City Attorney's Office).

Phase III: Initial review of documentation system and staffing. This phase involved: 1) interviews with LHH information technologies and clinical staff versed in the database documentation system at LHH and 2) initial reviews of chart documentation and the IT structure.

Phase IV: Development of detailed methodology (described in detail in the Methodology section).

Phase V: Implementation of the evaluation, including the operations review, staff interviews, patient analyses, and chart reviews.

Phase VI: Data review and analysis.

Phase VII: Development of the final report.

Phase VIII: Dissemination and presentation of findings.

Phase IX: Compliance and follow-up.

III. METHODS

a) Review of Current LHH Behavioral Health Patient Flow Operations

In the initial phases of this evaluation, DYJ reviewed all relevant legal documents, previous reports and related information on LHH behavioral health issues and concerns, and documents related to the functioning of LHH as well as the relationship between CBHS and LHH. A partial list of documents reviewed is in Appendix 2. The review also included a set of initial interviews with CBHS administrators and staff (including TCM staff) and external community agencies that link to LHH. This information was used to document the current LHH behavioral health operation and was used as background for the evaluation work, including preparing the staff interview protocols for different levels of administration and staffing. DYJ would also like to note that throughout this report, the term "behavioral health" is utilized. Behavioral health generally involves both mental health and substance abuse. Subsequently, behavioral health treatment or services involves all mental health treatment as well as treatment for substance abuse. Behavioral health staff includes all staff providing these services to LHH residents. This includes psychiatrists, psychologists, clinical nurse specialists, psychiatric social workers.

b) Staff Interviews

In the original proposal, DYJ planned to administer a survey to LHH behavioral health staff and conduct a select number of interviews. However, as DYJ started to obtain information from staff, it became clear that individual interviews would provide substantially more specific information than a survey. The resulting decision was to reject the survey method and instead conduct more staff interviews as a way of achieving more comprehensive results regarding the intersection of issues related to both the assessment and treatment of residents with behavioral health needs. It is important to note that given resource limitations, only 40 staff from relevant units of the Department of Public Health were interviewed. Subsequently, given the large number of potential staff involved, this can only be a limited sample. In addition, throughout the report, DYJ describe findings related to "frontline" staff. Most often, this describes certified nurse assistants or CNAs. These are staff who spend the majority of their

time in direct care of residents. They also tend to have the least amount of psychosocial-based training and skills needed to handle/manage residents with behavioral problems at LHH. Finally, the protocol for all interviews is in Appendix 3.

c) Behavioral Health Study Group Analysis

In order to evaluate whether LHH residents were served adequately by the facility, DYJ had to determine the needs of residents with behavioral health problems and concerns. Subsequently, DYJ sought to extract demographic and treatment information for LHH residents with behavioral health needs who reflected the type of patient defined in the Chambers settlement agreement. Although all residents at LHH are officially part of the "class," DYJ attempted to extract data that related specifically to the mental health and substance abuse (behavioral health) treatment needs of those requiring these services. The population of LHH behavioral health patients meeting these criteria was developed in order to determine which patients' information was to be extracted and analyzed.

In this study, Individuals with behavioral health needs who resided at LHH at any point in time between January 1, 2006 and December 31, 2008 would fall under the population of behavioral health patients and would constitute our behavioral health study group.

Since LHH did not possess a clear list of residents with behavioral health needs who would fall into the study group population, DYJ attempted to identify the population by using one or more of the existing data sources within LHH. DYJ approached this task by working with LHH staff and other City employees to develop a method of building the population of behavioral health patients. The first step was to determine which specific behavioral health needs were appropriate for the patients defined in the Chambers settlement agreement. DYJ conducted a series of interviews with key individuals, including Adrianne Tong from the San Francisco City Attorney's Office and, with permission by the City Attorney's Office, the plaintiff's attorneys from Disability Rights of California as well as DPH administrators, to determine whether patients with behavioral health needs resulting from dementia or a Traumatic Brain Injury (TBI)

should be included within this population. Given that it is not generally within CBHS' mandate to serve individuals with dementia or TBI unless they were previously involved with CBHS prior to their diagnosis, after substantial consultation, DYJ decided to exclude patients with these diagnoses from the Behavioral Health Study Group. One exception was if the TBI patients had a concurrent mental health and/or substance abuse diagnosis. Patients with all other behavioral health diagnoses would be included in the DYJ Behavioral Health Study Group.

DYJ made use of LHH's Invision database to determine which patients suffered from dementia or TBI. The Invision database, under the direction of Pat Skala (Senior Information Systems Manager at both LHH and San Francisco General Hospital), contains various patient data including International Statistical Classification of Diseases and Related Health Problems (ICD-9) diagnostic codes. Pat Skala's IT generated a list of all LHH patients within the 2006 to 2008 timeframe who had received an ICD-9 diagnostic code for dementia (codes 290-294) or TBI (codes 800-801, 803-804, and 850-854.1).

Using the list of dementia and TBI patients as a filter, DYJ began to build the Behavioral Health Study Group by examining several Laguna Honda records and databases that specified patients with behavioral health needs. Since no single database or list exists which documents these patients, using a recommendation from Ms. Regina Gomez, Director of Quality Management at LHH, we determined that use of the Pre-Admission Screening and Resident Review (PASRR) assessment process would be the initial stage in which to determine involvement with mental health assessment and services. The PASRR is a federally mandated assessment process utilized to evaluate residents with mental illness or developmental disabilities who are being considered for nursing facility placements and determines placement appropriateness. A PASRR I is required prior or upon admission to LHH for all patients, but can also be administered to existing LHH patients if there is a significant change in their physical or mental health. Findings from the PASRR I may also prompt a PASSR II review and assessment. In addition, since all LHH patients who may require specific treatment for mental illness are referred for an additional PASRR II assessment, DYJ determined that all residents referred for a PASRR II

assessment would be placed in the DYJ Behavioral Health Study Group. After reviewing all PASRR II documentation between 2006 and 2008, DYJ found that 516 patients without dementia or TBI were referred for a PASRR II assessment and therefore qualified for the Behavioral Health Study Group.

While the PASRR enabled DYJ to identify patients with mental health care needs, it does not focus on patients with needs resulting from alcohol and/or drug use. In order to capture substance-using patients for the Behavioral Health Study Group, DYJ chose to include patients who were referred to Substance Abuse Treatment Services (SATS) at LHH. Dr. Lorraine Killpack, the head of the SATS department at LHH, made available records of all SATS referrals between April 2006 and December 2008. Records of SATS referrals prior to April 2006 were not available at the time of the DYJ records review. DYJ found that 348 patients were referred to SATS during this time frame and therefore qualified for the Behavioral Health Study Group. A significant portion of these 348 patients had also received PASRR II referrals. Patients with dementia or TBI who had received SATS referrals were not excluded because behavioral needs arising from substance abuse may be separate from those arising from TBI or dementia.

In order to capture any patients with behavioral health needs who did not get a PASRR II or SATS referral, DYJ returned to the ICD-9 codes available in the Invision database. Pat Skala's team sent DYJ a list of all LHH patients within the 2006 to 2008 timeframe who had received an ICD-9 diagnostic code for a mental illness and/or substance abuse disorder (codes 291-292, 295-306, 308-309, and 310-313). A single patient may have received more than one of these relevant codes. DYJ found that 952 patient without dementia or TBI received an ICD-9 code relevant to behavioral health needs and therefore qualified for the Behavioral Health Study Group. A portion of these patients had also received PASRR II and/or SATS referrals.

Combining all qualifying patients for the Behavioral Health Study Group population resulted in an unduplicated total of 1,075 patients within the timeframe of 2006 to 2008. These patients either received a PASRR II referral for mental illness, a SATS referral for substance abuse, a

relevant ICD-9 diagnostic code for mental health and/or substance abuse, or a combination of the three. A total of 373 patients were excluded due to a dementia or TBI diagnosis. An additional 45 patients were excluded because they did not possess a social security number.

A Comparison Group of remaining LHH patients was developed for the analysis. Using the Invision database, DYJ received a list of all patients who resided at LHH at any point during the timeframe of 2006 to 2008. Any patient on the list who did not fall into the Behavioral Health Study Group, including those patients with dementia or TBI who were previously excluded from the Behavioral Health Study Group, or those patients without social security numbers, fell into the Comparison Group. The Comparison Group resulted in a total of 1,263 patients.

d) Random Chart Sample Reviews

DYJ sought to examine the assessment and treatment services provided to patients within the study group in order to evaluate the quality of behavioral health services being provided at LHH. All of the 1,075 Behavioral Health Study Group patients were classified as having behavioral health needs while residing at LHH. DYJ randomly selected a sample of 75 Behavioral Health Study Group patients and further examined their assessment and treatment data. This data was extracted from LHH patient charts, which contain various medical records produced or obtained during residency at the hospital.

DYJ coordinated with the medical records office at Laguna Honda to extract the charts of the 75 randomly selected patients for review. DYJ reviewed only 50 of the 75 patient charts due to time constraints. A proportion (56.0%) of the 50 patients whose charts were further reviewed had been discharged from the hospital at the time of review (April 2009). All discharged patients' charts, unless sent off-site, were in the medical records office. The remainder of the 50 randomly selected patients (44.0%) were residing in the hospital at the time of review. In-house patient charts were found both in the medical records office and in the wards where the patients were residing at the time.

DYJ developed a method for extracting assessment and treatment data after reviewing several patient charts from the random sample. In addition to extracting demographic and diagnostic data, each random sample patient's chart was examined for documentation of behavioral health treatment recommendations. Any given patient may have received multiple treatment recommendations by various hospital staff for different behavioral health needs. Treatment recommendations were determined based upon staff notes or medical assessments filed in a patient's chart, including the *History and Physical Examination, Annual Patient Medical Review*, the *Neuropsychological Consultation*, the *Substance Abuse Treatment Services (SATS)* assessment, the *Preadmission Screening and Resident Review* (PASRR I), and *Physician's Orders* forms. A six-month time frame was used for each patient, consisting of either the first six months of 2006, or if the patient was admitted to the hospital after January 2006, the first six months following admission date. Only treatment recommendations found within a given patient's time frame were recorded. Each incidence of a treatment recommendation was dated and categorized into one of the following behavioral health treatment categories: medication (for behavioral health only), group mental health treatment, individual one-on-one mental health treatment, group substance abuse treatment, and individual one-on-one substance abuse.

For each incidence of a treatment recommendation found within a patient's chart, DYJ searched for documentation that the specific treatment was received as a result of the recommendation. Receipt of treatment was primarily determined based upon staff notes or treatment records filed in the *Integrated Progress Notes*, *Physician Progress Notes,* or *Medication Records* section of a patient's chart. If a treatment recommendation was matched with a subsequent treatment reception, the date of the first incidence of the reception was recorded so long as it was within the relative six-month time frame for the given patient. It was also recorded if no treatment reception was found within the six-month time frame or if the patient refused the recommended treatment.

IV. RESULTS AND DISCUSSION

a) LHH Behavioral Health Patient Flow Operations

Implicit in the Chambers case settlement agreement is the *promotion of timely and adequate discharge* of capable residents from LHH. This includes the preparation of residents for safe discharge. Toward this end, this evaluation sought to determine current operations related to patient flow at LHH, including processes of admission and discharge. This process is described below (and presented graphically in Appendix 5) based on perceptions described to DYJ by LHH staff (N = 20) and staff from related external organizations (N = 7) during the months of October 2008 – March 2009.

Only three units at LHH were admitting new patients during the time of the interviews: the positive care unit, the rehabilitation unit, and the hospice unit. Patients are typically referred to these units by outside institutions, primary San Francisco General Hospital, based upon skilled and rehabilitative need. For patients with previously identified mental health and/or substance abuse issues (MH/SA), the admission potential is assessed by the attending physician at LHH, who refers for a psychiatry assessment. Assessments of the patient's psychiatric/behavioral needs are then conducted by the Laguna Honda Behavioral Assessment Team (BAT).

The BAT team results also allow LHH to screen those with problems that the institution cannot address and are subsequently less likely to be accepted to LHH. If the patient is admitted, the patient is matched with the most appropriate unit for their health care needs. The Interdisciplinary Team (IDT) for the respective patient meets to determine the appropriate interventions within 15 days of hospital admission. According to the LHH Resident's Guide, the IDT includes physicians, nursing staff, dietitians, social workers, activity therapists, and other staff. These interventions were not specified, except that they include 'individualized behavioral plans' and potentially some form of rehabilitation for a limited time frame.

After the initial team meeting, the IDT meets to assess the patient every three months, or upon change in the patient's health status (usually identified by the nursing staff). The stated goal of the LHH psychosocial unit is to encourage a sense of independence within each patient and to prepare patients psychologically for life outside the hospital. That is, some staff claimed that for patients with mental health and/or substance abuse issues, the discharge process is initiated upon admission to LHH, and discharge is avidly promoted throughout the patient's stay.

Generally, if the IDT determines that the patient has the 'capacity to leave,' a LHH social worker and/or TCM social worker facilitates a termination/discharge process. Almost all of the participants included in this evaluation stated that this process can be significantly delayed due to shortages in adequate housing for individuals with complex health care needs. Some participants also stated that the discharge process may be delayed due to patient resistance.

b) Staff Interviews

Interviews were conducted with 40 staff from LHH, CBHS, the TCM Team, representatives of the Department of Aging and Adult Services, and attorneys from Disability Rights of California (with the permission of the City Attorney's Office). The raw data from the interviews was analyzed using a grounded theory methodology. This method is described in more detail in Appendix 5.

The Staff Interviews section describes barriers to: successful patient rehabilitation, preparation for community transition and successful discharge of LHH behavioral health clients. The results are detailed in Appendix 6 and are organized around the major themes that resulted from using the grounded theory approach.

Complex Philosophy of Patient Care

1. *Differing Philosophies of Patient Care Undermine Coordination, Interdisciplinary Teamwork and Communication Among Departments*

   The complex nature of LHH's philosophy of care for mental health and substance abuse patients was a predominant theme that emerged in the study. Improvements in developing

a more formalized—rather than informal and fragmented—system of care would prepare patients more effectively for rehabilitation and ultimately community transition.

a. *Differing Philosophies of Patient Care*

Many administrative, medical, psychiatry, and frontline staff noted that different disciplines have disparate ideas about how models of patient care should be utilized. This lack of congruency among staff serves to affect the quality and consistency of behavioral health treatment by undermining interdisciplinary teamwork and communication, coordination of services between departments, and the overall continuum of care. These challenges serve to inhibit the preparation of patients for community transition.

b. *Fragmented Teamwork*

Teamwork was described as fragmented. For example, multiple caretakers for a patient lacked a consistent strategy or plan for that patient's wellness or disposition for discharge. Consequently, an individual case may be treated differently as the client interfaces with different departments, undermining the potential for consistent treatment and behavioral management. It was felt this inconsistency led to behavioral acting out, opportunities for manipulation and power struggles, and failure of patients to reach treatment/rehabilitation goals.

c. *Communication Between Departments*

Frontline and administrative staff explained that inadequate communication and coordination among the different departments are critical factors in creating an informal and fragmented system. In addition, some of the management, frontline and CBHS staff reported that disorganization at the administrative and executive level and the failure to implement standardized and written treatment protocols also serve to undermine a systematized continuum of care. Some staff mentioned that due to informal protocols, LHH is operating under a "problem reactive" rather than "preventive

model of care." Patient problems are addressed as they "pop up" or are "noticed" in the treatment milieu, rather then being addressed or anticipated before hand.

2. *Medical vs. Integrated Service Model of Care: The Professional Dominance of Medical Doctors and its Impact on the Philosophy and Quality of Patient Care*

The professional dominance of medical doctors in positions of leadership was another key theme that emerged from the data about the preferred and/or practiced model of care.

One theme that emerged was the perception by a number of LHH staff of the imposition of medical model values through the professional dominance of medical doctors. This subsequently impacts the following aspects of internal LHH culture and patient care.

a. *Patients' Potential for Community Discharge, Quality of Care, and Referral to Psychosocial Treatment*

Despite the perceived dominance of medical model values in many aspects of patient care, staff members from social work, administration, psychology, and nursing reported LHH is currently struggling with the transition towards an integrated model of care. Indeed, the psychosocial unit was developed several years ago, in an attempt to integrate services.

The desire for more training and education to implement an integrated model of care by nursing and some psychology and executive leadership was perceived to be resisted by medical leadership. This could explain why LHH has not implemented a formalized system to prepare patients for successful community transition.

Due to the reported inadequacy of integrated services model training and the imposition of medical model values from administrators, many frontline staff (i.e. certified nursing assistants) continue to utilize medical model values in practice. Implicit in this practice is the assumption that patients don't have the potential or the skills to learn important independent living strategies and serves to reinforce patient

institutionalization by making patients dependent on their providers. Patient dependency has the unintended effect of prolonging patient recovery and institutionalization.

Related to this finding are other staff perceptions which include psychiatry's use of medication as the primary means to address patients' psychosocial problems, perceptions of overmedication, and the enforcement of rules for behavior control rather than the promotion of social well being and recovery.

The professional dominance of medical doctors in interdisciplinary decision making processes also serves to reinforce medical model values in patient care and impacts the efficiency of LHH's internal referral process to psychosocial services. Because LHH is primarily a medical rehabilitation hospital, physicians must ultimately authorize a patient's referral to a psychosocial unit. Some psychosocial unit staff members reported that physicians, at times, fail to identify substance abuse and mental health needs in initial screening assessments. This oversight prevents some patients from receiving integrated service model treatment early on, reinforcing a "problem reactive" system of care rather than a "preventive" one.

b. *Administrative Prioritization of Funding and Resources to Integrated Service Model Services*

There is significant staff perception that program reductions and cuts favored maintaining existing physical health care services over integrated service model services for mental health and substance abuse patients. Staff felt that this was reflective of the low prioritization of the important mental health and/or substance abuse needs of patients. A majority of those interviewed in administrative positions see LHH's role in providing psychiatric services as secondary despite the clear needs of the resident population. This seems inconsistent with the findings that 46% of the patients studied in the 2006-2008 time frame of this evaluation fell into the Behavioral Health Study Group.

Since many of the interviews were conducted late last year, recent changes in administration and philosophy are not reflected in these findings. It is important to note that the new administration is beginning to shift priorities and resources towards a more integrated model.

c. *Representation of Frontline Staff and Middle Management in Decision-making Processes around Patient Care*

At the time of our interviews, a significant number of frontline and middle management staff reported that a small circle of administrative medical doctors have authority to determine the treatment model and philosophy of care. Nursing staff, in particular, want more interdisciplinary representation at the executive level. For example, certified nursing assistants are not a part of the IDT for the patient and their input is often excluded from patient care meetings.

It was noted that cultural and linguistic differences between frontline and administrative staff underscore power dynamics and create institutional barriers to involving staff, such as certified nursing assistants, in key decision-making processes.

Staffing Issues

Staffing levels, staff management, roles, and training were important themes that emerged in the study. Although with current changes in administration, these issues are in flux. However, challenges in these areas impact the quality of care at LHH.

1. *Confusion over Adequate and Appropriate Staffing Levels*

There was a general lack of consensus about the adequacy of the staff in all of these areas: staff to handle high-level patients with dual diagnosis and behavioral issues; the appropriate level of administrative staff; enough staff to insure patient and staff safety; adequate staff to provide timely medication; psychiatrist and psychologist availability for evaluation,

psychopharmacological consultation, and psychotherapy; and adequate substance abuse staff to meet increased needs as LHH accepts more DPH patients with complex treatment needs.

2. *Confusion over Staff Roles and Responsibilities*

Staff across all disciplines and management levels expressed concern that one of the primary roles of frontline psychiatric nursing staff is to de-escalate conflict with high-level patients with behavioral challenges. Although de-escalation and behavioral management of "difficult" patients is a primary responsibility of the frontline nursing staff, these staff members have the least amount of training and experience in this area. As a result, many participants in the study reported that patient care suffers because certified nursing assistants fail to de-escalate patients appropriately due to their relative lack of expertise and training.

The interviews also revealed a lack of agreement among psychologists, administrative staff and frontline nursing staff on the appropriate involvement of psychiatrists and psychologists in helping to de-escalate "difficult" patients on the frontline. Psychology and psychiatry staff tended to view their role as primarily consultative and not responsible for helping nursing staff to de-escalate patients with behavioral challenges on the frontline. Frontline and middle management staff felt that because psychiatry and psychology staff have more experience and training in behavioral management and de-escalation they ought to provide more "on the ground" help to nursing staff in order manage the treatment milieu more effectively.

3. *Staff Training Needs: Behavioral Management, Integrated Service Model Education, and Cultural Competency*

   a. *Behavioral management training*

      Despite the high rates of mental health and/or substance abuse issues among LHH residents, participants from the interviews (particularly those in the middle management level) described a lack of training and skills among much of LHH staff to productively deal with behavioral challenges associated with these complex health care needs. There was significant agreement across all disciplines and management levels

about the need for the nursing staff to receive more training in behavioral management and de-escalation. Currently, LHH utilizes SMART Training as the vehicle to teach frontline staff how to de-escalate conflict and manage behaviorally challenged patients.

b. *Integrated services model education*

Some middle management in psychology, nursing, and social work also expressed a need for more training and education in the integrated service model. Some management reported that because frontline staff are under-resourced and receive little support and training in behavioral de-escalation, they are left feeling burned out and become apathetic about patient needs and care. Thus, it is easier for frontline staff to support patients rather than teach and encourage them to use independent living skills. This dynamic facilitates a culture of helplessness – a collective sentiment that makes patients dependent on providers, thereby diminishing patient potential for community transition.

i. *Example.* Patients need to be encouraged by nursing staff to get up and walk three times daily. Due to time constraints, patient resistance, or apathy, nursing staff is often unwilling or unable to follow through with patient care recommendations. This leads to a feeling among middle management that their patient care protocols were being undermined by the nursing staff. In the worst cases, there was a negative impact on the patient's health and discharge disposition.

ii. *Example.* Patients receive little formal training in the activities of daily living (ADLs) and ADLs therefore become the *informal* responsibility of certified nursing assistants for patients with mental health and/or substance abuse issues. Due to time constraints, nursing staff are unable to take the time to train patients; rather, they perform the ADLs for patients. Subsequently, patients with MH/SA issues may not become skilled at ADLs that are important for independent living outside LHH, a contradiction to the promotion of discharge.

c. *Cultural competency*

It was noted that current staff demographics do not reflect the cultural diversity of the patient population. Specifically, there is a need for more bi-cultural and bilingual staff to serve the monolingual Chinese and Spanish speaking populations. As a result, many middle management staff reported that more cultural competency training is essential for staff to work effectively with patients from other cultures and socio-economic backgrounds. Staff diversity training was also deemed important to help staff work more effectively in interdisciplinary and multicultural teams.

Structure/Infrastructure

LHH's structure and infrastructure challenges are another prominent theme that emerged from the interviews. The mixing of differently diagnosed patients in open wards and the lack of updated technology diminishes LHH's ability to provide the most efficient, safe, and high quality services possible.

1. *Patient Mix Issues*

There was an expressed concern over patient and staff safety due to the mixing of high-level substance abuse and mental health patients with older lower-level patients in open units. LHH is experiencing a gradual change in patient population as the hospital takes on more "difficult" patients with complex substance abuse and mental health needs from DPH referrals. Previously, LHH treated lower-level patients without serious and complex behavioral health needs, making the higher-level of care necessary for the changing patient population a challenge for the hospital's system of care.

Some staff external to LHH reported that LHH's inability to separate patients based on the severity of diagnosis and symptoms is problematic. Top administrators note that it is difficult for the hospital to support both patient populations safely in open units. These units do not have rooms with locked doors, making it difficult for staff to structurally isolate and separate patients in crisis.

Additional LHH staff concerns which were mentioned during the interview process are: inaccurate assessments of SFGH referrals which underestimate the degree of potential patients' mental health and/or substance abuse issues; staff feeling intimidated and fearful of patients due to the open ward setting; and the need for more security personnel to intervene with physical violence.

Staff in general was optimistic that the design of the new LHH facility will help mitigate many of these concerns.

2. *Outdated Technology and the Lack of Information Support Systems Hinder Efficient Patient Care*

a. *Information Support*

Administrative and managerial staff identified inadequate information support systems (including the lack of electronic charts) as preventing LHH from implementing a more streamlined continuum of care. Staff is well aware of the multiple and overlapping databases in use at LHH and the attendant problems.

b. *Medical Technology*

There was a clear expressed interest in the need for more updated medical technology, including automated medication distribution technology.

Discharge Complexities

Discharge at LHH is a complicated process, with numerous barriers to what would be considered "adequate, timely discharge." Challenges in these areas significantly impact the discharge of patients from LHH to a lower level of care within the community.

1. Complex LHH Identity

The most prominent barrier to discharge that emerged from the interviews is described as a "complex LHH identity," and refers to the substantial differences that existed among LHH hospital staff as to what were LHH's primary roles, functions, and goals (or identity) within San Francisco's Department of Public Health (DPH). It became apparent that LHH did not have a clear identity and staff perceptions of it varied significantly.

This identity issue is considered the greatest barrier to adequate and timely discharge because it pervaded many aspects of patient care at multiple levels, from administration to bedside, often in the following way: individual staff member's understandings of the LHH identity often set the precedent for their own expectation of LHH services, and subsequently, for their expectations of their own duties and responsibilities. Since LHH did not have a clear identity within the DPH system, staff was often left to determine this identity on their own. This enabled the potential for uncertainty among staff and consequently led to a lack of consistency in the strategy and standard for patient care. For example, various staff members stated their perception of LHH as more rehabilitative, and not psychiatric. Interestingly, this perspective was espoused most willingly by psychiatry/psychology staff. While this perception of LHH as a rehabilitative facility and not a psychiatric facility is formally correct, the confusion over the LHH role in terms of treating psychiatric and substance abuse problems is a serious concern.

The lack of prioritization of MH/SA as a health care issue (despite the fact that 46% of patients have significant behavioral health issues) is evident in the Laguna Honda Resident Guide, where only one brief paragraph of the 46 page document mentions psycho-social care, as follows: "Upon admission, your social worker will assess your psychosocial needs and coordinate with

the Care Team to create individual care plans based on your specific needs and preferences. Your psychosocial needs are continually evaluated for changes in physical and mental health."

While the LHH website and Resident's Guide espoused LHH's pivotal role in San Francisco's safety net, as a health care facility geared toward Medi-Cal qualified patients with complex health care needs, several interview respondents described that many staff resisted this role, particularly those with patient gate keeping responsibilities. Again, this may be due to the lack of a centralized, strong perception of LHH's identity within the DPH system. This lack of consensus contributed to patient mix issues (described below) and alleged patient gate keeping.

2. *Relationship with TCM*

LHH is perceived by the respondents as having complex and poor relationships with the outside organizations with whom they interact. Those external organizations mentioned were TCM, San Francisco General Hospital, and a few scattered community-based organizations and housing resources. Since this section is about discharge, the focus will be on the relationship between LHH and TCM.

The relationship between LHH and TCM was described as contentious with a lack of communication between the two organizations. It was reported that TCM does not participate in patient IDT meetings and does not document patient notes in LHH patient charts. Consequently, TCM is sometimes perceived as having a poor working understanding of patients' complex health care needs, creating discharge plans that do not correspond to the patient's mental health or substance abuse needs, and placing patients in inadequate housing which can lead to patient harm and/or patient recidivism. There were similar negative perceptions of LHH staff by respondents from other agencies. At the time of issuance of this report, LHH does report substantial progress in this area and that they have moved far forward from this perception.

3. Bureaucracy with Government Organizations

There is a lack of coordination described between the Medicare/Medi-Cal bureaucracy (particularly Medi-Cal) and LHH related to the discharge process. This lack of coordination causes delays in the discharge of individual patients.

Discharge delays with specific examples related to Medi-Cal included: a three to six month wait to get a power wheelchair for a patient; the requirement of a fixed address before equipment will be sent; the wait for outpatient services until a patient moves from Medi-Cal pending to Medi-Cal funded.

4. Patient Resistance

The promotion of discharge has been described as frequently confounded by patient resistance. Cases of patient resistance to discharge have been described in situations where patients lack family/community support, and/or when patients desire a better housing option than the one available. In such cases, patients may prefer to live at LHH rather than in the community. Due to the monitoring LHH has been under the last few years, one participant described the situation as a "patient's market" – LHH is less likely to force patient discharge unless the discharge is actively desired. Therefore, a patient can use sequential housing placement refusals to continue living at LHH for an indefinite time frame. One interview participant who worked with patients regularly said that over 70 patients who are presently practicing resistance could probably be discharged to a lower level of care. Staff has expressed concern that unless a good, fair, structured method for discharge is developed and implemented, this discharge resistance is likely to worsen once the new LHH facility is opened.

Facilitators of Discharge

The analysis on the complexities of discharge purposely focused on barriers to discharge in an effort to identify those things which can improve the discharge process. However, several items were identified as making a significant positive contribution to the discharge process. These items are identified below to acknowledge significant and positive efforts that has already been done in this area and to provide vehicle or point of departure for other improvements that might be made.

One significant facilitator of discharge was the introduction of TCM in 2004 following the Davis, et. al. (2000) lawsuit. This was considered a major facilitator to discharge, primarily because TCM social workers can focus on discharge given their lower caseloads. LHH also provides an array of services for patients falling within the Davis lawsuit which also act as positive facilitators. These services include: individual psychotherapy, open-ended psychotherapy groups, focused topic groups, cognitive remediation groups, anger management groups, smoking cessation groups, addiction groups, volunteer visits, spiritual leader visits, and others.

c) Analysis: Behavioral Health Study Group and LHH patients

DYJ performed a comparative analysis of the Behavioral Health Study Group and the Comparison Group in order to identify differences between the two patient populations. In this case, the comparison group is comprised of all remaining LHH patients not selected into the Behavioral Health Study Group. DYJ procured various demographic and treatment data for each patient in each group from LHH's Invision database. The Social Security Death Index was also utilized to determine the current living status and date of death, if applicable, for each patient.

Behavioral Health Study Group Patient Analysis

The tables below illustrate the results of the Behavioral Health Study Group and Comparison Group Patient Analysis. The total number of unduplicated patients at LHH for the period -

January 2006 through December 2008 - was 2,338. Of this group, 1,075 fell into the study group population (45.6%). The remaining 1,263 (54.4%) patients were placed into a comparison group. Of the 1,075 Behavioral Health Study Group patients, 48.0% received a PASRR II referral, 32.4% received a SATS referral, and 88.6% received a relevant ICD-9 diagnostic code. 28.5% of patients received a PASRR II referral only (no SATS referral or relevant ICD-9 code), 12.8% received a SATS referral only (no PASRR referral or relevant ICD-9 code), and 39.2% received a relevant ICD-9 code only (no PASRR or SATS referral).

The largest proportion of Behavioral Health Study Group patients received an ICD-9 code for a depressive disorder (36.8%), followed by nondependent use of drugs (33.8%), alcohol dependence syndrome (14.5%), schizophrenic disorder (13.3%), affective psychosis (10.5%), and neurotic disorder (8.7%).

Behavioral Health Study Group and Comparison Group Analysis

1. Demographics

There are marked differences in the demographic makeup of the two patient classes. The majority of Behavioral Health Study Group patients are primarily male (64.5 %) while Comparison Group patients are split almost evenly between male and female (48.2% and 48.9%, respectively). For ethnicity, most of the Behavioral Health Study Group patients are white (44.0 %), followed by African American (29.4%); on the other hand, most Comparison Group patients are Asian (30.3%), followed by white (29.9%). Behavioral Health Study Group patients are younger, with an average age of 61 years, while Comparison Group patients have an average age of 74 years. Age was calculated by subtracting date of birth either from date of death (if the patient had expired) or from April 1, 2009 (if the patient was still alive at the time or living status was unknown).

Table 1a. Demographics: Gender

Gender	Study Group		Comparison Group	
	N	%	N	%
Female	379	35.3%	617	48.9%
Male	693	64.5%	609	48.2%
Unknown	3	0.3%	37	2.9%
Total	1,075	100%	1,263	100%

Table 1b. Demographics: Race/Ethnicity

Race/Ethnicity	Study Group		Comparison Group	
	N	%	N	%
Asian	140	13.0%	383	30.3%
Black	316	29.4%	258	20.4%
Hispanic	110	10.2%	175	13.9%
Native Am./Eskimo	6	0.6%	7	0.6%
Native Am./Pacific Islander	2	0.2%	0	0%
White	473	44.0%	378	29.9%
Other	8	0.7%	9	0.7%
Unknown	20	1.9%	53	4.2%
Total	1,075	100%	1,263	100%

Table 1c. Demographics: Age (years)

Age (Until April 2009 or at date of death)	Study Group		Comparison Group	
	N	Mean	N	Mean
	1,075	61.1 years	1,263	73.8 years

2. Length of Stay, Survival Rates and Discharge Location

Behavioral Health Study Group patients have a considerably shorter average length of stay in LHH (533 days) than Comparison Group patients (837 days). For their most recent admission into LHH (as of May 2009), 77.4% of Behavioral Health Study Group patients have been discharged, compared to 69.9% of Comparison Group patients.

There is also a disparity in the survival rates between the two classes. Of the 1,075 Behavioral Health Study Group patients, 737 (68.6%) were still alive in April 2009 while 338 patients (31.4%) had expired. Of the 1,263 Comparison Group patients, 650 (51.5%) were still alive in April 2009 while 571 (45.2%) had expired. Of course, age factored into this death rate as the comparison group was substantially older. An additional 42 (3.3%) discharged patients' survival rates are unknown because they did not have social security numbers from which this information was obtained and are no longer residing in the hospital. Two hundred and thirty Behavioral Health Study Group patients (21.4%) expired while residing at LHH as compared to 463 Comparison Group patients (36.7%).

Mirroring the difference in the average age of patients between the two classes, the average age at death for deceased Behavioral Health Study Group patients is 64 years while the average age at death for deceased Comparison Group patients is 78 years. For those patients who had been discharged from LHH and did not expire while residing at the hospital, the most prominent discharge location for both classes is to the patients' homes. For the Behavioral Health Study Group patients, 32% were discharged to their homes while 18.4% of the Comparison Group patients were discharged to the setting. No other discharge location accounts for more than 10% in either class.

Table 2a. Length of Hospital Stay (Days)

	Study Group		Comparison Group	
	N	Mean	N	Mean
Most Recent Admission	1,075	532.93 days	1,263	836.95 days
Total Time in Residence	1,075	819.63 days	1,263	1,279.42 days

Table 2b. Living Status

(Data as of April 2009)	Study Group		Comparison Group	
	N	%	N	%
Alive	737	68.6%	650	51.5%
Deceased	338	31.4%	571	45.2%
Unknown	0	0%	42	3.3%
Total	1,075	100%	1,263	100%

Table 2c. Age at death

Age (Years)	Study Group		Comparison Group	
	N	Mean	N	Mean
	338	64.14 years	571	77.80 years

Table 2d. Discharge Location

(Data as of May 2009)	Study Group		Comparison Group	
	N	%	N	%
Acute Care	69	6.4%	59	4.7%
Left Against Medical Advice	58	5.4%	13	1.0%
Board and Care	47	4.4%	25	2.0%
Coroner's Case	0	0%	1	0.1%
Died at LHH	230	21.4%	464	36.7%
Forensics Facility	2	0.2%	0	0%
Home	344	32.0%	233	18.4%
Long-term Care	1	0.1%	0	0%
Psychiatric Facility	1	0.1%	0	0%
SNF	3	0.3%	3	0.2%
Still at LHH	243	22.6%	379	30.0%
Transferred/Discharged to Another Facility or Specialty Hospital	10	0.9%	26	2.1%
Transferred/Discharged to Another Institution or Specialty	46	4.3%	46	3.6%
Other Facility	16	1.5%	13	1.0%
Other Care	2	0.2%	0	0%
Unknown	3	0.3%	1	0.1%
Total	1,075	100%	1,263	100%

d) Random Sample Case Study and Chart Reviews

DYJ found the chart extraction method, while straightforward, to be difficult to execute in practice. All patient charts at LHH are in paper and hard copy formats only and a patient will typically have multiple files in semi-chronological order. A single patient with a long inpatient history can have dozens of charts. On occasion, important sections of patients' files were missing. For example, one patient was missing a 2008 Annual Patient Medical Review and SATS

assessment. In other instances, substance abuse treatment was not documented in charts. For example, one patient was referred for one-on-one SATS treatment, but no documentation of this treatment existed in the patient's charts. The results of the chart reviews are therefore limited by the nature of the documentation system.

Using the chart extraction process described in the methods section, 75 cases were extracted randomly from the 1,075 Behavioral Health Study Group. Due to the difficulty of the process, only 50 cases were completed and included in the analysis. Furthermore, due to the fact that a majority of the 75 selected patients had been discharged, we decided to analyze all of the sampled cases still residing at LHH in order to draw a contrast to those already discharged. This selection process resulted in 28 cases discharged and 22 still in residence at LHH. Following the chart extraction process, DYJ analyzed the demographic, diagnostic and treatment data for these patients. Most demographic data was collected from LHH's Invision database and obtained while building the Behavioral Health Study Group of patients. Data was analyzed on a patient level and on a treatment level. The patient level analysis consists of information specific to an individual patient (see Table 2). The treatment level analysis (in Table 3) consists of information specific to an individual form of treatment across patients; a single patient may have received multiple forms of treatment.

Patient Level Analysis

The sample population consisted of 50 patients, 28 (56.0%) of whom had been discharged and 22 (44.0%) of whom were still residing at LHH at the time of review (May 2009). The majority (58.0%) of these patients are male. The prevalent ethnicity is African American (46.0%), followed by White (28.0%). The average age of the sample population is 61 years. Age was calculated by subtracting date of birth either from date of death (if the patient had expired) or from April 1, 2009 (if the patient was still alive at the time of review). When comparing demographics between discharged and in-house patients the percentages changed moderately. The majority of discharged and in-house patients remains male (53.6% and 63.6%, respectively), as well as African American (57.1% and 31.8%, respectively) and White (25.0%

and 31.8%, respectively). There is a moderate difference in average age, 58 years for discharged patients and 65 years for in-house patients.

Table 3a. Demographics: Gender, by Discharge Status

Gender	Discharged		In-House		Total	
	N	%	N	%	N	%
Female	13	46.4%	8	36.4%	21	42.0%
Male	15	53.6%	14	63.6%	29	58.0%
Total	28	100%	22	100%	50	100%

Table 3b. Demographics: Race/Ethnicity, by Discharge Status

Race/Ethnicity	Discharged		In-House		Total	
	N	%	N	%	N	%
Asian	0	0%	4	18.2%	4	8.0%
Black	16	57.1%	7	31.8%	23	46.0%
Hispanic	3	10.7%	3	13.6%	6	12.0%
Native Am./Eskimo	1	3.6%	0	0%	1	2.0%
White	7	25.0%	7	31.8%	14	28.0%
Other	1	3.6%	0	0%	1	2.0%
Unknown	0	0%	1	4.5%	1	2.0%
Total	28	100.0%	22	100.0%	50	100.0%

Table 3c. Demographics: Age (years)

Age (Until April 2009 or at date of death)	Discharged		In-House		Total	
	N	Mean	N	Mean	N	Mean
	28	58.14 years	22	64.85 years	50	61.09 years

Table 3d. Discharge Location (Discharged Patients only)

Location	Discharged	
	N	%
AWOL	3	10.7%
Convalescent	1	3.6%
Deceased	2	7.1%
Home	10	35.7%
Hospital/Acute Care	6	21.4%
Hotel	5	17.9%
SRO	1	3.6%
Total	28	100.0%

Table 3e. Length of Hospital Stay (Days)

	Discharged		In-House		Total	
	N	Mean	N	Mean	N	Mean
Most Recent Admission	28	142.43 days	22	1,810.68 days	50	876.46 days

Table 3f. Mental Health/Substance Abuse Needs

Needs	Discharged		In-House		Total	
	N	%	N	%	N	%
Mental Health	7	25.0%	11	50.0%	18	36.0%
Mental Health & Substance Abuse	12	42.9%	6	27.3%	18	36.0%
Substance Abuse	9	32.1%	5	22.7%	14	28.0%
Total	28	100.0%	22	100.0%	50	100.0%

In analyzing the time period of a patient's most recent admission into the hospital, the discharged patients have a considerably shorter average length of stay (142 days) than the in-house patients (1,810 days). The average length of stay for the entire random sample population is 876 days.

For the 28 patients who had been discharged at the time of review, the majority (35.7 %) were discharged to their homes, followed by 21.4 % transferred to another hospital or acute care, and 17.9 % who were discharged to a hotel. Two patients (7.1%) expired while residing in the hospital.

Using diagnoses found in patient charts, the random sample patients were categorized based on the type of behavioral health needs they possessed while residing at LHH. More patients had mental health needs than substance abuse needs. Thirty-six percent of patients had mental health needs only, 28% of patients had substance abuse needs only, and another 36% of patients had a combination mental health and substance abuse needs. These percentages shift slightly when comparing the discharged patients with the in-house patients. The highest proportion (42.9%) of discharged patients had a combination mental health and substance abuse needs while the highest proportion (50.0%) of in-house patients had mental health needs only.

Treatment Level Analysis

DYJ recorded 140 total mental health and/or substance abuse treatment recommendations within the six-month time frames for the 50 random sample patients. A large majority (85.0%) of the MH/SA treatment recommendations had documentation of a subsequent treatment within the six-month time frame. A small minority (2.9%) of the treatment recommendations were refused by the patients who received them and did not count toward the number of treatment recommendations that were not matched with subsequent documentation of treatment provision (12.1%). The percentage of treatment recommendations that were matched with treatment provision changes considerably by the type of recommendation,

though treatment was received more often than not. Medication recommendations were fulfilled 98.6 % of the time, group mental health recommendations were fulfilled 100 % of the time, individual mental health recommendations were fulfilled 75% of the time, group substance abuse recommendations were fulfilled 69.2% of the time, and individual substance abuse recommendations were fulfilled 60% of the time.

Table 4a. Treatment Recommendation Outcomes, by Type

Was Tx Received Following a Recommendation	Type of Treatment Recommendation											
	Medication		Mental Health - Groups		Mental Health - Individual		Substance Abuse - Groups		Substance Abuse - Individual		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Yes	72	98.6%	5	100%	12	75.0%	18	69.2%	12	60.0%	119	85.0%
No	1	1.4%	0	0%	4	25.0%	5	19.2%	7	35.0%	17	12.1%
Refused Tx	0	0%	0	0%	0	0%	3	11.5%	1	5.0%	4	2.9%
Total	73	100%	5	100%	16	100%	26	100%	20	100%	140	100%

Table 4b. Time Elapsed Until Treatment Received, by Type

	Type of Treatment Recommendation											
	Medication		Mental Health - Groups		Mental Health - Individual		Substance Abuse - Groups		Substance Abuse - Individual		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Same Day	70	97.2%	4	80.0%	4	33.3%	3	16.7%	4	33.3%	85	71.4%
1 day – 1 Week	0	0%	0	0%	3	25.0%	6	33.3%	0	0%	9	7.6%
1 – 2 Weeks	2	2.8%	1	20.0%	1	8.3%	1	5.6%	3	25.0%	8	6.7%
2 Weeks – 1 Month	0	0%	0	0%	2	16.7%	5	27.8%	5	41.7%	12	10.1%
1 Month – 100 Days	0	0%	0	0%	2	16.7%	2	11.1%	0	0%	4	3.4%
100 Days+	0	0%	0	0%	0	0%	1	5.6%	0	0%	1	0.8%
Total	72	100%	5	100%	12	100%	18	100%	12	100%	119	100%

Table 4c. Time Elapsed Until Treatment Received, by Mean Days and Type

Mean Time Elapsed Until Treatment Received (Days)	Type of Treatment Recommendation					
	Medication	Mental Health - Groups	Mental Health - Individual	Substance Abuse - Groups	Substance Abuse - Individual	Total
	.26 days	2.60 days	12.75 days	20.56 days	10.08 days	5.68 days

Table 4d. Patients with Major Mental Health Issues Seen by Psychiatrists

Location	Discharged
	N
Major MH Patients	12
Excluded	3
Seen by Psychiatrist	4
Not Seen by Psychiatrist	5

For those treatment recommendations that were matched with subsequent treatment provision, the amount of time elapsed between the date of recommendation and the first date of treatment service was calculated. The average amount of time that elapsed between treatment recommendation and treatment service was 5.7 days. This average changes considerably by type of recommendation. The average amount of time that elapsed between recommendation and service provision was 0.3 days for medication recommendations, 2.6 days for group mental health recommendations, 12.8 days for individual mental health recommendations, 20.6 days for group substance abuse recommendations, and 10.1 days for individual substance abuse recommendations.

A frequency distribution of the time elapsed between treatment recommendation and reception shows that the majority (71.4%) of recommended treatment was received the same day. By type of recommendation, the highest proportion of recommended treatment was received the same day for medication recommendations (97.2%), group mental health recommendations (80.0%), and individual mental health recommendations (33.3%).

The highest proportion of recommended treatment was received in one day to one week for group substance abuse recommendations (33.3%) and in two weeks to one month for individual substance abuse recommendations (41.7%).

DYJ sought to determine the mental health services provided to patients with severe mental health illnesses. Of the 50 random sample patients, 12 had received a severe mental health diagnosis, such as paranoid schizophrenia or manic depression. DYJ examined these patients' charts within the relative six-month time frame for any documentation of psychiatric treatment. Of these 12 patients, 3 were excluded from analysis because they either were residents at LHH for less than 30 days or had been diagnosed with severe mental illness in the past but displayed no documented mental illness symptoms during their residence at LHH. Of the 9 remaining patients, 5 (55.6%) had no documentation of any type of psychiatric evaluation or service in their charts. Of these five, however, they were being treated for their psychiatric conditions by their primary physicians. The remaining 4 patients (44.4%) had received treatment by a psychiatrist during the study period.

e) General Findings

This section includes a description of several additional findings that were identified in the process of this evaluation. Although these findings were not the main focus of our evaluation, they are nevertheless very important in understanding and improving the care for behavioral health clients.

1. *IT System*

   DYJ worked with LHH IT staff in several different ways during this evaluation. It is DYJ's impression that the IT infrastructure and staffing at LHH is not adequate to support the work of the facility and the staff. This was also a finding in the staff interviews. Furthermore, the large number of individual special-purpose databases confirms staff's need to find other ways to fulfill the information needs that are not being met by the Invision Database.

2. *Medical Charting System*

   The medical charting and documentation system is extremely difficult to work with and is a major impediment to providing efficient and quality services. LHH is working toward an electronic charting system which will be implemented in several years. In the interim, it might be possible to make some improvements to the current system to better support the mission of LHH.

V. RECOMMENDATIONS

This section does not repeat or paraphrase findings contained in earlier sections of the report. The focus is on making suggestions to enhance current systems and processes and avoiding suggestions which would call for the creation of new systems or processes that would add to the workload of staff or the burden on patients.

a) DPH System Level Recommendation

DYJ recognizes that local neighborhood and community concerns have been raised regarding the role of LHH with mental health and substance abuse patients. However, it is critical that the appropriate balance be struck between neighborhood concerns and the necessity for LHH to respond to the needs of the entire city and DPH as a whole.

With this major concern in mind, DYJ recommends that the Directors of Community Programs, Community Behavioral Health Services and the Executive Administrator of Laguna Honda Hospital convene a systems-level administrative group to review and integrate behavioral health policies, services and facilitate coordination regarding the assessment, treatment and discharge of behavioral health clients of the Laguna Honda Hospital.

DYJ recommends the group be co-chaired by the Administrative Director of Laguna Honda Hospital and the Director of Community Behavioral Health Services to provide the leadership necessary to resolve the complex responsibility and authority issues among the key entities and that LHH behavioral health treatment and discharge needs become more fully integrated with the community behavioral health services. DYJ believes this top-down approach is the appropriate way to address the communications, coordination, treatment and referral problems documented in this evaluation.

Recent events have led to an unprecedented turnover in the top tier of administration at LHH in a brief span of time. This includes the appointment of Ms. Mivic Hirose, formerly Chief Nursing

Officer, to the role of the Executive Administrator of LHH. Ms. Hirose is the first woman and the first nurse to occupy this role. This and other administrative staff changes provide a unique opportunity to develop a new model of service delivery that could focus on a more integrated model of medical, mental health and substance abuse services.

DYJ is aware of the current work on the LHH Organizational Enhancement Project and recommends that the response to these recommendations be integrated into that project.

b) LHH Policy Level Recommendations

DYJ recommends that the Executive Administrator of LHH convenes a group to write the new behavioral health policies or make the policy changes necessary to implement the LHH role defined by the system level group. At a minimum, the group should include LHH top administrative staff and high level staff from other stakeholders, including CBHS and the Department of Aging and Adult Services, and relevant community advisory board members.

The major tasks for this group will be to:

► Review the LHH Mission statement for conformance with the results of the system level work.

► Develop a standardized treatment model for behavioral health patients in LHH. This treatment model will guide the development of the operational processes that will be needed to carry out the policies. At a minimum, the treatment model must address the following:

1. The role of each of the clinical disciplines in the treatment of the behavioral health clients at LHH. The most crucial aspect of this work is to recognize the uniqueness and importance of what each discipline has to bring to the successful development and implementation of a complete and more integrated treatment model.

2. The chain of responsibility and authority for implementation of the overall treatment model and each disciplinary component. Currently, behavioral health coordination and supervision

falls under the Medical Staff and the Department of Psychiatry. However, clinical supervision is disjointed and cumbersome. All behavioral health clinical and administrative responsibility needs to be under a single manager, regardless of the credential (MD, Ph.D., LCSW, CNS, etc.) of the manager or the behavioral health staff. This unified administration will provide substantially better coordinated services in an integrated service model.

3. The implementation of a meaningful participative management system. The delivery of quality multi-disciplinary integrated services requires that all staff be involved in the management of the service delivery system, including mental health and substance abuse assessment and treatment. This means that all the disciplines have equal input into service delivery decisions.

4. The development of a "culture change model." System and policy level decisions will implement changes to the treatment delivery culture of LHH. This will require an explicit plan to make the necessary changes, including the designation and training of staff who will lead this effort (the "change agents"), the identification of incentives for changing, systems for tracking the progress of change, training needs, etc.

5. The role of Quality Management in: 1) measuring fidelity to the model; 2) overseeing plans of correction to maintain and enhance fidelity; and 3) measuring the outcomes of the treatment produced by the model.

c) LHH Operational Level Recommendations

All of the operational level tasks should be completed based on the policy guidance provided by the treatment model developed in the system and policy-level groups. The following recommendations address major areas that need to be considered:

1. *Interdisciplinary Teams.* Based on the system and policy level decisions, it is necessary to decide whether the IDTs are the best way to implement the treatment model. Since they are already in place, DYJ would recommend retaining the IDTs and making the changes

necessary to enhance and ensure their effectiveness as some teams are operating well while others are not.

2. *Separate Behavioral Health Units.* Within licensing constraints, consideration needs to be given to establishing one or more separate behavioral health units. These units might be either permanent or temporary placements for selected groups of behavioral health clients or they might be for all behavioral health clients. A possible function for one such unit could be to focus on discharge readiness and enhancement of the independent living skills necessary for patients to have the desire and skills to overcome resistance to discharge and succeed in transition to independent living. DYJ believes the pros and cons of separate units should be fully discussed to arrive at the best decision.

3. *Staffing.* Operationalizing the treatment model will produce estimates for needed staffing levels for each of the disciplines. Making projected changes to current staffing levels for the various disciplines will need to be addressed by LHH leadership and human resources. Staffing considerations should also include provisions for respite for staff experiencing stress from interacting with clients with challenging behavioral problems. Policy decisions will have substantial bearing on the necessary behavioral staffing requirements. But, given these findings indicating the extensiveness of the numbers of patients with mental health and substance abuse needs, it is urgently recommended that additional behavioral health staffing resources be required for substance abuse treatment, in psychology and in psychiatry. In order to meet this recommendation given existing resources, it is recommended that a rebalancing of the staffing be implemented in a way that is cost-neutral. DYJ is recommending that higher salaried physicians be replaced by registered nursing staff, social workers and psychologists. Clearly, psychiatry staff also needs to be enhanced as well. At the very least, the Substance Abuse Treatment Services (SATS) needs to be reconstituted and expanded in order to meet the challenging needs of this population.

4. *Training.* DYJ believes a comprehensive behavioral health training program needs to be developed by expanding current training activities. The major contents of the training

program should be dictated by the treatment model. Additionally, the training should include both discipline-specific training and Interdisciplinary Team training that includes safety training (such as the current SMART training) and coping with the behavioral challenges of patients. It should also include specific plans about how training will be followed up with in-vivo reinforcement in the daily working environment. The latter is especially important for frontline staff. The training program should include a team development component which emphasizes high quality multidisciplinary service delivery. A DPH or external consultant with team building expertise may be useful for this component.

5. *Communication.* Better external (DPH, CBHS, Community Programs) and internal (LHH) communication systems need to be developed. Effective staff communication is critical to the interdisciplinary delivery of services, discharge planning and in placement. Communications systems need to be a regular part of operations and structured such that all staff participate on a daily basis. This recommendation could be achieved through the development of new system(s), but can also be accomplished by improvements to the medical charting system.

6. *Medical Charting System.* DYJ assumes that DPH will continue working toward an electronic charting and medical record-keeping system as soon as possible. This is a highly critical and urgent need in light of the poorly functioning existing documentation system. In the interim, DYJ suggests making some improvements to the current system to better support the mission of LHH. One of the main changes that should be considered for the interim system is a more thorough and organized way to document interdisciplinary behavioral health treatment. One possibility would be to have a separate behavioral health progress notes section. The improved LHH system might ideally include appropriate chart information from the TCM team. Finally, regardless of the current or improved chart system used, a regular on-going chart audit function must occur, followed by the development of corrective action plans for deficiencies and input into the training function.

7. *Coordination of Discharge and Billing.* A problem-solving group should be convened and a plan developed to correct the disconnect between LHH care delivery and discharge timelines and Medicare/Medi-Cal reimbursements. A very high priority would be to develop a strategy to timely discharge patients who are ready.

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APPENDICES

APPENDIX 1

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Interviewee List

APPENDIX 1: ACKNOWLEDGEMENTS

We would like to extend our deepest appreciation and gratitude to LHH and DPH/CBHS administrators and staff, as well as all interviewees, for their invaluable time, support, and cooperation throughout the duration of this project. Specifically, we wish to thank Tom Mesa of CBHS for his much needed guidance and creative ideas and Jean Mayeda for her assistance with CBHS case reviews. Dr. Bob Cabaj was particularly helpful in the development of the final draft. His coordination of input and feedback greatly facilitated the completion of the final report. We would also like to thank Trevor D'sa and Ms. Nancy Wong from Pat Skala's Office of Information Technology who provided us with much of the data necessary to conduct our analysis. Finally, special acknowledgements need to be made to Louise Lee and Margaret Abderrahmane from the LHH medical records department for their support during three weeks of intensive review of medical records. Ms. Adrianne Tong of the City Attorney's Office provided much guidance in understanding the structure and history of LHH.

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APPENDIX 2: LIST OF PROJECT DOCUMENTS REVIEWED

Name of Document	Type of Document
LHH PAS/PASARR Level I Screening Document	Forms
LHH Substance Abuse Treatment Services Resident Assessment Form	Forms
LHH Department of Psychiatry Flow Chart	Hospital Organization
LHH Substance Abuse Treatment Services - Clinical Services and Staff	Hospital Organization
LHH Leadership Team Flow Chart	Hospital Organization
LHH Clinical Psychiatry Department Caseloads	Hospital Organization
LHH PASARR Process Flow Chart	Hospital Organization
LHH Department of Psychiatry Schedule of Groups	Hospital Organization
Notes and Agenda - LHH Organizational Effectiveness/Culture RFP Meeting	Notes/Memos
Executive Summary - Complex Client Management and Placement Task Force	Official Documents
Settlement Agreement between the DOJ and SF regarding LHH	Official Documents
LHH 2007 RFQ - Project Area 4: Organizational Culture Analysis	Official Documents
LHH 2009-2010 Program Change Request	Official Documents
Conservatorship and Related Legal Issues: Task Force Recommendations	Publications
Complex Client Management and Placement	Publications
Laguna Honda Hospital: Past into Future	Publications
The Next Era for LHH: Psychiatric Services in the New Hospital	Publications
Our (LHH) History	Publications
Overview of MH Services for SF Memorandum	Notes/Memos
Noticed of Proposed Transfer/Discharge	Forms
LHH 2009 Educational Calendar	Publications
LHH Smart Training Power Point Slides	Hospital Organization
LHH 2008 Quarterly Nursing Education Calendar	Hospital Organization
LHH 2009 Dementia/Transition/SMART Update Calendar - As of 2/2/09	Hospital Organization

APPENDIX 3: KEY QUESTIONS FOR INTERVIEWS AT LHH EVALUATION/ASSESSMENT

Treatment system: The key concerns regarding the LHH treatment of patients with behavioral needs seems to be regarding not only their treatment but also the system that responds to their needs. An additional factor raised by the lawsuit is the critical issues germane to admission into LHH and discharges into the community. Admission at this time is difficult but still occurs with some regularity given the fact that LHH has a large mostly ill and aging population. Also there have been some initial concerns with the "class of patients" that fall under the lawsuit since many organic brain injured and dementia patients P(including Chambers) have behavioral health needs. However, after consultation with Barbara Garcia, the class of patients under Chambers at this time is primarily those with diagnosed DSM IV diagnosis.

Discharge Concerns: The court order requires LHH to reduce their population to 760 and their current population is at 830 or 840. Discharge for disruptive behavior seems to be problematic, the general perception is that LHH doesn't seem to be able to handle more disabled and behavioral disruptive patients at LHH and sends them to SFGH and doesn't ever want them back. Related to the discharge issue is that the lawsuit seems to be predicated on the fact that plaintiffs are trying to be discharged into the community with supportive living and integrated community care. Since LHH is very expensive compared to other facilities, there is a perception that LHH doesn't want to discharge them as their finances may be impacted. Some have indicated that they see this as another excuse to cut staffing further.

External Perceptions: Another perception is that they have high staff to patient ratios and CBHS doesn't seem to know how many behavioral health staff they have nor do they know what they do. CBHS seems to have one perception of LHH while LHH staff feel that they are not understood well. There are also some who believe that LHH staff will not necessarily tell us the truth honestly.

External vs. Internal: There are those working outside of the system such as the Department of Aging and Adult Services (DAAS), Department of Public Health (DPH) and Community Behavioral Health Services (CBHS) and then there are those working in LHH (DPH-LHH). We seem to get two perspectives, it would be best to get as many people on both sides who are honest and willing to really discuss the key concerns truthfully. There may be misperceptions on both parts as we go further into this assessment and we need to find the truth.

Interview Protocol: With this simple and rough background information so far, the following open ended questions are germane, the order is not important nor is how the information is presented, but get as much information as you can to respond to the following areas and please summarize your interviews to these basic areas:

1) **Roles and functions**: have the staff member describe their roles (get their cards, we need the documentation, and make sure you indicate that the interviews are confidential though they will be listed as one of the interviewees.

2) **Describe the Behavioral Health System at LHH:** How do people get admitted, how do they get assessed, treated? What is the process for discharge and referral

3) **Treatment focus**: What is their role in the treatment process and how does treatment work at LHH?

4) **Support:** What types of external support are there for patients with behavioral health issues?

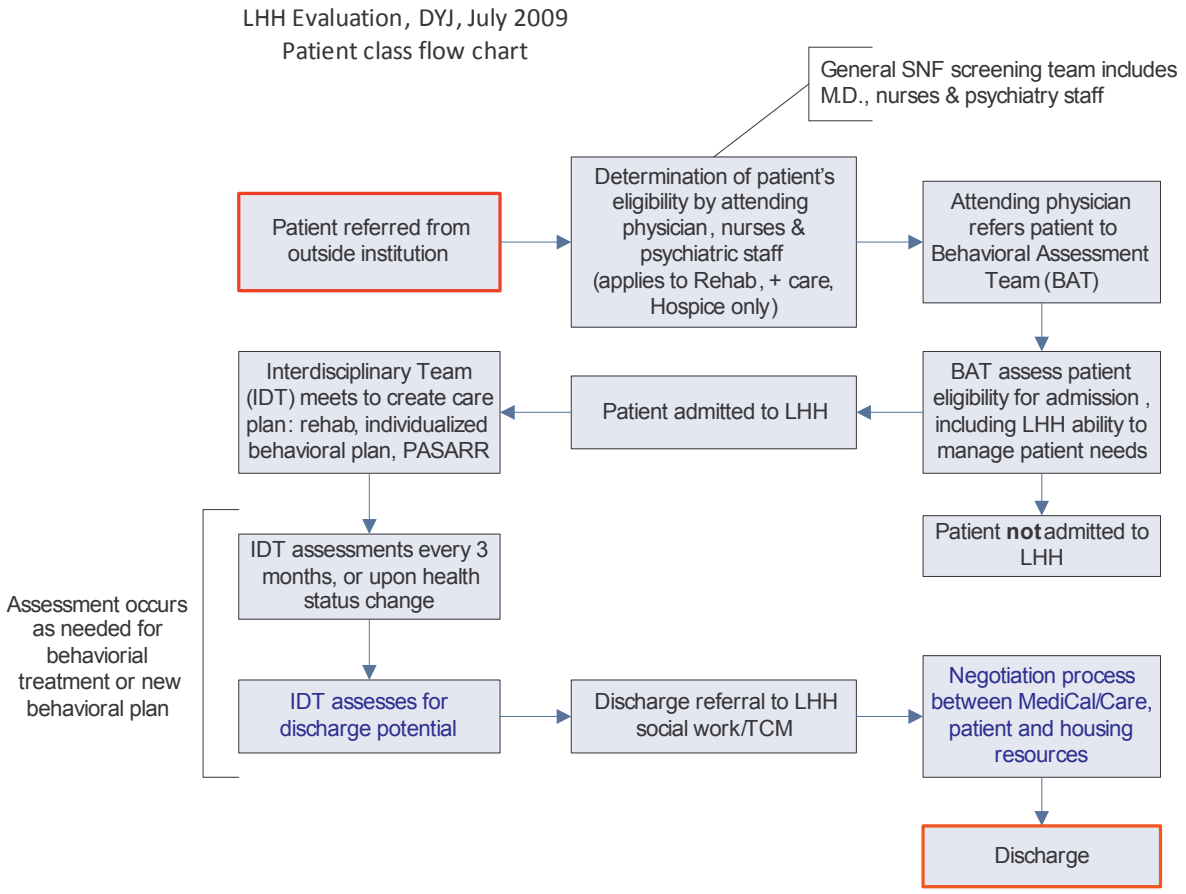
5) **Problems:** What do they do well in the behavioral health treatment of clients? What are some of the barriers to treating these patients?

6) **Chambers Lawsuit:** What do they know about the lawsuit and why do they think it occurred?

7) **Responsiveness:** How can the behavioral health system be more responsive to the needs of patients at LHH? How can LHH help patients transition to the community (at least those who are able)?

8) **Other interviews?** Is there anyone else you think it may be important for us to interview to better understand this process? Could we re-contact you if we have any additional questions?

APPENDIX 4: LHH BEHAVIORAL HEALTH PATIENT FLOW OPERATIONS



APPENDIX 5: GROUNDED THEORY METHODOLOGY

Grounded theory was the primary method used to analyze qualitative data, in the form of interview summaries and participant observation, gathered from Laguna Honda Hospital between October 2008 and February 2009 by Davis Ja and Associates, Inc. researchers. Developed at U.C. San Francisco over forty years ago, grounded theory is today among the most widely used and respected methods for qualitative data analysis. As the name suggests, it is an approach and method that is fundamentally based on the premise that researchers should develop theory *through rigorous analysis of empirical data*. As a methodology, it is *data driven* to reduce investigator bias and to produce empirically validated concepts. DYJ researchers working in the grounded theory analysis are fully trained in the guidelines of systematic data gathering, coding, synthesizing, categorizing and interrogating required by grounded theory analysis.

For this project, grounded theory was performed in the following fashion: all interview summaries and participant observation memos produced by five DYJ researchers involved in the Laguna Honda Hospital evaluation were transcribed into electronic text documents. Twenty-seven documents and hundreds of pages of data resulted. Each of these text documents was then imported into a standard data management program (M.S. Excel) to perform the grounded theory analysis. As researchers reviewed these documents, common or prevalent concepts from the texts were organized into a *standardized code list*. This list consists of over 100 codes. DJY researchers then performed a word-by-word, line-by-line content investigation of each document. When the text suggested a code from the standardized code list, it was logged. After the coding process, researchers grouped codes with similarities into *themes*. This was completed for all documents by two independent and blinded researchers trained in grounded theory.

These themes were then collectively reviewed by five DYJ researchers, and were part of the basis for the construction of the narratives and recommendations that resulted from this evaluation. Through this grounded theory approach, the narratives and recommendations therefore emerge from the data.

APPENDIX 6: STANDARDIZED CODES FROM GROUNDED THEORY ANALYSIS

Discharge:
- Discharge Process (adequate/inadequate)
- Patient discharge Readiness
- Community Discharge

Resources/Relationships:
- External Relationships (good/fair/poor)
- Levels of Outside Resources (good/fair/poor)
- External supports (good/fair/poor)
- Resource Management (good/fair/poor)
- Issues with DPH/SFGH/CBHS

Patient issues:
- Level of Patient Functioning (good/fair/poor)
- Complex patient needs/treatment
- Behavioral Challenges
- Patient Resistance
- Discharge Disposition (good/fair/poor)

Patient Care:
- Complex Philosophy of Care
- Informal Treatment
- Psychosocial values/medical model values
- Quality of Care (good/fair/poor)
- Preventative model of care
- Reactive model of care
- Continuum of Care (good/fair/poor)
- Patient over-institutionalization
- Patient dumping
- Patient recidivism (good/fair/poor)

LHH Staff:
- Stake holding
- Gate keeping
- Professional Dominance
- Victim Blaming
- Power Plays
- Finger Pointing
- Interdisciplinary Teamwork (good/fair/poor)
- Division of Labor
- Staff Training
- Medicine Heavy
- Apathy (good/fair/poor)
- Culture Issues
- Staff Issues (good/fair/poor)
- Staff competence (good/fair/poor)

Lawsuit:
- Illegitimate Law Suit Claims
- Scapegoat
- Complexity of Lawsuit

Structure/Infrastructure:
- LHH Infrastructure
- Funding/Timing Issues
- Bureaucracy Issues
- New Building
- Transition period
- Patient Mix (good/fair/poor)

Other:
- Gradual Improvement
- Recommendations for Report
- Working within Resources
- Complex LHH Identity

APPENDIX 7: STUDY GROUP PARTICIPANTS & ICD-9 BEHAVIORAL HEALTH DIAGNOSES

Table 5. Frequency of Study Group Participants, by Relevant ICD-9 Behavioral Health Diagnoses (not mutually exclusive)

ICD-9 Behavioral Health Diagnoses	Study Group Participants	
	N	%
Alcoholic Psychosis	41	3.8%
Drug Psychosis	2	0.2%
Schizophrenic Disorder	143	13.3%
Affective Psychosis	113	10.5%
Paranoid State	23	2.1%
Nonorganic Psychosis	37	3.4%
Neurotic Disorder	93	8.7%
Personality Disorder	44	4.1%
Sexual Deviation or Disorder	1	0.1%
Alcohol Dependence Syndrome	156	14.5%
Drug Dependence	64	6.0%
Nondependent Abuse of Drugs	363	33.8%
Adjustment Reaction	38	3.5%
Depressive Disorder	390	36.3%
Disturbance of Contact	26	2.4%
Disturbance of Emotions	1	0.1%
Total	1,075	100.0%

APPENDIX 8: INTERVIEW LIST

Name	Organization
Adrianne Tong	San Francisco City Attorney's Office
Anne Hinton	Department of Aging and Adult Services
Anne Hughes	LHH
Barbara Garcia	Community Programs
Bob Cabaj	Community Behavioral Health Services
Brenda Austin	LHH
Carol Baillie	LHH
Charles Stinson	LHH
Diane Guevara	LHH
Elayne Hada	Community Programs
Elisa Ramirez	LHH
Elissa Gershon	Disability Rights California
Elizabeth Gray	Community Programs
Elizabeth Zirker	Disability Rights California
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Gail Cobe	LHH
Hosea Thomas	LHH
Janet Gillen	LHH
Jill LeCount	LHH
Jim Zelaya-Wagner	LHH
Joanne Holland	RTZ Associates
John Coyne	LHH
John Kanaley	LHH
Kim Swain	Disability Rights California
Linda Edelstein	Department of Aging and Adult Services
Lisa Pascual	SFGH/UCSF
Lorraine Killpack	LHH
Luis Calderon	Targeted Case Management
Lupita Ramirez	LHH
Marc Slavin	LHH
Margaret Colfer	Targeted Case Management
Michael Coleman	LHH
Mivic Hirose	LHH
Pat Skala	LHH
Regina Gomez	LHH
Steven Thompson	LHH
Susan Edelsberg	LHH
Tim Skovrinski	LHH
Tom Lawlor	LHH
Tom Mesa	Community Behavioral Health Services
Vera Chow	LHH