1/24/05

To: Paul Isakson, M.D., LHH Medical Director
Timothy Skovrinski, M.D., Asst. Medical Director

From: Maria V. Rivero, M.D.
Attending Physician LHH Admissions Ward

Re: Gregg Sass Memo "Economic Impact of the SFGH – LHH patient flow policy change"

I want to alert you about methodological flaws in the attached memo from Gregg Sass to Dr Mitchell Katz of 12/16/04 titled as above, which was sent to Dr. Derek Kerr by an LHH patient family member who received it from Dr Katz in the course of a meeting.

1. The financial impact statement is based on the Web Based Referral Tracking System (WBRTS), which is unreliable and unsuitable for fiscal analyses
2. The conclusions are not reproducible or verifiable because there is too little information about the methodology in the fiscal calculations.

In Mr. Sass' memo, he gives figures for "number of patients pending transfer to LHH" based on "data recorded in the Web Based Referral Tracking System". Since the start of the Flow Project, the LHH physicians and psychologists involved in screening of admissions from SFGH have documented that the WBRTS is flawed, and greatly overstates the number of patients who are **actually** approved and ready for LHH transfer. See attached memos of 5/7/04 and 6/21/04 showing that only 4% to 20% of listed patients were actually ready for transfer. The reasons for the inaccuracy of the WBRTS are as follows:

1. SFGH Case Managers will enter patients into the WBRTS "before the patient is actually ready for the move to LHH" (Patient Flow Committee minutes 2/13/04) or even if discharge to a facility other than LHH or home is pending. As this has been explained to me, these patients are entered for 'tracking purposes only'. This practice is documented in the SFGH to LHH Patient Flow Project minutes of February 13, 2004 (attached).
2. It can take up to 72 hours or longer for patients to be removed from the WBRTS once the patient has been discharged, has died or is no longer at a lower level of care.
3. Patients already at a lower level of care who are on SFGH's 4A SNF appear on the WBRTS as LHH referrals, if the team on 4A believes they will need intermediate or long term care. It is unclear whether these patients, who are not eligible for acute care reimbursement were excluded from this analysis.
4. Even if the patient is at a lower level of care there may be barriers besides the lack of an LHH bed that prevents the patient from being admitted to LHH. These include:

a) The patient has no SNF needs
b) The patient refuses LHH placement
c) Medical Instability or pending diagnostic tests or procedures, with SFGH physician delay or cancellation of LHH transfer
d) Behavioral Instability that makes patient unmanageable at LHH
e) Patient needs restrictive physical restraints (prohibited at LHH)
f) Need for equipment or treatments that exceed LHH capabilities
g) Patients awaiting conservatorships or court orders for transfer

Many such patients were routinely listed as awaiting LHH placement on the WBRTS.

Prior to late February of 2004 when I first began attending the daily placement meetings at SFGH and even for some months after, the names of such ineligible patients would stay on the WBRTS for days or even weeks. This practice did not conform to SFGH Policy #12.2R, as we explained in our memo of 5/7/04 (attached). This gave the erroneous impression that there were large numbers of patients at SFGH waiting for LHH beds. This flaw was repeatedly brought to the attention of Anne Kronenberg and the Patient Flow Committee, and was gradually partially corrected.

I reviewed my own notes on the patients listed on the WBRTS lists that I receive daily at SFGH for selected days dating back to 2/27/04. This information (attached) was presented to the Patient Flow Committee. I have also compared my figures to the data as presented on the graph in the Sass memo. I cannot determine without further information how he arrived at the figures shown, but I can say that my estimates of the number of patients **actually** ready for transfer to LHH are significantly lower than the numbers Mr. Sass is presenting. My estimates are based on hand counts of my screening notes, having interviewed the patients, reviewed the medical records and spoken with SFGH personnel. Because this is first hand data, and not based on raw surrogate markers, it is more accurate.

In the first week of March of 2004 (the period that most closely reflects pre-flow practices), I observed that an average of 3 or fewer patients were ready at SFGH Acute Care and awaiting LHH transfer. This contrasts with Mr. Sass' figure of approximately 10. During the months of September to November of 2004, the number of patients waiting for LHH beds averaged 0. We were taking virtually every referral the day they appeared on the list or in some cases before they were even submitted. His figures show an average of 3 patients waiting. Therefore, by my data, there has been a change from 3 to 0 waiting. His calculations conclude that the waiting list was reduced from 13 to 3 patients. Mr. Sass' calculations are over 3 times higher than our observed numbers. Based on the **actual** number of patients and using Mr. Sass' billing data, the realized cost savings would be $510,000, not $1.7 million.

Therefore:

There are two factors that caused the decline of patients listed on the WBRTS following the Flow Project:

1. An increase in the number of transfers to LHH (the real savings).
2. A reduction in the number of ineligible referrals appearing on the WBRTS.

Since Mr. Sass did not account for the latter factor in his calculations, I believe his analysis significantly over-estimates the cost savings from the Flow Project.

Two other points bear mentioning:

1. Anne Kronenberg and others who attend the daily placement meetings for Med/Surg at SFGH have repeatedly assured us that they understood that the WBRTS was inaccurate, and we (Dr. Tim Skovrinski, Dr. Brenda Austin, and Dr. Maria Rivero) have been told that this data would not be used or portrayed by DPH administration as an accurate reflection of the LHH 'waiting list'

2. Dr. Katz has publicly quoted numbers of SFGH patients accepted and waiting for an LHH bed "at any one time" in January of 2004 as 20 (5/17/04 LHH Medical Staff Meeting) or 25 (6/7/04 Matier and Ross Interview SF Chronicle) or 30 (11/17/04 Mayor's Meeting at LHH) or 35 (6/24/04 City Services Committee Hearing on LHH). I am wondering how these statements can be reconciled with the data provided in Mr. Sass' memo. His figures show that the average number of patients waiting in January 2004 was 9, with the high point during the month being 16 and the lowest value being 7. These are from the WBRTS, which as I have demonstrated, over-states the true numbers.

I would greatly appreciate your review of this important information. Feel free to share this memo with Gregg Sass, Dr. Mitchell Katz or others as appropriate

Cc: Dr. Brenda Austin
Dr. Derek Kerr
John Kanaley, LHH CEO

City and County of San Francisco

Department of Public Health

Gavin Newsom,
Mayor

Gregg Sass,
Chief Financial Officer

MEMORANDUM

December 16, 2004

To: Mitch Katz

From: Gregg Sass

Subject: Economic impact of the SFGH – LHH patient flow policy change

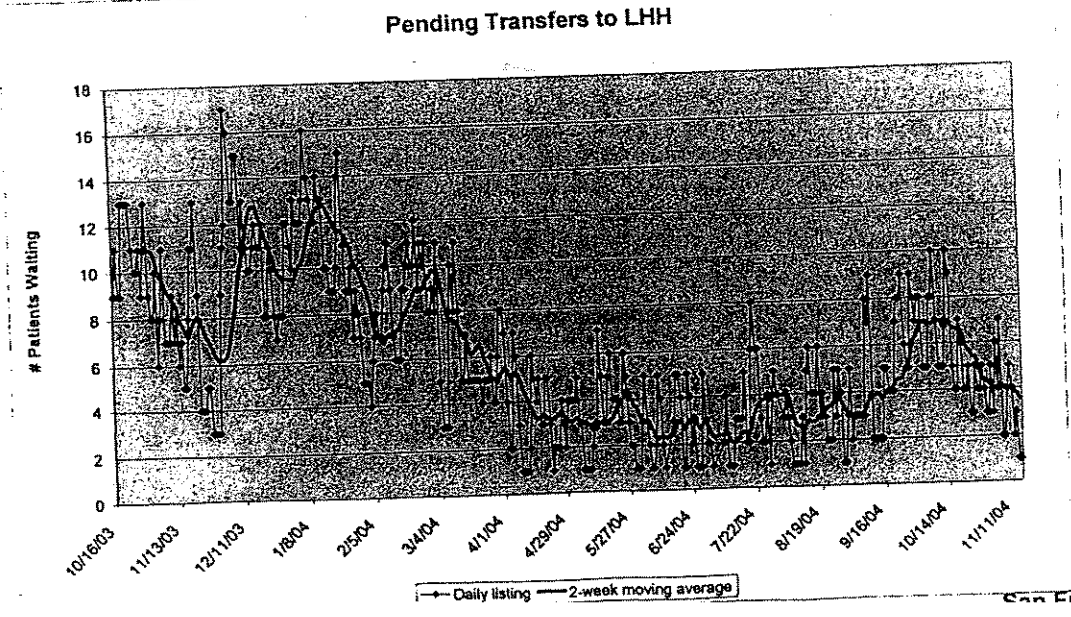
In response to your request, we have completed a review of changes in policy around transfers of patients from SFGH to LHH.

Background

Beginning in April of 2004, a Committee representing physician, nursing and administrative management from Laguna Honda Hospital, San Francisco General Hospital and the Health Department Central Office established a new process to evaluate patients at SFGH who were waiting for beds at LHH. The goal of the Committee was to reduce the backlog of patients waiting and expedite transfer to LHH.

Change in number of patients waiting for transfer to LHH

The following chart summarizes data recorded in the Web Based Referral Tracking System which tracks the number of patients at SFGH that were pending transfer to LHH during the period 10/15/03 to 11/15/04. The chart displays daily statistics and a 2-week moving average. It is clear from the chart that the number waiting for transfer has declined significantly, from a high point in December of 2003 where the average number reached 13, to recent months when as few as one or two were pending transfers. The decline appears to be stabilizing at a level that is approximately 10 patients below level in the previous year.



San Francisco, CA 94102

Financial impact

In order to evaluate the financial impact of this change in practice, we conducted a study of patients transferred to LHH during the three-month period from May 1 to July 31. 2004. Based on a review of billing and collection information for each of those patients, we determined that while many had a payor source, a large number of the patients were being paid at administrative or skilled nursing rates by the Medicare and Medi-Cal programs, and a significant number of patients did not have a payor source. The average reimbursement per day for this population was $720.52 at SFGH on the date immediately prior to transfer. In addition, patients who were covered by the Medi-Cal program and who were being paid at the acute per diem rate draw an additional $581 per day in Disproportionate Share payments. Including that additional revenue brings the total average per diem payment to $858.58.

Earlier transfer of patients to LHH frees up available beds for acute admissions. Based on a review of inpatient payments and patient days at SFGH during the fiscal year ended June 30, 2004, the average reimbursement per patient day, inclusive of Disproportionate Share payments was $1,330.

It is reasonable to assume that patients who occupy SFGH beds previously occupied by LHH transfers would draw the average payment of $1,330 per day. It is also reasonable to assume that the effect of a permanent decrease in the number of patients waiting for transfer creates a permanent increase in the number of available beds. Therefore the estimated financial impact of the change in policy is $1,720,680 computed as follows:

Average payment per day at SFGH	$1,330.00	
Average payment per day – LHH transfers	$ 858.58	
Net difference	$ 471.42	
Number of days per year	x 365	
Revenue per available bed	$ 172,068	
		$ 172,068
Revenue per available bed		x 10
Additional available beds		$ 1,720,680
Additional revenue per year		

This estimated benefit is most likely conservative, in that the LHH average payment is based on what was paid on the last day of service during a period of time that the patient flow policy was in effect, May to July 2004. As can be seen from the previous chart, the number of patients waiting for LHH beds had already been substantially reduced and the larger backlog of patients that were waiting in 2003, and who presumably included more de-certified patients had already been transferred. If the delay in transferring patients were lengthened, more patients would be decertified for acute level payment, and average daily revenue of patients waiting for LHH beds would likely be less that what is computed above.

Anne explained that she had toured both LHH and SFGH to understand the patient flow issues. She identified as a sub-goal that each facility's staff involved in this process tour the other facility if they had not done so already.

Alexander Hines asked for a definition regarding "timely transfers." Anne explained that Mitch Katz had asked that this process first focus on the easy transfers. She noted that timely transfers for the relatively straightforward cases should be 24 hours. Same-day transfers are the goal because we know that other comparable facilities can do this.

There was a discussion regarding the patients that get placed at SFGH's 4A unit. Some of these patients are better suited for LHH. The group suggested that the ideal would be a joint (LHH & SFGH) assessment before a patient gets placed from SFGH acute to 4A, so that the patient can move directly to LHH if that is the most appropriate course of action. There was also a discussion about transferring from SFGH's ED to LHH, but this was identified as a more complex issue for future discussion.

Anne asked that the group focus first and foremost on reducing the length of time and that with this done many of the problematic issues will be resolved.

Case Scenario discussion for a med/surg case:

* At SFGH, nursing staff, UR case managers, social workers and physicians decide which patients to refer for long-term care.
* SFGH UR case manager initiates a referral in the Referral Tracking System. This will often happen before the patient is actually ready for the move to LHH. The clock for the transfer process starts ticking at this time even though LHH is not able to really initiate the process on their end.
* When patient is ready for transfer, SFGH staff faxes appropriate information to LHH Admitting. (This part of the process is not yet electronic.) This fax contains the key clinical information that allows LHH to make a determination.
* At this point, LHH has a policy to respond to SFGH within 24 hours. In many cases, this response is a request for additional information.

It was suggested that LHH visit SFGH each day in person to get information about patients in person. The group agreed to pilot this for one month beginning on Wednesday, February 18. The med/surg patients are discussed by SFGH staff each morning at 8am, as are psych patients. SFGH will move one of these placement meetings to 8:30 am so that one LHH staff person can attend both meetings. Anne noted that she or her staff will attend these meetings as well. The staff representing LHH and SFGH need authority to make decisions about transfers.

Anne also asked if LHH had explored the concept of using sitters, which some patients from SFGH require. Neither SFGH nor LHH are budgeted for sitters. Tim Skovrinski said that they are discussing how this would work, but there is a difficulty with developing a sitter room in LHH's wards.

May 7, 2004

To: Anne Kronenberg and the Members of The Patient Flow Committee

From: LHH Medical Staff Subcommittee on Admissions

RE: Feedback for Patient Flow Committee Meeting of 5/11/04

Cc: Mitchell Katz, M.D., Director, San Francisco Department of Health
Edward A. Chow, M.D., President, San Francisco Health Commission

Pursuant to a directive from Dr Katz, we are presenting our feedback to the Patient Flow committee regarding several issues that need further consideration and discussion.

We see a misalignment between the expectations of the DPH regarding LHH's role in patient care, and our professional obligation to society as a whole and our individual patients. As medical staff members, we are bound to a code of ethics and a social contract that confer upon us stewardship for the safety and welfare of our patients. These mandates are above and beyond organizational needs and requirements.

"A physician shall respect the law and also recognize a responsibility to seek changes in legal requirements which are contrary to the best interests of the patient." Principles of Medical Ethics, AMA

"The primary obligation of the hospital medical staff is to safeguard the quality of care provided within the institution. The medical staff has the responsibility to perform essential functions on behalf of the hospital in accordance with licensing laws and accreditation requirements...In a situation where the economic interests of the hospital are in conflict with patient welfare, patient welfare takes priority." "Economic incentives and levels of care." AMA Professional Ethics

"Collective activities aimed at ultimately improving patient care may be warranted in some circumstances, even if they create inconvenience for the management." "Collective Action and patient advocacy." AMA Professional Ethics

We cannot participate in processes that violate our professional identity and obligations. Medical and legal experts from the California State Licensing and Certification and the Office of Civil Rights of the United States Department of Justice have repeatedly upheld this position.

It is being asserted that the genesis of our concerns is fear of change. We do not oppose change, progress or legitimate authority. However, we do oppose change without due process and in violation of established policies, procedures and bylaws.

We do oppose change that excludes the participation of those affected, and endangers patient safety.

The unauthorized change in our Admissions Policy and practice is the most egregious example of a recent change in violation of Hospitalwide Policies and Procedures, instituted over the objections and vote of both the medical staff and the Medical Executive Committee. Further examples are the attempts to override the admissions decisions of LHH screeners and the LHH Medical Director. These contravene the Medical Staff Bylaws and SFGH policy #12.2R, which states,

"Acceptance of a patient is contingent on the evaluation and approval of service chief at LHH."

Finally, we are dismayed at the number of referrals that continue to appear on the Referral Tracking Site Data list for patients that have been discharged, are ineligible, or have been denied admission to LHH. This practice does not conform to SFGH policy #12.2R that states

"the case manager will update the on-line referral with changes in patient's clinical condition as well as adverse decisions by LHH. CM will acknowledge LHH denials and will cancel referrals no longer appropriate for LHH."

Because of these irregularities, the Referral Tracking Site Data lists give a false impression that large numbers of patients are at SFGH awaiting LHH placement. In the reports that are currently generated, upwards of 79% of the referrals listed are ineligible to come to LHH or already discharged. Furthermore, we have long disputed the validity of data contained in the lower level of care reports generated by Psychiatry and Med/Surg. In the attached tables, we have summarized our analysis of the lower level of care reports from the SFGH Referral Tracking Site data for Med/Surg from the start of the Patient Flow Project, 2/27 to 3/3 and most recently, 4/30 to 5/5/04. Comparable time periods have also been analyzed for Psychiatry. On average, 4% of the patients that appear on this report are at acute care awaiting LHH beds and only approximately 3% of all acute psychiatric patients are even referred to LHH. To state that this 4% of Med/Surg patients and 3% of Psychiatry patients are "threatening our entire system" is so bewildering, that we appeal for an impartial review of available data at the earliest possible opportunity.

In his letter to the LHH Medical Staff dated April 14, 2004, Dr Katz draws a reductionistic connection between "ongoing reports that SFGH patients were spending inappropriate days in acute beds" and "fixing this problem by moving patients who are ready to transfer to LHH in a timely manner" and "...hemorrhaging millions of dollars by keeping patients who are ready to go to LHH at SFGH." Because no credible evidence has thus far been advanced to support these assertions, and because this is tantamount to scapegoating, we repudiate the attempt to link the fiscal crisis at SFGH solely to LHH.

June 21, 2004

To: Anne Kronenberg
Penney Mitchell, LCSW
Sharon Kwong, LCSW
Letty Lintag, RN

From: Maria Rivero, M.D.

Cc: Tim Skovrinski, M.D.
Paul Isakson, M.D.

RE: Referral Tracking Site Data

During the past week (6/14/04 to 6/18/04), the number of patients listed on the Referral Tracking Site Data forms who are NOT ready for Laguna Honda has been increasing. Of 51 patients listed total, 21 patients had a referral destination of LHH. Of those only 4 were actually ready for transfer to LHH. One patient was cancelled three times during that week, yet still appeared on the list. One third of the patients with an LHH destination were already discharged and another third were still acutely ill or in restraints and therefore not ready.

I remain concerned that Dr Katz and other DPH administrators may be misled by the information contained in these documents. If patients are being entered into the tracking system before they are ready in order to facilitate the referral process for discharge planners or as a means for LHH screeners to do early evaluations to hasten the transition to a lower level of care, those referrals should be clearly identified. Patients who are not ready for LHH on the basis of agreed upon criteria should not be included in tabulations of delays in SNF tranfer.

SFGH REFERRAL TRACKING SITE DATA FOR 3 DAYS BETWEEN 4/30/04 AND 5/5/04
(4/30, 5/3, 5/5)

METHODOLOGY: Data was coded and analyzed by M. Rivero, MD, who was present at each of the meeings and familiar with the patients

CATEGORY	TOTAL PATIENTS SCREENED %	TOTAL PATIENTS SCREENED NUMBER	LHH REFERRALS %	LHH REFERRALS NUMBER
Ineligible or Inappropriate for LHH				
Already Discharged	7.9%	14	17.3%	14
On 4A / Short Term	6.7%	12	14.8%	12
Refused LHH	6.7%	12	14.8%	12
Medically Acute	6.2%	11	13.6%	11
Behaviorally Unstable / In Restraints	5.1%	9	11.1%	9
Pending Discharge Home / Other Facility	1.1%	2	2.5%	2
Awaiting Conservatorship / Court Order	1.7%	3	3.7%	3
No SNF Need	2.8%	5	6.2%	5
Not Referred To LHH	54.5%	97	N/A	N/A
Subtotal (Ineligible LHH Referrals)	92.7%	165	84.0%	68
Eligible and Appropriate for LHH				
On 4A, Awaiting LHH	5.1%	9	11.1%	9
On Acute, Awaiting LHH	2.2%	4	4.9%	4
Subtotal (Eligible Referrals)	7.3%	13	16.0%	13
GRAND TOTAL*	100.0%	178	100.0%	81

SFGH REFERRAL TRACKING SITE DATA FOR 3 DAYS BETWEEN 2/27/04 AND 3/3/04
(2/27, 3/2, 3/3)

METHODOLOGY: Data was coded and analyzed by M. Rivero, MD, who was present at each of the meeings and familiar with the patients.

CATEGORY	TOTAL PATIENTS SCREENED %	TOTAL PATIENTS SCREENED NUMBER	LHH REFERRALS %	LHH REFERRALS NUMBER
Ineligible or Inappropriate for LHH				
Already Discharged	16.8%	32	23.2%	32
On 4A / Short Term	13.1%	25	18.1%	25
Refused LHH	10.5%	20	14.5%	20
Medically Acute	10.5%	20	14.5%	20
Behaviorally Unstable / In Restraints	1.6%	3	2.2%	3
Pending Discharge Home / Other Facility	9.4%	18	13.0%	18
Awaiting Conservatorship / Court Order	1.6%	3	2.2%	3
No SNF Need	0.0%	0	0.0%	0
Not Referred To LHH	27.7%	53	N/A	N/A
Subtotal (Ineligible LHH Referrals)	91.1%	174	87.7%	121
Eligible and Appropriate for LHH				
On 4A, Awaiting LHH	2.6%	5	3.6%	5
On Acute, Awaiting LHH	6.3%	12	8.7%	12
Subtotal (Eligible Referrals)	8.9%	17	12.3%	17
GRAND TOTAL*	100.0%	191	100.0%	138

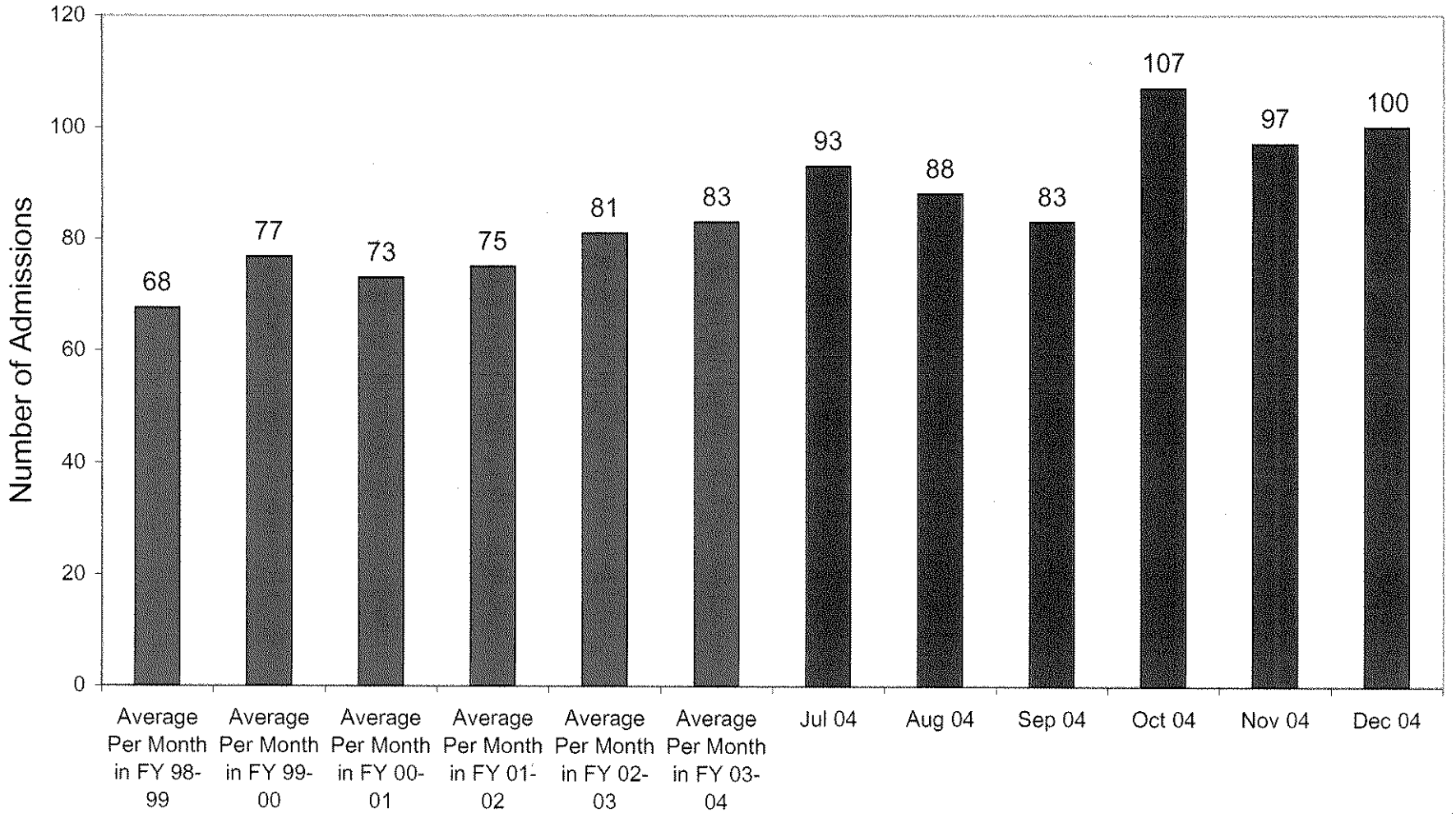
SFGH REFERRAL TRACKING SITE DATA FOR 6 DAYS BETWEEN 2/27/04 AND 4/30/04
(2/27, 3/4, 3/10, 3/29, 4/18, 4/30)

METHODOLOGY: Data was coded and analyzed by M. Rivero, MD, who was present at each of the meeings and familiar with the patients.

CATEGORY	TOTAL PATIENTS SCREENED %	TOTAL PATIENTS SCREENED NUMBER	LHH REFERRALS %	LHH REFERRALS NUMBER
Ineligible or Inappropriate for LHH				
Already Discharged	14.6%	53	20.6%	53
On 4A / Short Term	14.3%	52	20.2%	52
Refused LHH	9.4%	34	13.2%	34
Medically Acute	11.6%	42	16.0%	41
Behaviorally Unstable / In Restraints	4.7%	17	6.6%	17
Pending Discharge Home / Other Facility	4.4%	16	6.2%	16
Awaiting Conservatorship / Court Order	1.6%	6	2.3%	6
No SNF Need	1.9%	7	2.7%	7
Not Referred To LHH	29.0%	105	N/A	N/A
Subtotal (Ineligible LHH Referrals)	91.5%	331	87.8%	226
Eligible and Appropriate for LHH				
On 4A, Awaiting LHH	4.1%	15	5.8%	15
On Acute, Awaiting LHH	3.8%	14	5.4%	14
Subtotal (Eligible Referrals)	7.9%	29	11.2%	29
GRAND TOTAL*	99.4%	360	99.0%	254

* Totals less than 100% secondary to rounding error

Laguna Honda Hospital
Total Admissions Per Month in FY 04-05 Versus
Average Per Month in FY 98-99, FY 99-00, FY 00-01, FY 01-02, FY 02-03, and FY 03-04



LAGUNA HONDA HOSPITAL

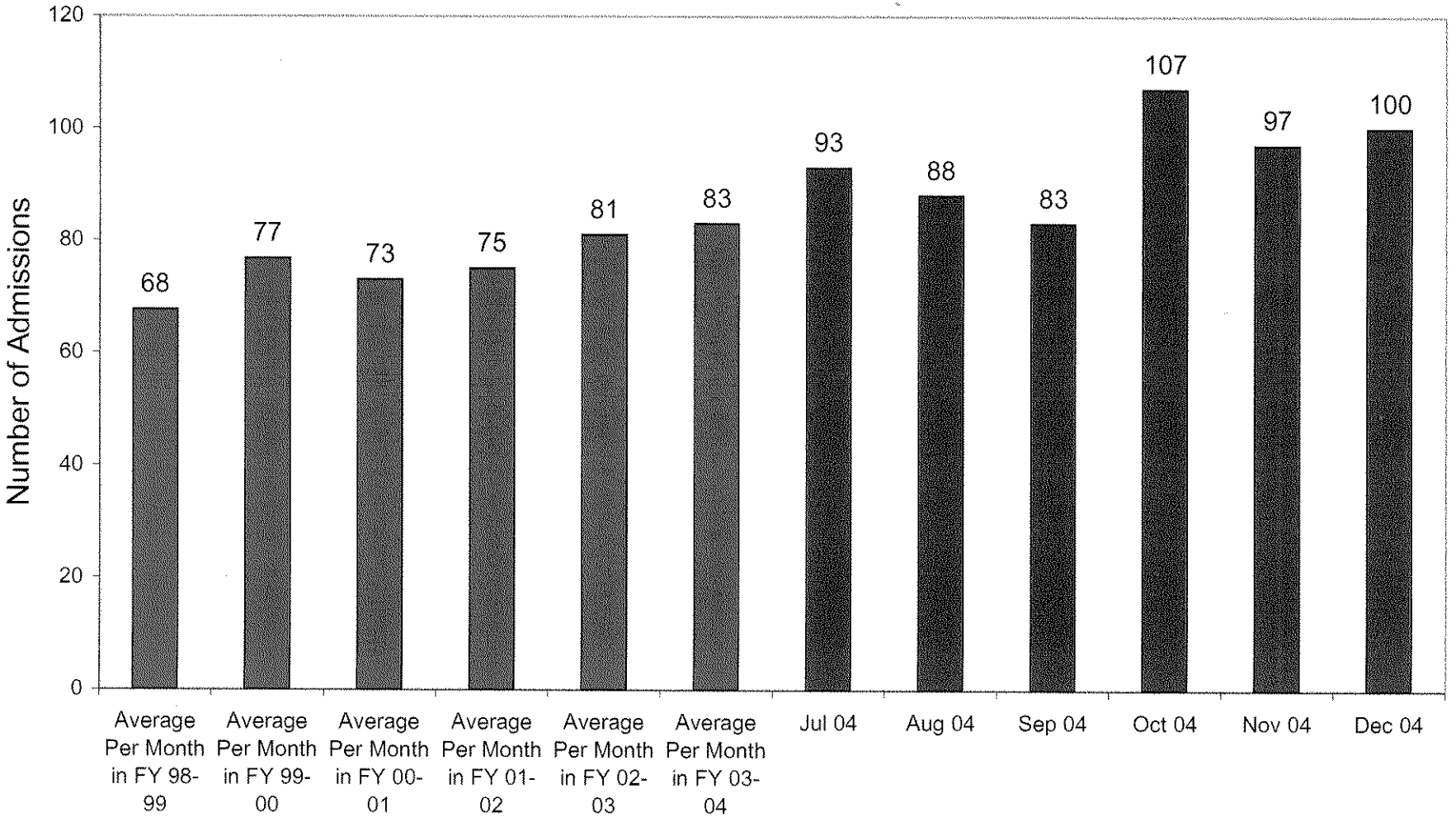
DISCHARGES

JANUARY 2004 - DECEMBER 2004

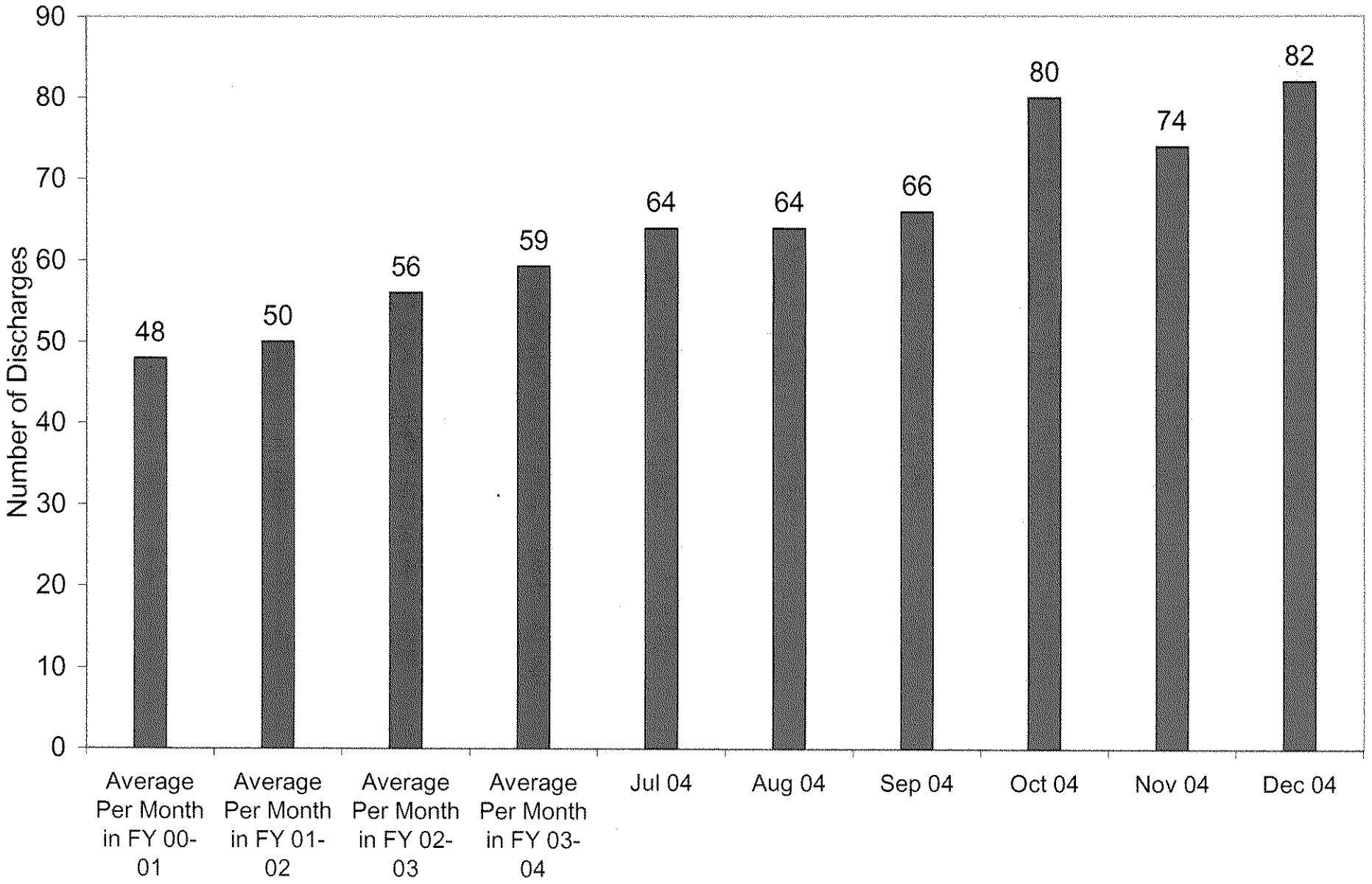
Discharge Location	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Average Per Month
EXTERNAL DISCHARGES														
Cal Pac Acute			1	2	1						1		5	0.4
Chinese Hospital Acute										1			1	0.1
R.K. Davies Acute													0	0.0
Kaiser Acute												1	1	0.1
Mt. Zion Acute								1		2			3	0.3
St. Francis Acute				1						1			2	0.2
St. Luke's Acute			1		1	2			1				5	0.4
St. Mary's Acute	2	3	2	2	1	2	1		1	3	1	2	20	1.7
SFGH Acute	16	13	23	18	16	19	16	17	19	21	25	29	232	19.3
Seton Acute				1		1				1			3	0.3
UC Med Acute	8	10	9	11	14	10	7	10	11	17	12	16	135	11.3
VA Hospital Acute													0	0.0
Home	22	22	22	18	25	29	23	26	27	23	24	25	286	23.8
Board and Care		1	2		2			2			2	2	11	0.9
AMA			2	2	1	1	2	1				3	12	1.0
AWOL	3	2	4	8	4	3	11	5	4	5	7		56	4.7
5150	2		4	1	2	2	2	1	1	3	2	3	23	1.9
Other Misc	2	1	2		3	1	2	1	2	2		1	17	1.4
Out of County*										1			1	0.1
SUBTOTAL	55	52	72	64	70	70	64	64	66	80	74	82	813	67.8
INTERNAL DISCHARGES														
Discharge From M7A to Other Unit	6	7	9	9	8	9	6	6	3	5	6	11	85	7.1
Discharge From Other Unit to M7A	5	12	11	8	9	11	10	7	2	10	8	12	105	8.8
Discharge From L4A to L4S		3	1	3			2		2	1	2	2	16	1.3
SUBTOTAL	11	22	21	20	17	20	18	13	7	16	16	25	206	17.2
EXPIRED	24	22	28	30	20	28	25	28	17	25	18	14	279	23.3
TOTAL	90	96	121	114	107	118	107	105	90	121	108	121	1298	108.2

*Out-of-county count begins in October 2004

Laguna Honda Hospital
Total Admissions Per Month in FY 04-05 Versus
Average Per Month in FY 98-99, FY 99-00, FY 00-01, FY 01-02, FY 02-03, and FY 03-04



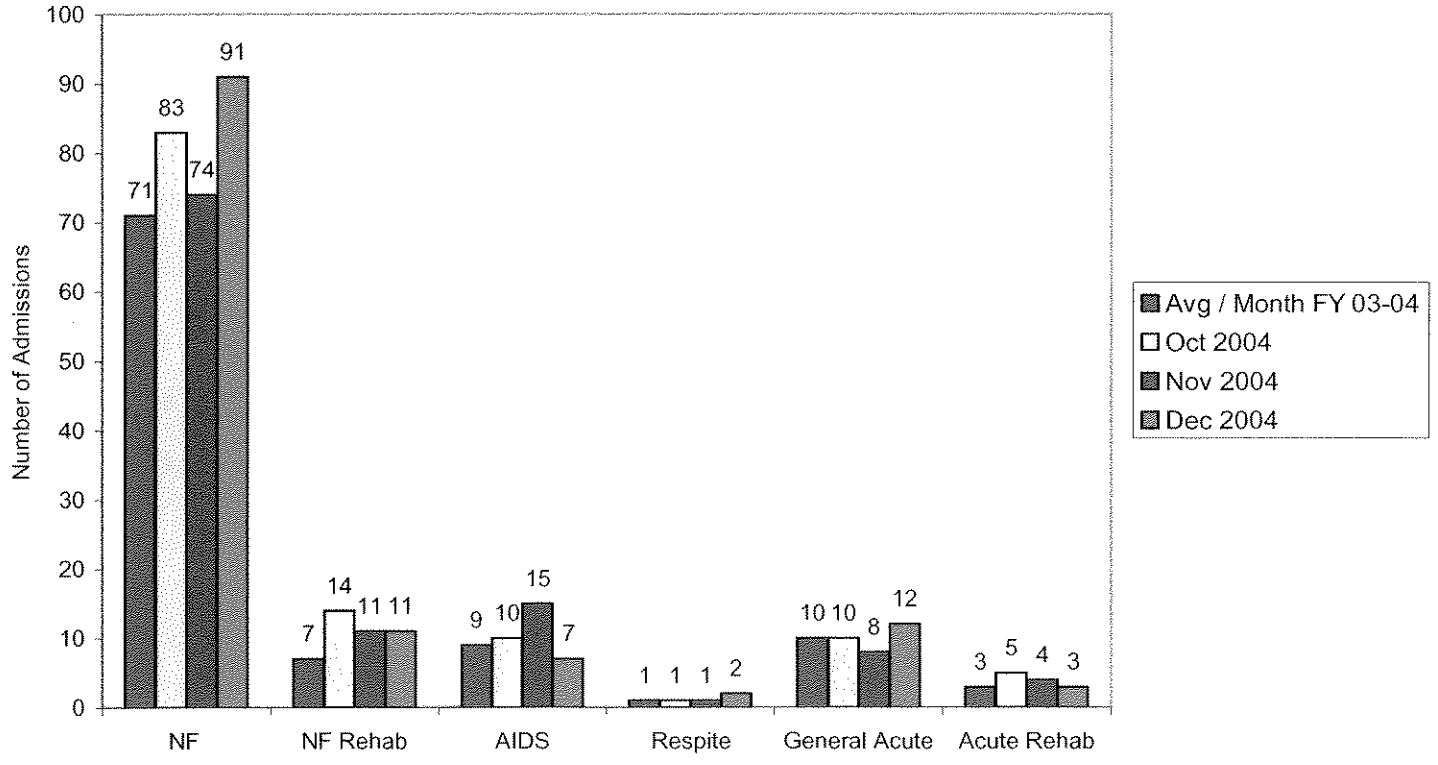
Laguna Honda Hospital
Total Discharges* Per Month in FY 04-05 Versus
Average Per Month in FY 00-01, FY 01-02, FY 02-03 and FY 03-04



* *Excludes expirations and internal transfers.*

Hollingsworth, J.

LHH Admissions
FY 03-04 vs. October 2004 - December 2004



Sources of Reimbursement for LHH Admissions
FY 03-04 vs. October 2004 - December 2004