

The Ja Report: A Job Half Done

A Critical Analysis of:

“Evaluation & Assessment of LHH Behavioral Care &
Service Access: A Final Report”

by
Davis Y. Ja & Associates, Inc.

July 2009

by:

Maria V. Rivero, MD, FACGS¹
Internal Medicine, Geriatric Medicine
Past LHH Medical Director (1997–1998)

Derek Kerr, MD, CNA
Internal Medicine, Medical Oncology, Palliative Medicine
Certified Nursing Assistant (1988)

DRAFT FOR COMMENTS

Please send comments to:

Maria Rivero, MD
58 West Portal Avenue, #116
San Francisco, CA 94127

September 14, 2009

¹ Fellow of the American College of Geriatrics Specialists.

The Ja Report: A Job Half Done

A Critical Analysis

CONTENTS

Introduction and Summary	1
1. The Chambers Settlement: A More Integrated View	1
2. Not Meeting Requirements of the Chambers Settlement	2
3. Undermining the Chambers Settlement?	3
4. Medical Services — Vital for Safe Community Discharges	4
4.1 100% Medically Ill Patients	4
4.2 Physician Specialists in Long Term Care	5
5. Improving Discharge to the Community	5
5.1 Discharge Rates for BH Patients Are Better	5
5.2 Assessing Existing LHH Behavioral Health Services	5
5.3 Correlating BH Services Provided and Successful Community Discharge	6
5.4 Minimizing the Role of Key Disciplines in Community Placement	6
5.5 Missing the BIG PICTURE — Major Barriers to Community Placement	6
6. Were Behavioral Health Needs Properly Assessed?	7
6.1 Clinical Needs or Diagnostic Categories?	7
6.2 Failure to Exclude Critically-Ill Patients	8
6.3 Defining and Evaluating BH Needs	9
6.4 Defining Standards of Care Before Making Recommendations	9
6.5 Assuming All Treatment Recommendations Are Valid	10
7. Deficient Data Gathering	10
7.1 Inadequate Document / Literature Review	10
7.2 Mistaking Regulatory Mandates for a “Complex LHH Identity”	11
7.3 Regulatory Requirements and “Patient Resistance” to Discharge	12
7.4 Questioning the Interdisciplinary Team Model	12
7.5 Projecting Non-existent BH Services Onto LHH	12
8. Methodology Flaws	13
8.1 The CBHS Connection	13
8.2 Davis Ja & Associates: Lack of Professional Integration	14
8.3 Davis Ja & Associates: Lack of Clinical Experience	15
8.4 The Interviews: Not an Integrated Sample	15
8.5 No Quotes From Interviews	16
8.6 No Quantified Measures for Interview Responses	16
8.7 Changes of Methodology After Evaluation Is in Progress	17
8.8 Violating Randomization — Switching From Random to Purposive Sampling	17

9. Lack of Evidence Base 18

 9.1 Failure to Review “Gatekeepers” of Patient Flow..... 18

 9.2 Unsubstantiated Conclusions and Statements 19

 9.3 Attributing Statements to “Frontline Staff” Excluded From Interview Group..... 19

 9.4 Undocumented Assertions..... 20

 9.5 Unfounded Recommendations 20

10. Scapegoating Medical Doctors and the “Medical Model” 20

 10.1 Impact on “Quality of Patient Care”?..... 20

 10.2 Collaboration or Dominance?..... 21

 10.3 Taking Responsibility..... 21

 10.4 Institutional Model or “Medical Model” 22

 10.5 Blaming Medical Doctors for Decisions Beyond Their Control 22

 10.6 False Allegations of Cultural Insensitivity 23

 10.7 Medical Doctors Do Not Control Nursing Services 23

 10.8 Medical Doctors Do Not Control Behavioral Health Resources..... 23

 10.9 Not Following Recommendations of BH Consultants 24

11. Conclusion 25

Introduction and Summary

This is a Critical Analysis of the Ja Report, written by two Medical Doctors, each having 20 years of direct patient care experience at Laguna Honda Hospital (LHH). We have cared for many hundreds of patients with Behavioral Health (BH) needs. Also, we both have some familiarity with research methodology.

The opinions expressed are ours alone and are not intended to reflect those of LHH, or of its Medical Staff.

However, this analysis was written in response to widespread concerns among LHH's Medical Staff about the recommendation to reduce primary medical services at LHH in order to increase behavioral health services.

We agree that there are unmet BH needs at LHH that require enhanced BH care. We agree that community placement should be the first option for LHH patients. In order to facilitate successful community discharges, and improve quality of life, adequate medical as well as behavioral services are required for LHH's medically-ill population.

Our analysis shows that the Ja Report's evidence-base is weak, while the clinical and ethical implications of reducing LHH medical services are considerable.

We appreciate the enormous task Ja accomplished and the new information uncovered. However, because of inadequate data, bias, and flawed methodology, the Ja Report:

- 1) Constricts the intent of the Chambers Settlement.
- 2) Overestimates behavioral health patients at LHH.
- 3) Omits the outcomes of behavioral health services.
- 4) Does not correlate BH services with community discharges.
- 5) Minimizes the need for medical and other services at LHH.
- 6) Minimizes major barriers to discharge.
- 7) **Fails to note LHH's success rate in discharging BH patients.**
- 8) Ignores laws that govern LHH's identity.
- 9) **Does not disclose potential researcher bias.**
- 10) Draws conclusions that are not evidence-based.
- 11) **Presents biased data and improperly "randomized" samples.**
- 12) Scapegoats medical doctors for systemic barriers to discharge.
- 13) Crosses professional boundaries by advising on medical services.

Accordingly, the Ja Report recommendation to reduce medical services for LHH residents is unacceptable. It is potentially harmful, likely to increase the barriers to safe community discharges, and may increase adverse outcomes after discharge. We hope our analysis will be considered, and look forward to helping develop an equitable, more Integrated Model of Care at LHH.

1. The Chambers Settlement: A More Integrated View

The Chambers Settlement Section IX (p. 21) states:

"It is the intent of this section to enhance mental health/substance abuse services at LHH by promoting mental health/substance abuse services that will prepare and enable residents to be discharged to the community and to provide timely access to community based mental health and substance abuse services to class members who need those services upon discharge."

To that end, San Francisco is required to take several major steps, including:

- A. *“San Francisco will provide access to primary health care to meet those needs in addition to class members’ physical health care needs (Emphasis added).” (Chambers, p. 22)*
- B:1 *“Conduct an assessment of Mental Health/substance abuse services needed, provided and available to LHH residents and **what community expertise** would be helpful to promote better discharges and linkages (Emphasis added).” (Chambers, p. 22)*
- B:2 *“Make recommendations regarding mental health and substance abuse services provided at LHH...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 (Emphasis added).” (Chambers, p. 22)*

Class members for the Chambers Lawsuit are defined as:

*“**All** adult Medi-Cal beneficiaries who are residents of LHH; or on waiting lists for LHH; or within two years post-discharge from LHH; or patients at San Francisco General Hospital or other hospitals owned or controlled by the City and County of San Francisco, who are eligible for discharge to LHH.” Chambers et al. v. CCSF Settlement Agreement (p. 3).*

2. Not Meeting Requirements of the Chambers Settlement

- a. The Ja Report does not include an assessment of existing community behavioral health services.

According to the contract between DPH and Davis Y. Ja & Associates, and according to the Ja Report itself, the scope of work includes:

“Determine the level of community expertise available to promote better discharges and linkages for class members to CBHS mental health and substance abuse services.” (p. 9)

Yet, the Ja Report solely mentions LHH behavioral health (BH) services and **does not evaluate community-based BH resources as required**, even though administrators from CBHS and other community service providers were among the interviewees.

- b. The Ja Report does not evaluate outcomes of BH services currently provided at LHH. However, such services can only be “enhanced” after first determining their goals and effectiveness.
- c. The Ja Report does not evaluate the need for Medical Services at LHH, yet recommends reducing the number of physicians. Meeting “physical health care needs” is a required part of the Chambers Settlement (p. 22).
- d. The Ja Report incorrectly constricts Chambers class members:

“There have been some initial concerns with the ‘class of patients’ that fall under the (Chambers) lawsuit, since many organic brain injured and dementia patients (including Chambers) have behavioral health needs. However, after consultation with Barbara Garcia, the class of patients under Chambers at this time is primarily those diagnosed with DSM IV diagnosis.” (Appendix 3, p. 54)

But the Chambers Settlement is clear that the “class of patients” includes **all** LHH residents, regardless of medical or behavioral needs.

3. Undermining the Chambers Settlement?

The Chambers Settlement is based on the Americans with Disabilities Act and The Olmstead Decision of the U.S. Supreme Court. The intent of these laws is to prevent unnecessary institutionalization of disabled persons. The remedy is to facilitate placement in the “most integrated community setting based on residents’ needs and preferences.”

“The parties recognize that the integration and collaboration of physical health care services with mental health and substance abuse services are important components to community transitions for many class members.” (Chambers Settlement, p. 21)

To increase Behavioral Health services at LHH **at the expense of Medical Services** undermines the spirit of the Chambers Settlement. **All** LHH residents who desire discharge to a more integrated community setting (and those who prefer to stay at LHH) have a right to receive both physical health services and BH services, as needed.

To reduce LHH medical services, without an evidence-based evaluation of these services and the medical needs of LHH residents, seems to undermine the equal rights intent of the Chambers Settlement.

The Ja Report demonstrates that there is a two-fold higher success rate for community discharge for the BH group than the Comparison Group. (See Table below extracted from Table 2d “Discharge Location”) (p. 35)

	<u>Behavioral Group</u> (N = 1,075)	<u>Comparison Group</u> (N = 1,263)
Board & Care	4.4%	2%
Home	32%	18.4%
Left AMA	5.4%	1%
Community SNF	0.3%	0.2%
Long Term Care	0.1%	0%
Total Discharges	42.2%	21.6%

Since the BH group has twice the community discharge rate of the Comparison Group, shouldn’t resources be aimed at improving community discharges among the larger Comparison Group as well? The Chambers Settlement plaintiffs include both groups — not just those LHH residents with mental health and substance abuse issues.

According to Ja’s demographic data (pp. 31–32), the **BH group is predominantly younger, white males.**

	<u>Age</u>	<u>White</u>	<u>Asian</u>	<u>Male</u>
Behavioral Group	61	44%	13.0%	64.5%
Comparison Group	74	29.9%	30.3%	48.2%

The Department of Public Health (DPH) and the Targeted Case Management (TCM) program have taken the position that the majority (up to 80%) of LHH residents can be discharged. Is there a risk that increasing

resources for the predominantly younger white male BH population may reduce discharge opportunities for older patients, women, and Asians?

Ja seems to undermine the spirit of the Chambers Settlement in advocating for special behavioral health units that may be:

“... either **permanent** or temporary placements for selected groups of behavioral health clients.” (p. 47)

Why does Ja propose permanent placement in LHH psychosocial units when it is agreed by all that the psychosocial units should “*focus on discharge readiness and enhancement of independent living skills*”? All psychosocial units should be considered transitional — not permanent placement locations — in order to match the intent of Chambers.

4. Medical Services — Vital for Safe Community Discharges

4.1 100% Medically Ill Patients

LHH is licensed as an “Acute Care Hospital with a Distinct-Part Nursing Facility.” Patients admitted to LHH must have a primary medical need. In breaking down LHH patients into 46% BH and 54% comparison groups, Ja creates an artificial dichotomy. Virtually 100% of LHH patients have disabling medical illness requiring skilled nursing and medical care. The “BH group” is a **subset of the medically-ill patients** with a range of BH needs, but they are not a separate group. Therefore, we agree with the view that:

“A majority of those interviewed in administrative positions see LHH’s role in providing psychiatric services as secondary ...” (p. 21)

Current levels of medical services are needed to provide adequate patient care, meet regulatory requirements, and facilitate safe community discharges for LHH residents — **all** of whom have medical needs.

Data in the Ja Report indicate that the Comparison Group are older and sicker than the BH group, as seen by the high mortality rates in the table below (from Tables 2c and 2d, pp. 34–35).

	<u>Behavioral Group</u>	<u>Comparison Group</u>
Discharged to Acute	6.4%	4.7%
Died at LHH	21.4%	36.7%
(Died After Discharge)	(10%)	(8.5%)

However, given their younger age, the BH group is clearly a medically ill population, with high rates of acute hospitalizations and death. During the Ja Report study period, 31.4% of all BH patients died — at an average age of 64.1 years. This is much younger than the 77.8 years for the comparison group.

By comparing overall death rates from Table 2b (p. 34) with the LHH death rates Table 2d (p. 35) one finds that 10% of the BH group (108 patients) died after discharge from LHH, compared to 8.5% of the Comparison Group. This higher out-of-hospital mortality for BH patients is concerning, and should be reviewed.

Therefore, the BH group requires careful medical evaluation prior to community discharge (and post-discharge) due to high rates of life-threatening medical illnesses.

4.2 Physician Specialists in Long Term Care

LHH primary care physicians are specialists in long term care. In addition to Internal Medicine or Family Practice certification, some have subspecialty certification in relevant fields (e.g., Geriatrics, Infectious Disease, Oncology, Palliative Medicine, and Nephrology). Importantly, they have added expertise in caring for patients with complex chronic illness, severe disabilities, dementias and other mental impairments. They are experienced in complying with regulatory mandates, collaborating with interdisciplinary teams, and taking a resident-centered rather than a disease-centered approach. The long tenures of LHH physicians show they are committed to the care of their patients while providing years of clinical experience — along with continuity of care.

LHH primary care physicians are frontline staff, not consultants; they follow the residents daily for medical problems, attend IDT meetings, and are involved in care planning. Because LHH patients are medically-complex, the interdisciplinary model with designated primary physicians minimizes disease and disability, and is most appropriate for all patients desiring a safe transition to community settings.

5. Improving Discharge to the Community

5.1 Discharge Rates for BH Patients Are Better.

Ja’s data comparing discharges to more integrated settings shows that the BH group has a 42% rate of community discharge versus only 22% for the Comparison Group.

Discharges to More Integrated Setting: (Table 2d, p. 35)

	<u>Behavioral Group</u> (N = 1,075)	<u>Comparison Group</u> (N = 1,263)
Board & Care	4.4%	2%
Home	32%	18.4%
Left AMA	5.4%	1%
Community SNF	0.3%	0.2%
Long Term Care	0.1%	0%
Total Discharges	42.2%	21.6%

In other words, LHH residents with Behavioral Health needs are being discharged to community settings at twice the rate of other LHH residents. The 2:1 discharge ratio favoring the BH group patients challenges the argument that more resources are needed for BH patients, at the expense of sicker patients — both groups need services.

5.2 Assessing Existing LHH Behavioral Health Services

*“... 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” (p. 9)*

In order to assess BH services **provided**, one must enumerate existing services, describe their goals and standards, evaluate their effectiveness as outcomes, and then identify gaps in these services. None of this is provided in the Ja Report.

It would have been helpful if Ja had drawn data from LHH's Psychiatric "Routine Consultation Request" forms introduced in December 2004. These forms have check-boxes for "Psychiatry," "Neuro-Psychology/Psychology," and "Substance Abuse Treatment Services," as well as various special assessments. A review of data collected by these forms could at least help quantify and categorize requested BH services. Which service is most needed? Which one(s) need increased resources?

Although Ja lists LHH "Clinical Psychiatry Department Caseloads" among the Project Documents Reviewed, nowhere in the Ja Report do we have an examination of caseloads of BH staff, the time required to assess BH clients or to provide BH services, the staff hours or FTEs available, nor the community workload standards for comparable services.

5.3 Correlating BH Services Provided and Successful Community Discharge

At a minimum, some explanation of how each BH service improves successful community discharge should have been included in the Ja Report. Ja does not enumerate or describe the available BH programs relevant to facilitating discharges. It is not clear that all BH services are aimed at improving discharges. For example, if the Smoking Cessation Program is included among the surveyed BH services, how does this program improve discharge opportunities to the community?

5.4 Minimizing the Role of Key Disciplines in Community Placement

Medical Services are not mentioned, despite the 21.4% LHH mortality rate for the BH group — except to say Medical Doctors should be cut! Admittedly, we are assuming the BH group patients died from their medical problems, rather than from their BH problems. Given our experience at LHH, it is safe to say that reducing medical services could result in increased mortality for BH patients – and all LHH patients.

Omitted from the Ja Report are therapeutic activities for patients with BH needs. No one from the LHH Activity Therapy Department was interviewed. The Rehabilitation Services Department's Restorative Care Program is not mentioned in the report. Neither is the LHH Nursing Department's Restorative Care Program (Best Practices Award from California Health Care Association, 2008).

"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." (pp. 23–24)

Barely mentioned in the Ja Report is the fact that nursing staff already receive behavioral and de-escalation training via the SMART program at initial hire, plus an annual refresher course. Ian Cook, MD, the Psychiatrist-reviewer for the U.S. Department of Justice recently gave "high marks" to LHH's SMART training process. What more does Ja recommend? Nursing staff also receive Dementia-care training. The Ja Report does not describe the additional levels of BH training envisioned, yet advocates for more BH resources.

5.5 Missing the BIG PICTURE — Major Barriers to Community Placement

Understandably, the underlying assumption of the Ja Report is that a lack of BH services at LHH is a major barrier to successful community discharge. Yet, the interviewees tell a different story:

"Almost all of the participants included in this evaluation stated that the process can be significantly delayed due to shortages in adequate housing for individuals with complex health care needs." (p. 18)

As noted in the Chambers Settlement major barriers to discharge include:

- Lack of supportive housing and case management services.
- Lack of Community Resources.
- Lack of 24-hour-care services in the community.
- Complex Medical Problems.
- Physical Disabilities.

Confounding variables that are major barriers to successful discharge were not addressed by Ja before making his final recommendations.

6. Were Behavioral Health Needs Properly Assessed?

6.1 Clinical Needs or Diagnostic Categories?

“Since LHH did not possess a clear list of residents with behavioral health needs who would fall into the study group population, DJY attempted to identify the population by using one or more of the existing data sources within LHH.” (p. 12)

Ja used three data sources to create a group of patients with BH needs:

Invision Computerized Database: N = 952 Patients

Invision uses ICD-9² diagnosis codes to categorize patients with various illnesses. This data was used to make a list of all of the LHH patients who had received an ICD-9 code for a mental illness and/or substance abuse disorder (excluded were some patients with dementia or brain injuries).

“DJY found that 952 patient without dementia or TBI received an ICD-9 code relevant to behavioral health needs.” (p. 14)

An ICD-9 code does not describe the severity or acuity of a diagnosis. An ICD 9 code, by itself, does not indicate the extent of needed specialty BH services such as psychotherapy or psychopharmacology. Physicians request BH services based on the clinical severity of their patients’ condition — not on their ICD-9 diagnostic codes.

ICD-9 codes do not discriminate between mental health or substance abuse issues that are inactive, past history, stable, or end-stage. Medical doctors **do** list these inactive or historical problems on admission notes and orders as a matter of record — but **not** because of an active clinical need. Ja did not exclude the “inactive” cases from these 952 patients in his analysis.

Of the 952 BH patients Ja extracted from the Invision Database, 33.8% had a diagnosis of “nondependent use of drugs” (p. 31). This DSM IV³ category includes tobacco, marijuana, and alcohol use — even when it is inactive or “in remission.” How many of these 322 patients simply had a past history of tobacco, marijuana, or alcohol use?

² International Classification of Diseases, 9th Edition. Coding practice guidelines from the Centers for Medicare and Medicaid Services (CMS) state primary diagnoses should be coded first (followed by secondary, tertiary [third], and other diagnoses), and that diagnoses no longer applicable should **not** be coded. It is unclear whether DPH’s Invision database — a system designed for billing purposes — has ever been “scrubbed” to remove inactive ICD-9 diagnoses.

³ Diagnostic and Statistical Manual of Mental Disorders, 4th Edition.

Further, ICD-9 codes such as “psychosis NOS” may include psychiatric manifestations of medical conditions such as delirium, diabetes, and thyroid disorders whose treatment is primarily medical, with BH consult services as needed.

Importantly, LHH is **prohibited from accepting, and does not admit**, patients with acute or unstable psychiatric illnesses. Therefore, those LHH patients who **do** have ICD-9 codes for mental illness are psychiatrically stable or have inactive psychiatric problems. **Accordingly, the BH services they need are less intensive than one would imagine by looking at diagnostic codes such as “schizophrenia” or “manic depression.”**

In sum, the indiscriminate use of the Invision database may have inflated the number of patients with BH “needs.” Without addressing the levels of need, or stratifying them, a sampling bias may have been introduced.

PASSR II: N = 516 patients

“DYJ determined that all residents referred for PASSR II assessment would be placed in the DYJ Behavioral Health Study Group.” (p. 14)

PASSR does not identify patients with severe medical illnesses that overwhelm psychiatric problems (e.g., about half of the PASSR II recommendations for BH services for LHH Hospice patients are received by the Hospice Attending physician after the patient has died).

SATS Referrals: N = 348 Patients

Substance Abuse is also defined in the Ja Report as a referral to Substance Abuse Treatment Services (SATS). There is no information about the types of SATS referrals made. Do they include referrals for tobacco or marijuana smokers? Did Ja realize that SATS referrals are sometimes made to provide “medical cannabis” for patients with medical symptoms but without BH needs? Were these included or excluded?

Therefore, the BH group as constructed by Ja may overestimate the number of LHH residents who need, or who could benefit from, BH services to facilitate community discharges.

On the other hand, Ja excludes from the BH group those with dementia or brain injuries without concurrent psychiatric diagnoses. This group includes some of the more difficult patients to discharge and includes many patients with behavioral problems who could benefit from BH services.

In fact there are a range of BH needs among LHH residents, whether they have a secondary psychiatric diagnosis or not. Unfortunately, Ja’s methodology does not identify or stratify this population, because **Ja’s methodology is not clinically based.**

6.2 Failure to Exclude Critically-Ill Patients.

“In this study, individuals 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.” (p. 12)

Casting such a wide net will inflate the number of BH patients. **Many severely medically-ill patients are admitted to LHH for a few days or weeks and either die or are returned to acute care hospitals.** For example, almost 300 patients were admitted to Hospice during the study period. About 50% of

Hospice patients had histories of substance abuse and/or a mental health diagnosis, and 65% died within a month of admission to LHH. Therefore, Ja's BH group may have included these terminally-ill patients.

6.3 Defining and Evaluating BH Needs

The Ja Report does not define criteria for "who can benefit" or who "has BH needs"? Other than those who meet exclusion criteria, the Ja Report assumes that **all** LHH residents with a Mental Health / Substance Abuse diagnosis (whether an active or an inactive diagnosis) will need, and benefit from, BH services:

"All of the 1,075 Behavioral Health Study Group patients were classified as having behavioral health needs." (p. 15)

However, there are a number of LHH residents having mental health/substance abuse (MH/SA) diagnoses (according to Ja's definition) who may **not** benefit from BH services because they:

- a. Have a severe medical illness that eclipses their substance abuse or mental health symptoms.
- b. Have subsequent severe cognitive impairments that render them unlikely to benefit from psychologically-based BH services.
- c. Have a stable or inactive psychiatric illness that is well compensated and can be managed by their primary physician with BH consultative support, as needed.
- d. Have behavioral health conditions but are non-compliant with, or refuse, BH interventions.

The number of LHH residents who fall into these categories that may not benefit from **more** MH/SA services is not specified. However, they are included in the group with BH "needs." **Again, sampling/selection bias may skew the Ja Report's conclusions and recommendations.**

6.4 Defining Standards of Care Before Making Recommendations

On page 39, under "Treatment Level Analysis," Ja states that 85% of the study group had treatment delivered within the study time frame of six months. How do we interpret this information? What is the community standard of care for timeliness of BH treatment in facilities similar to LHH?

What is missing in Ja's data of the patients with "severe mental health illness" is an assessment of the clinical acuity, severity, and impact of the BH diagnosis. In our experience, most seasoned primary care physicians can adequately treat and monitor medical patients who also have uncomplicated, chronic and stable mental illness with as needed psychiatric consultations, rather than every six months.

Group therapy referrals for SATS were fulfilled within six months in 69% of the cases. Many dying Hospice patients have substance abuse histories. Some receive PASSR recommendations for SATS that are inappropriate because they are too ill. Since Hospice admitted about one-third of the new patients during the study period, it may be that the 69% delivery of treatments is optimal. However, there is no way to determine what is considered adequate BH treatment, since this was not defined prior to the study.

The delay in attending SATS groups was 20 days. There is no explanation of the reasons for the delay. Did attendance delays result from patient non-compliance with group attendance, inter-current illness, discharge to acute care, or inadequate BH staff?

There was only a 10-day delay for 1:1 SATS counseling. What were the causes of this delay? Is that below community standards?

6.5 Assuming All Treatment Recommendations Are Valid

In the “Treatment Level Analysis” section, Ja does not address whether or not treatment recommendations were appropriate for the patient – only whether or not the recommendations were implemented. **Were the Ja & Associates reviewers clinically competent to discern whether the recommendations made were valid and appropriate?** Without this clinical assessment, the “BH needs” could be overestimated.

Also, some recommendations are not feasible. For example:

- a. The PASSR Psychologist recommended “Dance Therapy” for a Hospice patient with breast cancer and extensive skeletal metastases to both legs.
- b. The PASSR Psychologist recommended 1:1 psychotherapy for a patient with depression and severe memory loss from Alcoholic Dementia that made learning and retention impossible.

7. Deficient Data Gathering

7.1 Inadequate Document / Literature Review

According to Appendix 2 (p. 53) the Ja Report failed to review essential documents related to LHH’s licensing and regulatory requirements. **Without studying these documents, it is difficult to draw conclusions about LHH’s purpose or identity. The major documents omitted from the Ja Report’s review include:**

- License of Laguna Honda Hospital and Rehabilitation Center.
- California Code of Regulations Title 22, Division 5, Chapter 3 sections on Skilled Nursing Facility (SNF) regulations and licensing requirements.
- OBRA 1997 Federal Nursing Facility Regulations, Federal Code of Administration Title 42, Centers for Medical and Medicaid (CMS) Nursing Facility Regulations.
- State of California Department of Health Services Statement of Deficiencies for LHH Acute Care Hospital and Distinct Part SNF surveys between 2004–2009 and Plans of Correction submitted by LHH to State L&C.
- LHH Hospitalwide Policies and Procedures File 20-03, *Admissions To LHH And Relocation Between LHH SNF Units*, (Revised 11/22/05).
- LHH Medical Staff Bylaws, Rules and Regulations, Policies and Procedures.
- San Francisco Department of Public Health, Placement Task Force, *Current Trends of DPH Community Placement for Single Adults*, 11/30/06.

7.2 Mistaking Regulatory Mandates for a “Complex LHH Identity”

“The most prominent barrier to discharge that emerged from interviews is described as the ‘complex LHH identity’ ... It became apparent that LHH did not have a clear identity and staff perceptions of it varied greatly.” (Emphasis added) (p. 27)⁴

Skilled Nursing Facilities such as LHH are highly regulated. LHH’s identity is defined by laws governing DPNFs. In the words of Long Term Care Ombudsman Benson Nadell, LCSW, LHH is a **“Regulatory Silo.”**

It’s clear from the statements made, that Ja, as well as some of the staff interviewed, did not understand the regulatory constraints governing admission and discharge decisions by “gatekeepers” at LHH. Therefore, they perceived a “complex LHH identity” instead of a legally-established identity.

“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.” (p. 54)

However, the LHH Admissions Policy states under Part A: Admissibility and Screening Procedures, Section 4:

“LHH cannot adequately care for prospective residents with the following:

- ***Mental illness or developmental disability requiring an organized program of active psychiatric intervention.***
- ***Primary psychiatric diagnosis without coexisting dementia or other medical diagnosis requiring SNF or acute care.***
- ***Significant likelihood of unmanageable behavior endangering the safety or health of another resident ...”***

Further, Title 22 California Code of Regulations, Division 5, Chapter 3, Article 5, Section 72515, under “Admission of Patients” states:

“The licensee shall:

A: Admit a patient only on physician orders.

B: Accept and retain only those patients for whom it can provide adequate care.”

⁴ The full quote reads: “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 [to be] the greatest barrier to adequate and timely discharge because it pervaded many aspects of patient care at multiple levels ...”

The U.S. Department of Justice (DOJ) Findings Letter of May 6, 1998 highlighted the risks of mixing patient populations:

“The potential for harm is heightened by LHH’s practice of housing frail residents who are confined to their beds with residents who are ambulatory and have aggressive or combative behaviors.” (Emphasis added) (p. 4)

“LHH does not take sufficient steps to protect residents who are at risk of harm from their own acts and the acts of others, particularly residents with cognitive impairments and dangerous behaviors.” (Emphasis added) (p. 3)

Hence, there are clinical, regulatory, and ethical reasons for “staff with patient gatekeeping responsibilities” to not accept patients for whom safe and adequate care cannot be provided.

7.3 Regulatory Requirements and “Patient Resistance” to Discharge

“LHH is less likely to force a patient discharge unless the discharge is actively desired.” (Emphasis added) (p. 29)

“Staff has expressed concern that unless a good, fair, structured method for discharge is developed and implemented, this discharge resistance is likely to worsen.” (p. 29)

State Licensing and Certification (L&C) requires that Nursing Facilities provide a 30-day notice to residents who are to be discharged. Unless the resident is a danger to themselves or others, they have the legal right to appeal their discharge first to the Long Term Care Ombudsman and then to State Licensing and Certification. Residents are also entitled to a California Department of Health Services hearing, where it is determined whether discharge is appropriate.

In practice, it is difficult to discharge a resident with skilled nursing needs from LHH if the resident does not want to be discharged — no matter how many structured methods LHH develops. Structured methods are already defined by law.

7.4 Questioning the Interdisciplinary Team Model

“... it is necessary to decide whether the IDTs are the best way to implement the treatment model.” (p. 46)

IDT assessments are mandated by the Federal OBRA ’87 and State regulations for both the completion of the Minimum Data Set (MDS) and Resident Assessment Instrument (RAI). The IDT is **required** for substituted consent for restraints and psychoactive medications in residents without decision-making capacity or surrogate decision makers. There are many such residents at LHH.

7.5 Projecting Non-existent BH Services Onto LHH

“These units do not have rooms with locked doors, making it difficult for staff to structurally isolate and separate patients in crisis.” (p. 25)

Patient seclusion is not permitted by LHH’s license as a medical SNF.

*“Staff across all disciplines and management levels expressed concern that one of the role of **frontline psychiatric nursing staff** is to de-escalate conflict with high level patients with behavioral challenges.”* (Emphasis added) (p. 23)

LHH, a medical SNF, does not have “frontline psychiatric nurses.”

“Behavioral Health Staff includes all staff providing these services to LHH residents. This includes psychiatrists, psychologists, clinical nurse specialists, and psychiatric social workers.” (p. 11)

LHH has no clinical nurse specialists dedicated to psychiatric care.

The BH services, staff, and patients Ja seems to project onto LHH already exist — at the Mental Health Rehabilitation Facility (MHRF)/Behavioral Health Center (BHC). That facility is the Health Department’s psychiatric hospital.

In sum, because of deficient data gathering and an inadequate evidence base, Ja conveys inaccurate information about LHH.

8. Methodology Flaws

All methodologies, whether Qualitative or Quantitative, must demonstrate scientific rigor and procedures to ensure reliability and validity. The Ja Report uses both Qualitative and Quantitative methodologies, but each is flawed and they are mixed together inappropriately. As a result, the Ja report loses credibility and objectivity.

8.1 The CBHS Connection

A hallmark of good research is to disclose any bias that could skew the results. There are undisclosed potential researcher biases in the Ja Report.

- a. According to public records, Davis Y. Ja PhD, co-owns property in San Francisco with the current Director of Research, Evaluation and Quality Management for CBHS (the same City agency that contracted with Davis Ja & Associates to conduct this study). That property is the same address as the office of Davis Y. Ja & Associates. Also, they share the same residential address in the City. According to the CBHS organizational chart, the Director of Research, Evaluation and Quality Management reports directly to Bob Cabaj, MD, the Director of CBHS.
- b. William (Bill) McConnell, PhD, is listed as a consultant on the Ja & Associates Research Team. (p. 52). From 1985 until his retirement in June 2007, McConnell worked for CBHS as Director of Quality Management.

These undisclosed connections with the agency that hired Ja & Associates raises questions about whether an independent assessment of LHH was made.

8.2 Davis Ja & Associates: Lack of Professional Integration

The Davis Ja & Associates Research Team included: Four PhD's, one MSW, two MAs and two staff without a listed credential (p. 52), but did **not** include a Psychiatrist or Medical Doctor. There is no mention of possible **researcher bias**, or how it was addressed.

The contract between Davis Ja & Assoc. and the DPH includes "Section 12: Qualified Personnel":

"Work under this agreement shall be performed only by competent personnel under the supervision of, and in the employment of Contractor."

While the scope of work was limited to assessing Behavioral Health Services, clearly Davis Ja & Associates are not competent to advise the DPH on staffing needs for Medical Doctors such as Internists, Geriatricians, or other specialists.

"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." (p. 47)

The California Business and Professions Code, as well as professional organizations (APA, AMA, etc.), delineate the professional boundaries between Psychologists and Medical Doctors. These boundaries were crossed in the Ja Report's recommendation to reduce medical doctor staffing.

While there is an overlap between the disciplines of Psychology (PhD) and Psychiatry (MD), their scopes of practice and licensing are sufficiently different that one cannot provide Peer Review for the other. Accordingly, the absence of Psychiatric expertise within the Ja & Associates Team weakens their assessment of Psychiatric service needs at LHH. Similarly, since the Ja Team did not include a Medical Doctor, any recommendation about medical services is outside their scope of expertise.

Ja states in his report:

"Behavioral Health staff includes all staff providing these services to LHH residents ... psychiatrists ..." (p. 11)

Accordingly, Behavioral Health at LHH cannot be adequately evaluated without the input of a Psychiatrist. The unique roles of each clinical discipline cannot be understood without a Psychiatrist's perspective.

A Psychiatrist is required when evaluating a BH program for the following reasons:

- Knowledge of standards of care for psychiatric illness.
- Knowledge of medical problems confounding psychiatric illness.
- Specific training in pharmacotherapy.
- Qualified to evaluate staffing of psychiatrists at LHH.
- Knowledge of physician peer review

Ja reports on:

“... staff perceptions which include psychiatry’s use of medication as the primary means to address psychosocial problems ...” (p. 21)

This “finding,” concerning as it may be, would be more credible had a hospital-based psychiatrist been on the Ja team.

8.3 Davis Ja & Associates: Lack of Clinical Experience

Despite the lack of clinical experience on the Ja & Associates team, authoritative statements are made about clinical needs, services, training, and staffing.

According to the California Board of Psychology: “A search of our records shows that Davis Ying Ja is not currently, and never has been, a licensee of our Board. A search has also found that this person is not licensed by the Board of Behavioral Sciences or the Medical Board either.”

The Ja team Social Worker is an Associate Clinical Social Worker, who graduated in 2006 and lists Ja & Associates as her only employment following graduation. The Ja team M.A. is a researcher with no clinical background. Of the three PhD consultants, only one (Daniel Taube, JD, PhD) is a licensed clinical psychologist in California. His role and contributions to the Ja Report are not mentioned.

Therefore, Ja & Associates lack the qualifications to make recommendations about clinical needs, services, training, and staffing. Their clinical advice should be interpreted with caution.

8.4 The Interviews: Not an Integrated Sample

While recommending an integrated model of care, Ja’s sample of interviewees was not integrated.

Data extracted from interviews will depend largely on the selection of interviewees. It is an axiom of Qualitative Methodology that a balanced sample of participants in a process is required. For example, in a study of the delivery and receipt of BH services at LHH, this would mean interviewing a fair sample of physicians because they order and review BH services. **The risk of presenting a biased sample of perceptions, amounting to an opinion poll, is considerable — even if Grounded Theory methods are used. Grounded Theory methodology does not eliminate sampling bias in the selection of those interviewed.**

a. Who Was Interviewed at LHH?: Administrators & BH Staff

Without defining the term “relevant,” Ja explains that:

*“Only 40 staff from **relevant** units of the Department of Public Health were interviewed.” (Emphasis added) (p. 11)*

The list of those interviewed by Ja & Associates is in Appendix 8 on page 60. **Of the 41 persons on the Interview List, 15 (37%) were based outside of LHH.** Of the approximately 1,500 employees at LHH, only 26 were selected for interviews.

- **61.5% of those interviewed were middle- and upper-management staff.**
- **42% of those interviewed were behavioral health staff (including BH managers).**

b. Who Was Excluded?: The Interdisciplinary Team

- **No CNAs [who are defined as “frontline staff”]**
- No direct patient care nurses [RNs or LVNs]
- No Charge Nurses
- No Activity Therapists
- No Dietitians
- Only one of 17 Nurse Managers (a recent hire who manages a specialty unit).
- Only one of 15 social workers who attend IDTs (the second social worker interviewed is the department head of Medical Social Services).
- Only 3 of 25 (12%) Primary Care Physicians, who order and review BH services, were interviewed. (Of the primary care physicians, 2 of those interviewed had primarily administrative responsibilities, while the third was a specialty unit physician).
- **No Resident Advocates** – The Long Term Care Ombudsman was not interviewed.
- **No LHH Residents**, family members, or surrogate decision makers were interviewed.

c. False Dichotomy in the Interview Sample

Ja emphasizes the “External vs Internal” issue as a key question in the Interview Methodology:

“There are those working outside the system such as the Department of Aging and Adult Services (DAAS), Department of Public Health (DPH) and Community and Behavioral Health Services (CBHS) and then there are those working in LHH ...” (p. 54)

The fallacy of this dichotomy is that LHH administration is allied to administration at DPH, SFGH, and CBHS — all serve under the DPH Health Director. In fact, 5 of the LHH managers among the 26 LHH interviewees came to LHH from SFGH.

As previously noted, hardly any LHH frontline caregivers working within IDTs were interviewed. As a result, it is not surprising that Ja missed this key perspective while emphasizing that of the Administrative/BH Interview Group.

The exclusion of significant numbers of physicians from the interviews may explain why terms such as “medicine heavy” appear in the Ja Reports’ Appendix of “Code Terms from Grounded Theory Analysis.”

8.5 No Quotes From Interviews

Quotes are as essential to Qualitative studies as numbers are to Quantitative studies. Ja provides no interview quotes to support his “findings.” There is no way to assess the objectivity of Ja’s interpretation of the interviews. One cannot determine if the Ja Report gives “findings” — or Ja’s spin on the findings.

8.6 No Quantified Measures for Interview Responses

The Ja report uses vague terms, such as “several,” “some,” and “a significant number” to describe how many interviewees made specific points. **The use of the term “significant” in this research context is inappropriate because it implies statistical significance.** Of 41 interviewees, how many is “several” or “some” — and how significant is either percentage? While Qualitative Analysis does not require giving raw numbers (n), they would have been helpful in this context.

Also, the weight or reliability of interview responses is not defined. For example, a non-LHH administrator’s opinion about LHH clinical processes should carry less weight than that of an LHH clinician who has first-hand knowledge. Similarly, the opinion of a recent employee should carry a less weight than a long-standing, knowledgeable employee. Primary evidence is different than hearsay evidence. For example, interview “findings” about the exclusion of CNAs from IDT meetings could **not** have come from someone regularly attending these meetings, yet they were given full weight.

8.7 Changes of Methodology After Evaluation Is in Progress

a. Changing the interview methodology in mid-stream

“In the original proposal, DYJ planned to administer a survey to LHH behavioral staff and conduct a select number of interviews. However, it became clear that individual interviews would provide substantially more specific information than a survey.” (p. 11)

Ja presents no explanation or data to support his statement that interviews would yield more specific information than a survey.

b. Switching from a “random” sample to a “purposive” sample for the “random case study” [See Section 8.8 below].

8.8 Violating Randomization — Switching From Random to Purposive Sampling

“DYJ randomly selected a sample of 75 Behavioral Health Study Group patients and further examined their assessment and treatment data.” (p. 15)

*“DYJ reviewed only 50 of the 75 patient charts **due to time constraints.**” (p. 15)*

One may wonder whether 50 out of 1,075 patients (4.6%) is an adequate sample representative of the BH group. The answer is no — not because of the small sample size, but because of **a flaw in the way Ja selects the 50 of 75 charts for the “Random Sample Case Study and Chart Review”:**

*“Furthermore, **due to the fact that the 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 residing still in residence at LHH.**” (Emphasis added) (p. 36)*

Clearly this is no longer a random sample. **“This selection process” is a breach of randomization procedure that may introduce bias into the conclusions.** Yet Ja continues to refer to the sample as “random.” For example:

*“DYJ recorded 140 total mental health and/or substance abuse treatment recommendations within the 6 month time frames for the **50 random sample patients.**” (Emphasis added) (p. 39)*

*“Of the **50 random sample patients**, 12 had received a severe mental health diagnosis such as paranoid schizophrenia or manic depression ... Of these 12 patients 3 were excluded from analysis... Of the 9 remaining patients, 5 (55.6%) had no documentation of any type of psychiatric evaluation or service in their charts.” (Emphasis added) (p. 42)*

The problem with **purposive** samples — like Ja’s 50 patients — is that they **cannot be used to assess prevalence**. **Purposive samples are useful for describing phenomena**. Therefore, **Ja’s 50-patient purposive sample cannot be used to derive any prevalence conclusions about the 1,075 patients in the BH cohort**. That requires a true random sample. Indicators that bias may have been introduced by Ja’s manipulation of the “50 random sample patients” are given below:

Example: Whereas the **percentage of African Americans in the total BH cohort is 29%, the percentage of African Americans in the 50 “random sample patients” is 46%**. (Compare Table 1b on p. 32 vs. Table 3b on p. 37). This difference is more than expected on the basis of random variation.

Example: Whereas the mortality rate for the total BH cohort of 1,075 patients was 31.4%, with 21.4% dying at LHH, the “random sample” of **50 patients had just two deaths among those discharged, or 4% overall** (p. 39). Here too, one doubts the claim of randomization.

Given the power of random sampling for drawing conclusions about a larger population, why would Ja weaken his methodology by switching to a purposive sample? **We surmise that this purposive sample excluded severely medically ill patients**. Why? Because the death rate was only 4% in the purposive sample of 50 patients, as compared to 31% for the larger BH cohort. Had Ja properly randomized the 50 patient sample, we believe that the death rate among those patients would be closer to 31%, and many more patients would meet his exclusion criterion because they were so medically ill that they:

“... were residents of LHH for less than 30 days.” (p. 42)

The fact that Ja continues to refer to the sample as “random” is disturbing.

As a matter of scientific integrity, Ja should have clearly stated that the “50 random sample patients” cannot be used to derive prevalence conclusions about the needs or services of the larger BH population at LHH.

9. Lack of Evidence Base

9.1 Failure to Review “Gatekeepers” of Patient Flow

The Ja Report purports to study “patient flow” but without interviews of relevant admissions/screening staff, nor review of the LHH Admission Policy, nor attendance at meetings of the Admissions Screening Committee.

“... this evaluation sought to determine current operations related to patient flow at LHH.” (p. 17)

“... the admission potential is assessed by the attending physician at LHH, who refers for a psychiatry assessment.” (p. 17)

Not mentioned, and not interviewed, were the two screening nurses who replaced experienced MDs in 2005 in order to provide “enhanced screening,” nor was the LHH Admissions Coordinator interviewed. Also not interviewed was the Hospice physician who admitted about one-third of the patients to LHH during the Ja Report study period.

Ja did not attend LHH Admissions Screening Committee meetings to determine the role of this committee in patient flow.

The LHH Hospitalwide Admissions Policy and Procedure is not listed among the documents reviewed by Ja.

Furthermore, the Ja Report does not mention that the *Department of Justice* and *Chambers* settlement agreements limited “flow” by imposing a new screening mechanism: The Diversion and Community Integration Program (DCIP). The relative impediments to flow created by DCIP versus physician “gatekeepers” were not evaluated or even mentioned.

In conclusion, there are many “gatekeepers” at LHH, other than admitting physicians, that impact patient “flow.”

9.2 Unsubstantiated Conclusions and Statements

“For example, certified nursing assistants are not part of the IDT for the patient, and their input is often excluded.” (p. 22)

Ja draws conclusions about Certified Nursing Assistant (CNA) participation in the Interdisciplinary Team (IDT) without:

- Observing IDT meetings.
- Reviewing IDT meeting attendance logs.
- Interviewing CNAs.
- Interviewing more staff who regularly attend IDT meetings.

9.3 Attributing Statements to “Frontline Staff” Excluded From Interview Group

“... throughout the report DYJ describes findings related to ‘front-line’ staff. Most often this describes certified nursing assistants or CNAs. These are staff that spend the majority of their time in direct care of residents.” (pp. 11–12)

It is not stated how Ja reaches his conclusions about “frontline staff” since no CNAs were listed as having been interviewed.

For example:

“Many ... frontline staff noted that different disciplines have disparate ideas about how models of patient care should be utilized.” (p. 19)

“Frontline and administrative staff explained that inadequate communication and coordination among the different departments are critical factors in creating an informal and fragmented system.” (p. 19)

Who were these “frontline staff,” and why were their names not recorded in the interview list?

9.4 Undocumented Assertions

“LHH is experiencing a gradual change in patient population as the hospital takes on more “difficult” patients with complex MH/SA needs from DPH referrals. Previously, LHH treated “lower level” ... (p. 25)

Where is the evidence to support this conclusion? The DOJ findings letter of 1998, listed in Appendix 2 as having been reviewed by Ja, speaks to the same problem and LHH was criticized then for housing younger, behavioral patients on the same open wards as vulnerable elders. Also, LHH opened several Psychosocial Units in 1997 to better serve the needs of “difficult” behavioral health patients. Therefore, this patient population is not new, except for an upsurge during the 2004 Flow Project. Ja does not adequately substantiate a need for more BH services at LHH — unless, perhaps, a more acute psychiatric population is being planned to flow into LHH.

9.5 Unfounded Recommendations

“DYJ is recommending that higher-salaried physicians be replaced by registered nursing staff, social workers and psychologists.” (p. 47)

While Ja & Associates are not competent to make recommendations about LHH Medical Services staffing, and were not contracted to do so, they failed to properly suggest a separate survey of medical care needs before recommending service reductions.

Before making such a major recommendation, an evidence-based assessment of physical health care needs at LHH, and a survey of current medical workloads and staffing would be necessary. Then, the medical needs of LHH patients — and the resources available — could be compared with those of similar hospital-based SNFs. It is customary that health care professionals consider such data and community standards of care before recommending re-allocation of scarce health care resources. **As a matter of professional ethics, a recommendation to competently assess medical needs and services at LHH should have been made — before advocating to reduce physician services to this medically-ill population.**

10. Scapegoating Medical Doctors and the “Medical Model”

Using a narrowly-selected group of interviewees — an opinion-poll of administrators and behavioral health staff within and outside LHH — the Ja Report condemns medical doctors in the section titled:

“Medical vs Integrated Service Model of Care: The Professional Dominance of Medical Doctors and its Impact on the Philosophy and Quality of Patient Care” (p. 20)

10.1 Impact on “Quality of Patient Care”?

While claiming to show an impact on “Quality of Patient Care” — a term based on bench-mark standards and outcome measures — little of these are found in the Ja Report. There is some data on delivery of recommended services, but this falls short. Many “findings” in the Ja Report are unsubstantiated by data, yet accepted at face value without verification. (See Methodology Flaws, Section 8.)

10.2 Collaboration or Dominance?

“There is a significant staff perception that program reductions and cuts favored existing health care services over integrated model services for mental health and substance abuse patients. Staff felt this was reflective of the low prioritization of the important mental health and/or substance abuse services.” (p. 21)

The Ja Report fails to mention that medical doctors:

a. Increased Mental Health and Substance Abuse Services at LHH:

- Conceived, initiated, and supported the Psychosocial Units that were co-developed with a Psychologist in 1997.
- Started the Substance Abuse Treatment Service (SATS) by hiring and supporting a SATS Psychologist and a SATS Counselor in 1998.
- Converted Medical Requisitions (Class 2232) in order to hire more BH staff.
- Appointed a Psychologist as LHH “Chief of Psychiatry.”
- When the BH Department was having difficulty recruiting psychiatrists, it was UAPD — the Union representing medical doctors at LHH — that convinced the City to provide a bonus that was instrumental in retaining two overworked Psychiatrists and recruiting a third.
- Except for the Psychiatrists, the BH staff has expanded over the past ten years.

b. Promoted An Integrated Model of Care at LHH:

- Voted to change the Medical Staff Bylaws to include Psychologists in the LHH Medical Executive Committee in 2003, in order to integrate the Medical Staff.
- Planned and developed the Hospice & Palliative Care Service, a Therapeutic Community based on a person-centered, interdisciplinary model, rather than a medical model, in 1988.
- Introduced the “Eden Alternative” to LHH in 1998. Two LHH physicians became certified in this psychosocial model that was implemented on the Admitting Ward and Spanish Focus Community.
- Convened and Planned “LTC 2000: Planning Our Future,” a 1996 LHH Task Force whose mission was to create a more resident-centered and interdisciplinary team model of care for LHH.

10.3 Taking Responsibility

“A significant number of frontline and middle management staff reported that a small circle of administrative medical doctors have the authority to determine the treatment model and philosophy of care.” (p. 22)

We do not dispute that some LHH doctors have been domineering. We have known similarly domineering persons in other disciplines. Had Ja & Associates taken the time to interview more frontline medical doctors, a more balanced perspective would have emerged. Individual management styles cannot be attributed to a “medical model,” given the above examples of medical collaboration.

Who hires, directly supervises and gives authority to these medical doctors? It's the LHH Executive Administrator (who is not a medical doctor). LHH has a multi-disciplinary Hospitalwide Executive Committee where non-doctors comprise a majority, chaired by LHH's Executive Administrator. LHH also has a largely non-medical Governing Body, the Health Commission. **Given this administrative structure, the ultimate responsibility for the philosophy of care cannot be attributed to Medical Doctors alone.**

10.4 Institutional Model or "Medical Model"

Had Ja & Associates used an integrated interview sample that included more doctors, it would have been clearer that LHH is operating under an "Institutional/Hospital Model" rather than under a "**Medical Model.**" This model is not driven by doctors primarily. **It is pervasive in the culture of all hospitals and nursing homes. All hospital staff are trained and practice under an institutional or hospital model of care, as defined by regulatory mandates.**

The regulatory environment imposes medical requirements on all hospital employees, including medical doctors. This institutional model, though aimed at resident-centered care, makes demands that inhibit a holistic and integrated approach.

Had Ja, et al. been more familiar with LHH's licensing status, they would not have been surprised that:

"... various staff members stated their perception of LHH as more rehabilitative and not psychiatric. Interestingly, this perspective was espoused most willingly by psychiatric/psychology staff." (p. 27)

Of course, they, like all of us, work within legal and licensing mandates. LHH is licensed as a medical hospital, not as a psychiatric one.

10.5 Blaming Medical Doctors for Decisions Beyond Their Control

"Nursing staff, in particular, want more interdisciplinary representation at the executive level. For example, certified nursing assistants are not part of the IDT for the patients, and their input is often excluded from patient care meetings." (p. 22)

The claim that CNA input is "excluded" from Interdisciplinary Team Meetings is not factual. Physicians do not determine whether CNAs participate. That is under the control of their supervisors, the Charge Nurse or Nurse Managers.

"The professional dominance of medical doctors in interdisciplinary decision-making processes ... impacts the efficiency of LHH's internal referral process to psychosocial services ... physicians must ultimately authorize a patient's referral to a psychosocial unit." (p. 21)

The implication that medical doctors do not refer patients to Psychosocial Units is unfounded. Often, physician referrals were not accepted because the behavioral disorders did not meet the admissions criteria for Psychosocial Units (e.g., patients with personality disorders, who are disruptive and difficult to manage on busy medical wards).

10.6 False Allegations of Cultural Insensitivity

In the Section titled “*Medical vs. Integrated Model of Care: The Professional Dominance of Medical Doctors and its Impact on the Philosophy and Quality of Patient Care*,” Ja alleges:

“It was noted that cultural and linguistic differences between frontline staff and administrative staff underscore power dynamics and create institutional barriers to involving staff, such as certified nursing assistants, in key decision-making processes.”
(p. 22)

The implied allegation of cultural insensitivity on the part of physicians is unacceptable. At the time of the Ja Report study, LHH had some 25 physicians regularly attending IDT meetings, and 64% were women. Their ethnic/cultural/linguistic backgrounds included 5 Asian Pacific Islanders, 3 African Americans, 3 Latinos, 2 Indian/Middle Eastern, 5 Jewish, and a very diverse group of 7 “whites.” Almost one-third of the physicians were foreign born.

10.7 Medical Doctors Do Not Control Nursing Services

The Ja Report notes:

“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.” (p. 20)

The Nursing Department is not under the Medicine Department. **Nursing controls and determines its own training and services, sometimes in collaboration with Medicine.** For example, the Restorative Nursing Program includes Activities of Daily Living (ADL) orders that are Nursing-initiated — independently from medical orders. Medical doctors cannot take credit for the success, nor be assigned blame for the failings, of this program.

“Due to the reported inadequacy of integrated services model training and the imposition of medical model values from administration, many frontline staff (i.e., certified nursing assistants) continue to utilize medical model values in practice.” (p. 20)

This claim is puzzling. There is a degree of “defensive medicine” practiced due to concerns about liability and regulatory citations, and this imposes more “medical work” on everyone. Medical orders do drive some of the nursing work at the unit level. But the training of CNAs is wholly under the purview of Nursing. Medical doctors do not tell CNAs how to care for patients.

10.8 Medical Doctors Do Not Control Behavioral Health Resources

- **The closure of some Psychosocial Units before the demolition of Clarendon Hall and the failure to re-create them in the main building was an administrative decision from the interdisciplinary Utilization Management Committee.** Though chaired by a medical doctor, the decision was made collectively and could have been appealed to the Executive Administrator — who has the ultimate responsibility.
- **The closure of the Adult Day Health Center, a key integrated service model program that prevented institutionalization of patients trying to live in the community, was not cut by LHH’s Department of Medicine.**

- **The layoffs of CNAs who provide restorative care and psychosocial support to LHH residents was not a medical decision.**

In short, cuts in psychosocial resources cannot be simply attributed to medical doctors, or to a medical model of care.

10.9 Not Following Recommendations of BH Consultants

Implicit in the Ja Report is blaming a medical model of care for not following recommendations made by BH consultants. But consultants usually offer a number of “recommendations” to be considered — not necessarily implemented. The Ja Report methodology of counting recommendations and tallying how many were followed does not account for these “suggestions to be considered.”

What is missing from the Ja Report is any interview with ward physicians to determine why some recommendations for Behavioral Treatment were not followed. Ward physicians simply do not have the time to write down all the reasons for all their decisions. As noted in the Ja Report, some key documents were missing from some charts. Therefore, chart reviews should have been supplemented by brief physician interviews — before implying that physicians were delinquent or at fault.

11. Conclusion

In conclusion, we agree with the 20 Primary Care Physicians who signed the following Resolution:

RESOLUTION OF THE LHH MEDICINE SERVICE

Re: Davis Y. Ja & Associates Report:

**“Evaluation and Assessment of Laguna Honda Hospital
Behavioral Care and Service Access: A Final Report,” July 2009**

We, as Primary Care Physicians of Laguna Honda Hospital, support an Integrated Model of Care for our medically and behaviorally complex patients.

Our Interdisciplinary Teams include Certified Nursing Assistants and front-line staff. We collaborate with each discipline, as well as our consultants, and include their input in patient care decisions.

We support the discharge of our patients to the most integrated setting in accordance with their needs and preferences.

However, because of concerns related to bias, inadequate data, flawed methodology, and lack of professional qualifications to assess physician services at LHH, we reject the following Ja Report recommendation:

“DYJ is recommending that higher salaried physicians be replaced by registered nursing staff, social workers and psychologists.” (p .47)

It is our professional opinion that this recommendation is invalid, inappropriate, unethical, and potentially harmful to our patients, as well as to their safe discharge to more integrated settings.