Comparison of Laguna Honda Hospital Admission Policy Changes During 2004

Note: SNF = Skilled Nursing Facility

This document compares various changes made during 2004 to five separate versions of the LHH hospitalwide Policy and Procedure Number 20-03, "Admission to LHH and Relocation between LHH SNF Units," that appeared on the LHH intranet. The following sections of the policy are compared, including:

- The Policies section
- The Purposes section
- Part A, Admissibility and Screening Procedures section (selected paragraphs only)
  - Admission Priorities
  - Hospitalwide Exclusion Criteria
  - Screening Processes
  - Perceived Discrimination in Admission Practices
- Part B, (Specific) Admission Criteria and Procedures (Psychosocial Cluster Units only)

Policies unique to various specialty Units [wards] at LHH (Part B) with the exception of the specific policies regarding the psychosocial cluster units, policies regarding patients temporarily transferred to other healthcare facilities (Part C), and the policies regarding relocation within LHH (Part D) are not included in this analysis.

Five Versions of Policy 20-03

February 6, 2004	Referred to here as the "Original" admissions policy.
March 2, 2004	Director of Public Health Dr. Mitch Katz's unilateral revision; rejected by the Medical Staff. The Medical Staff and Medical Executive Committee were reportedly not informed of the policy changes prior to its posting to the LHH Intranet.
June 10, 2004	This "Integrated Policy" was proposed and approved by the Medical Staff and Medical Executive Committee; it was repeatedly tabled for discussion and final adoption by the hospitalwide Executive Committee. It was never officially adopted by LHH, although it was posted to the LHH intranet between June and November 2004.
November Amalgam Date Range	An amalgam version of various versions of the policy between 7/13/00 and 2/5/04 that was temporarily resurrected in November 2004. The date-range usage was unusual because policies usually carry a single date of adoption, not a date range. This version was posted to the intranet somewhere between mid-November and November 30, approximately two weeks to one month before a scheduled Superior Court hearing scheduled for December 13. As a result of this November amalgam version appearing, the citizen taxpayer lawsuit over the admission policy changes was withdrawn without prejudice, and the Court hearing was cancelled.
December 16, 2004	It is not known whether the Medical Executive Committee agreed to the December 16 changes beforehand; the policy was announced at the December 23 LHH-Joint Conference Committee (JCC) meeting. It is reported that the Medical Staff may have been unaware of, and had not approved, key changes made in the December 16 version prior to its adoption, and were only informed of the new version following the LHH-JCC December 23 announcement. The most important change in this version is that Dr. Katz obtained what he had sought all along during the admission policy dispute with the LHH Medical Staff: He has been given final arbitrator authority over disputed decisions regarding who is admitted to LHH.

Summary of Key Changes

Policies

Policy 1: Until the December 16 version appeared, all prior versions had indicated LHH would "accept and care for" San Francisco residents who meet SNF care criteria. The December 16 version changed Policy 1 to "accept and retain" San Francisco residents, eliminating the words "care for." The December 16 version also added "acute care" to the criteria, in addition to SNF care. While LHH has a limited number of acute care beds, LHH is a licensed distinct-part SNF. Adding acute care to the criteria may allow more SFGH acute patients to be transferred to LHH. The December 16 version finally added "for whom it can provide safe and adequate care," which had not existed in the prior versions; the addition of this provision was an important victory for the Medical Staff. The December 16 version eliminated the phrase that prospective residents are welcomed regardless of race, color, creed, etc.

Policy 3: Until the December 16 version appeared, all prior versions had indicated LHH would assess the needs of both "newly accepted applicants and current residents." The December 16 version changed "newly accepted applicants" to "new residents." This change may permit the assessments for new admissions to be performed *upon* admission, rather than *prior to* admission; an assessment performed *prior* to admission might prevent an inappropriate admission before it occurs.

Policy 3 [new]: In the "integrated policy" dated June 10 that was proposed and approved by the Medical Staff, they inserted a new Policy 3 citing LHH's By-laws and Title 22 to provide that admissions to LHH shall be made by active members of the medical staff at their ***sole*** discretion. The "sole discretion" provision was deleted from the December 16 version; if Title 22 indicates that the admitting physicians have **sole** discretion, then the December 16 version may inappropriately countermand provisions of Title 22, due to the new paragraph A-5.2 in the December 16 version that grants Dr. Katz final arbitrator authority over disputed admissions.

Policy 4: The March 2 version unilaterally changed by Dr. Katz changed the phrase "LHH shall centrally coordinate in-House relocations" by eliminating the word "in-House," opening the door for an interpretation that relocations between LHH and SFGH will be centrally coordinated, and that moving a patient from SFGH to LHH is merely a relocation within the "system." Also, this policy had formerly focused on two issues: Maintaining the facility's census, and minimizing the impact of relocations on residents. The March 2 version eliminated maintaining the census, and instead introduced prioritizing a) Optimizing utilization of resources, b) Optimizing bed availability for new admissions, and c) Minimizing the impact of relocations on residents. In the June 10 version proposed by the Medical Staff, they attempted to restore the focus to being "in-House" and changed the priorities to make minimizing the impact on residents as top priority (i.e., as subparagraph "a"), and making the resource utilization and bed availability secondary when considering relocation decisions. The November amalgam version restored the February 6 wording, but the December 16 version reinstated the March 2 language Dr. Katz had introduced (eliminated "in-House," and prioritized resource utilization for new admissions and bed availability higher than minimizing impact on residents). The changes requested by the Medical Staff on June 10 were not included.

Purpose

Purpose 1: Until the December 16 version appeared, all prior versions indicated in Procedure 1 that all residents admitted would receive "compassionate and competent" care. The December 16 version changed it to read that residents would receive "adequate" care.

Purpose 2: Until the December 16 version appeared, all prior versions indicated in Procedure 2 was to "appropriately allocate Hospital resources." The December 16 version changed the focus on Procedure 2 to allocate "services" in coordination with resources.

Admission Priorities

Paragraph A-1:

- The February 6 version, like the pre-February 2004 "date range" version that was used as the November amalgam version in November 2004, had stated that only the LHH Executive Administrator could modify the priorities for admission to LHH; Dr. Katz's unilateral March 2 version introduced that the Administrator's "designee" could modify the admission priorities.
- The pre-February version (the date-range November amalgam version) showed that at one point, only bona fide San Francisco residents could be admitted to LHH; the December 16 version does not include in paragraph A-1 that only San Francisco residents may be admitted.
- The December 16 version also adds a new clause that the priorities can be modified by either the Administrator or his designee if in their "professional discretion" they determine otherwise based on the "totality of circumstances." The totality could conceivably be interpreted to include financial pressures at SFGH as being the reason SFGH patients might receive first priority for admissions. This last point was among the principal reasons the admissions policy lawsuit had been filed.
- The December 16 version adds a clause that says only those patients for whom LHH can provide "adequate care" will be admitted, and does not mention the provision that admitees must have "SNF level of care" needs. Even LHH's focus on providing SNF care may be being replaced with "adequate care."

Paragraph A-2: The February 6 version had stated that all admissions must meet SNF-level of care as defined by Title 22 (unless patients were being admitted to one of LHH's three small acute care units). In the June 10 version proposed by the LHH Medical Staff, they attempted to add "as defined by federal and state regulations," but in the December 16 version, Paragraph A-2 has been completely removed, including removal of any mention of SNF level of care criteria and removal of the reference to Title 22 (see last bullet point above).

Priority 1:

- **In the February 6 and earlier versions of the policy, the first priority for admission was given to "persons not in a medical facility" precisely because it is medically unethical to place at a higher priority those already receiving care in another medical facility ahead of those who are not receiving any care whatsoever. Dr. Katz's March 2 version changed the first priority to ***only*** those already admitted to SFGH who are "ready for discharge to SNF level of care," and moving those not in a medical facility down into Priority 2. This represents a huge change in priorities. All versions (including prior to February 6) ignored DPH's mission to provide *equal access* to all San Franciscans.**

- The Medical Staff attempted a compromise in the June 10 version by introducing two categories within Priority 1, with equal first priority: First, persons at home or who are "conserved" (wards of the Public Guardian or clients of Adult Protective Services only) ***and*** have an urgent need for SNF admission, followed by SFGH patients who are ready for discharge to SNF level of care[1], ***whether or not the SFGH patients have an urgent need***. The Medical Staff's suggestion for having two sub-categories within Priority 1 was incorporated in the December 16 version, albeit with further word changes. Dr. Katz got his way in the December 16 version: SFGH patients were moved up in to Priority 1 for admissions, which was one of several key issues during the nine-month argument over Dr. Katz's unilateral changes to the admission policy.

Priority 2:

- **In the February 6 and earlier versions of the policy, the second priority for admission was formerly for SFGH patients.** In the June 10 version, the Medical Staff proposed that the second priority would be those not in a medical facility *who would benefit from SNF care*. Therefore, until the March 2 version appeared, patients at home received a higher priority for admissions than SFGH patients.
- In the December 16 version, the second priority is for those persons not in a medical facility, dropping out the proviso that they would benefit from SNF care. Compared to the "persons at home" or who are conserved category in the first priority for the December 16 version, it appears that if you are at home (i.e., not in a medical facility) but do not have an urgent need for SNF care because your needs are non-urgent, SFGH patients will continue to receive a higher priority ***even if SFGH patients are not "urgent" themselves***. This glosses over the fact that many patients at home with progressive illnesses for which their caregivers can no longer provide adequate care are left to the "discretion" of physicians to determine whether the lack of caregiver resources is sufficiently "urgent" to justify admission ahead of the non-urgent patients from SFGH. Indeed, in the February 6 and earlier versions of the policy, there was no distinction made between those "not in a medical facility" vs. those who were "at home." That level of stratification was an attempt at compromise raised in the June 10 version. Those people at home with non-urgent needs who are not in a medical facility lost out to Dr. Katz's insistence that SFGH patients ready for discharge will have a higher priority for admission to LHH, regardless of the SFGH patients' urgency level, simply because SFGH patients may have no place to be discharged to.

Priority 3:

- In the February 6 and earlier versions, and in Dr. Katz's March 2 unilateral change to the policy, persons could be referred to LHH by "City/County welfare or health agencies." The June 10 version proposed by the Medical Staff, and subsequently included in the December 16 version, moved that stipulation to Priority 1, and narrowed the City/County agencies to just those who are wards of the Public Guardian or who are clients of Adult Protective Services.
- The June 10 and December 16 versions moved the old Priority 4 into Priority 3.

Priority 5: In the February 6 version, priority 5 was for San Francisco residents who were in medical facilities outside of San Francisco (i.e., SF residents who had been sent out-of-county). In the pre-February version (i.e., the November amalgam version), this category was in Priority 6. While the Medical Staff kept the provision that out-of-county patients had to be San Francisco residents when it moved this category to Priority 4 on June 10, the December 16 version eliminated the requirement that patients be San Francisco residents. It now reads that "Patients who are residents presently in a medical facility ... outside of San Francisco," are in the new Priority 4 (unless this was a clerical error in dropping the words "San Francisco" to describe which residents were being talked about: Residents of San Francisco versus residents in out-of-county facilities irrespective of their county of origin).

Hospitalwide Exclusion Criteria

Paragraph A-3:

- In the February 6 and earlier versions, and in Dr. Katz's March 2 unilateral change to the policy, this paragraph contained a subheading that read "Hospital wide exclusion criteria" before listing in bullet format specific reasons patients could be excluded from admission. The subheading was removed in the December 16 version (see next bullet point). This is significant because if LHH ***were*** to become able to "adequately care" for people it had formerly excluded, one of the first things that could change in LHH's mission is treatment of people with mental illnesses. This is not inconceivable, since as of December 23, 2004, LHH is now in the process of deleting from its mission statement its former focus of providing long term care, despite the will of voters who passed Prop A in 1999 authorizing building an LHH replacement facility as a **long-term care SNF** for frail elderly and disabled.

[1] With the introduction of the concept of SFGH patients needing SNF level of care on a ***short-term*** basis, DPH is unilaterally changing LHH's mission by ignoring the November 1987 Report of the Blue Ribbon Committee on Laguna Honda Hospital that concluded **LHH's mission was "To provide a comprehensive and coordinated range of services for the *elderly and disabled* residents of San Francisco in need of supervised *long-term care* for health problems," not short-term care for SFGH patients who could be cared for *at SFGH's* own *SNF Unit*.**

- In an apparent attempt to collaborate with Dr. Katz, the Medical Staff's June 10 proposed policy sought to add "potential" exclusion criteria for both medical reasons and psychiatric/behavioral reasons, with the proviso that the exclusion criteria listed were not "absolute." In the December 16 version, the "Hospitalwide exclusion criteria" subheading has been completely removed, and in its place there is just a statement that "LHH cannot adequately care for residents with the following ..." dropping all mention that certain criteria are grounds for automatic exclusion for admission.
- Other changes in the December 16 version concerning categories excluded from admission are:
  - In all earlier versions including the Medical Staff proposal of June 10, but removed in the December 16 version, there had been an exclusion that residents who might endanger the safety and health of the resident (e.g., "themselves") *and* others would be excluded. Indeed, the California 5150 provisions place patients on involuntary psychiatric hold if they pose a danger to themselves or to others. The December 16 version no longer considers patients who pose a health or safety danger to themselves as an "unmanageable behavior," as it says only "endangers the safety or health of another resident."
  - The citation to Title A of the California Administrative code regarding excluding those with mental illness or developmental disability who require organized, active psychiatric interventions has been removed; while these patients may still be excluded, the citation to the statute has been removed for some reason.
  - In the February 6 through June 10 versions, patients who required a ventilator or were unstable on a BiPAP, (a medical device regulating Bilevel Positive Airway Pressure) were to be excluded. The exclusion of those unstable on BiPAP machines may have been because they are normally used for patients with acute respiratory failure, and LHH may not have had sufficient acutely-trained staff to closely monitor acute patients in LHH's SNF setting. The latter requirement regarding excluding those who are unstable on a BiPAP has been eliminated in the December 16 version.
  - In the February 6 and earlier versions, and in Dr. Katz's March 2 unilateral change to the policy, patients who were at risk of elopement (running away) or wandering out of the facility were excluded unless they were admitted to a "secure unit or a unit with a Wanderguard." The proposal by the Medical Staff on June 10 removed the terms "secure unit" and "Wanderguard" and replaced it with the phrase "Elopement or wandering not containable with available elopement precautions (door alarms, resident locators)." The December 16 version further removed the description of what is meant by "available elopement protections."
  - Regarding those with communicable diseases, the December 16 version removes the word "appropriate" from all preceding versions of the policy that had formerly read "Communicable diseases for which *appropriate* isolation rooms are not available at LHH [emphasis added]." It now reads: "Communicable diseases for which isolation rooms are unavailable." Some LHH staff members remain concerned that patients are being admitted and placed in *inappropriate* and ineffective isolation, often late, since sometimes staff are not notified by referring facilities that isolation is necessary, or has been ordered, prior to the admission. Some staff feel it is completely ***inappropriate*** for the word "appropriate" to have been deleted from the list of exclusions. Considering the issue of elopement risk described above, the issue of having sufficient and *appropriate* isolation rooms is troubling.

Screening Candidates for Admission (Changed to "Admission of Applicants" in December 16 Version, Dropping "Screening")

Paragraph A-4.1:
- The pre-February version (the date-range November amalgam version) contained a requirement in paragraph 4.1 that admissions screening needed to ensure that all admissions must meet **Title 22 SNF-level criteria**. That provision was removed from the February 6, March 2, and June 10 versions, but was re-instated as paragraph 4.2 in the December 16 version reportedly due to concerns raised by the Deputy City Attorney assigned to LHH. The error in deleting the Title 22 requirement from the section describing screening requirements potentially displayed a critical lack of understanding of legal requirements by whomever had unilaterally deleted the requirement from the March 2 version, further calling into question decision-making capabilities of administrators.

Paragraph A-4.3:
- The pre-February version (the date-range November amalgam version) indicated that potential admissions who have behavioral or psychiatric problems would be screened by an LHH psychiatrist; all versions (from February 6 through December 16) have changed "psychiatrist" to "behavioral specialist." In some cases, decisions made by LHH behavioral specialists in 2004 about the safety of potential admissions were attempted to be overruled by a ***non-LHH*** behavioral specialist who, located off-site, was unfamiliar with LHH's physical plant. [Note: This paragraph was variously paragraph 4.3 or 4.4 in all versions, except the December 16 version, in which it is numbered paragraph 3.4.]

Paragraph A-4.7:
- Paragraph 4.7 in the pre-February version (the date-range November amalgam version) dealing with referrals from the Community Mental Health Services (CHMS) division of DPH (see footnote 3 on page 12), was deleted

beginning on February 6 and has not been included in the December 16 version. That paragraph had called for screening of CMHS referrals to be performed by both the "[LHH] Medical Director and a [LHH] staff psychiatrist," and that their recommendation would be forwarded to the Screening Committee before any decision would be made.

Paragraph A-4.8:
- The pre-February version (the date-range November amalgam version), paragraph 4.8 included in the description about referrals to the psychosocial units that the screening would be performed by the Screening Committee and the psychosocial treatment team "as described in Part B, Section 9." That section is described below, but much of Section 9 has been deleted beginning with at least the March 2 version, and all versions up to and including the December 16 version, no longer carry the cross-reference to the full description formerly contained in Part B, Section 9.

Perceived Discrimination in Admission Practices

Paragraph A-6: (A-5 on 12/16)
- In the February 6, March 2 (Dr. Katz's unilateral change), and the Medical Staff's proposed June 10 versions of Policy 20-03, each contained the stipulation that a) The LHH Executive Committee would be the review body in regard to any perceived discriminatory admission practices, and b) Staff, patients, families, or others should forward their concerns about potential discrimination to the LHH Executive Committee for resolution. In the December 16 version, all of the language previously contained regarding discrimination has been removed. In its place, there is just a short statement that "problems" with admission should be brought to the [LHH Executive] Administrator and [LHH] Medical Director for resolution, not to the larger LHH Executive Committee.
- Throughout 2004, Dr. Katz has battled with the LHH Medical Staff over his insistence that he be given the ultimate arbiter authority as the sole decision maker regarding who gets admitted to LHH. Dr. Katz got his way in the December 16 version with the addition of a brand new paragraph that had not formerly existed in any of the earlier versions of the admissions policy, granting him "final authority to resolve problem" admissions in consultation with the Administrator (who is a direct report to Dr. Katz) and the Medical Director (who is an indirect report to Dr. Katz). It is unlikely that either direct or indirect reports will oppose their ultimate boss should there be disagreements or disputes regarding the abiter's admission decisions.

Specific Admission Procedures (Psychosocial Unit Clusters only)

Paragraph B-9:
- The pre-February version date-range amalgam version that was resurrected in November contained in the subheading a breakout of which Units provided what level of psychosocial programming, list Units E200, W200, S200, C3, D3, E3, and G3. The specific units were eliminated from the February 6 version and have not been included since.

Paragraph B-9.5:
- The pre-February version date-range amalgam version that was resurrected in November specified that one of the specific admission criteria to the Medical Psychosocial Unit would include patients with dementias having behavior problems, but ***without*** "prominent psychiatric disorders." In the March 2 version, the qualifying clause "without prominent psychiatric disorders" was eliminated, suggesting that patients with prominent psychiatric disorders ***could be*** admitted to the Medical Psychosocial Unit, despite the fact that LHH does not have any Psychiatric Technicians on staff.
- The pre-February version date-range amalgam version included a statement that behavioral problems that were **solely** secondary to chemical dependence alone would be excluded; the March 2 version dropped the word "solely" from those who would be excluded.

Paragraph B-9.6:
- The pre-February version date-range amalgam version contained a requirement that referrals from facilities other than LHH (i.e., out-of-house referrals) needed to complete a "psychosocial cluster **Non-LHH referral form**." That requirement was deleted on March 2 and was not re-instated.

Paragraph B-9.7:
- The pre-February version date-range amalgam version contained a requirement that referrals from within LHH to the psychosocial clusters needed to complete an "**internal** referral/evaluation form." That requirement was deleted on March 2 and was not re-instated.

Paragraph B-9.8:
- The pre-February version date-range amalgam version contained a provision that if a candidate is accepted for the psychosocial clusters and no beds are available, that they would be placed on a waiting list for admission. That provision was deleted on March 2 and was not re-instated.

Paragraph B-9.10 Through B-9.12
- The pre-February version date-range amalgam version contained three paragraphs regarding discharge and relocation from the psychosocial cluster, a strategy to move patients through the continuum of psychosocial clusters to place them eventually in the least restrictive setting, and a provision to discharge patients to an acute psychiatric facility in the event the resident becomes unmanageable at LHH. All three paragraphs were deleted on March 2 and were not re-instated.

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Policies

Policy	February 6, 2004	March 2, 2004	June 10, 2004	November Amalgam 7/13/00–2/5/04	December 16, 2004
	"Original" Policy	Dr. Katz's Unilateral Revision: Rejected by Medical Staff; Medical Staff and Medical Executive Committee Not Informed Prior to Posting to Intranet	"Integrated Policy" Proposed and Approved by the Medical Staff and Medical Executive Committee; Repeatedly Tabled for Discussion at Hospitalwide Executive Committee	Medical Staff and Medical Executive Committee Not Informed Prior to Posting to Intranet	Medical Executive Committee Agreed to Change; Announced at December 23 LHH-JCC Meeting, Medical Staff Informed Following LHH-JCC 12/23 Announcement
1	LHH will accept and care for San Francisco residents who meet skilled nursing facility (SNF) care criteria (see priorities and exclusions below) and are at least 16 years of age. Prospective residents are welcomed at LHH regardless of race, color, creed, religion, national origin, ancestry, sex, sexual orientation, disability, HIV status or related condition, marital status, political affiliation, or age (over 16).	Same as February 6.	Same as February 6.	Same as February 6.	LHH will accept and retain those San Francisco residents: a. Who meet skilled nursing facility (SNF) and acute care criteria. b. For whom it can provide safe and adequate care. c. Who are at least 16 years of age.
2	All applications for admission to LHH shall be screened prior to any admission decision.	Same as February 6.	Same as February 6.	Same as February 6.	Same as February 6.
New # 3 June 10			**Admission to LHH shall be by an active member of the Medical Staff and is solely at the discretion of such member (LHH By-Laws and Title 22).**		
3	LHH shall assess the physical, mental, social and emotional needs both of newly accepted applicants and of current residents to determine whether each resident's care unit environment is best able to meet these needs.	Same as February 6.	Same as February 6.	Same as February 6.	LHH shall assess the physical, mental, social and emotional needs of both new and current residents to determine whether each resident's care environment is best able to meet these needs.
4	LHH shall centrally coordinate in-Hospital relocations in a timely manner to maintain the facility census and to minimize the potential for adverse impact on the resident.	LHH shall centrally coordinate resident relocations to: a. Optimize utilization of resources. b. Optimize bed availability for new admissions. c. Minimize the potential for adverse impact on the resident.	LHH shall centrally coordinate in-Hospital relocations to: a. Minimize the potential for adverse impact on the resident b. Optimize utilization of resources. c. Optimize bed availability for new admissions.	LHH shall centrally coordinate in-Hospital relocations in a timely manner to maintain the facility census and to minimize the potential for adverse impact on the resident.	LHH shall centrally coordinate resident's relocations to: a. Optimize utilization of resources. b. Optimize bed availability for new admissions. c. Minimize the potential for adverse impact on the resident.
5	LHH shall appropriately notify residents and their surrogate decision-makers of plans for relocation within the facility.	Same as February 6.	Same as February 6.	LHH shall appropriately notify residents and their surrogate decision-makers (SDMs) of plans for relocation within the facility.	Same as February 6.

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Procedures

Policy	February 6, 2004	March 2, 2004	June 10, 2004	November Amalgam 7/13/00–2/5/04	December 16, 2004
	"Original" Policy	Dr. Katz's Unilateral Revision: Rejected by Medical Staff; Medical Staff and Medical Executive Committee Not Informed Prior to Posting to Intranet	"Integrated Policy" Proposed and Approved by the Medical Staff and Medical Executive Committee; Repeatedly Tabled for Discussion at Hospitalwide Executive Committee	Medical Staff and Medical Executive Committee Not Informed Prior to Posting to Intranet	Medical Executive Committee Agreed to Change; Announced at December 23 LHH-JCC Meeting, Medical Staff Informed Following LHH-JCC 12/23 Announcement
1	To assure that all San Francisco residents in need of skilled nursing, acute, or rehabilitation services who are admitted to LHH receive compassionate and competent care in the appropriate service setting.	Same as February 6.	Same as February 6.	Same as February 6.	To assure that all San Francisco residents in need of skilled nursing, acute, or rehabilitation services who are admitted to LHH receive **adequate** care in the most appropriate service setting.
2	To appropriately allocate Hospital resources.	Same as February 6.	Same as February 6.	Same as February 6.	To allocate **services** in coordination with Hospital resources.
3	To provide a standard procedure for placement or relocation of residents within the facility.	Same as February 6.	Same as February 6.	Same as February 6.	Same as February 6.

Admission Priorities (for Exclusion Criteria, see below)

Priority	February 6, 2004	March 2, 2004	June 10, 2004	November Amalgam 7/13/00–2/5/04	December 16, 2004
	"Original" Policy	Dr. Katz's Unilateral Revision: Rejected by Medical Staff; Medical Staff and Medical Executive Committee Not Informed Prior to Posting to Intranet	"Integrated Policy" Proposed and Approved by the Medical Staff and Medical Executive Committee; Repeatedly Tabled for Discussion at Hospitalwide Executive Committee	Medical Staff and Medical Executive Committee Not Informed Prior to Posting to Intranet	Medical Executive Committee Agreed to Change; Announced at December 23 LHH-JCC Meeting, Medical Staff Informed Following LHH-JCC 12/23 Announcement
	Paragraph A-1: The Administrator of Laguna Honda Hospital shall determine which outside care levels receive priority. Only the Administrator may modify this prioritization, which currently is:	Paragraph A1: Admission priorities are listed below. Exceptions require specific approval of the Administrator of Laguna Honda Hospital (or designee).	Same as March 2.	Paragraph A-1: Only residents of the City and County of San Francisco may be admitted to Laguna Honda Hospital. The City Charter and regulations shall determine who are bona fide residents.	Paragraph A1: The administrator or designee shall be responsible for screening patients for admission to LHH to ensure that the facility admits only those patients for whom it can provide adequate care. The following sequential priority will be followed unless the administrator or designee in his/her professional discretion based on the totality of circumstances consistent with the patient's best interest determines otherwise:
	Paragraph A-2: With the exception of admission to acute care units M7A and L4A, all admissions must meet SNF-level criteria defined by Title 22.	Same as February 6.	Paragraph A-2: With the exception of admission to acute care units M7A and L4A, all admissions must meet SNF-level criteria as defined by **state and federal regulations** (e.g., Title 22).	Paragraph A-2: The Administrator of Laguna Honda Hospital shall determine which outside care levels receive priority. Only the Administrator may modify this prioritization, which currently is:	
1	Persons not in a medical facility, who cannot receive adequate care in their present circumstances.	Patients at San Francisco General Hospital ready for discharge to SNF level of care will be admitted before persons in categories 2–5 below.	• Persons at home, persons who are wards of the Public Guardian and persons who are clients of Adult Protective Services, where patient safety and the need for urgent SNF care is paramount. • Patients at San Francisco General Hospital who are ready for discharge to SNF level of care and who can be safely cared for at LHH.	Persons not in a medical facility, who cannot receive adequate care in their present circumstances	• Persons at home, persons who are either wards of the Public Guardian or clients of Adult Protective Services and where the admitting physician determines that urgent admission of the patient is necessary (i.e., patients who will be routed to emergency services if not promptly admitted to LHH, patients who are victims of domestic violence, abuse or neglect, or hospice patients whose families are overwhelmed by their care needs). • Patients at San Francisco General Hospital ready for discharge to SNF level of care.
2	Patients at San Francisco General Hospital.	Persons not in a medical facility, who cannot receive adequate care in their present circumstances.	Persons not in a medical facility who will benefit from SNF care.	Patients at San Francisco General Hospital	Persons not in a medical facility.

Priority	February 6, 2004	March 2, 2004	June 10, 2004	November Amalgam 7/13/00–2/5/04	December 16, 2004
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3	Persons referred by a City/County welfare or health agency.	Same as February 6.	Patients at other San Francisco medical facilities who are eligible for SNF care.	Same as February 6.	Patients at other San Francisco medical facilities.
4	Patients at another San Francisco medical facility.	Same as February 6.	Persons who are residents of San Francisco who are presently in a medical facility or private circumstance outside of San Francisco.	Same as February 6.	Patients who are residents presently in a medical facility or private circumstance outside of San Francisco.
5	Persons who are residents of San Francisco, but who are presently in a medical facility or private circumstances outside of San Francisco.	Same as February 6.		Persons not in a medical facility, who are receiving adequate care, but whose providers are unwilling or imminently unable to continue such care.	
6				Persons who are residents of San Francisco, but who are presently in a medical facility or private circumstances outside of San Francisco.	

Hospitalwide Exclusion Criteria:

February 6, 2004	March 2, 2004	June 10, 2004	November Amalgam 7/13/00–2/5/04	December 16, 2004
Paragraph A-3: Hospitalwide exclusion criteria:	Paragraph A-3: Hospitalwide exclusion criteria:	Paragraph A-3: LHH may need to exclude individuals who meet other criteria (listed below). These are not absolute exclusion criteria; each person will be considered individually to see if needs can safely be met.	Paragraph A-3: Staff will refer to the Admissions Coordinator all inquiries regarding the admissibility of a proposed applicant and bed availability. The Admissions Coordinator will maintain contact with the referring sources during the screening process. Hospitalwide exclusion criteria:	Paragraph A-2: LHH cannot adequately care for residents with the following:
• Communicable diseases for which appropriate isolation facilities are not available at LHH. • Persons under police hold • Mental illness or developmental disability requiring an organized program of active psychiatric intervention, according to Title A of the California Administrative Code, paragraph 278.2(1), (b), (c) • Need for most types of chemotherapy • Ventilator or BiPAP • TPN (total parenteral nutrition) • Active medical problem requiring ICU care • Primary psychiatric diagnosis without coexisting dementia or other medical diagnosis requiring SNF or acute care • Highly restrictive restraints • Significant likelihood of unmanageable behavior that endangers safety or health of resident or others, such as: – Actively suicidal – Violent or assaultive behavior – Criminal behavior, including but not limited to possession of weapons, drug trafficking, possession or use of illegal drugs or drug paraphernalia – Sexual predation – Elopement or wandering, unless admitted to a secure unit or a unit with Wangerguard	Same as February 6.	**Paragraph 3.1: Potential medical exclusion criteria:** • Has communicable diseases for which appropriate isolation facilities are not available • Needs chemotherapy administered on site • Requires ventilator or is unstable on BiPAP • Requires TPN (total parenteral nutrition) • Requires ICU-based medical care **Paragraph 3.2: Potential psychiatric/behavioral exclusion criteria:** • Is under police (forensic) hold • Has primary psychiatric diagnosis without coexisting dementia or other medical diagnosis requiring SNF or acute care • Requires highly restrictive restraints • Has significant likelihood of unmanageable behavior that endangers safety or health of others, such as: – Actively suicidal behavior – Violent or assaultive behavior – Criminal behavior, including but not limited to possession of weapons, drug trafficking, possession or use of illegal drugs or drug paraphernalia – Sexual predation – Elopement or wandering, not containable with available elopement protections (e.g., door alarms, resident locators)	• Communicable diseases for which appropriate isolation facilities are not available at LHH • Persons under police hold, unless 24-hour guards are provided by the Sheriff's Department • Mental illness or developmental disability requiring an organized program of active psychiatric intervention, according to Title A of the California Administrative Code, paragraph 278.2(1), (b), (c) • Need for most types of chemotherapy • Ventilator dependent • TPN (total parenteral nutrition) • Active medical problem requiring ICU care • Primary psychiatric diagnosis without coexisting dementia or other medical diagnosis requiring SNF or acute care • Highly restrictive restraints such as 4-point soft • Significant likelihood of unmanageable behavior: – Actively suicidal – Dangerous to self or others – Violent or assaultive behavior – Criminal behavior, including but not limited to possession of weapons, drug trafficking, possession or use of illegal drugs or drug paraphernalia – Sexual predation – Elopement or wandering, unless admitted to a secure unit or a unit with Wangerguard	• Communicable diseases for which isolation rooms are unavailable • Police custody • Mental illness or developmental disability requiring an organized program of active psychiatric intervention • Need for administration of chemotherapy on site • Ventilator • TPN (total parenteral nutrition) • Active medical problem requiring ICU care • Primary psychiatric diagnosis without coexisting dementia or other medical diagnosis requiring SNF or acute care • Highly restrictive restraints • Significant likelihood of unmanageable behavior that endangers the safety or health of another resident, such as: – Actively suicidal – Violent or assaultive behavior – Criminal behavior, including but not limited to possession of weapons, drug trafficking, possession or use of illegal drugs or drug paraphernalia – Sexual predation – Elopement or wandering, not containable with available elopement protections

Screening of Applicants:

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Paragraph A-4: Screening of candidates for admission:	Paragraph A-4: Screening of candidates for admission:	Paragraph A-4: Screening of candidates for admission:	Paragraph A-4: Screening of candidates for admission:	Paragraph A-3: Screening of Applicants:
4.1: Referrals to the Rehabilitation, AIDS, and Hospice units are screened by attending physicians on those units.	Same as February 6.	Same as February 6.	4.1: With the exception of admission o acute care units M7A and L4A, all admissions must meet SNF-level criteria as defined by Title 22.	3.1: The unit's attending physicians screens referrals to the Rehabilitation, AIDS, and Hospice units.
4.2: All other resident referrals shall be reviewed by a Screening Committee (or subset thereof) that includes the following or their designees: M5 Admitting Physicians and Nurse Manager, Medical Director, Director of Nursing, Bed Control Coordinator (BCC), Director of Social Services, Utilization Management Coordinator, Admissions Coordinator, and others, as appropriate.	Same as February 6.	Same as February 6.	4.2: Referrals to the Rehabilitation, AIDS, and Hospice units are screened by attending physicians on those units.	3.2: Screening Committee that includes the following: M5 Admitting Physicians and Nurse Manager, Medical Director, Director of Nursing, Bed Control Coordinator (BCC), Director of Social Services, Utilization Management Coordinator, Admissions Coordinator, and other members as designated by the [hospital Executive] Administrator, will screen all other resident referrals.
4.3: The Screening Committee may ask a LHH behavioral specialist to evaluate potential admissions who have behavioral or psychiatric problems prior to deciding on admission.	Same as February 6.	Same as February 6.	4.3: All other resident referrals shall be reviewed by a Screening Committee that includes the following or their designees: M5 Admitting Physicians, Medical Director, Director of Nursing, Bed Control Coordinator, Director of Social Services, Utilization Management Coordinator, Admissions Supervisor, and others, as appropriate.	3.3: When immediate decision are received outside the regularly scheduled meeting times of the Screening Committee, the physician, nurse, and Director of Social Service members may screen resident referrals.
4.4: Referrals to the psychosocial units will be screened by the Screening Committee and the psychosocial treatment team.	Same as February 6.	Same as February 6.	4.4: The Screening Committee may ask for evaluation by a LHH psychiatrist of potential admissions who have behavioral or psychiatric problems prior to deciding on admission.	3.4: The Screening Committee may ask a LHH behavioral specialist to screen potential admissions that have behavioral or psychiatric problems prior to deciding on admission.
4.5: Decisions about restriction of residents' movements throughout the facility must be made in accordance with each resident's individual needs and preferences, and with the participation of the resident or surrogate in the placement decision and continuing care planning[2]. Residents lacking capacity for placement decisions may not have their ...	4.5: Decisions about restriction of residents' movements throughout the facility must be made in accordance with each resident's individual needs and preferences, and with the participation of the resident or surrogate in the placement decision and continuing care planning[2]. Residents lacking capacity for placement decisions may not have their movements restricted on a secure	4.5: Decisions about restriction of residents' movements throughout the facility must be made in accordance with each resident's individual needs and preferences, and with the participation of the resident or surrogate in the placement decision and continuing care planning[2]. Residents lacking capacity for placement decisions may not have their movements restricted on a secure	4.5: Persons shall be admitted to LHH only on the order of a LHH Admitting Physician.	3.5: The Screening Committee and the psychosocial treatment team will screen referrals to the psychosocial units.

[2] "If the stated purpose of a unit which prevents residents from free movement throughout the facility is to provide specialized care for residents who are cognitively impaired then placement in the unit is not considered involuntary seclusion, as long as care and services are provided in accordance with each resident's individual needs and preferences rather than for staff convenience, and as long as the resident, surrogate, or representative (if any) participates in the placement decision, and is involved in continuing care planning to assure placement continues to meet resident's needs and preferences." CMS Guidance to Surveyors, LTC Facilities/State Operating Manual F223(b).

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[**Note**: Incomplete February 6 copy of admission policy; contained only first two pages.]	unit without the participation of a surrogate or conservator.	unit without the participation of a surrogate or conservator.		
	4.6: Persons shall be admitted to LHH only on the order of a LHH Admitting Physician.	Same as March 2.	4.6: In all cases of admission from another facility, a physician's dictated discharge summary is required.	Paragraph 4: Admission of applicants:
	4.7: In all cases of admission from another facility, a physician's dictated discharge summary is required.	Same as March 2.	4.7: Referrals of residents by Community Mental Health Services[3] shall be reviewed by the Medical Director and a staff psychiatrist, who will forward the referrals with recommendation to the Screening Committee.	4.1: LHH shall admit a patient only on a LHH Admitting Physician's order.
			4.8: Referrals to the psychosocial units will be screened by the Screening Committee and the psychosocial treatment team, as described in Part B, Section 9 entitled "Psychosocial Cluster Units."	4.2: With the exception of admission to acute care units M7A and L4A, all admissions must meet SNF-level criteria as defined by Title 22.
				4.3: Decisions about admitting a resident in a setting that restricts his/her movements at LHH must be made in accordance with each resident's individual needs and preferences, and with the participation of the resident or surrogate in the placement decision and continuing care planning[1]. Residents lacking capacity for placement decisions may not have their movements restricted on a secure unit without the participation of a surrogate or conservator.
				4.4: In all cases of admission from another facility, a physician's dictated discharge summary is required

[3] Community Mental Health Services, a sub-department with the Department of Public Health, was renamed to the "Behavioral Health Services Division" in 2003. Subsequently, when the Blue Ribbon Committee charged with evaluating disputes concerning the Mental Health Rehabilitation Facility (MHRF), the MHRF was renamed to the "San Francisco Behavioral Health Center." "Mental health" is out, in favor of "behavioral health," as the politically correct buzz word.

Perceived Discrimination:

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	Paragraph A-6: Resolution of perceived discriminatory admission practices.	Paragraph A-6: Resolution of perceived discriminatory admission practices.	Paragraph A-8: Resolution of perceived discriminatory admission practices.	Paragraph A-5: Resolution of problem screening and admissions.
	The LHH Executive Committee will serve as the Hospital's review in regard to any perceived discriminatory admission practices. Allegations from staff, patients, families, or others of perceived discriminatory admission practices will be forwarded to this Committee for investigation and review.	Same as March 2.	Same as March 2.	5.1: Problems shall be brought to the [LHH Executive] Administrator and [LHH] Medical Director for resolution.
				5.2: The Director of Public health shall have the final authority to resolve problems but only after consulting with the [LHH Executive] Administrator and [LHH] Medical Director.

(Specific) Admission Criteria and Procedures (Psychosocial Cluster Units only)

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	Paragraph B-8: Psychosocial Cluster Units:	Paragraph B-8: Psychosocial Cluster Units:	Paragraph B-9: Psychosocial Cluster Units: • E200 – Neurobehavioral Psychosocial Unit (NPU) • W200 – Geriatric Psychosocial Unit (GPU) • S200 – Medical Psychosocial Unit (MPU) • C3 Behavioral Care Unit (BCU-C) • D3 Behavioral Care Unit (BCU-D) • E3 Behavioral Care Unit (BCU-E) • G3 Behavioral Care Unit (BCU-G)	Paragraph B-8: Psychosocial Cluster Units:
	General admission criteria for Psychosocial Cluster Units 8.1: Patients who have concomitant complex psychosocial problems in addition to meeting SNF-level criteria because of medical problems. 8.2: Capacity to benefit from programming offered within the psychosocial cluster. Treatment goals might include lessening of symptom severity, improvement in ability to relate to others, improvement in ability to perform activities of daily living, and reduction of specific target behaviors that impact on the resident's ability to interact socially in another environment.	General admission criteria for Psychosocial Cluster Units 8.1: Same as March 2 version. . 8.2: Same as March 2 version.	General admission criteria for Psychosocial Cluster Units 9.1: Same as March 2 Version, ¶ 8.1. 9.2: Same as March 2 Version, ¶ 8.2.	General admission criteria for Psychosocial Cluster Units 8.1: Same as March 2 version. . 8.2: Same as March 2 version.
	Admission criteria for the respective focus-specific psychosocial units 8.3: Neurobehavioral Psychosocial Unit: This unit is primarily for adults of all ages with primary medical problems and concomitant neurobehavioral sequelae of organic brain disorders such as head injury/brain trauma, cerebral tumors, infections disease processes affecting the central nervous system, cerebrovascular disorders, nutritional and toxic neurodegenerative disorders associated with drug and alcohol use, and organic mental disorders and/or dementia's with behavioral complications.	Admission criteria for the respective focus-specific psychosocial units 8.3: Same as March 2 version.	Admission criteria for the respective focus-specific psychosocial units 9.3: Neurobehavioral Psychosocial Unit: This unit is primarily for adults of all ages with primary medical problems and concomitant ***or primary*** neurobehavioral sequelae of organic brain disorders such as head injury/brain trauma, cerebral tumors, infections disease processes affecting the central nervous system, cerebrovascular disorders, nutritional and toxic neurodegenerative disorders associated with drug and alcohol use, and organic mental disorders and/or dementia's with behavioral complications.	Admission criteria for the respective focus-specific psychosocial units 8.3: Same as March 2 version.

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	8.4: Medical Psychosocial Unit: [Renumbered from p. 9.5 in pre-February 5 version] This unit is primarily for persons under the age of 65 with primary medical problems who also have behavioral problems due to psychiatric diagnoses such as schizophrenic disorders, schizo-affective disorders, major affective disorders, atypical psychosis, paranoid disorders, organic mental disorders, and dementias with behavioral complications. 8.5: Geriatric Psychosocial Unit: [Renumbered from p. 9.4 in pre-February 5 version] This unit is suitable for persons aged 65 and older, or those with medical problems common to older adults, as well as concomitant diagnoses such as mentioned above [presumably in p 8.4], unless better placed in the dementia cluster. Patients with dementia will be individually evaluated for placement within the psychosocial cluster or the dementia cluster.	8.4: Same as March 2 version. 8.5: Same as March 2 version.	9.4: Geriatric Psychosocial Unit: This unit is suitable for persons aged 65 and older, or those with medical problems common to older adults, as well as concomitant diagnoses such as schizophrenic disorders, schizo-affective disorders, major affective disorders, atypical psychosis, paranoid disorders, organic mental disorders, and dementias with behavioral complications without necessarily having prominent psychiatric disorders, unless better placed in the dementia cluster. Patients with dementia will be individually evaluated for placement within the psychosocial cluster or the dementia cluster. 9.5: Medical Psychosocial Unit: This unit is primarily for males under the age of 65 with primary medical problems who also have behavioral problems due to psychiatric diagnoses such as schizophrenic disorders, schizo-affective disorders, major affective disorders, atypical psychosis, paranoid disorders, organic mental disorders, and dementias with behavioral complications ***without prominent psychiatric disorders***.	8.4: Same as March 2 version. 8.5: Same as March 2 version.
	Exclusion criteria for Psychosocial Cluster Units • Uncomplicated dementia without behavioral problems • Behavioral problems that are secondary to chemical dependence alone • Severe personality disorders not amendable to treatment • Behavioral problems that are primarily forensic	Exclusion criteria for Psychosocial Cluster Units Same as March 2 version.	Exclusion criteria for Psychosocial Cluster Units • Uncomplicated dementia without behavioral problems • Behavioral problems that are ***solely*** secondary to chemical dependence alone • Severe personality disorders not amendable to treatment • Behavioral problems that are primarily forensic	Exclusion criteria for Psychosocial Cluster Units Same as March 2 version.
	Procedures specific to Psychosocial Cluster Units 8.6 Re-numbered from p. 9.6 in pre-February 5 version; completely new text] For residents whose movements throughout the facility are restricted, the IDT will document participation of	Procedures specific to Psychosocial Cluster Units 8.6 Same as March 2 version.	Procedures specific to Psychosocial Cluster Units 9.6 Referrals from outside LHH require completion of the psychosocial cluster non-LHH referral form available from Admissions and Eligibility as well as any other forms	Procedures specific to Psychosocial Cluster Units 8.6 Same as March 2 version.

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	the resident, conservator or surrogate decision-maker in placement decision-making and care planning.		routinely used for admissions. Screening is done by the LHH Screening Committee which includes representation from the psychosocial cluster. An interdisciplinary evaluation team from the psychosocial cluster will assess the candidate, make a decision within ten (10) days of referral, communicate the decision to the referral source, and coordinate the admission with Admissions and Eligibility and the LHH Bed Control Coordinator.	
	8.7 The Psychosocial Unit IDT, including a psychiatrist and/or psychologist, will re-evaluate the appropriateness of the resident's placement one month after admission, quarterly thereafter and as needed.	8.7: The Psychosocial Unit IDT will re-evaluate the appropriateness of the resident's placement one month after admission, quarterly thereafter and as needed.	9.7 Referrals from within LHH require completion of the psychosocial cluster internal referral/evaluation form. An interdisciplinary evaluation team from the psychosocial cluster will assess the candidate, make a decision within ten (10) days of referral, communicate the decision to the referral source and send them a completed copy of the referral/evaluation form, and coordinate the admission with the LHH Bed Control Coordinator. 9.8 Candidates who are accepted for admission when beds are unavailable will be placed on a waiting list.	8.7: Same as March 2.
			Discharge or relocation 9.9 The Psychosocial Unit IDT, including a psychiatrist and/or psychologist, will re-evaluate the appropriateness of the resident's placement one month after admission, quarterly thereafter and as needed. 9.10 Cluster continuum: The goal is to promote movement along the continuum of services provided throughout the cluster in order to promote effective treatment and adaptation in the least restrictive setting both within LHH and the community at large. 9.11 Residents will be discharged/relocated when they have achieved a level of functioning more	

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			suitable to another setting. 9.12 Discharge to acute psychiatric facilities will be made according to usual hospital procedures in the event that residents become unmanageable due to imminent threat of harm to self or others , or the inability of the LHH Unit to meet the acute psychiatric needs of the resident.	