Michael Lyon, 128 Faith Street, San Francisco CA 94110, 415-215-7575, mlyon01@comcast.net

Clerk, SF Board of Supervisors, 1 Dr. Carlton B. Goodlett Place, Room 244, San Francisco, CA 94102

Dear Supervisors,

California Health & Safety Code, Sec. 1440, delegates to the county Supervisors exclusive control of county hospitals, such as Laguna Honda, with plenary power to make all rules, and with exclusive power to appoint and fire all officers.

Therefore, I request you as a citizen and taxpayer of San Francisco, to fully perform your duty and exercise your full authority under this state law to take charge of Laguna Honda, to set aside the new "first priority" admissions policy of Mitchell Katz, to order that screeners at Laguna Honda have exclusive power to determine who can be safely admitted, and to require that Laguna Honda immediately conduct a security assessment and adopt a written safety plan, as required by Section 1267.2 Health & Safety Code. In addition, you are requested to exercise your budget authority and instruct Dr. Katz, Laguna Honda administration, and the Controller not to charge the Laguna Honda Medical Staff or any other Laguna Honda budgeted funds for the costs of out-of -county housing of patients the LHH Medical Staff deem unsafe. Finally, it is your responsibility to carry out state law and Health Commission policy assuring equal access to all eligible SF residents. You are legally responsible for what happens at Laguna Honda and continuation of present policies will deepen the present dangers. Please exercise the control that the Health and Safety Code gives you.

Enclosed is a copy of the amended version of my July 22 taxpayer suit against top administrators of the Department of Public Health and Laguna Honda Hospital. There are eight "causes of action":

1. The speed-up of SF General Hospital (SFGH) admissions into Laguna Honda Hospital (LHH) since 2000, and the March 2004 change in LHH admissions policy (giving priority to transferee patients from SFGH) have greatly affected security and safety at LHH, but LHH neither assessed these changes, nor developed plans and staffing to reduce consequent risks. Failure to do these things is illegal.

2. LHH Medical Staff performs admission screening as the designee of the LHH Chief Administrator, in accordance with Health and Safety codes. Health Department Director Mitchell Katz has violated these codes by giving non-LHH Staff the power to countermand screening decisions of LHH Medical Staff, even when LHH Medical Staff screener objects to an admission on the basis of Health and Safety Code guidelines.

3. Organized LHH Medical Staff objected formally and professionally to the March 2004 Admissions policy change (giving priority to transferee patients from SFGH) in proper fashion, in a letter from Chief of Staff Paul Isakson to Dr. Katz on April 7, 2004. Under the Business and Professions code, Katz has a duty to comply with these findings as they are based on the Organized LHH Medical Staff assessment of the clinical best interests of LHH patients. He did not.

4. Dr. Katz and the Chief Administrator of LHH have publicly stated on multiple occasions that the budget for the LHH medical staff would be used, and is being used, to pay for alternative care of transferee SFGH patients that LHH Medical Staff screeners reject as not appropriate for LHH. This is illegal retaliation per state Business and Professions Code (which prohibits retaliation against medical staff members for health care advocacy).

5. Using LHH funds for alternative care of transferee SFGH patients that LHH Medical Staff screeners reject is unlawful misappropriation of funds, since there is no provision in the LHH budget for expenditures for non-LHH patients. The Board of Supervisors enacts the budget, which allots funds to specified areas within departments.

6. The March 2004 Admissions policy was put into place in violation of the rules of the LHH Organized Medical Staff and in violation of legally binding rules for policy change at LHH, since no designated committee at LHH approved it.

7. Giving SFGH patients first priority for LHH admission is a breach of a compact with the public and San Francisco residents. The suit describes the factual and legal basis of this compact. Continuation of current LHH admission policies, based on unequal access, would make it impossible for the new LHH to operate on the basis of equal access. The concept of a new LHH with unequal access is in contradiction to many written statements made to the public by key players in DPH prior to the LHH bond issue vote.

8. The March 2004 LHH admissions policy giving SFGH inpatients first priority is a violation of city and state codes and policies about the duty to equally and fairly furnish SNF services to those unable to pay, or those unable to obtain SNF services because they are not commercially available in San Francisco.

The suit seeks relief to compel DPH to preserve LHH for all the eligible public, assure safety for LHH patients, staff and visitors, and protect Medical Staff's right to advocate for patients, by stopping DPH's illegal practices.

Michael Lyon

For further questions, please speak with my attorney Lynn S. Carman, 1035 Cresta Way, #3, San Rafael, CA 94903

Telephone 415-927-4023, Facsimile: 415-499-1687, e-mail: a7827@comcast.net

Disclaimer:

Like the transcript of the June 24, 2004 San Francisco Board of Supervisors' City Services Committee hearing on the LHH admissions policy change — which was originally a 60-page, double-spaced document that was reduced to only 24 single-spaced pages to save you paper — the enclosed document is a ***facsimile*** [reproduction] of a Writ of Mandamus filed in San Francisco County Superior Court by plaintiff Michael Lyon.

The Verified First Amended Petition for Writ of Mandamus, including attached Exhibits, on file with the Court is a 67-page document. The 40-page double-spaced filing with the Court has been reduced here to 19 single-spaced pages, for your convenience in printing fewer pages. (**Note:** The original page numbers of the Court filing are set in reverse type on a black rectangle in the left margin.) This facsimile of the Petition, including Exhibits, has been reduced to only 46 pages.

Minor formatting changes between the Court filing and this facsimile version have been made, which not do alter the content of the Court filing; any errors contained in the original Court filing have not been corrected.

LYNN S. CARMAN, SBN 028860
1035 Cresta Way, #3
San Rafael, CA 94903
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Attorney for Petitioner,
Michael Lyon

ENDORSED
FILED
San Francisco County Superior Court
AUG 12 2004
GORDON PARK-LI, Clerk
BY: ____________
Deputy Clerk

SUPERIOR COURT OF THE STATE OF CALIFORNIA
UNLIMITED JURISDICTION – COUNTY OF SAN FRANCISCO

MICHAEL LYON,

Petitioner

-vs.-

MITCHELL KATZ, M.D. Director of Public Health of the City and County of San Francisco; SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH, a department of the City and County of San Francisco; SAN FRANCISCO HEALTH COMMISSION, a board of the City and County of San Francisco; LAGUNA HONDA HOSPITAL AND REHBILITATION CENTER, an institution and sub-department of the Department of Public Health of the City and County of San Francisco; and LAWRENCE FUNK, Administrator of the Laguna Honda Hospital and Rehabilitation Center,

Respondents.
_______________________________________/

No. CPF-04-504376

VERIFIED FIRST AMENDED PETITION FOR WRIT OF MANDAMUS

JURY TRIAL WAIVED

Filed July 22, 2004

VERIFIED FIRST AMENDED PETITION FOR WRIT OF MANDAMUS

TO THE ABOVE-ENTITLED HONORABLE COURT:

The verified first amended petition for a writ of mandamus of Michael Lyon, pursuant to § 1087 Code of Civil Procedures, respectfully shows:

PARTIES[1]

1. Petitioner is a citizen of the United States, having been born in New York, New York, on December 7, 1939. He is a resident and citizen of the City and County of San Francisco, State of California (the "City"). He has resided in San Francisco, California since 1973. He currently resides in a residence of which he is a part owner, at 128 Faith, San Francisco.

[1] Headings and footnotes are not allegations or part of this Petition, and need not be admitted nor denied by the respondents.

Suit as resident and citizen under Green v. Obledo

2. Petitioner sues as a resident and citizen of the City, and on behalf of the public, pursuant to and as authorized by Green v Obledo (1981) 29 Cal.3d 126, to procure the due performance of public duties owed by the defendants, who are officers or an agency of the City.

Taxpayer suit

3. Petitioner has within one year last past been assessed and has paid a real property tax to the City in respect to his part interest in the residence at 128 Faith, San Francisco.

4. Petitioner also sues pursuant to § 526a Code of Civil Procedure, in his capacity as a citizen resident taxpayer of the City, to obtain a writ of mandamus and injunction to restrain and prevent illegal expenditure and waste of, and injury to, the public funds of the City.

Respondents

5. The respondent San Francisco Health Commission is, by § 4.110 City Charter, the governing board of the San Francisco Department of Public Health.

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6. The respondent San Francisco Department of Public Health (Department) is, by § 4.110 City Charter, a department of the City.

7. The respondent Mitchell Katz, M.D., is the Director of Public Health of the City, ("Director"), and as such is the chief officer of the Department. He is sued in his official capacity only.

8. The respondent Laguna Honda Hospital and Rehabilitation Center ("LH") is, by § 111 of Article 3, City Health Code, an institution and a sub-department within the Department.

9. The respondent Lawrence Funk is the Administrator of LH (the "LH Administrator"), and as such is the chief executive officer of LH. He is sued in his official capacity only.

11. The Health Commission, Department, Director; LH, and the LH Administrator each have the duty and power under §§ 4.104, 4.110, and 4.126 of the San Francisco Charter ("City Charter") and § 111 of Article 3 of the City Health Code, to maintain and operate LH.

12. Since before 1998, LH is and has been duly licensed by the state Department of Health Services (DHS) under § 1250 et seq. California Health & Safety Code, as a general acute care hospital with a distinct-part skilled nursing facility (SNF) as part of the hospital. The license is for 243 licensed general acute care beds, and 1,214 SNF beds, with also, physical therapy, speech pathology, audiology, and occupational therapy services.[2]

13. At all relevant times, San Francisco General Hospital (SFGH) is and has been duly licensed by the state DHS as a general acute care hospital with a distinct-part acute psychiatric hospital and a distinct-part skilled nursing facility as part of the hospital. The license is for 407 general acute care beds, 106 acute psychiatric beds, and 117 SNF beds.[3]

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Hospitals and skilled nursing facilities

14. - (1) Subd. (a) of § 1250 California Health & Safety Code provides that a "general acute care hospital" is a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including medical and certain other basic services.

-(2) Subd. (c) of § 1250 Health & Safety Code provides:

> " 'Skilled nursing facility' means a health facility that provides skilled nursing care and supportive care to patients who primary need is for availability of skilled nursing care on an extended basis."

15. § 1418.6 of the Health & Safety Code provides:

> "No long-term care facility shall accept or retain any patient for whom it cannot provide adequate care."

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[2] LH holds license No. 220000040 issued by DHS.

[3] SFGH holds license No. 220000063 issued by DHS.

16. 42 Code of Federal Regulations (CFR), § 483.15 provides:

"A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life."

17. 42 CFR § 483.15(h) provides that a SNF must provide a safe, homelike environment.

18. LH is certified by the state DHS, pursuant to Title 22, California Code of Regulations (CCR), § 51215, to participate in the federal-state Medi-Cal program as a hospital which furnishes skilled nursing facility (SNF) services, on condition, as required by Title 22, CCR § 51335(j)(2) that the Medi-Cal beneficiaries in LH have a medical condition which needs visits by a physician at least every 60 days, with constantly available SNF services.

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BACKGROUND FACTS

PART ONE

CALIFORNIA LAW, AND THE COMPACT BETWEEN THE CITY AND THE ELECTORATE WHO PASSED PROPOSITION A, WHICH RELATES TO LH.

The article XI police power to furnish SNF services of LH to those unable to pay.

19. The City, as a city and county, has the police power under article XI, section 7, California Constitution to provide for the public health, safety, and general welfare, ("the article XI, policy power"), by furnishing skilled nursing facility (SNF) services of LH to those in need who are unable to pay, (who are called the "medically indigent").

20. The article XI police power, when exercised for the purposes of furnishing SNF services to City residents who are unable to pay, is referred to in this Petition as the "police power to furnish SNF services to those unable to pay."

The delegated § 17000 power to furnish SNF services to those unable to pay.

21. The City also has the power which is delegated to the City, in its function as a county, by § 17000 Welf. & Inst. Code ("WI Code"), to aid and relieve medically indigent residents of the county by furnishing SNF services to those in need thereof; (therein, the "delegated § 17000 WI Code power to furnish SNF services to those unable to pay").

22. The respondents, in exercising the article XI police power or the delegated § 17000 WI code power to furnish SNF services to those unable to pay, are therein authorized to also admit patients who can afford to pay for the SNF services provided; all to the end that the net cost to the City to furnish SNF services to those unable to pay, is thereby reduced.

The article XI police power to furnish SNF services which are commercially unavailable to City Residents.

23. The City also has the police power under article XI, section 7, California Constitution, to furnish the SNF services of LH to San Francisco residents, including those who can pay therefore, whenever needed SNF services become commercially unavailable in San Francisco to San Francisco residents. In this respect the Director, the Department, the Health Commission, and the San Francisco Board of Supervisors have determined, expressly and implicitly, that there is a shortage of SNF beds in San Francisco which will increase dramatically in the next two decades to a shortage of 2,380 beds by 2020. Just one of such determinations is set forth in a report of the Director to the Mayor entitled Options for Laguna Honda Hospital White Paper, dated December 10, 1998, which found that:

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"The need for long-term care (both community-based and hospital-based) will grow over the next two decades. An estimated 6% of San Franciscans aged 18 - 64 and 23% of San Franciscans over the age of 65 have mobility problems or limitations in taking care of themselves. This translates to approximately 57,000 lives in the year 2000. Some of these individuals can be cared for in their homes mor in less intensive settings while others will require skilled nursing in institutions such as LHH. By the year 2000 there will be a shortage of 277 SNF beds in San Francisco. Estimates are that this shortage will increase to 2,380 beds by the year 2020 assuming that SNF beds continue to be used at the same rate (i.e. 33 SNF beds for every 1000 persons aged 65 and older). LHH is a critical component of San Francisco's long-term care delivery system."

The article XI police powers and the delegated § 17000 power to furnish SNF services to those unable to pay are inconsistent with and preclude the respondents from giving first priority of admission to LH to any persons, other than on a basis of (1) their relative need for the safety, protection and care afforded by the SNF services of LH and (2) the ability of LH to

adequately care for them consistent with their safety and the safety of others.

24. (1) The article XI police power of the City to furnish SNF services of LH to those unable to pay; (2) the article XI police power of the City to furnish SNF services of LH to City residents when, as is the case, there is a shortage of SNF beds commercially available in San Francisco , and (3) the delegated § 17000 WI Code power of the City to furnish SNF services to those unable to pay, are inconsistent with and preclude as a matter of constitutional and statutory law any ordinance, regulation, rule or practice of the City or the respondents which does not provide equal access to the SNF services of LH, (subject to the priority or triage of their relative need for the care and protection of, and the ability of LH to provide adequate SNF services consistent with their safety and the safety of the other residents and the staff of LH).

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25. The constitutional law mentioned above includes the equal protection right of all persons not to be arbitrarily or capriciously discriminated against in applying for public benefits made available to them by a city or county under local, state or federal law.

§ 17000 WI Code also prohibits first priority from being given to any group of medically indigent residents, over any other medically indigent residents.

26. If the City furnishes any SNF services or level of SNF services at LH under § 17000 WI code to residents who are unable to pay therefore, then the City must, under § 17000 WI Code, make the same SNF services or level of SNF services, at LH, similarly available to all other San Francisco residents who are unable to pay therefore, on an equal

basis; or, -- if the LH SNF services are limited, -- then, upon a priority or triage of their relative need for the care and protection of, and the ability of LH to provide, adequate SNF services consistent with their safety and the safety of the other residents and the staff of LH.

27. However, the new **first priority** policy for admission to LH which is complained of in this Petition violates the above equal access requirement of § 17000 WI Code, as shall be set forth more particularly below.

The City Health Code also precludes any policy which gives first priority for LH admission to SFGH patients.

28. § 115.1 of Article 3 of the City Health Code provides that the priorities of admission to LH are as follows:

"Notwithstanding any other provision of this Code, any sick, disabled, or injured person may be admitted to the institutions of the Director of Public Health of the City and County of San Francisco as an in-patient or out-patient. The Director of Public Health shall give preference in the admission of patients in the following order of priority:

1. Sick or injured persons is need of emergency care.

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2. Sick, medically indigent residents of the City and County of San Francisco.
3. Sick persons certified by the San Francisco Department of Social Services as eligible for benefits under [the state Medi-Cal Act § 14000 et seq. WI Code].
4. Sick residents of the City and County of San Francisco.

29. "Sick, medically indigent residents," as used in the above § 115.1 of Article 3, City Health Code, includes San Francisco residents in need of the care and protection of SNF services, who are unable to pay therefore.

30. The respondents, by § 115.1 of Article 3, City Health Code, are prohibited from adopting any policy to give **first priority** of admissions to LH for SNF services to **patients of SFGH**, inasmuch as patients of SFGH, as such, are not authorized by § 115.1 of Article 3, City Health Code to be given priority for admission to LH, over others.

Also, the Health Commission has adopted an "equal access" regulation which is binding on the respondents.

31. Health Commission Resolution No. 30-98, adopted September 1, 2004, provides that in providing quality health care that the Department shall "ensure equal access to all."

32. Inasmuch as Health Commission Resolution No. 30-98 is a written rule and regulation adopted pursuant to § 4.126 City Charter to which the respondents are subject, it follow that the policy of the respondents, which is complained of in this Petition, which purports to provide that **SFGH patients shall have first priority** to be admitted to LH for SNF services is facially **void ab initio**, as being contrary to the requirement of Health Commission Resolution No. 30-89 that the Department shall ensure equal access to its services to all.

The Laguna Honda Compact

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33. The 1998-1999 Civil Grand Jury of San Francisco, after a study of LH, concluded and recommended in 1999 that the City should build a replacement long-term care facility at the Laguna Honda site, by means of a bond issue which the Grand Jury recommended be placed on the ballot by the San Francisco Board of Supervisors. The Grand Jury report found and concluded that:

> "The Mayor and the Board of Supervisors must support the proposed bond issue. Passage of the proposition may be vital to the continued long term well being of many of the City's residents, especially its senior citizens."

34. Thereupon in 1999 the San Francisco Board of Supervisors, in a measure, proposed to the San Francisco voters that they approve Proposition A in a bond special election at the November 2, 1999 Consolidated Municipal Election, for the issuance of $299 million in City bonds, and tax themselves to pay for the bonds, in order to build a replacement long-term care facility with SNF services, (the "New Laguna Honda"), on the same site as LH now stands.

35. In the Voter Pamphlet for Proposition A:

- the Board of Supervisors and its members,
- the Mayor of San Francisco
- the Director,
- the members of the respondent San Francisco Health Commission,
- the Chief Medical Officer of the Community Health Network of the Department;
- the Chief Financial Officer of the Department;
- the City Attorney of San Francisco,

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all wrote official or paid arguments, and the respondent Director also personally paid for, -- and was publicized in the Voter Pamphlet for being one of the 3 largest contributors who paid for, -- many separate paid arguments in the Voter Pamphlet, -- in all of which official or paid arguments, and in their whole, these City officers and boards, representing in their official capacities and by their unanimity the City itself, represented and promised the voters, expressly and implicitly, that if they passed Proposition A, that the bond proceeds would be used by the City to build the New Laguna Honda as a long-term care facility with SNF services which would be available to, and would admit and furnish SNF services to all the public of San Francisco, -- including the frail, elderly and disabled of San Francisco in need thereof, -- irrespective of ability to pay, and on an equal basis, (subject to the priority or triage of their relative need for the care and protection of, and the ability of LH to provide, adequate SNF services consistent with their safety and the safety of the other residents and the staff of LH).

36. The voters, in reliance upon these representations and promises, did pass Proposition A; and the City commenced construction of the New Laguna Honda in November 2003 and has already spent a substantial portion of the Proposition A bond funds and Tobacco Settlement funds therefore, -- (which latter funds, by Proposition A, are required to be used in help construct the New Laguna Honda); -- **so that** the City, including the respondents, thereby became bound and required in law to use the New Laguna Honda, when it opens as scheduled in 2007, as a long-term care facility with SNF services which is open for admission on an equal basis to all of the San Francisco community, irrespective of ability to pay; including, on an equal basis, the frail and elderly of San Francisco; or, if the SNF services are limited, then, upon a priority or triage of the person's relative need for the care and protection of, and the ability of LH to provide, adequate SNF services consistent with their safety and the safety of the other residents and the staff of LH, (herein the "Laguna Honda Compact").

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The public use impressed upon LH, the LH site, and the New Laguna Honda Compact by the expenditure of Proposition A bond proceeds to construct the New Laguna Honda, pursuant to the Laguna Honda Compact.

37. Also, -- by each and all of the facts alleged in the preceding Paragraphs of this Petition, and by the Laguna Honda Compact, -- LH, the LH site, and the New Laguna Honda being constructed on the LH site, have each become dedicated and impressed with a public use, namely, to be used as and for a long-term care facility with SNF services for the public of San Francisco, on an equal basis for all, and irrespective of ability to pay; which public use admits, under the California law of the public use, of no preference or first priority to any group, including patients at SFGH, for admission to the New Laguna Honda for SNF services, (other than upon a priority or triage, in comparison with other candidates for admission, of their relative need for the care and protection of, and the ability of LH to provide, adequate SNF services consistent with their safety and the safety of the other residents and the staff of LH).

38. The Laguna Honda Compact and the public use alleged above are superior to any contrary provision in the City Charter, municipal codes, or regulations, rules or policies of the City or the respondents which purport to give **first priority** to SFGH patients for admission to LH for SNF services; and especially, without limitation, supersedes any contrary provisions in § 111.5 of Article 3 of the City Health Code.

PART TWO

THE DEMOGRAPHICS OF LH, AND THE LH WARDS

39. In 1998, approximately 17% of LH residents were between the ages of 21 and 55; approximately 30% were between 55 and 75; and approximately 54% were 75 or older; all, as set forth in a chart entitled "Laguna Honda Distribution of Residents by Age – June 30, 1998 vs. 2004," (herein the "LH Age Distribution Chart"), which is part of the official records of LH.

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40. A copy of the LH Age Distribution Chart is attached labeled **Exhibit A**. The contents of the chart in **Exhibit A** are referred to and incorporated as if fully set forth herein.

41. As of 1999, 97% of LH residents were on Medi-Cal, the State's medical program for many indigents; 2% were on Medicare; and only 1% were on private pay.[4]

42. Many LH residents need daily assistance for bathing, dressing, toilet, and transferring from bed or chair.[5]

43. Most of LH residents are in a chair all or most of the time. Approximately one- third are ambulatory, (with half of these able to ambulate only with assistance or devices).[6] In addition to functional impairment, many LH residents have chronic medical conditions associated with age and disability, and a significant number have either behavioral or psychiatric diagnoses which compound their medical ailment; so that the LH resident population needs extensive help with activities of daily living, is less mobile and have special care needs based on chronic physical and mental health problems.[7]

44. For many residents, LH is their last home, inasmuch, as reported in 1999, approximately one-third of LH's residents dies each year.[8]

46. LH, as it has for many years since before 1999, houses the majority of its SNF residents in floorwide open wards of 24 to 30 beds in rows, without any barriers between most beds, (except curtains which may be drawn around each bed for privacy, but which present no barrier to intrusion).

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[4] Report on the Placement (sic) of Laguna Honda Hospital of the Laguna Honda Replacement Planning Committee, (appointed by the Health Commission), which was presented to the Health Commission, dated April 20, 1999.

[5] Table 4 at page 9 of Report on the Placement of Laguna Honda Hospital, supra.

[6] Pages 8-9 of Report on the Placement of Laguna Honda Hospital, supra.

[7] Pages 8-9 of Report on the Placement of Laguna Honda Hospital, supra.

[8] Page 8 of Report on the Placement of Laguna Honda Hospital, supra.

The open wards at LH

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47. The common areas of LH used by LH residents are open, as are the many corridors of LH which are used by residents, staff, and visitors alike.

48. The small number of private and semi-private rooms for LH residents have no locks, hence have no barrier to intrusion from other LH residents so as to be, in practical effect, open resident rooms.

49. The interior of the aforesaid open resident rooms are not within LH staff view unless a staff member happens to be in the room.

50. The bathrooms for the residents of LH in the open wards, and for the residents in the open resident rooms, have no locks, hence, have no barrier to intrusion from other LH residents.

51. The residents' bathrooms are not within LH staff view when their unlocked doors are closed.

52. Some portions of the open wards are not within LH staff view, depending upon where the staff member is standing in the ward. Beds around which the occupant has drawn the curtain for privacy are not within view of LH staff. Common areas and hallways are not under observation of LH staff unless a staff member happens to be in the area.

The LH general acute care hospital open wards

53. Approximately 10 of the general acute care hospital beds of LH are in an open ward on Ward M7, in which the approximately 10 beds in one section of the open ward are general acute care hospital beds, and the other approximately 15 beds in the other section of Ward M7 are SNF beds; with an open large open doorway between the two sections which is not a barrier between the two sections.

Admittees from SFGH are younger and more aggressive so as to put Frail, elderly residents at risk of harm.

54. Residents admitted to LH from SFGH are, on average, younger and more robust than the average LH resident, and many LH admittees from SFGH are medically involved individuals with behavioral disorders which render them aggressive and combative; so as to thereby put frail, elderly residents of LH at risk of harm, due to the latter being housed in the same open wards with the former without any protection, (including both the open SNF wards throughout LH as well as the general acute care hospital ward in Ward M7).

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PART THREE

THE CHANGE IN LH ADMISSIONS POLICY

The prior LH admissions policy

52. In fiscal year 2000-01, and for many years prior, the admissions policy of LH was to give first priority of admissions to persons not in any medical facility, who cannot receive adequate care in their present circumstances, and to give second admissions priority to patients at SFGH, (herein, "the Prior LH Admissions Policy"). The Prior LH Admissions Policy was set forth in the Laguna Honda Hospitalwide Policies and Procedures manual, (the "Laguna Honda Policy Manual").

53. The basis for the Prior LH Admissions Policy was that persons in a medical facility are already in a safe environment; whereas those at risk or in danger at home are not in a safe environment; hence the ethical priority is to give first priority to those not already in a medical facility, on the basis that the home-bound individuals at risk have a higher immediate need for care and protection of the services at LH, than those already receiving care and protection in a medical facility.[9]

54. Elderly, frail residents were at risk at harm, even under the Prior LH Admissions Policy, due to housing of frail, elderly residents in the same open wards with ambulatory residents who are aggressive or combative. Thus the U.S. Department of Justice early found, determined and notified LH by letter dated May 6, 1998, that:

[9] April 7, 2004 notice and memorandum of Paul Isakson, M.D., Chief of Staff of LH, to the Director. (**Exhibit D** attached.)

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"LH Does not take sufficient steps to protect residents who are risk of harm from their own acts and the acts of others, particularly, residents with cognitive and dangerous behaviors . . . The potential for harm is heightened by LHH's practice of housing frail, elderly residents who are confined in their beds with residents who are ambulatory and have aggressive or combative behaviors."

55.Under the Prior LH Admissions Policy, the combined number of LH admissions of patients from SFGH, (namely, the total of both new admissions from SFGH, and readmissions of those who had been discharged to the community after being admitted to LH from SFGH), was 444 per year, or an average of 37 SFGH patients per month, as of the fiscal year 2000-01.[10]

Speed-up of admissions of SFGH patients to LH

56. At least by November 9, 2001, the respondents adopted a policy and have engaged in a continuing practice ever since to substantially speed up, and thereby increase, the influx of SFGH patients into LH, (herein, "the LH admissions speed-up policy").

57. The LH admissions speed-up policy was implemented as follows:

- (A) In February 2002 the Director adopted a policy and goal to reduce in-patient days for SFGH Psychiatry inpatients, and established the Patient Flow Committee at SFGH, with two committees, one of which was the Placement Committee, which was and continues to be authorized by the Director to place patients at all levels of care of the department.[11]

- (1) The Placement Committee is sometimes called the "Patient Placement Team."

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- (B) By June 2002, inpatient units were developed at SFGH to earlier identify SFGH patients with difficult problematic disposition issues, and to aggressively review discharge plans and coordinate discharges from SFGH. [12]

- (C) As a result of the above, LH admitted more SFGH patients than formerly.

- (D) In early 2004 the Director caused a Patient Flow Task Force to be formed, with over 20 representatives from SFGH and LH, with the stated goal of the Patient Task Force to improve the patient flow from SFGH to LH, and to significantly reduce, still further, the number of days spent by patients at SFGH awaiting transfer at a lower level of care.[13]

- (E) On or about February 26, 2004, the Patient Flow Task Force decided that thenceforth a screener from LH would now make daily rounds at SFGH to screen, and report to the Task Force, which SFGH patients, who were deemed ready by SFGH officials for discharge to LH, were too dangerous to be given adequate care at LH;[14] which plan was implemented by LH, (despite the fact that the Patient Flow Committee or its subcommittees were authorized by the Director to reject, and have countermanded from time to time, the screening decisions of the LH screener, either directly or by and through a "consultant" or "arbitrator" appointed by the Patient Flow Committee to accept or reject the LH screener's screening decisions, when the Patient Flow Committee has differed with the LH screener's decision that a given SFGH patient is too dangerous to be admitted to LH).[15]

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March 2, 2004 change in the LH admissions policy

58. On or about March 2, 2004, the Director and the LH Administrator unilaterally changed, and caused to be changed, the Prior LH Admissions Policy by changing, and causing to be changed, the Laguna Honda Policy Manual so as to now provide that SFGH patients who are "ready for discharge to SNF level of care will be admitted" before all other residents of San Francisco, regardless of any of the latter's relative or superior need for the care and protection of SNF services, (herein, the "New LH Admissions Policy").

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[10] Minutes of July 25, 2002 meeting of the JCC-LH.

[11] Minutes of June 11, 2002 meeting of the JCC-SFGH.

[12] Minutes of June 11, 2002 meeting of the JCC-SFGH.

[13] Minutes of February 26, 2004 meeting of the JCC-LH

[14] Minutes of February 26, 2004 meeting of the JCC-LH.

[15] Minutes of March 25, 2004 and April 22, 2004 meetings of the JCC-LH.

59. The provisions of the New LH Admissions Policy, as set forth in the March 2, 2004 revision of the Laguna Honda Manual, are set forth in *haec verba* in **Exhibit B**, and made a part of this Petition as if fully set forth herein.

The LH admissions speed-up policy and the New LH Admissions Policy has caused a 67% increase in the annual rate of SFGH patients admitted or readmitted to LH, per year, so that 79% of those now being admitted to LH are admitted or readmitted patients from SFGH.

60. **NOTE:** The term "readmitted," refers to those patients originally admitted to LH from SFGH, who, after their discharge from LH, are readmitted to LH.

61. As a direct result of the LH admissions speed-up policy and practice which commenced in fiscal 2001-02,[16] the number of all SFGH patients admitted to LH per month (both the newly admitted and the readmitted), increased to a monthly rate of 44 such admissions per month as of February 2004, immediately preceding the New LH Admissions Policy, -- which is a **19% increase** from the starting monthly rate of 37 such admissions per month which obtained in fiscal 2001-02 when the LH admissions speed-up policy commenced.[17]

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62. Also, as direct result of the addition of the New LH Admissions Policy on March 2, 2004 by the Director, the number of combined SFGH patients admitted to LH per month, (bot the newly admitted and the readmitted), rose to a much higher and unprecedented monthly rate of 62 such admissions, per month, for the three months of March through May 2004, -- which is a **67% increase** from the starting rate of 37 such admissions per month in the base year of fiscal 2001-02.[18]

63. Further, new admissions to LH from SFGH rose to a record rate of 79% **of all new admissions** to LH during the three months following the March 2, 2004 change to the New LH Admissions Policy.[19]

Changes in the age demographics at LH

64. The ratio of LH patients between the ages of 21 to 55, to LH residents 75 or older, has increased so that in 2004 there is now one such younger resident to every 2 such older residents, compared to the ratio of one such younger resident to every 3 such older residents in 1988, as set forth in the LH Age Distribution Chart, (**Exhibit A** attached to this Petition).

65. This is a dramatic 50% increase in the ratio -- i.e., from .33 to .50 -- of such younger residents, aged 21 to 55, to such older residents, aged 75 or older, which is due primarily to the LH admissions speed-up, and only partly to the New LH Admissions Policy, (which latter was in effect for only the last 3 months of the change period involved).

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Increase in LH residents with psychiatric/mood disorders

66. The number of LH residents with psychiatric/mood disorders, (i.e., anxiety disorder, depression, manic depression and/or schizophrenia) has increased from 210 such residents in 1998 to 294 in 2004, -- a 40% increase which is consistent with the creation of the psychosocial units at LH in 2001, for the stated purpos4e of providing a therapeutic environment for residents who have primary medical diagnosis complicated by complex psychosocial needs.[20]

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[16] Minutes of November 9, 2001 meeting of the JCC-LH.

[17] I.e., the number of such SFGH patients newly admitted or readmitted to LH rose from 451 per year, or 37 per month, in fiscal 2001-02, compared to 356 such LH admissions for the 8 months ended February 2004, -- which latter rate (which preceded the New LH Admissions Policy), equated to 44 such admissions per month, or 528 such admissions per year.

[**See**, minutes of the April 22, 2004; May 27, 2004; and July 22, 2004 meetings of the JCC-LH and the minutes of the July 25, 2002 hearing of the Joint Conference Committee for SFGH ("JCC-SFGH").]

[18] I.e., there were 187 new admissions from SFGH for the three months March through May of 2004, which is a rate of 62 per month, or 744 per year, of new admissions from SFGH.

[19] I.e., there were 199 new admissions to LH from SFGH during the months of March, April and May of 2004, compared to 151 new admissions to LH from all sources for the same period; so that the new admissions from SFGH during this period comprised 79% of all the new admissions to LH, for the period.

[20] **See**, minutes of November 9, 2001 meeting of the JCC-LH.

<u>Increase in violence at LH since the New LH Admissions Policy</u>

67. The monthly rate of aggressive problem behavior of LH residents which was reported to and recorded by LH, nearly doubled to 30 such incidents per month, following the March 2, 2004 change to the New LH Admissions Policy.

68. Thus, there was an average of 17 incidents of aggressive problem behavior of residents at LH, per month, in the prior nine months ended March 2004, compared to the sharp increase to 30 such incidents per month, in the three months following the start of the New LH Admissions Policy on March 2, 2004.

69. The monthly numbers of such incidents of aggressive problem behavior at LH for the 12-month period of June 2003 through May 2004 are set forth below.

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
17	21	15	15	20	14	16	20	18	39	23	27

<u>The Ombudsman officially determined that the New LH Admission Policy puts the LH frail elderly disabled at risk of harm.</u>

70. The San Francisco Long Term Care Ombudsman Program ("S.F. Ombudsman Program") is established pursuant to the federal Older Americans Act, 42 U.S.C. § 3001 et seq., and § 9700 et seq. and 15630 et seq. WI code.

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71. Benson Nadell is the Director of the S.F. Ombudsman Program, (herein, the "Ombudsman").

72. All long term care institutions including LH are mandated by the above ombudsman statutes to report all incidents of physical abuse upon elders to the local Ombudsman, ("Mandated Reports"), who has the duty and power under 42 U.S.C. § 3058g, subd. (a)(3)(A),(E), and (G), and §§ 9720, 9720.5, and 9722 Welf. & Inst. Code to:

- investigate such reports and inspect facility records to do so;

- analyze, comment on, and monitor the implementation of state and federal laws, regulations, and other governmental policies and actions that pertain to the health, safety, welfare and rights of long-term care facility residents, with respect to the adequacy of long-term care facilities; and,

- recommend changes in laws, regulations, policies, and actions.

73. On May 17, 2004, Ombudsman Nadell, acting in his official capacity in performance of his public duties under the Ombudsman statutes, found and determined that the New LH Admissions Policy and the screening process, which has been prior set forth, puts the regular resident at LH, (i.e., the frail and elderly population at LH) at risk of harm. The Ombudsman, acting in his official capacity, reported his official findings and determination to the Director by a reported dated May 17, 2004, in which, acting in his official ombudsman capacity to recommend changes in laws, regulations, pollicies and actions, requested that the Director take steps to remedy the situation. But the Director has taken no steps to remedy the situation.

74. A copy of the May 17, 2004 report of the Ombudsman to the Director is attached labeled **Exhibit C**.

75. Among other things, -- without limitation of anything alleged above, -- the Ombudsman, in his May 17, 2004 report to the Director, found and determined that (1) the Psychosocial Cluster Units, -- which were organized at LH as prior alleged, in approximately November 2001, -- were established in order to move a relatively younger, more involved population into LH; (2) that the majority of Mandated Reports of assaults on elder residents by other residents, received from LH, reflected a flow of a different type of population into LH, from the geriatric, (3) that most of the reported altercations have occurred in the common areas; (3) that this younger, more disruptive population proposed a risk of harm of the regular frail and disabled population at LH; and (4) that:

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> "The new Admissions Policy and the screening process for overflow of medically involved individuals with personality disorders from SFGH puts the regular resident at risk . . . "

<u>The New LH Admissions Policy rejected by the LH organized medical staff</u>

76. § 2282 California Business & Professions (Bus. & Prof.) Code requires every hospital to have an organized medical staff with appropriate officers and bylaws, and that the organized medical staff shall be self-governing in respect to the professional work performed.

77. LH does have an organized medical staff as required by § 2282 Bus. & Prof. Code, which medical staff has the exclusive power and duty, under § 2282 Bus. & Prof. Code, to make all decisions for LH in respect to professional matters including, implicitly, setting the standards of (1) what policies and practices are consistent with the professional duty and ability of the LH medical staff to provide adequate and safe treatment and care for their patients; (2) what admissions policies and practices create or foster unprofessional risk of harm to the health, safety, and well-being of the patients at LH; and (3) what policies and practice interfere with the professional duty of the LH medical staff to provide adequate and safe care to their patients, including both new admittees from SFGH and their patients who are already residents at LH.

78. Also, where as at LH a part of a licensed general acute care hospital is a distinct-part skilled nursing facility ("SNF"), the organized medical staff of the hospital has the same duties listed in the preceding Paragraph in respect to what policies and practices of LH constitute "adequate care" as required by § 1418.6 Health & Safety Code; what policies and practices of LH constitutes furnishing "care in a manner and in an environment that maintains or enhances" the qualify of life of the patients at LH without abridging the safety and rights of others," as required by 42 C.F.R. § 483.15; and what policies and practices of LH constitute safe care of LH residents as required by subd. (h) of 42 CFR § 483.15.

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79. The LH organized medical staff, -- executing its exclusive duty and power to reject admissions policies which in their professional judgment endanger their ability to furnish adequate and safe care both to proposed LH admittees and to the existing population of LH, and which endanger their ability to ensure that admittees to LH are not, individually or as a group, so dangerous as to present an environment that abridges the safety and rights of their existing patients at LH, -- did, on or about April 7, 2004, officially find and determine that the requirement of the New LH Admissions Policy to give first admissions priority to SFGH patients, coupled with the implementation of the LH admission speed-up policy, constitutes undue pressure upon the LH medical staff to admit or readmit dangerous patients from SFGH to LH, so as to pose undue hazards for all LH patients, many of whom are easy targets for such abuse, and endangers the entire LH community.

80. The rejection and objection of the New LH Admissions Policy by the LH organized medical staff, and the findings, determination and decision of the LH organized medical staff to reject the New LH Admission Policy, which is alleged in the preceding Paragraph, were set forth, on behalf of the entire LH organized medical staff, by Paul Isakson, M.D., Chief of Staff of the LH general acute care hospital, in an official notice and memorandum thereof to the Director, dated April 7, 2004. But the respondents have not, in response thereto, rescinded the New LH Admissions Policy or its provision for first admission priority, at LH, for SFGH patients.

81. A copy of relevant portions of the above April 7, 2004 notice and memorandum of the LH Chief of Staff, on behalf of the LH medical staff, is attached labeled **Exhibit D**.)

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FIRST CAUSE OF ACTION

82. Petitioner refers to and incorporates each of the allegations in the preceding Paragraphs as if fully set forth herein.

83. By each and all of the facts alleged in the preceding Paragraphs, the respondents have substantially changed the former set-up of LH by adopting and implementing the LH admissions speed-up policy and the New LH Admissions Policy, with the purpose and effect of increasing and prioritizing, as a matter of policy, the influx into LH of SFGH's overflow of medically involved patients with behavioral disorders; which in turn has so relatively increased the population of the LH population with medically involved patients with behavioral disorders as to (1) demonstrably and substantially increase the number and seriousness of incidents of aggressive or combative behavior by such behaviorally disordered residents against other LH residents, and (2) demonstrably and substantially increase the risk of harm to the residents, staff, and visitors of LH; all, however, in violation of § 1257.7 Health Code, for failure and refusal of the respondents to perform their mandatory ministerial duty, under § 1257.7 Health & Safety Code, to:

- conduct a new security and safety assessment, in light of the increased level of risk of harm to LH patients, staff, and visitors from the increased number of aggressive or violent behavior of patients with behavioral disorders which, -- by the increased and unprecedented influx into LH of SFGH's overflow of medically involved individuals with behavioral disorders, -- has been created by the LH admissions speed-up policy and the New LH Admissions Policy, from before these policies were adopted and implemented;

- use the new safety assessment to develop a written plan with measures to protect personnel, patients, and visitors from the aforesaid new, substantially increased level of risk of harm to LH patients and staff from aggressive or violent behavior of patients at LH; and,

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- hire sufficient personnel to provide security pursuant to the new security plan;

- implement the new written security plan for LH, a licensed general acute care hospital with a distinct-part nursing facility.

84. Accordingly, by each and all of the facts alleged in this First Cause of Acton, each of the respondents has a present and continuing mandatory ministerial duty under § 1257.7 Health & Safety Code, to (1) immediately conduct, and cause to be conducted, the new security and safety assessment of LH which is mentioned in the preceding Paragraph; (2) use the new safety assessment to develop a written plan with measures to protect LH patients, personnel, and visitors from the substantially increased level of risk of harm to them from aggressive or violent behavior of LH patients who have behavioral disorders; and (3) implement the new security plan, including hiring sufficient qualified security personnel; all, pursuant to and as mandated by § 1257.7 Health & Safety Code.

85. Petitioner here refers to and incorporates the words and figures of Paragraphs 123 through 125 of this Petition, as if fully set forth herein.

SECOND CAUSE OF ACTION

86. Petitioner refers to and incorporates each of the allegations in the preceding Paragraphs as if fully set forth herein.

87. § 1262.7 Health & Safety Code provides:

"(a) A skilled nursing facility, as defined in subd. (c) of Section 1250, shall admit a patient only upon a physician's order and only if the facility is able to provide necessary care for the patient.

(b) The administrator or designee of a skilled nursing facility shall be responsible for screening patients for admission to the facility to ensure that the facility admits only those patients for whom it can provide necessary care. The administrator, or his or her designee, shall conduct preadmission personal interviews as appropriate with the patient's physician, the patient, the patient's next of kin or sponsor, or the representative of the facility from which the patient is being transferred. . . ."

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88. The Director is not, and never has been, the administrator of LH.

89. At all times relevant to this Petition, the LH Administrator has not and does not screen patients for admission to LH, but, as authorized by § 1262.7 Health & Safety Code, has at all times appointed and designated one or more of the medical staff of LH to perform the screening function required by § 1262.7 Health & Safety Code to be conducted in respect to all candidates for admission to LH for SNF services.

90. Such persons who have been so designated from time to time, by the LH Administrator, to perform the screening required by § 1267.2 Health & Safety Code, are referred to below, collectively, as "the LH screener."

91. The respondent Director, Department and Health Commission have a mandatory ministerial duty to comply with, and not violate, the provision of § 1262.7 Health & Safety Code which requires that the administrator or designee of a skilled nursing facility, (here, the LH screener designed by the LH Administrator), shall be responsible for screening candidates for admission to the LH SNF to ensure that the facility admits only those patients for whom it can provide necessary care.

92. However, by each and all of the facts prior alleged in this Petition, the Director and Department have, are, and will continue to violate the above provision of § 1257.7 Health & Safety Code, by their policy and command, (which has been prior alleged), that the Patient Flow Committee at SFGH, including its committee, the Placement Committee, or the before-mentioned Patient Flow Task Force, as the case may be, shall (1) male placement at all levels of the Department, (including transferring SFGH patients to LH), and (2) shall have the authority to countermand screening decisions of the LH screener in respect to SFGH patients who are candidates for admission into the distinct-part skilled nursing facility of LH, but, who are ruled by the LH screener to pose too great a risk of danger to self or others to be admitted to LH.

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93. Further, the Director and the Department, by and through the aforesaid Patient Flow Committee, Placement Committee, and the Patient Flow Task Force which are subject to their direction and control, have violated § 1257.7 Health & Safety Code within the past year by rejecting, on one or more occasions, the exclusive decision of the LH screener, under § 1257.7 Health & Safety Code, that a SFGH patient or patients who were candidates to be admitted to LH, posed too great a risk of danger to themselves and to LH patients and staff, to be admitted into LH for SNF services; (so that therein the LH screener determined, as exclusively empowered by § 1267.2 Health & Safety Code that LH, under its set-up, was not able to furnish adequate, necessary or safe care for the SFGH patient proposed to be transferred to LH for SNF services); which acts constitute a continuing practice.

94. The respondents, unless ordered by the Court, will continue to violate § 1267.2 Health & Safety Code by continuing the policy and the practice alleged in the preceding two Paragraphs.

95. Petitioner here refers to and incorporates each of the allegations in Paragraphs 123 through 125 of this Petition, as if fully set forth herein.

THIRD CAUSE OF ACTION

96. Petitioner refers to and incorporates each of the allegations in the preceding Paragraphs as if fully set forth

91. As prior alleged, LH has an organized medical staff, pursuant to § 2282 California Bus. & Prof. Code.

92.The LH organized medical staff has unanimously rejected the New LH Admissions Policy on the professional basis that the requirement of the New LH Admissions Policy to give first admissions priority to SFGH patients, coupled with the implementation of the LH admission speed-up policy, constitutes undue pressure upon LH to admit or readmit dangerous patients to LH, which poses undue hazards for all LH patients, many of whom are easy targets for such abuse, and endangers the entire LH community of patients and staff.

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93.Accordingly, by the above-alleged rejection of the of the New LH Admissions Policy by the entire organized medical staff of LH, upon the professional basis and for the professional reasons stated in the April 7, 2004 notice and memorandum of Chief of Staff Isakson, (**Exhibit D** attached), the respondents have had, since April 7, 2004, the continuing mandatory ministerial duty under § 2282 Bus. & Prof. Code, to wit, (1) to comply with such decision, findings and determination of the LH organized medical staff, and (2) to vacate and set aside and to refrain from implementing the New LH Admissions Policy and the first priority provision of the New LH Admissions Policy which is complained of; but -- unless ordered by the Court, -- the respondents and each of them will fail and continue to fail to perform the aforesaid mandatory ministerial duty.

94. Petitioner here refers to and incorporates each of the allegations in Paragraphs 122 through 125 of this Petition.as if fully set forth herein.

FOURTH CAUSE OF ACTION

Violation of § 510 Bus. & Prof. Code

95. Petitioner refers to and incorporates each of the allegations in the preceding Paragraphs as if fully set forth.

96. § 510 Bus. & Prof. Code provides in part:

"(a) The purpose of this section is to provide protection against retaliation for health care practitioners who advocate for appropriate health care for their patients . . .

"(b) It is the public policy of the State of California that a health care practitioner be encouraged to advocate for appropriate health care for his or patients. For purposes of this section, 'to advocate for appropriate health care' means . . . to protest a decision, policy or practice that the health care practitioner, consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care, reasonably believes impairs the health care practitioner's ability to provide appropriate health care to his or her patients."

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"(c) The application and rendering by any individual, . . . corporation, or other organization of a decision to . . . penalize a health care practitioner principally for advocating for appropriate health care consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same

license or certification and practicing with the same license or certification and practicing according to the applicable legal standard of care **violates the public policy of this state**." (Emphasis added.)

97. The prior alleged decision of the LH medical staff to reject the New LH Admissions Policy, and the prior-alleged April 7, 2004 notice and memorandum of the Chief of the LH medical staff, on behalf of the member of the LH medical staff, (**Exhibit D** attached), constituted advocacy for appropriate health care of the patients of the LH medical staff, and, constituted a protest of a decision, policy and practice of the Director and Department – (namely, the New LH Admissions Policy and the manner in which the LH admission speed-up policy was administered), -- that the members of the LH medical staff, in the exercise of their professional judgment, reasonably believe impairs their ability to provide appropriate health care to their existing patients at LH; all, as stated in the April 7, 2004 notice and memorandum to the Director.

98. The advocacy and the protest alleged in the preceding Paragraph is collectively referred to below as the "health care advocacy and protest" of the LH medical staff.

99. The Director, Department, LH, and the LH Administrator have retaliated against and penalized the members of the LH medical staff for their health care advocacy and protest by adopting a policy, at some time between May 17, 2004 to June 24, 2004, that the cost of paying outside locked psychiatric facilities for caring for SFGH patients rejected by the LH medical staff as too dangerous, (either by such dangerous SFGH patients being denied admission or, if admitted, being sent back by LH medical staff), -- shall be paid out of the budget appropriations for the LH medical staff, (herein, "the retaliatory policy").

100. The retaliatory policy necessarily entails and threatens that one or more of the LH medical staff will suffer being discharged from employment, by depletion by the retaliatory policy of appropriations for the LH medical staff, out of which to pay them; and, – by reducing the unexpended funds in the LH medical staff budget, — reduces the ability of the LH medical staff as a whole, to adequately and safely care for their LH patients; but notwithstanding, the respondents have, are, and will, – unless restrained by the Court, – engage in and continue to engage in the practice of carrying out the retaliatory policy in every respect, by paying and causing to be paid the City's cost to pay private outside facilities and/or their staff for the care of SFGH patients who are denied admission to LH by the LH medical staff (or who, if once admitted to LH, are discharged by LH as being too dangerous to self or to other LH patients), out of the LH medical staff budget or appropriations for the LH medical staff.

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101. More particularly, – but without limitation of anything alleged above, – the Director, on or about May 17, 2004, announced the retaliatory policy at a meeting of the Director with the LH medical staff by stating to the medical staff, in substance, that:

- (1) if the LH Medical staff did not accept patients with skilled nursing needs from SFGH who don't quite fit LH in order to save the Department money, the Department would reduce services, wards and staff at LH to pay for the care of those patients.

- (2) SFGH patients who need skilled nursing level of care, but are deemed by the LH medical staff to be unsafe for LH, will be placed in private psychiatric facilities with dollars from the LH medical staff budget.

102. On June 24, 2004, at a public hearing of the City Services Committee of the San Francisco Board of Supervisors, the Director publicly re-announced the retaliatory policy by stating to the Committee that, if SFGH patients are denied admission to LH by the LH medical staff, that the denied patients would be sent to private locked psychiatric facilities outside the county, with the expense therefore taken out of the LH medical staff budget. And when the Director was asked by a Committee member if the Director had ever indicated that the budget for the LH medical staff would be shrunk if they did not go along with the Director's decision, (i.e., the New LH Admissions Policy), the Director answered, "Absolutely."

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103. At the May 27, 2004 public meeting of the Joint Conference Committee for Laguna Honda ("JCC-LH") which included two members of the Health Commission, the LH Administrator publicly told the JCC-LH that when the LH medical staff denies admission to someone from SFGH, that the LH medical staff's budget is used by LH and the LH Administrator to pay for this SFGH patient's placement elsewhere.

104. The Director, Department, LH, and the LH Administrator have carried out the retaliatory policy, alleged in this Fourth Cause of Action, by taking and paying for the cost to pay outside psychiatric facilities to care for SFGH patients rejected by the LH medical staff, out of appropriations enacted by the Board of Supervisors for the LH medical staff; and the Health Commission, with notice of this retaliatory policy, has by its silence approved this

retaliatory practice so as join in carrying out the retaliatory policy; and the respondents and each of them will, unless restrained by the Court, continue to so carry out the aforesaid retaliatory policy.

105. The above threats and retaliatory policy of the Director, and the carrying out by the respondents of the above threats and retaliatory policy, are void and ultra vires in that they constitute a violation of § 510 Bus. & Prof. Code and the public policy of the State of California which is set forth in § 510 Bus. & Prof. Code, which prohibits any retaliation or penalty against the LH medical staff members for their health care advocacy and protest which is alleged in this Fourth Cause of Action. Accordingly, a writ of mandamus and injunction must be issued to enjoin the Director to vacate and set aside his aforesaid retaliatory policy, and to order the respondents to refrain from implementing such policy in hole or in any part.

106. Petitioner here refers to and incorporates each of the allegations in Paragraphs 123through 125 of this Petition, as if fully set forth herein.

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FIFTH CAUSE OF ACTION

Misappropriation of public funds

107. Petitioner refers to and incorporates each of the allegations in the preceding Paragraphs as if fully set forth herein.

108. The respondents have, are, and will, unless restrained by the Court, continue to carry out the retaliatory policy alleged in the preceding Fourth Cause of Action by engaging in the practice of paying private outside facilities or their staff for the care of those SFGH patients who are denied admittance by LH, or who are returned to SFGH because they are too dangerous for LH to handle, out of the fiscal year budget and appropriations enacted by the San Francisco Board of Supervisors for the support of LH, primarily if not wholly from the budget and appropriations for the LH medical staff; -- despite and irrespective of the fact that all such payments are an unlawful, void and ultra vires misappropriation, mis-expenditure and waste of City funds, in violation of §§ 9.100, 9.102, 98.103, 9.105, and 9.113 of the City Charter, and in violation of § 3.18 of the City Administrative Code, (herein, "the ultra vires policy and practice to misappropriate City funds"); which policy and practice is unlawful, void and ultra vires due to the fact that such SFGH patients either never became patients of LH or its medical staff, (because they were rejected by LH), or ceased to be LH patients, (because they became discharged from LH on the basis that LH was unable to care for them), and, as such, are not any patients of LH or the LH medical staff; -- so that there was and is **no provision in the LH fiscal year budget or in the appropriations** enacted by the Board of Supervisors for the LH medical staff, or for LH medical staff expenditures, or for or in the separate Laguna Honda Fund of the City, for such payments to care for persons who are not patients of either LH or the LH medical staff; all, constituting unlawful, void, and ultra vires expenditure of public funds of the City, in violation of the foregoing provisions of the City Charter and the City Administrative Code which are mentioned in this Paragraph.

109. Accordingly, by each and all of the facts alleged in this Firth Cause of Action, a writ of mandamus and injunction should be issued to order the respondents to perform their mandatory ministerial duty to vacate and set aside, and to refrain from implementing, their above alleged ultra vires policy and practice to misappropriate City funds.

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110. Petitioner here refers to and incorporates each of the allegations in Paragraphs 123 through 125 of this Petition.

SIXTH CAUSE OF ACTION

111. Petitioner refers to and incorporates each of the allegations in the preceding Paragraphs as if fully set forth herein.

112. The provisions in the Laguna Honda Policy manual are regulations and rules of the Department and of LH, and are also rules of the LH medical staff adopted under § 2282 Bus. & Prof. Code, which are binding upon the respondents unless and until such provisions are amended in the manner and process which is provided therefore in the Manual.

113. The Prior LH Admissions Policy was adopted by the procedures and process set forth in the Laguna Honda Policy Manual, which requires every LH hospital-wide rule or policy to be adopted by a process in which a designed committee of LH must first approve the proposed new rule or regulation.

114. However, the New LH Admission Policy was inserted, or caused to be inserted, into the Laguna Honda Policy Manual without the approval or knowledge of the aforesaid designated committee of LH, so as to be unlawful, void, and ultra vires, for not being adopted in the manner required by the Laguna Honda Policy Manual which is, as alleged above, both (1) an administrative regulation of a public agency, under administrative law made and provided therefore; and also, (2) a rule of the LH organized LH medical staff which was adopted by the medical staff under § 2282 Bus. & Prof. Code; so that the respondents and each of them have the present and continuous mandatory ministerial duty to vacate and set aside, and refrain from implementing, the New LH Admissions Policy, whatsoever or at all.

115. Petitioner here refers to and incorporates each of the allegations in Paragraphs 123 through 125 of this Petition, as if fully set forth herein.

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SEVENTH CAUSE OF ACTION

Violation of the Laguna Honda Compact and the public use

116. Petitioner refers to and incorporates each of the allegations in the preceding Paragraphs as if fully set forth herein.

117. As prior alleged, the Director and Department, on or about March 2, 2004, adopted the New LH Admissions Policy, (**Exhibit B** attached), and the respondents have a policy and practice to implement the New LH Admissions Policy, namely, that henceforth SFGH patients ready for discharge to SNF level of care shall have first priority to be admitted to LH for SNF services, ahead of and superior to all other residents of the San Francisco community, who may, under the New LH Admissions Policy, only be admitted to LH if there are no SFGH patients ready for discharge to the LH for SNF services.

118. The adoption and implementation of the New LH Admissions Policy by the Department, Director, LH, and the LH Administrator, violates the Laguna Honda Compact, and the public use which is prior alleged in this Petition, in that:

- **First**. The New Laguna Honda long-term care facility with SNF services, will, when opened as scheduled in 2007, be filled with the resident population from the existing LH, who by that time will be, -- due to the New LH Admissions Policy, -- primarily SFGH patients transferred to LH for SNF services as the first priority of admission, over and in denial to others of the San Francisco community, such as the frail, elderly and disabled of San Francisco who are or may be in at least equal need, if not more so, for the care and protection of the SNF services of LH, than the SFGH patients who are being admitted or readmitted, and will be continued to admitted or readmitted, as the first priority for admission at the existing LH, between now and the opening date of the New Laguna Honda.

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- **Second**. Not only will the New Laguna Honda be filled, from the outset, predominantly with a group comprised of transferees from SFGH, but, these transferees from SFGH who will have become the majority of the patients at the New Laguna Honda will have a legal right, once they have been admitted for SNF services, to continue filling the available SNF beds at the New Laguna Honda until they die or no longer require SNF services, so as to thereby further displace others of the public of San Francisco, including but not limited to frail, elderly and disabled San Francisco residents, who are or may be in equal if not more need for the care and protection of the SNF services of LH, than the favored group of SFGH transferees.

- **Third**. To the extent, as will naturally occur, that the initial group of transferees from SFGH die or leave the New Laguna Honda, the New LH Admissions Policy prevents their being replaced by any substantial number or percentage of the frail, elderly and disabled of San Francisco who are or may be in equal need, if not more need, for the care and protection of the SNF services of LH, than SFGH patients;

so that therein, -- by each and all of the facts prior alleged in this Cause of Action, -- the New LH Admissions Policy and its continued implementation is a substantial and material breach of the Laguna Honda Compact, and of the mandatory ministerial duty of the respondents to comply with the Laguna Honda Compact, and to comply with the public use which is set forth prior in this Petition; so that the New LH Admissions Policy is void, unlawful, and ultra vires in violation of both the Laguna Honda Compact and the aforesaid public use impressed upon LH. Accordingly, therein and thereby, the respondents and each of them (1) have a present and continuing mandatory ministerial duty to comply with the Laguna Honda Compact and with the aforesaid public use by vacating, setting aside, and refraining from implementing the void, unlawful and ultra vires New LH Admissions Policy, and (2) have a present and

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continuing mandatory ministerial duty under the Laguna Honda Compact and public use to admit all candidates for admission to the SNF services of the New Laguna Honda, including but not limited to frail, elderly or disabled residents of San Francisco, upon an equal basis, irrespective of ability to pay; all, subject only to the priority or triage of their relative need for the care and protection of, and the ability of LH to provide, adequate services consistent with their safety and the safety of the other residents and the staff of LH.

119. Petitioner here refers to and incorporates each of the allegations in Paragraphs 122 through 124 of this Petition as if fully set forth herein.

EIGHTH CAUSE OF ACTION

Violation of (1) Article XI police powers, (2) the delegated § 17000 duty to furnish SNF services to those unable to pay, (3) § 115.1 of Article 3 of City Health Code; and (4) the equal access regulation of the Health Commission.

120. Petitioner here refers to and incorporates each of the allegations in the preceding Paragraphs as if fully set forth herein.

121. The New LH Admissions Policy, by giving **first priority** to admission to LH for SNF services:

- (1) **facially violates** the article XI, section 7, California Constitution police power to furnish SNF services on an equal basis to those unable to pay, (which article XI police power is prior set forth in this Petition);

- (2) **facially violates** the delegated § 17000 WI Code duty to furnish SNF services on an equal basis to those unable to pay, (which duty is prior set forth in this Petition);

- (3) **facially violates** the article XI, section 7, California Constitution police power to furnish SNF services on an equal basis to San Francisco residents, including those who can pay, when as in case at bar such SNF services have become commercially unavailable in San Francisco;

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- (4) **facially violates** § 115.1 of Article 3, City Health Code; which prioritizes admissions to LH upon factors which exclude SFGH patients, per se, as having any priority whatsoever in being admitted to LH for SNF services or any other service;

- (5) **facially violates** Resolution 30-98 of the Health Commission, which specifically requires that the Department **shall ensure equal access** to all Department services, including, the SNF services at LH; and,

- (6) **facially violates** the public use with which LH is impressed, namely, to be used as and for a long-term care facility with SNF services for the public of San Francisco; which public use admits, under the California law of the public use, of no preference or priority to any group, including patients at SFGH, for admission to the existing LH for long-term care services, including SNF services, (other than upon a basis of degree of relative need, availability of SNF beds, and the ability of LH to furnish care which is adequate and safe both for the admittee and to the other residents of LH).

122. Therein and thereby, be each and all of the facts alleged in this Eighth Cause of Action, the New LH Admissions Policy is unlawful and void because ultra vires, in violation of each and all of the above provisions of article XI, section 7 of the California Constitution; § 17000 WI Code; § 115.1 of Article 3 of the City Health Code; Resolution 30-98 of the Health Commission; and the aforesaid public use with which LH is dedicated and impressed.

FURTHER FACTS COMMON TO ALL CLAIMS

123. The respondents, in doing each of the acts and omissions to act which are complained of in each of the First through Eighth Causes of Action, -- and in failing to perform each of the duties which are alleged in this Petition, -- therein did, are, and will continue to act illegally and ultra vires as alleged in each of the First through Eighth Causes of Action; so that each of the acts and omissions and failures to perform the duty of which the Petitioner complains did, are, and will constitute and comprise expenditure of, and will cause, public funds of the City to be expended unlawfully, illegally, and ultra vires, and were, are, and will be, to boot, a waste of the public funds of the City, all in violation of § 526a, Code of Civil Procedure.

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124. Each of the respondents has had, has, and will continue to violate the mandatory ministerial public duty to perform the acts, or to refrain from performing the acts, which are alleged by the Petitioner in each of the First

through Eighth Causes of Action to be required to be performed by the respondents, or to be refrained from, by the provisions of the state Constitution; statutes; the City Charter, Health Code, and Administrative Code; Health Commission Resolution 30-98; the Laguna Honda Compact; and the public use which are alleged in each of the First through Eighth Causes of Action; but, there is no plan, speedy, or adequate relief at law or equity, and money damages are inadequate; so that the injury to the Petitioner and the public by the violation of the duties complained of in each of the First through Eighth Causes of Action is immediate, continuing, and irreparable.

125. (a) The Petitioner and others did, in a public hearing on June 24, 2004 of the City Services Committee of the San Francisco Board of Supervisors, make oral demands to the Director and the LH Administrator, -- who were present at the public hearing and heard the demands, -- to rescind the New LH Admissions Policy which is complained of in this Petition; but the Director and LH Administrator have failed and refused to do so.

(b) The Petitioner, by and through his counsel of record, did, at the same June 24, 2004 meeting of the City Services Committee, also requested that the respondents cease implementing the New LH Admissions Policy, unless and until the respondents conducted a new security and safety assessment, and adopted and implemented a new security plan, as required by § 1267.2 Health & Safety Code; but, the respondents have failed so to do.

- (c) In any event, any demand to cease the acts and omissions complained of in this Petition was would be entirely futile, hence excusing any requirement to make any such demand upon the respondents.

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WHEREFORE the plaintiff prays for the following judgment and orders:

Judgment as to all Causes of Action

1. That the petitioner Michael Lyon have judgment in his favor and against the respondents and each of them, jointly, and also severally, in respect to each of the First through Eighth Causes of Action of this Verified First Amended Petition for Writ of Mandamus; and that the respondents take nothing.

First through Eighth Causes of Action

2. That in respect to each of the First through Eighth Causes of Acton, that an alternative writ of mandamus and a permanent writ of mandamus be issued pursuant to § 1087 Code of Civil Procedure, together with a permanent injunction both under § 526a Code of Civil Procedure, § 3420 Civil Code, and § 526 Code of Civil Procedure, which orders each of the respondents to vacate and set aside and to refrain from implementing the New LH Admissions Policy which was adopted by the Director, the Department, LH and the LH Administrator on or about March 2, 2004, (to wit, the policy, rule, and regulation that henceforth patients of San Francisco General Hospital ready for discharge to SNF level of care shall have **first priority** to be admitted to LH for SNF services, over all others); and that the Director, Department, LH, the LH Administrator, and the Health Commission also vacate and set aside and refrain from implementing (1) the retaliatory policy and practice alleged in the

Fourth Cause of Action, [and] (2) the policy and practice which is complained of in the Fifth Cause of Action, (namely, the policy and practice of issuing, approving the payment of, and paying private locked facilities or their private staff for care of SFGH patients who never became, or had ceased to be, patients of LH or the LH medical staff, by checks or drafts drawn upon or against or credited to the LH medical staff budget and/or the appropriations by the San Francisco Board of Supervisors to or for the LH medical staff, unless there is both:

- (A) a provision in the current fiscal year or supplemental budget of the Laguna Honda medical staff enacted by the San Francisco Board of Supervisors therefore, and,

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- (B) an appropriation enacted by the Board of Supervisors to or for the Laguna Honda medical staff, therefore, or,

- (C) an appropriation in the Laguna Honda Fund of the City which was enacted by the Board of Supervisors for such purpose.

which appropriation is unencumbered and not exhausted, by which to pay such item or items.

For all Causes of Action

3. That the Petitioner have reasonable attorneys' fees pursuant to § 1021.5 Code of Civil Procedure.

4. That the Petitioner have costs of suit incurred, together with such other and further relief as may be just.

Dated: August 10, 2004

[Signature of Lynn S. Carman]

LYNN S. CARMAN

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VERIFICATION

The undersigned deposes and says:

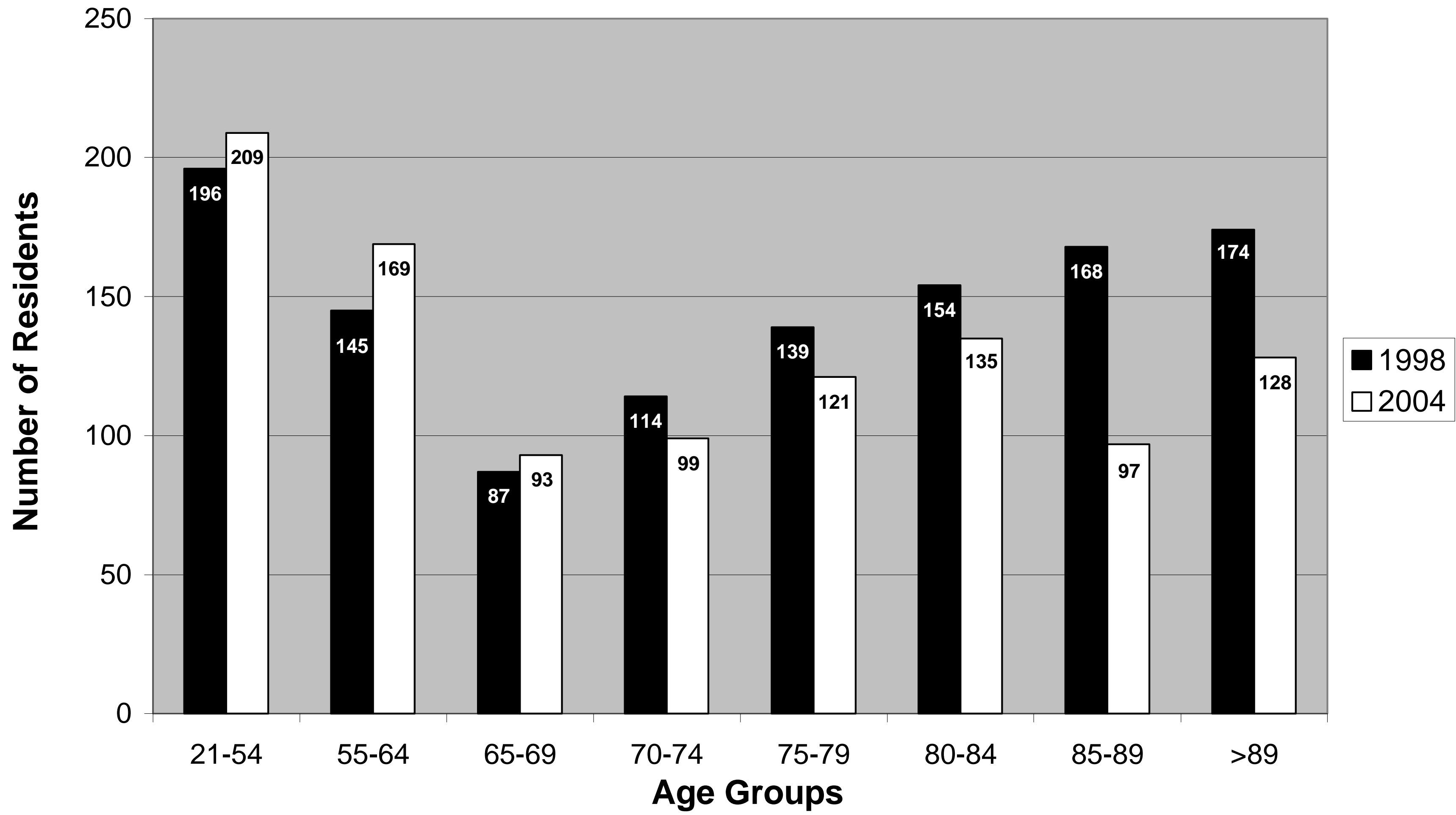
I am the attorney for the petitioner Michael Lyon in the within action and proceeding. I make this verification for the reasdon that the petitioner Michael Lyon is absent from the county where I have my office. I have read the within Verified First Amended Petition for Writ of Mandamus. I am informed and believe the matters therein to be true, and on that ground allege that the matters stated therein are true.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed in San Francisco, California, on August 12, 2004.

[Signature of Lynn S. Carman]

LYNN S. CARMAN

Exhibit A



Laguna Honda Hospital
Distribution of Residents by Age
June 30, 1998 vs. 2004
Number of Residents
250
200
150
100
50
0
196
209
145
169
87
93
114
99
139
121
154
135
168
97
174
128
21-54
55-64
65-69
70-74
75-79
80-84
85-89
>89
Age Groups
1998
2004

Exhibit B

ADMISSION TO LHH AND RELOCATION BETWEEN LHH SNF UNITS

POLICIES:

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).
2. All applicants for admission to LHH shall be screened prior to any admission decision.
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.
4. LHH shall centrally coordinate in-Hospital relocations in a timely manner to
   - optimize utilization of resources,
   - optimize bed availability for new admissions, and
   - 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.

PURPOSES:

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.
2. To appropriately allocate Hospital resources.
3. To provide a standard procedure for placement or relocation of residents within the facility.

ABBREVIATIONS:

&E: Admissions and Eligibility Department
BCC: Bed Control Coordinator
IDT: Interdisciplinary Team

PART A ADMISSIBILITY AND SCREENING PROCEDURES

1. Admission priorities are listed below. Exceptions require specific approval of the Administrator of Laguna Honda Hospital (or designee).

   1st Patients at San Francisco General Hospital ready for discharge to SNF level of care will be admitted before persons in categories 2-5 below.

   2nd Persons not in a medical facility, who cannot receive adequate care in their present circumstances.

   3rd Persons referred by a City/County welfare or health agency.

   4th Patients at another San Francisco medical facility.

   5th Persons who are residents of San Francisco, but who are presently in a medical facility or private circumstances outside of San Francisco.

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.

3. Hospitalwide exclusion criteria:
   - 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 wanderguard

4. Screening of candidates for admission:

   4.1 Referrals to the Rehabilitation, AIDS and Hospice units are screened by attending physicians on those 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.

   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.

   4.4 Referrals to the psychosocial units will be screened by the Screening Committee and the psychosocial treatment team.

   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.[1] Residents lacking capacity for placement decisions may not have their

[1] 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,

movements restricted on a secure 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.

4.7 In all cases of admission from another facility, a physician's dictated discharge summary is required.

5. Staff will refer to the Admissions Coordinator of Admissions and Eligibility (A&E) all inquiries regarding the admissibility of a proposed applicant and bed availability. The Admissions Coordinator will maintain contact with the referring source during the screening process.

5.1 The Admissions Coordinator will coordinate with the Bed Control Coordinator (BCC) in determining current bed availability; and

5.2 The Admissions Coordinator will inform the Nursing office who is to be admitted the next day.

5.3. The Nursing office shall conduct and the Admitting office shall compile a midnight census to determine available beds.

5.4. The BCC, with the advice of the LHH attending physician, shall decide whether and under what circumstances a vacant bed shall be reserved for a resident who is discharged (i.e., temporarily) to another hospital or to an LHH acute unit, or relocated to an LHH isolation room.

6. Resolution of perceived discriminatory admission practices

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.

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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).

PART B ADMISSION CRITERIA AND PROCEDURES

1. Pre-Admission Procedures

1.1 The Conditions of Admission agreement shall state that all residents are to be assessed upon admission for appropriate placement and/or relocation within the facility.

1.2 Residents (or their representatives) will receive a copy of the Conditions of Admission agreement upon admission to the Hospital. The Conditions of Admission agreement will be reviewed and signed by the resident or the resident's surrogate decision-maker.

1.3. The Admissions Coordinator will facilitate collaboration among the admitting units (M5, Rehabilitation, AIDS, and Hospice) and Bed Control Coordinator (BCC) in placement decisions, which are based on the identified physical, mental, social and emotional needs and bed availability. Referral sources may discuss the appropriateness of referrals with staff of admitting units, but no final admission decision can be made until the Admissions Coordinator has evaluated the referral packet.

1.4. The M5 and specialty unit IDTs may place and take care of residents on other units, e.g., in isolation rooms or in designated satellite beds.

1.5. The Admissions Coordinator will facilitate collaboration among the admitting units and Bed Control Coordinator in placement decisions.

1.6 When planning an admission directly to a unit other than the usual admitting units (M5, Rehabilitation, AIDS, and Hospice), the Admissions Coordinator will: 1) coordinate with the Bed Control Coordinator (BCC) in determining appropriate bed availability; 2) inform the receiving unit physician; and 3) inform the receiving unit nurse manager.

2. M5 Admission Unit

Policies specific to M5 Admission Unit

2.1 M5 is a short-stay admissions units from which residents may go back to the community, to another facility or to another care unit within LHH.

2.2. The M5 IDT will discharge or relocate the resident as soon as an appropriate care unit bed is available, generally within one month.

3. M7A Acute Care Unit

Policies specific to admission to M7A Acute Care Unit

3.1. Only acutely ill LHH residents for whom appropriate medical care is available are admitted. Residents requiring surgical procedures, critical care, telemetry or hemodynamic monitoring cannot be accommodated on M7A.

3.2 All admissions to M7A are subject to ongoing utilization review as outlined in the Utilization Management Plan.

3.3 SNF residents who require blood transfusions, but who are not acutely ill, shall be admitted to M7A as “come and go” cases.

Procedures specific to the M7A Acute Care Unit

3.4 All residents admitted to the acute unit M7A, except those residents admitted on a “come and go” basis, shall have a separate complete medical record covering the period of their acute hospitalization.

3.5 Whenever a resident is admitted to M7A from either an LHH SNF care unit or from the Rehabilitation Department, she/he is discharged from the previous care unit and resident’s medical record is closed, except in those cases where residents “come and go” for transfusion.

3.6 A new SNF or Rehabilitation resident record will be started upon resident’s re-admission to a SNF care unit.

4. L4A Acute and L4S SNF Rehabilitation Care Units

Admission criteria specific to L4A Acute and L4S SNF Rehabilitation Care Units

4.1 Presence of one or more major physical impairments which significantly interfere with the ability to function, and which require an intensive interdisciplinary approach to effectively improve functional status.

4.2 Patient must be medically stable.

4.3 Patient requires rehabilitation physician management.

4.4 Patient requires the availability or supervision of rehabilitation nursing 24 hours daily in one or more of the following:
- Training in bowel and bladder management
- Training in self care
- Training or instruction in safety precautions
- Cognitive function training
- Behavioral modification and management
- Training in communication

Admission criteria specific to L4A — Acute Rehabilitation Care Unit

4.5 Rehabilitation needs will include at least two of the following: impairment in activities of daily living, impairments in mobility, bowel/bladder dysfunction, cognitive dysfunction, communication dysfunction, complicated prosthetic management, or other medical problems best addressed on the Acute Rehabilitation Unit.

4.6 Patient requires and has the ability to engage daily in three hours of at least two of the following therapies: physical therapy, occupational therapy, and/or speech therapy.

4.7 Patients must have a reasonable plan for discharge into the community.

Admission criteria specific to L4S — SNF Rehabilitation Care Unit

4.8 Rehabilitation needs will include at least one of the following: impairment in activities of daily living, impairments in mobility, bowel/bladder dysfunction, cognitive dysfunction, communication dysfunction, complicated prosthetic management, or other medical problems best addressed on the SNF-level Rehabilitation Unit.

4.9 Patient requires and has the ability to engage in at least one of the following therapies: physical therapy, occupational therapy, and/or speech therapy.

4.10 Patients must have a reasonable plan for functional improvement to achieve discharge into the community or relocation to a lighter care long-term unit.

Procedures specific to L4A — Acute Rehabilitation Care Unit

4.11 The Director of Rehabilitation Services/designee will perform pre-admission screening to assess the patient's ability to achieve significant improvement in a reasonable period of time with acute rehabilitation services.

4.12 A new SNF record will be started if the patient is discharged to a LHH SNF Care Unit.

Procedures specific to L4S — SNF Rehabilitation Care Unit

4.13 The Director of Rehabilitation Services/designee will perform pre-admission screening to assess the patient's ability to achieve significant improvement in a reasonable period of time with rehabilitation services.

5. O4 HIV / AIDS Care Unit

Admission criteria specific to O4 HIV / AIDS Care Unit

5.1 HIV / AIDS patients at SNF level of care
- who are receiving anti-HIV therapies, prophylaxis or treatment of HIV-related complications or have intercurrent medical problems, or
- who need palliative care and prefer an HIV / AIDS focused unit

5.2 AIDS patients at SNF level of care who have "dual or triple diagnoses," i.e., psychiatric and/or substance abuse issues, may be accepted to the unit after review of the complexity of the case by unit physicians, who may request LHH behavioral consultation.

6. C2 Hospice and Palliative Care Unit

Admission criteria specific to C2 Hospice and Palliative Care Unit

6.1 The patient is reliably diagnosed as having a terminal disease with a prognosis of weeks to months (generally six months or less).

6.2 The patient can benefit from the Hospice environment.

6.3 The patient and/or surrogate is informed of the diagnosis and prognosis and understands that medical treatment will be palliative.

6.4 A "No CPR" status has been discussed and ordered before admission. The resident/family should not desire, and the care plan should not include, frequent physiologic monitoring, biomedical testing, or life-sustaining interventions.

6.5 The patient's physician must communicate verbally with the Hospice physician in order to ensure that Hospice admission is appropriate, and that all pertinent medical data will be available.

Exclusion criteria specific to C2 Hospice and Palliative Care Unit

6.6 Patients with active major psychiatric and/or behavioral disorder or whose behavior is highly disruptive or potentially threatening to themselves or others are not appropriate for C2 Hospice and Palliative Care Unit.

7. K6 / L6 Secure Dementia Units

Policies specific to Secure Dementia Units

7.1 The goals of the Secure Dementia Units are:

- to promote the wellbeing and protect the health and safety of cognitively-impaired residents who might harm themselves by wandering or elopement; and
- to meet the needs of cognitively-impaired residents with a stable and structured environment and specialized dementia programming while minimizing use of individual restrictions and restraints.

Admission criteria specific to Secure Dementia Units

7.2 Ambulatory residents with serious cognitive impairment and a likelihood of unsafe wandering or elopement.

Exclusion criteria specific to Secure Dementia Units:

7.3 Residents with assistive devices likely to pose a risk to other frail, demented residents or whose aggressive behavior cannot be safely managed in this setting.

Procedures specific to Secure Dementia Units

7.4 The Admissions Coordinator and Screening Committee personnel will coordinate admission in collaboration with the Secure Dementia Unit IDT.

7.5 On admission the attending physician will coordinate an interdisciplinary assessment including cognitive and/or behavioral consultation.

7.6 The IDT will reevaluate residents for unit appropriateness one month after admission, then quarterly. The IDT will explore interventions that may reduce the wandering/elopement risk and permit relocation to another unit. For cognitively incapacitated residents whose movements throughout the facility are restricted, the IDT will document participation of the conservator or surrogate decision-maker in placement decision-making and care planning.

7.7 A resident of the LHH Secure Dementia Unit will be relocated as soon as reasonably possible to other LHH units or transferred to another facility or the community if the resident's status changes such that the resident is no longer ambulatory, the resident's cognitive status improves such that secured placement no longer is needed; or the resident's cognitive impairment is discovered to be caused primarily by a psychiatric rather than organic brain disorder.

7.8 Permissible Exception: If a resident ceases wandering but demonstrates or expresses preferential adaptation to the unit and benefits from the specialized programming, continued residence in the unit may be allowed at the discretion of the physician and

interdisciplinary team. To ensure availability of Secure Dementia Unit beds when needed, attempts should be made to adapt such a resident to another unit.

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 the 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.

Admission criteria for the respective focus-specific psychosocial units:

8.3 Neurobehavioral Psychosocial Unit (E200): 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, infectious 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 dementias with behavioral complications.

8.4 Medical Psychosocial Unit (S200): 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 (W200): This unit is suitable for persons aged 65 and older, or those with medical problems common to older adults, as well as concomitant psychiatric diagnoses such as mentioned above, unless better placed in the dementia cluster. Patients with dementia will be individually evaluated for placement within the psychosocial cluster or the dementia cluster.

Exclusion criteria for Psychosocial Cluster Units:

- Uncomplicated dementia without behavioral problems
- Behavioral problems that are secondary to chemical dependence alone
- Severe personality disorders not amenable to treatment
- Behavioral problems that are primarily forensic

Procedures specific to Psychosocial Cluster Units:

8.6 For residents whose movements throughout the facility are restricted, the IDT will document participation of the resident, conservator or surrogate decision-maker in placement decision-making and care planning.

8.7 The Psychosocial Unit IDT, including a psychiatrist and/or psychologist, will reevaluate the appropriateness of the resident's placement one month after admission, quarterly thereafter and as needed.

Exhibit C

5/17/2004 · S.F. Ombudsman Program

To: Mitchell Katz, M.D.Director, San Francisco Department of Public Health

From: Benson Nadell; Director of San Francisco Long Term Care Ombudsman Program

CC. Edward A.Chow M.D. President, San Francisco Health Commission
Lawrence Funk, Chief Executive Officer, Laguna Hospital & Rehabilitation Center
Terry Hill, M.D., Medical Director LHH
Paul Isakson.M.D.Chief of Staff, Laguna Honda Hospital.
Joseph Rodrigues;State Ombudsman;California Department of Aging

Re: **Does LHH serve the members of the Community?**

Introductory Remarks: The Ombudsman Program is an Older American Act Program (Federal) in California the Office of the State Ombudsman is within the California Department of Aging, and through a Designation and Certification Process passes on the statutory authority to 35 local sub-state Ombudsman Programs in California. Most of these local Ombudsman Programs reside in various host-agencies. In San Francisco the host agency is Family Service Agency of San Francisco, which contracts via the Office of Aging, Department of Aging and Adult Services. The comments, which follow, are not coming from FSA/SF but from the Ombudsman Program, and are in keeping with the statutory guidelines for the Long Term Care Ombudsman Program. The Statutory guidelines for the Ombudsman Program are to identify complaints, which result for actions or inactions by facilities, providers, government agencies, and other agencies, which adversely affect the Health, Safety, Welfare, or Rights of Elderly in Long Term Care. In addition, in California, the Ombudsman Program has additional mandates to investigate Abuse allegations received by an array of Mandated Reporters, who following the guidelines of Welfare and Institutions Code 15630 ff. –abuse and neglect against not only Elderly but also Disabled Adults, if the abuse and neglect occurs in long term care facilities. In addition to responding to complaints, and allegations of abuse and neglect, the Director of the Ombudsman Program is charged to comment on Legislation, Regulation, proposed Public Policy, and to make recommendations for changes to Legislation, Public Policy, Policies and Procedures, Regulations.

My comments:

The Ombudsman Program has had an ongoing presence at Laguna Honda, the MRF and SFGH 4-A as well as all the SNFs and DP SNFs and all the RCFE (Residential Care, Facilities for the Elderly throughout San Francisco. I have been with the Program since 1987 and as such, have a long-view on the supply and demand of both types of Long

Term Care Facilities, as well as the increasingly restricted rehabilitation services at the Hospitals, mostly under various Medicare+Choice plans.

I wish to comment on the most recent Admission Policy as well as the process of Screening for Admission to Laguna Honda. I am commenting based on the increased demand for long term care beds at the level of skilled nursing beds in San Francisco, in light of an actual diminishing supply of such Medi-Cal beds. My comments are mostly focused on the frail elderly with multiple chronic conditions, which makes their success in Home and Community settings difficult given the need for over-night supervision and care, and the fact that many are non-ambulatory, with declining mental capacity. The Ombudsman Program has access to residential care facilities and over the last 12 years, has seen the drying up of affordable and SSI placements, and within that diminishing number, the loss of all non-ambulatory beds. In their place has been an increase in relatively expensive large residential arrangements, where residents whittle away their savings, and then unable to pay the agreed-up monthly rates, are forced to move out, and look for an affordable residential facility, or if their health has deteriorated, and their care needs increased in a co-incidental fashion, which is often the case, to look for a Skilled nursing facility, which accepts Medi-Cal. The point is that with the passage of the Bond issue for Rebuilding LHH, the intent was to keep LHH available for the elderly in San Francisco, who otherwise would find themselves discharged from the hospitals in San Francisco, out of County. My reading of the Bond Vote was based on the assumption that LHH would admit persons who live in San Francisco according to a priority system based on risk, involvement with Adult Protective Services, the Public Guardian, as well as other Community base agencies, like those run by the Institute of Aging, Self Help for the Elderly, and others. In addition there are entire categorical groups of Disabled Adults in residential placement, who are involved in the Mental Health Systems who are also aging, and developing complex medical problems.

The new Admission Policy restricting admissions to individuals screened at SFGH is too restrictive, and creates problems for the many elderly living in San Francisco. The flow of patients to LHH have been over the last fours years been diversified into new programs at LHH: The Substance Abuse Treatment Service, the Psychosocial Units, the AIDs unit, the Rehabilitation Unit, in order to move a relatively younger, more involved population into LHH while maintaining the existing staffing formula predicated on a more typical custodial care model.

Screening Admissions to LHH from SFGH are wrapped up in multiple screening processes, which concern the Ombudsman Program. These screening processes are internal to Community Health Network, and as such constitute an additional barrier to admission for members of the community at large. In addition because it is not clear whether the screening is at the behest of lowering duration of stay in acute beds, or whether the screening is designed to shorten the length of stay at Laguna Honda-*pace* Davis case it has thrown the regular medical screening procedures in place at LHH into the background– where residents who are aware of resources, staffing, and case-mixes could decide on admissions.

According to Federal Regulations, a physician in the role of screening for admissions must decide whether a prospective resident is suitable for admission and can be cared for with existing resources. The multiple screening processes seem to muddy this process. Psychosocial Cluster Units were established five years ago, and their specialization has represented a shift in admissions policy. The Ombudsman Program receives mandated reports of abuse. The majority of these reports from Laguna Honda have been resident-to-resident altercations. The usual intervention has been to examine care plans and to determine with the facility increased protective measures to prevent a re-occurance. In serious cases, the IP intervened and the resident was removed. These reports are also reflected in internal documents, which Ombudsman don't have access to. Many of the residents who have altercated or been altercated against, repeat in subsequent reports. Most are below 60years of age, and reflect a flow of a different type of population, from the geriatric. Some of these residents are mental health clients, or substance abusers, or both. The Ombudsman program is concerned that the City is turning LHH into a sub-psychiatric facility, using a behavioral compliance model, with medications (despite the procedure to ensure informed consent) and has bypassed a different staffing model, based on using trained psych techs, nurses, and aides with specialized training. Most of the reported altercations have occurred in common areas where supervision is poor. <u>One remedy to prevent these patterns of altercation is to increase and train front line staff and to modify the screening process, to weed out persons with sociopathic tendencies, and those with criminal backgrounds</u>. In fact the DOJ report observed that a younger, more disruptive population proposed a risk on the regular frail and disabled population of the facility. The new Admission Policy and the screening process for overflow of medically involved individuals with personality disorders from SFGH puts the regular resident at risk, and displaces potential geriatric admissions from the community.

Rehabilitation: The rehabilitation facilities on the fourth floor have always been predicated on a Medi-Care model, even for younger persons. With TCF screening admissions for discharge potential, it would stand to reason that this definition be expanded for this track of patients, to include living skills, work place skills etc. There is a fantastic OT section in the hospital, which should be augmented to include these skills as well as self-care skills. For short-term admissions, self-care skills if correctly included in care plans, and used with reinforcement theory, could result in a higher degree of success. For the elderly resident, self- care skills could be taught, and encouraged to prevent excessive dependency, bed-riddenness and allow they to maintain their highest level of functioning. This could be included in the assessment process for each individual. Again if LHH did develop such a comprehensive rehabilitation model, which goes beyond the Medi-Care model of stopping a "plateau" even elderly from the community could return to their homes.

Substance Abuse Services: SATS have been in place at LHH for about 5 years to reflect the screening and admission of a specialized population from SFGH. These services could be provided in a specialized residential unit, since participation is voluntary rather than being mapped on to the traditional geriatric service model of LHH. Although a good and necessary specialization, it bolsters the Admission Policy of only admitting residents

from SFGH.Again; the elderly at risk citizen from the community is displaced indirectly by this service within the Community Health Network.

Hospice: Laguna Honda Hospital has the best SNF based hospice in the Bay Area, with the collaboration with the SF Zen Center, Many other hospitals would like to transfer terminal patients to this hospice, and many terminal patients in the community would like in the last few months be accepted for admission. This hospice unit, is Best Practice, and should serve the community at large, and the bureaucratic maneuvering of securing admission to SFGH first, is totally unnecessary. The Ombudsman Program goes to other nursing facilities, where hospice has been reduced to morphine- drip and isolation.

The Settlement of the Davis case. The settlement has set certain screening and assessment procedures in motion. It is the opinion of the Ombudsman Program that this estimable set of changes is more relevant to the younger disabled resident, who would succeed in HCB long-term care settings, with supports. For the elderly however, the benefits are more dubious. San Francisco has the highest percentage of elderly living alone in any municipality, with little involvement for family caregivers. IHSS services max out, at 387 per month, with no overnight services. San Francisco has lost over 200 medical beds in the last 10 years. Placement of the at-risk very frail elderly is difficult, and Discharge Planners at SFGH and other hospitals are scrambling for placements, which would be safe. Many San Franciscans are removed from San Francisco, alone, without any contact with friends and neighbors. This was one reason why San Franciscans were so much in support of the LHH Bond vote. The Settlement of the Davis Case, will further agendize the new Screening and Admission Policy, displacing the ordinarily chronically compromised elderly San Franciscan away from possible placement in LHH. The Settlement should speak to a subset of admitees from LHH and not for the entire population being admitted.

Money:Medi-Cal money is state and federal dollars, and is supplemented by City and County General Fund dollars. The provisions of the Medicaid Program do not allow a screening and admission process that is overly selective. All San Franciscans should be receive equivalent consideration.

For the above reasons, The Ombudsman Program is recommending a more nuanced Admission Policy, which puts the frail at risk elderly person who lives alone in San Francisco at the top of the priority list.

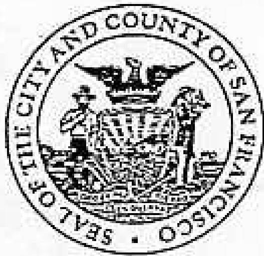
Respectfully Yours,

Benson Nadell
Program Director
San Francisco Long Term Care Ombudsman Program

Exhibit D

CITY AND COUNTY OF SAN FRANCISCO

LAGUNA HONDA HOSPITAL



Medical Services

Paul Isakson, M.D.
Chief of Staff

TO: Mitchell Katz, M.D., Director, San Francisco Department of Public Health

CC: Lawrence Funk, Chief Executive Officer, Laguna Honda Hospital & Rehabilitation Center
Terry Hill, M.D., Medical Director, Laguna Honda Hospital & Rehabilitation Center
Valerie Ng, M.D., Ph.D., Chief of Staff, San Francisco General Hospital
Edward A. Chow, M.D., President, San Francisco Health Commission
Robert L. Weinmann, M.D., President, Union of American Physicians & Dentists

FR: Paul Isakson, M.D., Chief of Staff, Laguna Honda Hospital & Rehabilitation Center
Medical Staff Members, Laguna Honda Hospital & Rehabilitation Center

DT: April 7, 2004

RE: Medical Staff Response to Recent Changes by Dr. Mitchell Katz to the Admissions Policy for Laguna Honda Hospital & Rehabilitation Center

Changes made on March 1, 2004 to the LHH Admissions Policy are of serious concern to the LHH Medical Staff who unanimously rejected these changes on March 10th, 2004, including:

1) Allowing only SFGH patients to be admitted to LHH
2) Stopping admissions from the community and respite admissions
3) Pressuring LHH to admit or readmit patients who have proven to be dangerous or
4) Pressuring LHH to admit more patients than can safely be cared for given staffing limitations

We are disturbed by the absence of discourse with the LHH Medical Staff, as the previously existing policy was developed and ratified by established due process.

We believe it is more ethical to give priority to persons who are at risk or in danger at home than to SFGH patients who are already in a safe environment. Limiting LHH admissions to only SFGH will jeopardize the welfare of the frail and elderly in SF, and result in increased costs. Similarly, our respite program is designed to keep at home individuals at risk for institutionalization by providing needed vacations for caregivers. Respite programs, funded by the federal Medicare program, are an essential component of contemporary geriatric care. LHH's respite program has been terminated. We fear this administrative decision will lead to deterioration of quality of life, caregiver burnout and preventable institutionalization of this vulnerable population. We also strongly object to the pressure you have applied to admit or readmit dangerous patients to LHH as this poses undue hazards for all LHH patients, many of whom are easy targets for such abuse, and endangers the entire LHH community. It is our belief that the perceived short-term cost saving of this new policy will result in increased long-term costs.

The mission of the San Francisco Department of Public Health is to protect and promote the health of all San Franciscans.

LHH is a Skilled Nursing Facility (SNF) that provides a community resource for the entire population of San Franciscans. We are also supported by all of the city taxpayers. The LHH Medical Staff is charged with providing quality health care for residents, following ethical (service to the SF community), legal (Federal Register Rules and Regulations Governing Skilled Nursing Facilities; The United States Department of Justice,

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Civil Rights Division), safety, clinical, and fiscal responsibilities. LHH serves as a safety net for individuals at risk in the community, working closely with community agencies including the SF Office of the Public Guardian and Adult Protective Services (APS). Admissions from the community of vulnerable individuals in need of long term, short-term respite or terminal care have always been a top priority. The availability of LHH beds for these populations minimizes their inappropriate use of emergency rooms and acute care. The LHH Medical Staff is expert in providing geriatric, rehabilitation, geropsychiatric, and palliative care while meeting the SNF regulatory requirements. Illustrative examples of difficulties resulting from the change in the LHH Admissions Policy are in Appendix A.

While much effort has been expended assessing flow issues from LHH to SFGH, little has been done to examine how effective the coninuum of patient care is from LHH to SFGH. Example problems are: 1) very frequent diversion of LHH (and former SFGH) patients to hospitals not at all familiar with the patient, 2) diversion on the basis of lack of ICU beds, rather than placing patients into Med-Surg beds, 3) delayed appointment times for needed radiologic procedures for LHH patients (e.g., CT-scans and ultrasounds), 4) delayed appointment times for out-patient clinics, and 5) delays in accepting 5150 transfers to PES. These procedural problems in the flow towards SFGH seriously impair the complete continuum of DPH care.

The DPH is trying to cope with many gaps in the continuum of care, including inappropriate or inadequate placement options for young, vigorous individuals with cognitive impairments and for aging individuals with severe psychiatric disorders, inconsistency between substance abuse approaches at LHH and SFGH, and the absence of a jail SNF. These are complex issues without expedient solutions. LHH is not in a position to resolve all of the issues facing the DPH. In particular, the Nursing staffing shortage at LHH limits our ability to expand our programming. The LHH Medical Staff strives to provide quality clinical care and will continue to do so in a deliberate and considered manner

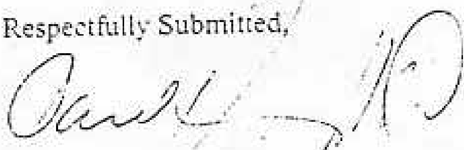
Meanwhile, LHH has already implemented the following solutions to address capacity for care at LHH:

1) Hospital-wide reassessment of LHH patient placement and discharge potential
2) Streamlined admissions procedures to facilitate timely admissions
3) Shifting to mixed-gender units to enhance flexibility
4) Expansion of SNF level Rehabilitation beds
5) Expansion of AIDS/HIV beds
6) Relocation of long term palliative care patients to other units to increase beds on Hospice
7) Expansion of the Psychosocial Program from 3 to 6 units to increase psychosocial treatment
8) Reduction of barriers to admitting patients with specialized needs or equipment
9) Implementation of the Substance Abuse Treatment Services program as part of our behavioral medicine program.
10) Medical and Behavioral reviews of patients referred to LHH, to determine appropriate placement.

Additional suggestions are proposed in Appendix B.

We are eager to participate in finding solutions that will safely and effectively promote the health of San Franciscans. We welcome the opportunity to meet with you and work collaboratively, and look forward to a response regarding this urgent matter.

Respectfully Submitted,



Paul Isakson, M.D., LHH Chief of Staff, on behalf of the entire LHH Medical Staff

Attach: Appendix A: Illustrative examples and LHH Admissions Policies of the LHH Admitting Units (M5, C2 Hospice, L4 Rehabilitation, O4 AIDS/HIV, and East, South, and West 200, E3, G3, and F3 Psychosocia Units) and the LHH Substance Abuse Treatment Services (SATS) program
Appendix B: Proposed solutions for DPH patient flow and care issues

ATTACHMENT A

- **Admissions Unit**
- **Rehabilitation Unit**
- **Hospice Unit**
- **AIDS Uni5t**
- **Psychosocial Units**
- **Substance Abuse Treatment Services (SATS)**

Admissions Unit Physicians Statement

While supporting the goal of improving flow between Laguna Honda Hospital (LHH) and San Francisco General Hospital (SFGH), we the attending physicians on the admissions unit with over 20 years of combined experience in this setting, are concerned about the recent changes that have occurred in admissions screening and policies regarding admissions from home and facilities other than SFGH.

> ***"The San Francisco Department of Public Health shall ...Ensure equal access to all"***
>
> Mission Statement of the San Francisco Department of Public Health

LHH is a community resource for the entire population of San Franciscans, supported by all taxpayers. We serve as a safety net for individuals at risk in the community, working closely with community agencies including the San Francisco Public Guardian and Adult Protective Services. Admissions from the community of vulnerable individuals in need of either long term care or short-term respite have always been a top priority. In our opinion, it is unethical to give priority to SFGH patients who are in a safe environment, over persons who are at risk or in danger at home. Admissions from home occur almost weekly to the admissions unit.

One example is Mr L., a developmentally disable diabetic man on dialysis, being cared for by his elderly mother. When his father became ill, the burden of caring for both of them overwhelmed his mother. Mr L. Was evaluated in the emergency room at SFGH, but not admitted. Within a few days, he was referred to LHH and he was quickly admitted directly from home, avoiding a costly and unnecessary acute care stay.

Another more recent referral is Mrs W., an elderly blind woman, who is confined to a wheelchair. She was admitted to a private hospital in San Francisco with multiple bruises. Her mentally ill daughter is suspected of abusing her. Mrs W. Was referred to the Public Guardian for conservatorship and placement. Under the current admissions policy, Mrs W. Can't be admitted to LHH, and is at risk of being discharged into an unsafe home situation.

These are only two examples that illustrate how limiting LHH admissions to only SFGH patients will jeopardize the welfare of the frail and elderly in San Francisco, and result in increased costs. Similarly, our respite program is designed to keep individuals at risk for institutionalization at home by providing needed vacations for caregivers. Respite programs are an essential component of contemporary geriatric care. The federal Medicare program supports and funds respite stays. This program has been terminated at LHH, and we fear that this administrative decision will lead to preventable institutionalization of this vulnerable population.

"The Justice Department has promulgated regulations pursuant to Title II of the American with Disabilities Act that require public entities to provide services to qualified individuals with disabilities in the most integrated setting...San Francisco is failing to ensure that LHH residents are being served in the most integrated setting pursuant to the ADA...residents remain at LHH because there are barriers to an alternative placement, primarily a lack of available housing." Findings letter of LHH investigation by The United States Department of Justice, Civil Rights Division (DOJ) May 6, 1998.p14.

LHH is a skilled nursing facility, mandated to provide 24 hour supervision for residents and a safe environment for everyone. All residents of LHH must meet minimum Medicaid/Medi-Cal skilled nursing level of care criteria. We are not licensed as a shelter, an assisted living facility, a Board and Care or a psychiatric facility. Individuals who do not meet skilled nursing criteria must be free of institutionalization. Placement at LHH i snot in the best interest of a patient without appropriate needs, nor is this cost effective, as we are not reimbursed for residents without skilled needs. This point was recently emphasized by the DOJ and re-emphasized by the Protection in Advocacy group.

Admissions screening for LH involves the interpretation of federal and state mandated requirements, clinical prognostication and risk stratification and matching needs of referrals with available staffing, and community milieu. As such, we must rely on experienced LHH clinicians to do our admissions screening.

"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...The potential for harm is heightened by LHH's practice of housing frail, elderly residents who are confined to their beds with residents who are ambulatory and have aggressive or combative behaviors." Ibid DOJ letter May 6, 1998 p4.

"The facility must ensure residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and rights of others..." Federal Register Rules and Regulations Governing Skilled Nursing Facilities, Section 483.15

Safety and supervision of residents is one of the top priorities in admission screening. One cornerstone of the DPH response to the citations of both the BOJ and The State of California Licensing and Certification was to implement more thoughtful and stringent criteria for admission of individuals from whom we cannot provide adequate care. We, the admission s unit attending physicians must not admit residents who in our clinical judgment cannot be adequately supervised, or pose a danger to themselves or others. Predatory behavior is a particular problem, due to the large number of LHH residents who lack decision-making capacity. The decision to admit

residents with potentially unsafe behaviors must rest with the clinicians who will be accepting responsibility for the case. In all circumstances, we must err on the side of safety.

"No long term care facility shall accept or retain any patient for whom it cannot provide adequate care" California Health and Safety Code 1418..6

There are populations whose needs cannot be adequately met within the Department of Public Health (DPH) with existing programs. The existence of this population points to gaps in the network of care. Using LHH as a stopgap measure to solve this problem by administrative fiat is a poor substitute for addressing complex social issues with thoughtful, collaborative solutions and allocation of adequate resources. Such expediency driven measures, as are currently being implemented, have drawn the attention of the entire spectrum of regulatory agencies to LHH in recent years, with consequent administrative and financial burdens, and tarnishing of the reputations of committed clinicians at LHH who have long served the people of San Francisco. Moreover, it is not appropriate to disregard the clinical staff and patients of one facility for the purpose of realizing a potential cost savings for another facility. We are dismayed at the repeated emphasis on cost savings for SFGH as the justification of this new admissions policy.

As a final note, we have witnessed with concern, the impact that our current admission s policy has had on the relationship between LHH and other facilities in San Francisco. Referrals from SFGH are inadequate to keep our beds filled. We believe that outside hospitals will find other skilled nursing facilities during this time, leaving LHH with empty beds in the future. More importantly, is it fair or just to restrict access to LHH to only one group of San Franciscans, when the rebuilding of LHH was approved by a majority of voters? Would the rebuild have been approved if the voters had known that only patients from SFGH would benefit from LHH? Laguna Honda must be [a] resource available to everyone in San Francisco.

[Handwritten signatures]
Maria Rivero MD and Timothy Skovrinski MD
Attending Physicians, Admissions Unit
Laguna Honda Hospital
March 31st, 2004

Psychosocial Cluster Units

As members of the LHH medical staff our duties include the provision of safe and appropriate placement of patients. The opportunity to receive care at Laguna Honda Hospital must remain available as a viable, safe, and quality option for all San Franciscans.

> The mission statement of the Psychosocial Cluster Units at Laguna Honda Hospital is to provide specialized interdisciplinary expertise, holistic treatment, comprehensive therapy and psychological/behavioral management to residents of Laguna Honda Hospital, as well as patients throughout the Community Health Network and other healthcare systems of San Francisco. The cluster is designed to treat residents with primary medical diagnoses who also have complex psychosocial problems that can benefit from a structured environment which focuses on their behavioral needs. The goal of treatment is to achieve the highest possible level of psychological, behavioral, cognitive, and social functioning within the least restrictive level of care and environment.

The Psychosocial Unit teams are fulfilling their mission by caring for chronically ill people whose problem behaviors are persistent, challenging and sometimes dangerous. We are doing so in the context of inadequate physical environment and minimal staffing. Many of the people housed on these units were formerly at Napa State Hospital or other locked facilities; many have traumatic brain injury and are at high risk for elopement. While our residents do meet skilled nursing facility criteria (Title 22) for admission, their psychiatric and behavioral needs are equally severe. These needs are consistently underappreciated. LHH is not a licensed psychiatric facility, and our Psychosocial Units are not locked—in fact they will soon become less secure as we comply with OSHPD/State of California regulations. We do not have any Licensed Psychiatric Technicians on staff. In light of all this, it is essential to individualize placement decisions—as a medical staff we have a duty to provide a safe and appropriate environment for all our patients.

The demand to increase patient flow within the DPH has significantly disturbed the population mixes of the Psychosocial cluster units. The disparity of patient needs on certain units has created real difficulties in maintaining safe and therapeutic programming. This is especially true on the units that have become co-ed. It can be no surprise that the needs of a 30 year old non-demented HIV positive gay man are very different from the needs of an 80 year old with Alzheimer's dementia and persistent wandering. Currently we are cohorting such disparate people, and the units are subsequently less stable and less safe for our most vulnerable residents.

The gaps in the continuum of care in SF County must be addressed. The DPH is feeling the impacts of the closure of St Mary's Care Unit (HIV/AIDS Dementia), as well as of the new constraints on the MHRF admission criteria. Serious gaps remain in residential and outpatient substance abuse treatment, both voluntary and court mandated.

No facility can provide all services to all people. We must divert people who can not be managed here to more appropriate treatment. The distinct needs of each individual must be recognized and accommodated if we intend to preserve LHH as a safe and therapeutic facility.

Rehabilitation Unit: Concerns regarding the Admission Policy

The number of Community Reintegration Program (CRP) beds is slated to increase frrm 6 Acute Rehabilitation beds to 15 Acute Rehabilitation beds and from 22 SNF Rehabilitation beds to 45 SNF rehabilitation beds in the new facility. The CRP units is the only clinical unit in the Link Building. This unit was specifically designed to accommodate the needs of patients who require intensive rehabilitation services and demonstrate the potential for discharge to the community within 90 days.

The increase in SNF Rehabilitation beds is the result of the demand for such beds, as waiting lists for these beds are not uncommon. Over the past 2 years, San Francisco General Hospital (SFGH) has unofficially received first priority for these beds. A great deal of effort has been made to streamline the process of effectively and efficiently transitioning patients from SFGH to LHH in order to meet the patients' rehabilitation needs and to help to free up much needed beds at SFGH. In doing so, the majority of referrals from outlaying hospitals have been left "dormant," with the patient sitting for weeks at the referring facility, often never to be admitted to LHH. Like many of the patients referred from SFGH, these patients may have benefited from focused inpatient rehabilitation services to assist in transitioning them quickly from hospital to home. These patients, San Francisco residents like those from SFGH, have been denied this opportunity.

The Acute Rehabilitation beds at LHH were increased for several reasons, particularly the anticipation of attracting more Medicare patients. Patients with Medicare have the option of choosing the site of their inpatient rehabilitation. It has not been uncommon for patients to refuse admissions to LHH on the basis of its current physical plant. Further, it is not uncommon for patients to be referred to other outlaying rehabilitation programs while they are inpatients at SFGH without LHH being sited as an option. Given that the demand for SNF Rehabilitation beds is such that SFGH commands first priority, it is interesting to note that SFGH refers only a scant number (approximately 2 or so per year) of Medicare patients for Acute Rehabilitation services to LHH. Granted, it may be due to the overall concerns of the current physical plant. However, ongoing advances in rehabilitation programming and expertise, along with recent Best Practices recognitions highlight the excellence of the rehabilitation program at LHH. The increase in Acute Rehabilitation beds in the new facility is due to the anticipation that the combination of programming, combined with the state of the art, therapeutic environment will attract both non-funded and funded patients from LHH and from other hospitals as well. Medicare funding, as well as other private insurance, is a crucial source of revenue that can help the rehabilitation grow and continue to achieve extraordinary levels of excellence. Diverting such patients away from our program does the patients and the DPH a disservice. LHH should not be considered or presented as the rehabilitation program of last resort. Even before completion of the new facility, all patients with inpatient rehabilitation should be referred to LHH and informed of the excellence of its rehabilitation services.. All patients should be given the opportunity to benefit from what LHH has to offer. Give the anticipated number of beds in the new hospital, there should be enough beds within the Acute Rehabilitation unit to accommodate patients from SFGH and other hospitals.

Educating public sentiment about the merits of the program at LHH should begin now. It doe4s not begin with an exclusionary policy that meets the needs of only select populations. It does not begin with offering LHH services only to those who have no where else to go as this sends the wrong message to patients about the excellence of the services offered at LHH. Needless, to say, as has been argued extensively in the past, LHH may be one of the best way to circumvent unnecessary admissions to acute hospitals within the city. From a rehabilitation standpoint, allowing patients to prepare for return to the community through intensive rehabilitation services, community reintegration exercises and comprehensive discharge planning, is one of the best ways to prevent unnecessary hospital admissions, not only for SFGH patients, but for other San Franciscans as well.