The expectation for the Benchmark Facility Tours assumed, at the very least, that both publicly-funded facilities would be comparable to Laguna Honda. However, the tours re-iterated just how unique Laguna Honda is, primarily due to the population served. It should also be noted that both Coler-Goldwater and Oak Forest had significant acute care facilities on their campus while Laguna Honda's sister acute care facility, San Francisco General, is off-campus. This split campus affect is difficult to measure against single-campus facilities that may benefit from greater centralization and sharing of services.

Coler-Goldwater matched Laguna Honda operationally in terms of comparable reimbursement rates, but not in terms of how resident populations are housed. Coler-Goldwater does not accommodate residents by clinical clusters, whereas Laguna Honda is currently grouping residents by common need or characteristic for improved quality care. This operational difference made comparisons to Laguna Honda difficult.

Oak Forest differed from Laguna Honda more than expected in part due to the extremely low reimbursement rates and C.N.A. staffing levels. Laguna Honda's budgeted bed capacity and matching budgeted staffing levels allow for quality care comparable to several privately-funded facilities toured. But as with Coler-Goldwater, the primary difference between the facilities was their dissimilar populations.

The two charts at the end of this section help describe Laguna Honda's population. Note in particular the following characteristics:

- **94% of Laguna Honda residents use a wheelchair**
- **31% use extended-leg wheelchairs**
- **45% require a mechanical lift for transferring**
- **54% have behavior or cognitive impairments**

Laguna Honda residents offer a picture of individuals with a lifetime of physical, mental, or social neglect. These are individuals who require greater assistance than the population normally seen in an average nursing home.

The following five different populations receive skilled nursing care at Laguna Honda, and the sixth population receives some level of acute and/or subacute care:

- Dementia Residents
- Psychosocial Residents
- Complex Medical Residents
- High Support Residents
- Rehabilitation Residents
- Acute/Sub-Acute Residents

The unique needs of the different populations are described as follows:

Dementia Residents—are unable to manage self-care at home or in community settings due to dementia or other cognitive impairments. Safety and security are of primary concern for this population who are expected to remain at Laguna Honda indefinitely. Typical clinical presentations are:

- Alzheimer's Disease
- Multi-infarc dementia (MID)
- Short-term memory impairment
- Judgment impairment due to perception (such as left/right neglect)
- Impulse control due to an unmet need or anxiety (such as wandering)

Dementia residents are necessarily dependent upon their environment as a therapeutic setting with the goal of safety and security. Important features of dementia residents' environment include:

- Cueing opportunities (such as which room is their bedroom, where is the toilet room, etc.) provide important visual "clues".
- Personalization of rooms (such as "memory cabinets", picture rails, etc.) helps reclaim a sense of self-identity, maximizes attention span, and reinforces directional cueing.
- Stimulation control (such as private bedrooms, small-group dining rooms, etc.) help minimize intake overload.
- Stimulation outlets (such as indoor/outdoor wandering paths, come-and-go activities, etc.) allow release of anxiety and agitation.
- Security issues (such as protection from aggressive residents, non-axial entries and exits, etc.) increases feelings of security and improves emotional well-being.
- Creative resolution of paradoxes (such as need for stimulation but problems of overstimulation, need for predictability versus value of prompting curiosity, etc.).
- High spatial/storage needs to accommodate bulky assistive devices unique to the declining dementia resident (such as "ultimate walkers".)

Psychosocial Residents—require a therapeutic environment due to a primary medical diagnosis with concomitant complex psychosocial problems. Rehabilitation is the ultimate goal for this population. Goals of treatment 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 the resident's ability to interact safely and socially in another environment. The average length of stay varies. A few residents (approximately 15%) stay two weeks to two months, some residents (approximately 35%) stay six to 16 months, and the remainder stay longer than 16 months. Typical clinical presentations are:

- Spinal cord injury
- Substance abuse
- Multiple sclerosis
- Delusional presentations
- Depression
- Judgment impairment or impulse control due to behavioral problems (such as acting out)

Like dementia residents, psychosocial residents are also dependent upon their environment as a therapeutic setting, but the goal is clarification of the environment as opposed to comfort and predictability of the environment. Important features of psychosocial residents' environment include:

- Orientation to place (such as wayfinding) helps the resident adjust to the environment.
- Personalization of rooms (such as private rooms) helps reclaim a sense of self-identity as well as reduce territorial issues.
- Behavior control (such as small-group dining rooms, time-out rooms, etc.) helps modify inappropriate actions.
- Behavior outlets (such as access to the outdoors, vigorous activities, etc.)
- Range of security issues (such as protecting frail residents from psychosocial residents, observation of the residents for behavior control, etc.)
- Rehabilitation opportunities (such as cooking, self-medication, group therapy, egalitarian rooms, etc.)
- Average spatial/storage needs associated with skilled care residents.

Complex Medical Residents—have multiple medical problems with concomitant psychosocial issues. While many of these residents may be experiencing complications from their conditions or diseases, they are still for the most part alert, oriented and able to communicate. However, despite being cognitively intact, many of these residents have significant social or behavioral issues. Unlike the psychosocial resident

population whose therapeutic goal is rehabilitation back into the community, the complex medical residents' behavioral goal is to restore social interactions for maximum independence in a group setting. Hence, the full name, Complex Medical/Restorative Care (CMRC), better reflects the population served. Typical clinical presentations are:

- Spinal cord injury
- Mild retardation
- Diabetes
- CAPD (Continuous Dialysis)
- Wound care
- Cerebral vascular accident (CVA)
- Cardiovascular disease

Due to the psychosocial component of CMRC residents' care, their environmental needs are similar to the psycho-social residents' needs with an additional requirement to accommodate medical care. Important features of the CMRC Residents' environment include:

- Orientation to place (such as wayfinding) helps the resident adjust to the environment.
- Personalization of rooms (such as private rooms) helps reclaim a sense of self-identity as well as reduce territorial issues.
- Behavior control (such as small-group dining rooms, time-out rooms, etc.) helps modify inappropriate actions.
- Behavior outlets (such as access to the outdoors, varied activities, etc.)
- Range of security issues (such as protecting frail residents from psycho-social residents, observation of the residents for behavior control, etc.)
- High spatial/storage needs to accommodate numerous assistive devices unique to the medically-dependent CMRC Resident, which are often bulky and high maintenance (such as power wheelchairs that need cleaning, re-charging, etc.)

High Support Residents—represent a diverse population, all requiring high support according to their population sub-set needs. The population sub-sets are chronic care, AIDS, and hospice. Typical clinical presentations and environmental needs by sub-set are:

- **Chronic Care** (commonly referred to as total care) 50% of chronic care residents are non-ambulatory and non-alert, but the focus for all chronic care residents is high-level maintenance without rehabilitation. This palliative care requires vigilant physical care but does not present safety risks such as elopement or substance abuse. Specific clinical presentations are:

  - Severe CVA
  - Severe retardation
  - Tracheostomy care
  - Contracture prevention

  Specific environmental features include:

  - High spatial/storage needs to accommodate bulky assistive devices unique to the physically dependent chronic care resident (such as power lifts, tube feeding devices, special bed attachments, etc.)

- **AIDS** residents represent the full spectrum of needs for all populations from dementia, acutely ill and frail to chronically ill but young and active. The average length of stay is six weeks to several months or years. Specific clinical presentations are:

AIDS with:
- Chemotherapy treatment
- Wound care
- Dialysis
- Substance abuse

Specific environmental features include:

- All environmental features required for the dementia residents' population.
- Family-centered design due to higher visitation rates, especially for female residents who have children.
- Accommodations for age-appropriate activities such as a pool, gym or movie theater.
- Participating in cooking.
- Self bathing.
- Specific medication use needs (such as an infusion lounge, IV-heavy medication room, etc.)
- Isolation rooms.
- Oxygen therapy.

- **Hospice** improves the quality of life for terminally ill patients and their families during the last stages of illness, death and bereavement by providing palliative and supportive care. Specific clinical presentations represent the full spectrum of illness and disease but primarily:

  - Cancer
  - Hepatitis C

  Environmental features represent the full spectrum of needs for all populations from dementia, acutely ill and frail to chronically ill but young and active. Unique needs include:

  - Transition gateway entry to reflect and encourage a change in attitude, and to assist with the goal of controlled, but significant visitation.
  - Overall soothing atmosphere (such as orderly details, lack of visual clutter, adjustable lighting, noise reduction, etc.) due to the high-emotional intensity of this unit.
  - Fluid transition from public to private space to allow a sense of privacy while simultaneously providing a sense of being connected to the public, larger-world context.
  - Maintaining a sense of self while declining (such as high-quality bathing for comfort and body- image value, mirrors for body-image reassurance, etc.)
  - Family-centered design (such as home cooking accommodations, guest quarters, etc.), in which the definition of family includes staff and volunteer individuals.
  - Varied, home-like storage needs (such as a portable bar, keyboard, furniture, etc.)
  - Opportunities for pleasure (such as smoking, visual or physical access to gardens, etc.)
  - High-use gathering accommodations (such as memorial services, consultation spaces, etc.)

Rehabilitation Residents—includes residents who need acute and skilled rehabilitation.

Acute Rehabilitation provides short-term physical restorative services to patients discharged from the hospital but in need of intensive rehabilitative services. These patients are medically stable and can tolerate three hours per day of physical therapy. Average length of stay is two to eight weeks.

Skilled Rehabilitation provides less intensive rehabilitation services to residents discharged from acute rehab care. These residents cannot tolerate three hours per day of physical therapy, or they are being weaned off therapy. Average stay is one to three months. Typical clinical presentations are:

- Cerebral vascular accident (CVA)
- Orthopedic conditions
- Guillain-Barre syndrome

Important features of rehabilitation residents' environment include:

- Facilities to maximize independence with the goal of full rehabilitation (such as a transitional apartment, training toilets and kitchens, self-bathing and showering, etc.)
- Facilities that accommodate heavy use of equipment as opposed to storage of equipment (for example, few lifts are used but much physical therapy equipment and personnel will be needed in the bedrooms, bathrooms, etc.)
- Facilities to accommodate the full spectrum of rehabilitation residents from young adults to elderly.
- Facility accommodations should aim to meet *Commission for Accreditation of Rehabilitation Facilities (CARF)* standards.

Acute/Subacute Residents—includes residents who need a range of acute to skilled medical and nursing care. The population sub-sets are acute medical, subacute/admissions, and subacute/chronic respiratory.

Acute Medical provides short-term general medical care services primarily to Laguna Honda residents to reduce the necessity of transfer to another hospital. The acute care service is also required in order to meet distinct-part skilled nursing facility licensing criteria. Average length of stay is six weeks. Typical clinical presentations are:

- Uncomplicated pneumonia
- Urinary track infections
- Stroke
- Osteomyelitis
- Endocarditis
- Sepsis
- Uncontrolled adult diabetes
- Oxygen support
- Antibiotic therapy
- Blood transfusions

Clinical presentations necessitating transfer to another facility are:

- Heparin flush
- Pressure agent monitoring
- Chest catheter
- Frequent chest x-rays

Subacute/Admissions is essentially an assessment program to transition residents into the most appropriate long-term care population. The need for observation of these residents in a social setting is paramount to the assessment goal of this program. Residents will generally progress from "subacute" and more ill, to less acute and ready for transfer. Residents typically agree to a structured routine over a two-week period.

Clinical presentations represent the full-spectrum of medical and nursing care needs provided for at Laguna Honda.

Subacute/Chronic Respiratory care will be a new service for Laguna Honda. A ventilator unit is not anticipated. Typical clinical presentations are expected to be:

- Chronic obstructive pulmonary disease (COPD)
- Emphysema
- Airway patency care (suctioning greater than 3 times per day)

Important features of the acute/subacute residents' environment include:

- The full-spectrum of residents from dementia to active-but-ill will need to be accommodated; therefore, SNF-level amenities will need to be incorporated on all acute units to some degree (such as social dining, activities, security, etc.)
- Specific medical needs (IV-heavy medication rooms, increased respiratory therapy support, monitoring, etc.)
- Consideration needs to be given to the increased level of activity on these units (such as more noise from moist coughing, suctioning, increased equipment use, etc.)
- The atmosphere should acknowledge the transitional nature of these units. For example, the admissions residents have agreed to waiver certain privileges; therefore, the opportunity to smoke should not be denied.

In summary, no facility toured showed evidence of such a diverse population. Because Laguna Honda cares for such a wide range of individuals, a balance must be found operationally and architecturally to meet the diversity of needs seen today while remaining flexible for future changes. This balance should allow for those who are active to have independence within a secure setting, while allowing for those who are inactive to have an environment that facilitates the care they require for a dignified existence. Each facility toured offered insights for different ends of the population spectrum, but ultimately, the new Laguna Honda will be an intensely unique facility.