City and County of San Francisco

Department of Public Health
Laguna Honda Hospital and Rehabilitation Center

November 5, 2004

Jan Eldred, M.S.
Senior Program Officer
California HealthCare Foundation
476 Ninth Street
Oakland, CA 94607

Dear Jan,

Thank you for the opportunity to respond to the review team's request for more information on the proposed project on changing the culture of care at Laguna Honda and implementing a social rehabilitation model. The attached document provides the information as requested by the review team.

Thank you for your time and continued interest in our grant proposal. Please feel free to contact me if you have any questions.

Yours truly,

Mivic Hirose, RN, MS, CNS
CHCF Leadership Program Fellow, Cohort II
(415) 759-4510

Attachments:
1. CHCF Leveraging Leadership Grant Proposal Supplemental Info
2. Dr. Lisa U. Pascual's CV

cc: Lisa Pascual

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CHCF Leveraging Leadership Grant Proposal Supplemental Info

Applicants: Mivic Hirose, RN, MS, CNS and Lisa U. Pascual, MD
Applicant Agency: San Francisco Department of Public Health/Laguna Honda Hospital and Rehabilitation Center
Date: November 5, 2004

Recommendation #1: Information on the Social Rehabilitation Model

Social rehabilitation model description

This social rehabilitation model is adapted from the BioPsychoSocialSpiritual (BPSS) model that was developed in 2003 at the San Francisco Department of Public Health's Mental Health Rehabilitation Facility[1] (MHRF). The BPSS model development was completed just months prior to the MHRF being designated to close and unfortunately has not been tested. However, when the model was introduced to the staff, there was universal agreement that it served to: (1) provide a structured care model that minimized role conflict, validating the significance of each discipline represented on the interdisciplinary team[2] (IDT), (2) clarify the organization's values and culture, and (3) provide a clear articulation of how the clients participate in goal setting for rehabilitation or recovery. The model is consistent with the concept of recovery from disability and provides a template for assessment, prescription, intervention planning, decision making and evaluation of care.

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[1] In September 2003, the Mayor of San Francisco established a Blue Ribbon Committee to determine the optimal programmatic design of the MHRF given the available services and unmet needs of persons with mental illness in San Francisco. The Committee recommended the conversion of the MHRF from a 147 bed skilled nursing facility to a hybrid model, which adds a mental health rehabilitation center, a residential care facility and a residential treatment facility.

[2] Federal regulations recommend that the assessment and care planning of clients in a skilled nursing facility is best accomplished by an interdisciplinary team that includes facility staff with varied clinical backgrounds. Such a team brings their combined experience and knowledge together for a better

At that time, the social rehabilitation program goals were basically twofold. First, to establish a service delivery paradigm that would build cohesive interdisciplinary teams, and secondly, to articulate and provide a structure for the organization's visions of holistic and comprehensive care delivery and reintegration of long-term care clients into the community.

The model consists of five domains. Collectively, these domains represent the domains of care and balanced combination of modalities called for in meeting the client's care needs (Figure 1). The discipline-specific contributions to the client's rehabilitation/recovery plan have been outlined within each of these domains to assist the IDT in recognizing where their specific discipline's contribution are most appropriate. It is also emphasized that none of the domains are mutually exclusive and there is overlap expected. Further, it allows the interdisciplinary team to skillfully titrate and tailor interventions to each individual's needs.

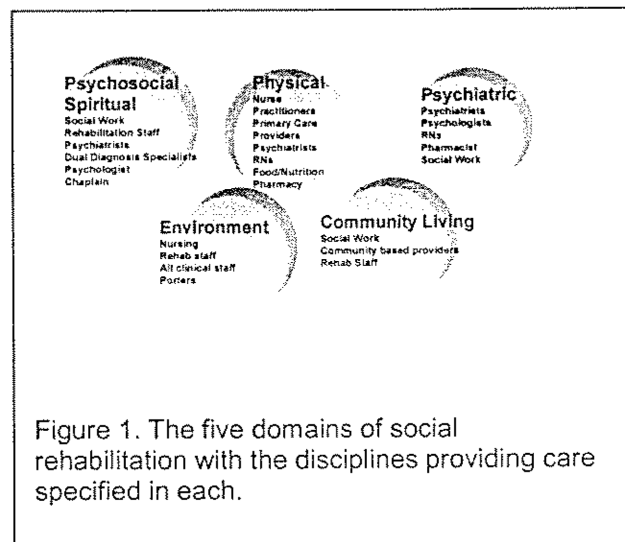

Figure 1. The five domains of social rehabilitation with the disciplines providing care specified in each.

The domains are described as:

1. *Biological* - This represents biological and/or physical health issues. Primary care, health promotion and management of chronic diseases are represented here.

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understanding of the strengths, needs and preferences of each resident to ensure the best possible quality of care and quality of life.

2. *Psychiatric* - Medications to relieve psychiatric symptoms and prevent relapse are generally acknowledged as a revolution in the history of psychiatry and is represented in this domain. Individualized supportive psychotherapy is also within this domain.

3. *Psychosocial and Spiritual* - There are a myriad of care modalities subsumed in this area. There is psychotherapy, psychoeducation, psychosocial interventions and nursing interventions. All of these modalities help clients and their families and/or significant others to cope with the illness and its complications as well as help prevent relapse. Spirituality signifies hope or how one finds meaning and purpose for their lives. It may be religion or any other form of spirituality where the clients finds hope, meaning and purpose. Hope is very important, as without hope, people cannot find a way out of their current situation. Clearly, all staff have a role here.

4. *Environment* - In addition to physical plant and safety issues, in this domain we consider, culture, staff skill level and counter-transference. In the therapeutic community, the total structure of the unit (care setting) is used as an element of treatment. This normalizes client participation in the unit management and creates a structured community in which individuals learn new ways of interacting. Our aims include:

   - Providing a stable coherent social organization that facilitates individual treatment;
   - Structuring client's activities and promoting collaborative relationships between clients and health care professionals;

- Enhancing interpersonal and communication skill level of staff and paying careful attention to counter-transference issues in order to provide a humanizing, noninstitutional and therapeutic environment.

5. *Community Living* - The focus here is on assessment and planning for the client's return to the community. Considering the client's physical, psychiatric and/or life skills disability, the interdisciplinary team assures the required services and resources are in place to enhance the client's continued rehabilitation and recovery as they transition from the facility to the community.

The guiding principle of the model is empowering the client's self-care ability and is accomplished using the following formula:

Client's Rehabilitation/Recovery Goals =

Preferences + Skill (Functional) Level + Clinical Needs

The IDT determines the client's rehabilitation/recovery goals and incorporates the client's preferences, their current self-care skill (functional) level and their clinical needs. Empowerment is operationalized using a formulation based on Orem's Self-Care Model and explicated by Dr. Patricia Underwood (former Chair of the San Francisco Health Commission) using the grid shown in Figure 2. Putting it all together, this is the delivery model template.

The template demonstrates the levels of self-care down the left side. Assessments, goals/expectations, and interventions/prescriptions directed at attaining, regaining or retaining the client's self-care functioning are described in the columns. Each level in the self-care model assumes a self-care deficit.

The self-care model guides the clinical focus onto the individual and his/her self-care ability in living day-to-day; rather than on a specific disability, symptom or condition. It also requires the treatment team to include the client in treatment planning.

	Resident Ability to Meet Self-care Demands	Expectations for Resident Participation	Resident will:	Staff will:	Helping Methods:
Level 1	Requires minimal assistance	Minimal assistance in all areas of self care	Manages self care with minimal assistance	Minimal assistance (25% from staff) Support independence; encourage ongoing involvement in family and community activities, medication compliance, participation in therapy and other community programs	Support
Level 2	Able to meet self care demands; Requires moderate assistance	Able to participate in planning; may have limited resources, input or action	Meet self care demands in accord with social and cultural norms	Moderate assistance (50% from staff) Increasingly involve resident in decisions about managing self-care Include family and support system when available	Nurse-patient relationship, using teaching and role-modeling Support Teaching Supervision
Level 3	Able, with verbal and/or physical assistance; Requires extensive assistance from another person and equipment or device	Able to participate in own care, but may not do so willingly or at the level expected by nursing staff	With verbal assistance, resident will handle own self-care demands	Extensive assistance (75% from staff) Assist resident to re-establish self-care behavior Assist resident to learn new self-care behaviors	Guidance Support Therapeutic environment Act and do rarely (Teaching may be premature)
Level 4	Unable; requires assistance; Dependent on caregivers	Unable to participate	Accept nursing assistance with self-care, to ensure survival	Total care (100% from staff) Provide protection Ensure self-care needs are met. Emphasis: Physical survival in a sheltered environment	Use all helping methods except teaching. Attempt to elicit participation, but not expect or demand it pt nursing assistance with self-care, to ensure survival

Figure 2. Template to be used by the interdisciplinary teams in developing self-care competencies for clients.

In summary, this social rehabilitation model will change the care delivery model at LHH on one 30-bed unit. This model identifies domains of care and the work to be accomplished by each discipline. The model also identifies domains where each discipline focuses on making their specific contribution to the client's rehabilitation plan. Another feature of this model is that it cannot be implemented without client input, involvement and preferences. Focusing on the client's self-

care ability will promote facilitating timely discharges to the community, preventing institutionalization, and reducing costs of hospital stay.

References:

1. Bachrach, L.L. (1992). Psychosocial Rehabilitation and Psychiatry in the Care of Long Term Patients. American Journal of Psychiatry 149:11, 1455-1463.
2. Orem. http://www.nursesnetwork.co.uk/envo/modules.php?op=modload&name=News&file=article&sid=74&mode=thread&order=0&thold=0. Accessed November 2004

Recommendation #2: Involvement of Lisa Pascual, MD on the project

I have spoken to Dr. Lisa Pascual and she has told me that she is very interested in joining the project as a co-applicant, physician advisor and champion. Attached is her curriculum vitae.

Recommendation #3: Timeline

We agree with the recommendation. The project will fully focus on one unit. The planning that has occurred at present are as follows:

1. Discussion and buy-in from San Francisco Department of Public Health:
   a. Roma Guy, MSW, Commissioner, San Francisco Health Commission
   b. Dr. Mitchell H. Katz, Director of Health, SFDPH
   c. Dr. Paul Isakson, LHH[3] Medical Director

[3] Laguna Honda Hospital and Rehabilitation Center

d. Dr. Timothy Skovrinski, LHH Assistant Medical Director

e. Gayling Gee, RN, MS, LHH Co-Director of Nursing

f. Janet Gillen, LCSW, LHH Social Services Director

g. Service Employees International Union (SEIU) Locals 250 and 790 LHH Shop Stewards. Local 250 represents LHH Certified Nursing Assistants and Licensed Vocational Nurses and Local 790 represents the Registered Nurses at LHH. The working relationship between labor and LHH Nursing Administration is collaborative and positive.

2. Identification of the pilot unit: Unit E-4. This unit is a 30-bed for clients with complex co-morbid, chronic diseases, often with history of substance abuse. Additionally, there are a small number of beds dedicated to traumatic brain and spinal cord injury rehabilitation.

3. A presentation to the SFDPH Health Commission on the pilot development and grant proposal is planned for the November 16, 2004 Health Commission meeting at Laguna Honda Hospital. If the grant will be awarded by this time, we will announce at this meeting.

Recommendation #4: Advisory Group

The creation of a small advisory committee is an excellent recommendation. We feel that the following individuals would offer exceptional strategic and planning recommendations in shaping and executing the grant:

1. Luis Calderon, IHSS Public Authority
2. Roma Guy, MSW, San Francisco Health Commissioner

4. Lisa Pascual, MD, Chief of Rehabilitation Services, University of California, San Francisco at San Francisco General Hospital and LHH
5. Representative from the Independent Living Resource Center
6. Mozettia Henley, DNS, RN, LHH Program Supervisor

The advisory committee will be convened late November 2004. If the selection committee has other or additional recommendations for the advisory committee, please let us know.