**City and County of San Francisco** **Department of Public Health**
**Laguna Honda Hospital and Rehabilitation Center**

October 8, 2004

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

Dear Jan,

On behalf of the San Francisco Department of Public Health and Laguna Honda Hospital, I am submitting our grant application titled 'Social Rehabilitation: Changing the Culture to Close the Gaps in the Long-Term Care Continuum.' Thank you for the opportunity.

Please feel free to contact me for clarification or questions. Have a nice day.

Yours truly,

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

# CALIFORNIA HEALTHCARE FOUNDATION

# PROPOSAL COVER SHEET

*(Please type or print clearly.)*

Date October 8, 2004

## Organization Information

Name of Requesting Organization (or Individual)
San Francisco Department of Public Health: Laguna Honda Hospital and RehabilitationCenter (LHH)

Primary Contact
Mivic Hirose, RN, MS, CNS

Title
Co-Director of Nursing, LHH

Address
375 Laguna Honda Boulevard

City
San Francisco

State
CA

Zip Code
94116

Telephone
(415) 759-4510

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(415) 759-2374

E-mail
mivic.hirose@sfdph.org

## Proposed Project

Project Title
Social Rehabilitation: Changing the Culture to Close the Gaps in the Long-Term Care Continuum

Brief Summary of Proposed Project
The proportion of the long-term care population who are < 55 years of age in San Francisco has increased over the past ten years and the trend is projecting upwards in the coming years. The expansion of the care culture of rehabilitation and community reentry is vital to avoiding the institutionalization of disabled adults. The project proposal aims to implement a Social Rehabilitation model at Laguna Honda Hospital, one of the largest skilled nursing facilities in the country. A paradigm shift from institutionalization to community placement and from custodial care to rehabilitation is imperative for the culture change to occur. This innovative approach will change the skilled nursing care delivery model at LHH.

## Tax Status

☑ Tax exempt, charitable organization *(Attach copy of IRS determination letter)*

☐ Government tax-exempt unit

☐ For Profit *(Attach completed IRS W9 form)*

☐ Other, please specify: _____

## Proposed Budget & Timetable

Project Budget
$50,000.00

Project Timetable (# of months)
12 months

## Signatures

Project Director
Mivic Hirose, RN, MS, CNS

Organization
Laguna Honda Hospital and Rehabilitation Center

***For CHCF use only***

| Tracking Number | Date Received |
|---|---|

**Background**

Laguna Honda Hospital and Rehabilitation Center (LHH) is a unique long-term care facility and is one of the largest of its kind in the United States that provides long-term care (LTC) to approximately 1,065 residents. LHH is owned and operated by the City and County of San Francisco Department of Public Health (SFDPH) and provides care to San Francisco citizens ages 18-100. Depending on their specific care needs, residents may stay at LHH for a few months or several years.

Approximately 22% of LHH's resident population are $\leq$ 55 years of age, which is double the national average. The younger cohort of the LTC population in San Francisco has increased over the past ten years and the trend is projecting upwards in the coming years. To this end, the expansion of the care culture of rehabilitation and community reentry is vital to avoiding the institutionalization of disabled adults and to achieving the new facility's[†] vision of innovative model of accessible adult care and rehabilitation.

**Objective**

There are two philosophies of care at LHH: one is focused on residents who have the potential to transition back to the community and the other is focused on residents who need a structured skilled nursing environment of care. The project proposal focuses on implementing a care delivery model that promotes effective use of health care workers, appropriate utilization of scarce resources and promotes accountability to the public who fund public health in San Francisco. The ultimate goal is twofold. First, to provide a framework for the healthcare team that enables expeditious development of the team in an effective working group. The second goal is to enable our residents to acquire or regain the functional skills needed to live in the community and to achieve their highest level of independence/self-care in a holistic manner (body, soul, mind, and social) and manage their disabilities. The objective of the project proposal is to successfully implement a care delivery model, adopted as Social Rehabilitation at LHH.

**Significance of the Project**

Recently, SFDPH completed a strategic planning process identifying the external threats to the Department and LHH. These are: (1) increasingly multiple-diagnosed/complex clients; (2) changing city

[†] In November 2003, San Francisco began one of its most significant civic revitalization projects, the rebuild of the nearly 80-year old facility to a 1,200 bed long-term care facility that will encourage rehabilitation and independent living while setting the standard for enhancement of the quality of life.

demographics and the expectation that the total number of adults with disabilities in San Francisco will increase; (3) funding for indigent healthcare is decreasing; (4) budget constraints at all levels of government; and (5) nationwide staffing shortages.

Changing our care models in a way that addresses the requisite health care is essential to modulate these threats to the viability of LHH as a provider of long-term care services for all San Franciscans. Additionally, this change is needed to move LHH forward in meeting the Department's mission and vision to ensure that SFDPH clients are receiving services at the appropriate level of care.

The funding source for 95% of LHH residents is Medi-caid, known as Medi-Cal in California. Because skilled nursing reimbursement is recognized as inadequate nationally, LHH is dependent on the City and County of San Francisco's general fund to supplement this reimbursement. With the decline of the economy in recent years, the general fund contribution for LHH has decreased.

While LHH has marginally responded to the changes in the resident population (increasing disabled young adults and decreasing elders) the care delivery models in use continues to support traditional medical and nursing models of care. These models meet the needs of the elderly, focusing on restoring and maintaining physical functioning (bathing, toileting, eating, mobility) of residents, yet is clearly not aligned with the healthcare needs reflected in the demographic changes. Health promotion services developing the younger adult population's capacity to manage self-care needs and maintain their overall health are absent. The project proposal will close this gap.

***Olmstead* Decision**

Internal and external perceptions of LHH influence the culture of care. The court ruling on the *Olmstead*[‡] decision also has significant implications and in the past, LHH has been criticized by external and regulatory agencies about its perceived reticence to discharging patients to the community. The San Francisco community's perception is that individuals who are admitted to LHH are at risk for long-term institutionalization. Basically, LHH continues to be seen as an almshouse for the poor and disenfranchised, even though this model does not best serve the clients and community's needs. The perception that the SFDPH

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[‡] In 1999, the United States Supreme Court decided in Olmstead v. L.C. that confining persons with disabilities in institutions without adequate medical reasons is a form of discrimination that violates the American with Disabilities Act (ADA) of 1990.

would like the community to have is that LHH is a rehabilitation center to provide skilled nursing rehabilitation with the goal of re-integrating as many clients as possible into community independent living. The internal perception of many LHH staff is not incongruent with that of the San Francisco community. However, our vision and goal is to ensure effective discharge planning and restore residents to their highest level of functioning, and returning them to their community with the least amount of incapacity.

Given the financial and regulatory challenges, the need to create an innovative approach to care delivery that focuses on maximizing the individual's rehabilitation potential and meets the intent of the *Olmstead* and regulatory ruling is urgent. The forecast for ensuring the viability of LHH as a reliable, affordable, quality long term care facility is dismal if the status quo continues, given these threats. A paradigm shift from institutionalization to community placement and from custodial care to rehabilitation is imperative for the culture change to occur. Furthermore, in order to meet the mission of the new facility, the culture change must occur prior to the occupancy of the new facility.

**Target Population**

The target population includes: (1) uninsured, indigent, and underinsured, (2) low-income and impoverished, and (3) homeless. These vulnerable populations within the target population include: low-income racial and ethnic minority persons, mentally ill, multiple diagnosed, people with chronic disease, people with disabilities, substance users, or persons with HIV/AIDS. The project proposal will focus on LHH patients who are admitted to the community reintegration program. The expected number of participants who would benefit from the project proposal is 60-90 residents during this grant period.

**Intervention/Approach**

The steps to implementing the project proposal are as follows:

1. Introduce the Social Rehabilitation model.
2. Create an interdisciplinary team, including nursing (registered nurses, licensed vocational nurses, certified nurse assistants), medicine, activity therapy, dietitian and social workers who will partner with residents in developing their social rehabilitation plan.
3. Begin training of the interdisciplinary team members.
4. Clinically operationalize the Social Rehabilitation model.

5. Develop a database program to capture factors and barriers to closing the gap in the long-term care continuum.
6. Ongoing evaluation of progress.

**Innovativeness**

This innovative approach will change the skilled nursing care delivery model at LHH on one 30-bed unit. One of the biggest disadvantages of interdisciplinary team models is the tendency of the team to establish a 'hierarchical order' and continued clarification and re-clarification of roles and responsibilities. This Social Rehabilitation model identifies domains and the work to be accomplished by each but also identifies domains where each discipline focuses on making their specific contribution to the patient's rehabilitation plan. Another feature of innovation of this model is that it cannot be implemented without patient input, involvement and preferences. Focusing on the patient's self-care ability will promote facilitating timely discharges to the community, preventing institutionalization, and reducing costs of hospital stay.

**Replicability**

At the nine-month point of the grant funding period, the Social Rehabilitation model will be expanded to another 30-bed unit. And because the model provides a well-defined service delivery system, it is anticipated that it will be easily replicable. The holistic and rehabilitation approach is generalizable throughout the facility as well as any organization that relies on interdisciplinary teams that provide services to populations receiving skilled nursing care.

**Leveraging Leadership Lessons**

Given a committed group of individuals who share the same vision, believe in the mission, and are an effective team, the power to make changes is achievable. The project proposal aims to create a new LHH that is responsive to the changing population and demographics by changing the culture and values of the traditional roles of long-term care providers and caregivers. The role of the long-term care provider and caregiver will be to promote independence and rehabilitation, not to perpetuate the resident as dependent on the provider. To this end, the investment in team building, creating vision, managing change, changing culture, and measuring outcomes are the leadership lessons learned from the CHCF Leadership Program that is needed and will be applied in implementing the Social Rehabilitation model at LHH.

**Quality Measures**

To evaluate the effectiveness of the interventions and the model, the following quality indicators will be measured throughout the project phase: (1) skilled nursing length of stay; (2) skilled nursing costs; (3) staff job satisfaction; (4) resident satisfaction, (5) # of discharges; (6) # of readmissions; (7) clinical data such as physical functioning, behavior/emotional patterns, quality of life; and (8) gaps in community based long-term care alternatives. Focused groups will be conducted to obtain qualitative data such as strengths and weaknesses, improvements to overall interdisciplinary team operations, and changes in the culture of inclusiveness of residents in the rehabilitation care plan.

**Project Timeline**

| Steps | Target Date |
|---|---|
| 1. Hire part-time clinical nurse specialist. | January 2005 |
| 2. Conduct assessment on team dynamics and create team building training. | February 2005 |
| 3. Adopt Social Rehabilitation model. | March 2005 |
| 4. Conduct training sessions for staff and implement model. | April 2005 |
| 5. Monthly meetings with unit staff, interdisciplinary team, project staff. | Ongoing |
| 6. Data collection on selected clients. | Ongoing |
| 7. Begin implementation on 2nd unit. | August 2005 |
| 8. Summarize and analyze data. | October 2005 |
| 9. Prepare and finalize reports. | November 2005 |

**Sustainability**

The Social Rehabilitation model will be put into practice throughout the hospital's 40 care units. It is anticipated that at least two care units will have fully integrated the model in their interdisciplinary team functions during the twelve-month funding period. After this time, the implementation team members will continue the implementation one unit at a time. The time devoted to continuing this project will be part of their work commitments.

# CALIFORNIA HEALTHCARE FOUNDATION
## Budget Request

**Submitted by** (primary contact): Mivic Hirose, RN, MS, CNS

**Organization**: San Francisco Department of Public Health/Laguna Honda Hospital and Rehabilitation Center

☑ Total Budget Request ☐ Year One ☐ Year Two

| | Project Budget | |
|---|---|---|
| 1. | Project Staff Salary & Benefits | $45,000.00 |
| 2. | Project Staff Travel | $1,500.00 |
| 3. | Office Operations<br>*(Includes expenses for telephones, postage, copying, and supplies )* | |
| 4. | Other Direct Costs<br>*(Includes expenses for printing, equipment, space rental )* | |
| | a. | |
| | b. | |
| | c. | |
| | d. | |
| 5. | Consultant Fees & Travel | $3,500.00 |
| | ***Subtotal*** : | **$50,000.00** |
| 6. | Indirect Cost on Subtotal (*if applicable* )* | |
| 7. | Subcontracts | |
| | ***TOTAL*** : | **$50,000.00** |

* CHCF allows a maximum of 10 percent of direct costs, excluding any amounts for subcontracts.

**SOCIAL REHABILITATION: CHANGING THE CULTURE TO CLOSE THE GAPS IN THE LONG-TERM CARE CONTINUUM**
**In-Kind Support Contributions (estimated)**

Applicant Agency: San Francisco Department of Public Health/Laguna Honda Hospital and Rehabilitation Center
Request to California HealthCare Foundation: $50,000 for 12 months
Budget prepared by: Mivic Hirose, RN, MS, CNS Ph:415.759.4510 e-mail:mivic.hirose@sfdph.org

| **Item** | |
|---|---|
| LHH Project Staff Salary and Benefits | |
| 1. Co-Director of Nursing/Project Director (2 hours per week) | $ 6,363.50 |
| 2. Nursing Supervisor/Project Coordinator (4 hours per week) | $ 12,105.60 |
| 3. Unit Nurse Manager (8 hours per week) | $ 21,970.00 |
| 4. Physician (4 hours per week) | $ 11,937.00 |
| 5. Charge Nurse (8 hours per week) | $ 16,474.00 |
| 6. Educator (8 hours per week) | $ 17,020.00 |
| Office Operations | |
| 1. Printing Costs | $ 1,000.00 |
| 2. Office Supplies | $ 1,000.00 |
| **Total In-Kind Support Contributions** | $87,870.10 |

Social Rehabilitation: Changing the Culture to Close the Gaps in the Long-Term Care Continuum

**Key Project Staff**

| | |
|---|---|
| Project Director: | Mivic Hirose, RN, MS, CNS<br>Co-Director of Nursing<br>Laguna Honda Hospital and Rehabilitation Center |
| Project Coordinator: | Mozettia Henley, DNS, MSN, RN<br>Program Director<br>Laguna Honda Hospital and Rehabilitation Center |

Please see attached curriculum vitaes for more information.

City and County of San Francisco

Department of Public Health

Mitchell H. Katz, MD
Director of Health

October 7, 2004

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

Dear Ms. Eldred:

I am writing with full support of the project proposal submitted by San Francisco Department of Public Health and Laguna Honda Hospital, titled 'Social Rehabilitation: Changing the Culture to Close the Gaps in the Long-Term Care Continuum.' I can think of no person better suited to lead this project other than Ms. Mivic Hirose.

If the project is funded, Ms. Mivic Hirose will be designated as the project director. Ms. Hirose has worked for the Department for over 18 years. She has had many direct nursing care roles including staff nurse and charge nurse in medical-surgical, critical care, and outpatient dialysis nursing. She has held advanced practice roles, such as medical-surgical nurse educator, clinical nurse specialist, research nurse, discharge planning coordinator, and informatics nurse liaison. Her administrative positions have included Medical-Surgical Nursing Director, Compliance Officer, and most currently, the Co-Director of Nursing and Hospital Associate Administrator at Laguna Honda Hospital and Rehabilitation Center, our Department's long-term care facility. In addition, Ms. Hirose recently completed her fellowship with the California HealthCare Foundation's Leadership Program. Through Ms. Hirose's leadership, I am confident that the project will be successful.

This proposal is aligned with the Department's Strategic goals to ensure that San Franciscans have access to the health services they need; and that services, programs, and facilities are cost effective and resources are maximized. As the proportion of the long-term care population in San Francisco has increased over the past ten years and will continue to project upwards in the coming years, it is vital to the Department that the skilled nursing care delivery model shift to a culture of rehabilitation and community reentry. By funding the project, LHH will be able to implement this new model of care prior to the rebuilding of the new 1,200 bed hospital.

I am committed to providing resources for our LHH employees to participate in the project. Institutional resources include use of LHH conference and training rooms. Other institutional investments include our clinical educators, nursing, and interested interdisciplinary team members who will participate as key resources for the implementation and evaluation component



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of the program. We are also committed to scheduling release time for our employees as appropriate. These commitments are in-kind support and total over the $50,000 requirement for the proposal.

It is with great enthusiasm that I fully support without reservation this project proposal. And I am prepared to fully support Ms. Hirose in her endeavors.

Please feel free to contact me if you have any questions. Thank you.

Sincerely,

MITCHELL H. KATZ, MD
Director of Health