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Another Public Health Crisis:

Why Dumping Patients Out-of-County Is Wrong

by Patrick Monette-Shaw

Photo: SFGOV-TV video, September 5, 2017.

Raquel Rivera Addresses Commissioners: Raquel is the Family Council Coordinator for the St. Luke's sub-acute unit where her sister Sandy is a patient. Raquel presented terrific testimony on behalf of families to the Health Commission's second on September 5, 2017.

Why is the healthcare system of a great city like San Francisco turning its back on its most vulnerable citizens who all too frequently are discharged out-of-county due to severe shortages in a wide array of healthcare facilities in the City?

As noted in September 2017, one of the world's greatest cities should not be sending its most fragile residents into exile because they need levels of care unavailable in-county in San Francisco.

There are great benefits to knowing how many San Francisco residents are, or have been, involuntarily discharged to out-of-county facilities, what their age ranges are, what kind of facilities they were discharged from and types of facilities they're discharged to, and what part of San Francisco they had lived in. These are all evidenced-based measures of what types of services and types of facilities are inadequate in San Francisco.

Policymakers and elected officials need to obtain such data to guide and inform decisions about building out additional facility capacity in-county.

With modern state-of-the-art Electronic Healthcare Record (EHR) databases currently in use at all acute-care hospitals and acute psychiatric facilities in the City to track patients' medical records, aggregate out-of-county discharge data can easily be extracted from EHR databases without breaching an individual patient's healthcare privacy and confidentiality protected by HIPAA (Health Insurance Portability and Accountability Act). HIPAA was enacted into law in August 1996 to reform the insurance market and simplify healthcare administrative processes.

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Impacts on People Discharged Out-of-County

There are a number of adverse impacts to people who face being dumped out-of-county, including but not limited to:

- Immediate separation from their friends, families, and communities they have lived in for years, and the resulting isolation that brings.
- Severed long-term relationships patients have developed with their primary care physicians and other healthcare providers, destroying caregiver support systems they had built and nurtured over long periods of time.
- Isolation from neighborhoods and communities patients had relied on for their sense of identities and belonging.
- Being disenfranchised from San Francisco and stripped of their residency status and voting rights on ballot issues of interest to them.

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- **Immediate separation and isolation from friends, families, and communities they have lived in for years.**
- **Severed long-term relationships with their primary care physicians and other healthcare providers.**
- **Increased risk of '*transfer trauma*,' a diagnosis known to increase morbidity and mortality from the trauma of being relocated."**

- Increased risk of "*transfer trauma*," a diagnosis that is known to increase morbidity and mortality from the trauma of being relocated. San Francisco's Ombudsman, Benson Nadell, testified in 2017 to San Francisco's Health Commission that transfer trauma is a documented effect from relocation of frail disabled persons, because "*Caregiver relationships are disrupted; the nexus of communications necessary to preserve continuity of care are broken;* [and] *the* [patient is] *moved from the familiar to the unfamiliar*."

  When nursing home patients are transferred out-of-county, family members report that they visit less frequently, and patients spend more time in bed. Many of these patients die within a year, even without terminal diagnoses.

- There are no certificate-of-preference programs, or other mechanisms, to help San Franciscans dumped out-of-county return to San Francisco should additional beds in facilities appropriate to their needs be built out, or become available through vacancies via attrition.

"Another adverse impact is termination of home-based services and supports provided through San Francisco's *Community Living Fund* when CLF clients are admitted to a SNF or to an acute care hospital, or they choose to move to, or are placed in, a facility out-of-county."

- Termination of home-based services and supports provided through San Francisco's *Community Living Fund* (CLF), a program to help prevent being "*institutionalized*" in a skilled nursing facility or in a Residential Care Facility for the Elderly (RCFE) should their health deteriorate to the point where they can no longer live at home. CLF-funded services are terminated when a CLF client is admitted to a SNF or to an acute care hospital, or they choose to move to, or are placed in, a facility out-of-county. Few other jurisdictions, if any, have a similar CLF, as San Francisco does.

Moving physically- or mentally-challenged patients out of San Francisco is clearly detrimental to their health, given the uncertainties of a new location and skilled nursing staff. It leaves fragile patients stranded, miles away from their families and friends.

Changes to the quality of care patients receive when they are transferred to another county that has lower standards of care compared to the care they had been receiving in San Francisco, is a well known adverse effect from out-of-county transfers. This is compounded by the loss of familiar surroundings and accessibility to support from their families.

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Why Out-of-County Discharges Matter

If your healthcare needs deteriorate as you age or acquire a disability and you need more care than you know how to get in your own home, or you don't have a home, you are likely to end up a patient in an acute-care hospital. This is true for the physically ill, as well as the mentally ill. The ideal outcome of an acute hospitalization is to stabilize a patient before discharging them to a location — whether to their own home or to a specialty facility — where they can access the level of care they need.

Unfortunately, acute hospital and acute psychiatric beds are both very expensive, and patients who no longer need them must leave to free the bed up for the next person. Acute-care facilities are profit-driven, even when they claim to be a non-profit hospital. They have a financial incentive to get patients in and out of an acute care hospital as quickly as possible to free up an acute-facility bed for the next patient. Hospitals work aggressively to discharge patients to a so-called "post-acute" lower level of care as a profit-driven strategy to maximize their revenues.

"Acute-care hospitals work aggressively to discharge patients to a so-called 'post-acute' lower level of care as a profit-driven strategy to maximize their revenues. Where do patients go, since there are not enough services or facilities in San Francisco for them?

Out of county, of course."

Where do patients go, since there are not enough services or facilities in San Francisco for them? Out of county of course, away from their families, friends, caregiver support systems, and familiar places that preserve their personhoods and quality of life.

A report considered by both San Francisco's Department of Public Health (SFDPH) and the San Francisco Health Commission in February 2016 — "*Framing San Francisco's Post-Acute Care Challenge*" — documented that all public-sector and private-sector hospitals cited out-of-county placement as necessary to transfer patients from acute-care facilities to lower levels of care. Sadly, the report failed to even examine or recommend building out additional capacity in-county.

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Unfortunately, five years ago on February 19, 2016 the *San Francisco Examiner* published an article discussing the "*Post-Acute Care Shortage*" report that was presented to the Health Commission on February 16. That article quoted then- Health Commissioner David Pating, MD — a psychiatrist and Chief of Addiction Medicine at Kaiser San Francisco Medical Center — as having said: "*I hope we will **consider out-of-City** [i.e., out-of-county] and **maybe even multi-county** [discharge placement] options*."

It was shocking to hear a psychiatrist like Pating advocate for breaking up therapeutic bonds patients had created for years with their healthcare and mental health providers by increasing out-of-county discharge placements. Pating, of all people, should have known about the emotional and therapeutic trauma patients endure when access to their caregiver support systems are abruptly severed. And it was obvious Pating didn't understand that all along, all hospitals in San Francisco have been discharging patients to a variety of, and multiple, counties (Pating's "*multi-county*" proposed solution). Thankfully, Dr. Pating is no longer a member of the Health Commission!

When it comes to patients — whether private-pay or those who rely on Medi-Cal — needing sub-acute skilled nursing facility ("sub-acute SNF") care 24/7 for medical conditions that require ventilators, or tracheostomy care with frequent suctioning, it is best done on a hospital's campus having an on-site ICU. All acute care hospitals other than CPMC's own hospitals have had to transfer sub-acute patients out-of-county since 2012 when CPMC stopped admitting patients from all other hospital systems to its sub-acute SNF unit, despite it being the only such facility remaining in San Francisco.

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Then CPMC stopped accepting any new patients to its sub-acute SNF at St. Luke's Hospital in 2017 — even from its own hospitals — leaving San Francisco without any in-county sub-acute SNF beds at all, the only county in California without such beds. Progress began in 2017 and 2018 to open new sub-acute SNF beds, but no replacement sub-acute unit has opened in the City during the past four years. For the past four years, an unknown number of new patients needing sub-acute SNF level of care have been discharged out-of-county.

It is traumatic enough for patients who need SNF or assisted living level of care to face being placed in such types of facilities. But discharging them to another county adds to their trauma at a time when they need to feel the support of their own community and see familiar faces.

"It is traumatic enough for patients who need SNF or assisted living level of care to face being placed in such types of facilities. Discharging them to another county adds to their trauma."

Tip of an Iceberg?

We know that a minimum of 1,746 San Franciscans have been discharged out-of-county between July 1, 2006 and December 31, 2019 from data shown in Table 1 this author has obtained from San Francisco's Department of Public Health over the years in response to successive public records requests.

"We know that a minimum of 1,746 San Franciscans have been discharged out-of-county between July 1, 2006 and December 31, 2019.

That data is just the tip of the out-of-county discharge iceberg, because of many gaps in the data provided."

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Table 1: Out-of-County Discharges, July 1, 2006 — December 31, 2019

	Fiscal Year	Laguna Honda Hospital	SFGH[1]	Private-Sector Hospitals	Total
1	FY 06–07	35		?	35
2	FY 07–08	36		?	36
3	FY 08–09	14		?	14
4	FY 09–10	18	27	?	45
5	FY 10–11	6	54	?	60
6	FY 11–12	19	41	?	60
7	FY 12–13	26	30	39	95
8	FY 13–14	28	42	2	72
9	FY 14–15	25	68	25	118
10	FY 15–16	20	56	261	337
11	FY 16–17	20	40	449[2]	509
12	FY 17–18	25	57	**49**[3]	131
13	FY 18–19	14	182	**?**	196
14	FY 19–20 7/1/2019 – 12/31/2019	8	20	**?**	28
15	FY 19–20 1/1/2020 – 6/30/2020	6	**?**	**?**	6
16	FY 20–21 7/1/20 – 4/31/21	4	**?**	**?**	4
	Total[4]	**304**	**617**	**825**	**1,746**

[1] San Francisco residents discharged from SFGH but not admitted to LHH. Data prior to FY 09-10 for SFGH unavailable; not tracked electronically; off-site paper storage.

[2] DPH only asked six private-sector hospitals to provide data: Chinese Hospital, University of California San Francisco, St. Mary's, St. Francis, CPMC, and Kaiser. Chinese Hospital reported an unknown number of San Franciscans discharged out-of-county, and St. Mary's, St. Francis, Chinese Hospital, and Kaiser have not provided data to DPH. The data shown here are only from CPMC (312) and UCSF (137) for calendar year 2016 and FY 2016–2017, respectively.

[3] On September 29, 2019 DPH and its consultant, Milliman, reported to the Board of Supervisors Public Safety and Neighborhood Services Committee that 49 patients had been discharged by 5 of 7 private sector hospitals to out-of-county sub-acute or post-acute facilities as part of Milliman's contractual sub-acute provider capacity analysis. DPH creatively claimed no breakdown of the data had been ***officially*** "*supplied to the City and County of San Francisco by Milliman* ," and so the records request was simply closed. It's not known when in 2018 the discharges were made, or which private-sector hospital-based facilities were involved. It's also not known whether the 49 patients were all San Francisco residents, or if some were residents of other counties sent back to their originating jurisdictions.

[4] Data excludes out-of-county patient diversions prior to hospitalization via the Diversion and Community Integration Program (DCIP), and "Transitions" and successor programs, and excludes out-of-county placements chosen by families due to a lack of appropriate level of care beds in San Francisco.

Note: Data is preliminary and subject to change by SF DPH.

Source: San Francisco Department of Public Health responses to records requests.
Updated: **May 19, 2021**

"Data about the true number of out-of-county discharges is incomplete:

- **First, 921 — 53% — of the 1,746 discharges are from San Francisco's two public-sector hospitals.**
- **The 825 additional out-of-county discharges were from a small subset of the eight private-sector acute medical hospitals.**
- **Four of the eight hospitals did not provide DPH with the data requested.**

That was patently ridiculous, precisely because all hospitals have been using Electronic Healthcare Records (EHR) systems for decades. The historical data must be available electronically."

The gaps in data about the true number of out-of-county discharges is incomplete due to a variety of factors:

- First, 921 — 53% — of the 1,746 discharges are from San Francisco's two public-sector hospitals, SFGH and Laguna Honda Hospital.

- Second, the 825 additional out-of-county discharges were from a small subset of the eight private-sector acute medical hospitals in San Francisco, including CPMC's three campuses (Davies, Van Ness, and Mission Bernal/old St. Luke's Hospital), Chinese Hospital, St. Mary's Hospital (perhaps including Kentfield Hospital on St. Mary's campus), St. Francis Memorial Hospital, Kaiser Hospital, and UCSF.

  Although SFDPH had requested out-of-county discharge data from all eight private-sector hospitals as part of a so-

called *Post-Acute Care Collaborative* report titled "*Framing San Francisco's Post-Acute Care Challenge*" in 2016, only four of the eight hospitals provided their out-of-county discharge data to DPH — CPMC's three campuses and UCSF, and then only for two fiscal years (FY 2015–2016 and FY 2016–2017), out of the 15-year period. The remaining four hospitals — Chinese Hospital, St. Mary's, St. Francis, and Kaiser — did not provide DPH with the data requested in 2016. That was patently ridiculous, precisely because all hospitals have been using Electronic Healthcare Records (EHR) systems for decades. Those four hospitals ***must*** have records stored electronically they could have provided to SFDPH.

- Third — and most worrisome — is that DPH itself has failed to produce additional out-of-county discharge data from SFGH for two years since December 2019, wrongly claiming that it's new EHR database (named "Epic") is unable to track out-of-county discharges, which as I've previously reported is pure nonsense (see my June 2021 article "*SFDPH's Epic Lie: A $167.4 Million Database That Couldn't*"). [**Note:** I will be writing a follow-up article soon because I filed and won a Sunshine complaint against DPH over SFGH's claim Epic is unable to track out-of-county discharges.]

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Vignettes of Patients Discharged Out-of-County

A sampling of stories about patients dumped out of county include:

- A case of a middle-aged gay patron of San Francisco's Cinch Saloon who suffered a stroke, fell off a bar stool, and sustained a traumatic brain injury one evening while at the tavern. I'll call him "Gordon." He was taken to SFGH, where he languished for months. His close friends tried to get him admitted to Laguna Honda Hospital. They were rebuffed and were told Gordon needed "*too much*" physical medicine rehabilitation therapy — physical therapy, occupational therapy, and speech pathology — and couldn't be admitted to LHH. It's well known that delays in receiving rehabilitative therapy following strokes leads to poorer patient outcomes and progressive functional decline.

  > **"Following a stroke, 'Gordon' languished for months at SFGH, then denied admission to LHH. He was discharged out-of-county to a SNF in Antioch specializing in care for dementia and Alzheimer's patients. He languished there, isolated, for more months."**

  He languished for months in an acute-care ward at SFGH — at acute-care hospital billing rates — until he was discharged out-of-county in 2011 to a skilled nursing facility in Antioch specializing in dementia and Alzheimer's patients. Gordon was socially and culturally isolated from his friends and family without anybody to communicate with, given the number of dementia patients he was thrust into. He languished there isolated for more months, since his friends were unable to endure the obstacles of travelling to Antioch to visit him. Gordon's family had to fight to get him discharged to take him back to Ohio for care.

- Consider "Ray," who had been a sub-acute skilled nursing facility (SNF) unit patient for nine years in CPMC's St. Luke's Hospital former sub-acute SNF unit. When it was closed, Ray was transferred in July 2017 to a facility in San Jose. He felt pressured to leave St. Luke's because a social worker had told him that the longer he waited, the further he'd have to go, perhaps as far as Sacramento or Los Angeles. Ray felt he had no choice but to accept discharge to San Jose. After being transferred, Ray's health quickly deteriorated and during one incident at the new facility, his oxygen tube disconnected. He fell out of bed and couldn't breathe until a nurse arrived to reconnect his life-support oxygen.

  > **"Consider 'Ray,' then a patient in CPMC's St. Luke's Hospital former sub-acute SNF unit. He felt he had no choice but to accept discharge to San Jose. After being transferred, his health quickly deteriorated. Ray's story is one example of 'transfer trauma'."**

  Ray asked for different oxygen equipment like he had previously had at St. Luke's, but was told if he needed different equipment he would have to leave and transfer to a different facility. He reportedly said he no longer had the will to live

and was just waiting to die. Ray's story is one example of "transfer trauma," which is known to increase morbidity and mortality from the trauma of being relocated.

- "Billy," who had faced a major surgery in San Francisco, and was eventually discharged out-of-county to a facility for mental health patients in the South Bay. He had been told he would receive post-surgery occupational therapy (OT) and physical therapy (PT) to resume being able to walk. Although the facility provides on-site OT and PT, Billy is making few gains toward post-surgery independence, in part because Medicaid (Medi-Cal in California) restricted his post-hospitalization OT and PT to just five sessions.

  He's now surrounded in the facility by residents who are decades older and unable to communicate due to dementias. He has nobody with whom to converse. There's no phone in his room, and whether he is brought a limited-time use phone is at the sole discretion of staff on duty. Staff have turned down his requests to use a phone multiple times. There is no on-site resident library and no resident access to computers, so Billy misses out on email, social media, music, on-line education, entertainment, and information-searching. He'd like to buy an iPad, but staff told him there's no wi-fi, even though he can see staff down the hall working on their computers.

"Take 'Billy,' who faced a major surgery in San Francisco and was then discharged out-of-county to a facility for mental health patients in the South Bay. He's now surrounded by residents who are decades older and unable to communicate due to dementias.

It appears San Francisco dumped him into the South Bay, and forgot about him. Billy is reluctant to complain, fearing he would face transfer to an even worse facility, perhaps even further away."

Sadly, it appears San Francisco dumped him into the South Bay, and forgot about him. His San Francisco social worker and his conservator aren't checking in with Billy, and aren't returning calls he's left for them. These isolating practices may be categorized as abuse, yet San Francisco maintains no oversight, as if "*out-of-sight, out-of-mind*" is OK.

Billy's friends in San Francisco find the two-hour one-way commute to visit him in the South Bay overwhelming; sadly, he has not received ***any*** visitors, which adds to his sense of isolation. Billy is reluctant to complain, fearing he would face transfer to an even worse facility, perhaps even further away. Being forced to find a different facility to relocate to — often on short notice — is a familiar and frequent concern of many patients who've been discharged out-of-county. Many patients also fear being retaliated against if they voice too many complaints about the quality of care being provided to them. Retaliatory relocation is a fear many patients and their families share.

- Then there's a patient I'll call "Paul," who had been living in a rent controlled unit in San Francisco. He developed problems in two of his toes, so his caregivers made an outpatient podiatry appointment at a clinic affiliated with a private-sector hospital in the City. Unfortunately, he was not prepped properly for the podiatry procedure, and not given antibiotics or a foot soaking solution after the two toenails were removed. Two days after being sent back home, Paul developed severe infections in his toes and quickly became severely disoriented, possibly from sepsis. He was admitted to a different acute care hospital in San Francisco, and spent a month-and-a-half hospitalized as doctors tried to resolve the infections in his toes, and reconstruct the top of his foot. His medical team worried the infection might migrate to other bones in his foot, and considered if they would have to amputate both toes, or possibly his whole foot.

"'Paul,' who was not prepped properly for an outpatient podiatry procedure and not given antibiotics, quickly developed severe infections in his toes and became severely disoriented. He was admitted to an acute care hospital to resolve the infections in his toes.

He was discharged to a short-term SNF for the infections to resolve. When his insurance ran out to cover the short stay in a SNF, he still had a large open wound on his foot. Paul was then placed in an assisted living facility in Daly City."

All of this — including costs of the month-long hospitalization — might have been completely avoidable, had the outpatient podiatory procedure to remove Paul's toneails administered antibiotics.

During his hospitalization, Paul's medical team at the hospital recommended that rather than discharging him to his

home, he should be placed in a short-term skilled nursing facility (SNF) in San Francisco until the infections were resolved. When his insurance ran out to cover the short stay in a SNF, he still had a large open wound on his foot, so his caregivers tried to get him admitted to Laguna Honda Hospital for more rehabilitation, but LHH declined to admit him (in part because he was not an SFGH patient). His family was forced to place Paul in a studio unit in an assisted living facility in Daly City in May 2021, rather than a facility in Richmond that would have been too far away to visit him daily. Although progress has been made resolving the infections in his toes and foot, Paul's family eventually concluded Paul should remain in the assisted living facility with nursing staff providing open wound care three times per week.

On October 28, his family received a notice his monthly fees (i.e., rent) would be raised by $500 per month, above the $3,730 he had been being charged. The $500 monthly rent increase to $4,230 represents a 13.4% increase. Paul's family reached out to the Ombudsman in Daly City, which is a state-mandated patient advocacy and oversight program. His family also reached out to the California Advocates for Nursing Home Reform (CANHR). The Ombudsman program and CANHR informed Paul's family about a recent California Assembly Bill, AB1482, that was signed into law in 2019. AB 1482 limits rent increases in cities and counties across the state — even if the local jurisdictions do not have local rental control laws — to just 5% plus the percentage change in the cost of living, or a maximum of 10%, whichever is lower.

"Paul's family received a notice his monthly fees in Daly City would be raised by $500 per month, a 13.4% increase. AB 1482 limits rent increases to just 5% plus the percentage change in the cost of living, or a maximum of 10%.

The CPI percentage increase ending October 31 was 1.1%; the rent increase should have been a total of 6.1%, not the maximum of 10%, and certainly not the 13.4%. It's not known if these facilities can get away with creatively rounding up to the full 10% maximum."

The most recent Consumer Price Index (CPI) percentage increase for all Urban Consumers in the San Francisco-Oakland-San Jose region for the 12-month period ending October 31 was 1.1%, as posted by the U.S. Bureau of Labor Statistics. That suggests Paul's rent increase should have been a total of 6.1%, not the maximum of 10%, and certainly not the 13.4% increase the assisted living facility tried to pawn off on him. The notice of the $500 increase should have been more like a $227.53 monthly increase (to a total of $3,957.53) using the 6.1% figure, but it's not known if these facilities can get away with creatively rounding up to the full 10% maximum, instead of the actual 6.1% CPI increase. His family is now working with healthcare advocates to obtain the lower 6.1% rate — which would be less than half of the $500 monthly rent increase.

Just two weeks after receiving notice of the rent increase on October 28, the assisted living facility then announced to Paul's family that it was selling its Daly City facility to help finance a luxury assisted living facility in San Francisco. News reports have documented that the new assisted living facility in San Francisco plans to charge between $16,600 and $27,000 per *month* — $199,000 to $324,000 annually ! — for a two-bedroom unit. Other assisted living corporate operators are also abandoning lower-cost assisted living facilities in favor of assisted living facilities for well-heeled, more profitable clients.

Paul's current facility is now being sold to another company that is already planning an additional rent increase in early 2022. His family is worried they will have to move him again, perhaps even further away.

"These vignettes of patients discharged out-of-county are far from being isolated cases."

These vignettes of patients discharged out-of-county are far from being isolated cases. Patient advocates, physicians, and mental health professionals have all reported many stories like this involving patients discharged far away, painfully.

Canaries in the Coal Mine

I began my quest for out-of-county discharge data after badgering the Laguna Honda Hospital Joint Conference Committee (LHH-JCC) — a subcommittee of the San Francisco Health Commission made up of Health Commissioners and senior staff of LHH — for months during 2012 and 2013 to publicly release aggregate data on the number of LHH patients discharged out of county.

The first trickle of data I obtained was for 28 LHH patients discharged out of county during FY 2013–2014. SFDPH eventually produced retrospective out-of-county discharge data going back to July 1, 2006 and had been providing periodic updates about out-of-county discharge data up until the end of 2019, just before COVID came along in March 2020. That's when SFDPH and SFGH creatively began claiming it's $167.4 million *Epic* replacement EHR database is unable to track out-of-county discharges.

The takeaway here is that the known 1,746 out-of-county discharges to date represent canaries in the coal mine. We're seeing just the tip of a very, very large *out-of-county discharge iceberg* submerged below the surface of the water that is now leaking into the coal mine. The actual number is certainly likely far, far higher. Without adequate reporting and repercussions, patient dumping of San Franciscans out-of-county following hospitalization is certain to keep increasing.

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We must not lose sight of just how severe the out-of-county discharge epidemic has grown — which is now a public health crisis. If San Francisco does not add additional in-county capacity quickly, as our aging population increases there will be many, many more people simply evicted, exiled, and dumped out of county.

Members of San Francisco's Board of Supervisors have been asked by a coalition of patient advocates for over four years to introduce and pass an Ordinance requiring that all hospitals in the City report aggregate data annually to SFDPH about San Franciscans discharged out-of-county. The Public Safety and Neighborhood Services Committee of our Board of Supervisors will soon hold a hearing on a very limited and currently inadequate draft Ordinance. As of this writing, the draft legislation requires hospitals to report out-of-county discharges ***only*** for those needing sub-acute SNF care placement.

"The Public Safety and Neighborhood Services Committee of the Board of Supervisors will soon hold a hearing on a very limited and currently inadequate draft Ordinance requiring hospitals to report out-of-county discharges only for those needing care in a sub-acute SNF.

The legislation must be amended to require reporting all categories of out-of-county discharges, stratified by all types of facilities, not just to sub-acute SNF's."

The legislation must be amended to require reporting of all categories of out-of-county discharges stratified by all types of facilities San Franciscans are discharged to, not just to sub-acute SNF's, among other sorely-needed amendments.

Watch this space.

Monette-Shaw is a columnist for San Francisco's Westside Observer *newspaper, and a member of the California First Amendment Coalition (FAC) and the ACLU. He operates stopLHHdownsize.com. Contact him at monette-shaw@westsideobserver.com.*