



U.S. Department of Justice

Civil Rights Division

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Office of the Assistant Attorney General

Washington, DC 20530

April 1, 2003

Dennis J. Herrera, Esq.  
City Attorney  
City and County of San Francisco  
City Hall, Room 234  
San Francisco, CA 94102

Re: Investigation of Laguna Honda Hospital and  
Rehabilitation Center

Dear Mr. Herrera:

In 1998, in a findings letter issued pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, we notified Mayor Willie Brown that the City and County of San Francisco ("San Francisco" or "City") was violating Title II of the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. § 12131 et seq., by failing to ensure that Laguna Honda Hospital and Rehabilitation Center ("LHH") residents were being served in the most integrated setting appropriate to meet their needs.<sup>1</sup> In December 2001 and March 2002, the Department of Justice ("DOJ") and the Department of Health and Human Services' Office for Civil Rights ("OCR") conducted tours of LHH and community providers to determine the status of the City's compliance with the ADA integration regulation, 28 C.F.R. § 35.130(d).<sup>2</sup> We write, pursuant to CRIPA, to supplement our ADA

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<sup>1</sup> The anti-discrimination provisions of Title II of the ADA apply to "public entities" and include local governments. 42 U.S.C. § 12131(1)(A).

<sup>2</sup> Pursuant to the agreement we entered with San Francisco in July 2001, the Department of Justice and OCR have conducted our review of LHH regarding the ADA integration issues jointly. Accordingly, herein, DOJ and OCR issue our findings with regard to the City's compliance with Title II of the ADA at LHH jointly.

findings. Based upon our review, we find that the City continues to be in violation of the ADA and continues to fail to ensure that LHH residents are being served in the most integrated setting appropriate to meet their needs.

Throughout both the December 2001 and March 2002 tours, LHH staff were helpful in accommodating our requests. LHH is staffed predominately by dedicated individuals who are genuinely concerned with the well-being of LHH residents. Nevertheless, we must report that San Francisco and LHH have failed or refused to provide critical information we requested. In April 2002, we wrote that we were waiting for a full response to our document requests before completing our updated findings regarding community integration issues. In June 2002, we again wrote, indicating that we would not postpone our review indefinitely due to continued delays in responding to our requests. Although LHH agreed to provide some of the remaining outstanding documents in September 2002, despite repeated requests, as of this date, we have not received them. In addition, in September 2002, the City took the position - for the first time - that documents purportedly justifying a rebuilding of all 1,200 beds of the nursing home were protected by the attorney-client privilege. We, therefore, have decided to issue our supplemental findings taking into account this history.

## I. BACKGROUND

### A. PROCEDURAL HISTORY

We initiated our CRIPA investigation of LHH in 1997. Following tours with expert consultants, we sent a letter to Mayor Willie Brown on May 6, 1998, setting forth our findings ("May 1998 Findings Letter"). Among other things, we informed Mayor Brown that LHH was violating the rights of its residents by not providing services in the most integrated setting appropriate to residents' needs.<sup>3</sup>

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<sup>3</sup> We also found that LHH was violating the constitutional and statutory rights of its residents by not ensuring residents' reasonable safety, not providing adequate health care services, not providing an adequate living environment, and engaging in unjustifiable and dangerous restraint practices. Our investigation of the current status of these issues is ongoing.

In July 2001, we met with City officials and attorneys to discuss the status of our investigation. During that meeting, and as set forth in our October 5, 2001 letter, we reiterated our intention to conduct a more focused review of LHH's compliance with Title II of the ADA to update our 1998 ADA finding. In December 2001 and March 2002, we conducted a comprehensive evaluation of LHH's assessment and discharge process, as well as the City's current capacity for providing community-based supports and services. At the conclusion of our tours, we briefed LHH executive staff about our continued concerns related to LHH's noncompliance with the ADA integration regulation. Consistent with our exit conferences, our updated findings demonstrate that LHH continues to violate Title II of the ADA by failing to serve persons with disabilities in the most integrated appropriate settings.

A significant number of LHH residents are unnecessarily isolated in the nursing home. We have identified several areas of deficiencies that contribute to the unnecessary isolation of qualified residents at LHH. These areas include inadequate assessments, inadequate discharge planning, and inadequate capacity in the community to meet the needs of LHH residents for whom community placement is appropriate.

## **B. FACILITY DESCRIPTION**

LHH was first opened in the 1860's, and over the years has grown into one of the largest publicly-operated long term care facilities in the United States, providing approximately 31% of all skilled nursing beds in San Francisco. LHH is licensed as an acute care hospital with a distinct-part nursing facility. However, only 23 of LHH's certified beds are licensed for acute hospital care.<sup>4</sup> In addition, of the 385,547 bed days of care provided at LHH in FY 2000-2001,<sup>5</sup> only 855 (0.22%) were for acute care and only 429 (0.11%) were for acute rehabilitation care.

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<sup>4</sup> The actual average daily census of acute care patients was reported by LHH staff to be consistently lower than the acute care bed capacity. For example, from January to December 2001, LHH's acute average daily census was 2.3 patients. LHH Utilization Management Committee Meeting Minutes, January 2001 through January 2002.

<sup>5</sup> The fiscal year for the City runs from July 1<sup>st</sup> to June 30<sup>th</sup>.

The remaining bed days are for skilled nursing care. As a distinct-part skilled nursing facility, LHH receives a higher daily reimbursement rate from Medicaid than free-standing skilled nursing facilities that are not a part of an acute care hospital.<sup>6</sup>

The average daily census in FY 2000-2001 was 1,059, and there were 1,500 full-time equivalent employees reported to be on staff during that period. A variety of different levels and types of services, primarily organized around the large open wards that characterize the facility, are provided within the context of the skilled nursing facility. These various services include medical and nursing care for people with AIDS, physical rehabilitation, and psychosocial rehabilitation care for people with a mental health diagnosis. There is also an in-patient hospice/palliative care center and an out-patient geriatric day health program on the LHH campus.

Medi-Cal, California's Medicaid program, is the largest payer of services at LHH. In FY 2000-2001, Medi-Cal paid for 97 percent of the total days of care at LHH. Two percent of the patient days was paid for by private payers, and one percent was paid for by Medicare.<sup>7</sup> Medi-Cal pays LHH \$236 per day for skilled nursing care. However, the actual operating cost per bed for LHH is reported by the facility to be \$347 per day, for an annual cost of approximately \$126,655 per year per skilled nursing bed. This means that the facility has a revenue shortfall of \$117 per bed day for the 97 percent of residents who are Medi-Cal recipients.<sup>8</sup> In fact, San Francisco budgeted \$39,450,729 from its general fund in FY 2001-2002 to make up for the revenue shortfall from Medi-Cal and other payer sources at LHH.<sup>9</sup>

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<sup>6</sup> See Cal. Welf. & Inst. § 14091.21.

<sup>7</sup> Laguna Honda Hospital, Annual Update, Fiscal Year 2000-2001, at 9.

<sup>8</sup> Id. at 17. If Laguna Honda were not licensed as an acute care hospital, but only as a free-standing nursing facility, Medi-Cal would pay Laguna Honda only \$131 per day for care.

<sup>9</sup> Organizational Budget Performance, San Francisco Office of the Controller, Fiscal Year 2001-2002, at 18 <[www.sfgov.org/site/uploadfiles/controller/budinfo/HealthConsolidated.pdf](http://www.sfgov.org/site/uploadfiles/controller/budinfo/HealthConsolidated.pdf)> (visited February 7, 2003).

In 1999, San Francisco voters approved a \$299 million general obligation bond for the replacement of LHH.<sup>10</sup> The City has developed plans for rebuilding LHH with a capacity of 1,200 beds and an additional 140 assisted living units, for a total cost of \$401 million, or about \$300,000 per bed.<sup>11</sup> Part of the rationale for replacing the facility was that the large open wards and other physical plant deficiencies do not comply with federal and state nursing facility regulations.<sup>12</sup> We understand that the site for the rebuild is being cleared, but that ground has not yet been broken for construction of the new nursing home.<sup>13</sup>

### C. LEGAL FRAMEWORK

With the passage of the ADA, Congress intended to provide a "clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1).<sup>14</sup> In Title II of the ADA, Congress set forth

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<sup>10</sup> Id.

<sup>11</sup> Program Status Report, Laguna Honda Hospital Replacement Program, City and County of San Francisco, December 2002, at 8 <[www.dph.sf.ca.us/LHHReplace](http://www.dph.sf.ca.us/LHHReplace)> (visited February 7, 2003).

<sup>12</sup> Project Description, Laguna Honda Hospital Replacement, Project Objectives, dated November 7, 2001 (included in materials provided by LHH staff during December 2001 and March 2002 tours). Mitchell H. Katz, M.D., Director of Public Health, Options for Laguna Honda Hospital White Paper, San Francisco Department of Public Health, December 10, 1998, at 3. See also 42 C.F.R. § 483.70(d)(1)(i) ("Bedroom must accommodate no more than four residents") and 42 C.F.R. § 483.70(d)(3) (variations permitted).

<sup>13</sup> See supra n.11, at 10.

<sup>14</sup> Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem ... discrimination against individuals with disabilities persists in such critical areas as ... institutionalization ... individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion ... failure to make modifications to existing facilities and practices ... [and] segregation." 42 U.S.C. §§ 12101(a)(2), (3), (5).

specific prohibitions against discrimination in public services furnished by governmental entities. Specifically, the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. The regulations promulgated pursuant to the ADA provide that "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (the integration regulation). The preamble to the regulations defines "the most integrated setting" to mean a setting "that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. pt. 35, App. A at 450.

In construing the anti-discrimination provision contained within the public services portion (Title II) of the ADA, the Supreme Court held that "[u]njustified [institutional] isolation ... is properly regarded as discrimination based on disability." Olmstead v. L.C., 527 U.S. 581, 597, 600 (1999). The Court explained that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." Id. at 600. The Court added that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." Id. at 601. The Court established a three-prong test to determine when States are required to provide community-based treatment for persons with mental disabilities. The Court held that States are required to provide such services when: (1) "an individual 'meets the essential eligibility requirements' for habilitation in a community-based program," at 602, based upon reasonable assessments of the treating professionals; (2) "the affected persons do not oppose such treatment," at 607; (3) and, "the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." at 607.

Unfortunately, as set forth below, San Francisco is failing to comply with the ADA based upon current and past City practices of failing to place persons now living in LHH in the most

integrated setting appropriate to meet their needs.

## II. FINDINGS

### A. LHH POPULATION

LHH has a wide age-range of residents from as young as 20 years of age to persons over 100 years old. Individuals living at LHH are significantly younger than the average nursing home resident in California. Twenty-one percent of LHH residents are under 55 years of age. In California, residents under the age of 55 make up less than 10 percent of the average nursing home population.

LHH has increased its admission rate for younger individuals disproportionately to other long term care facilities in California over the last ten years. The proportion of males at LHH under the age of 55 has tripled from 1990 to 2000. The proportion of residents over the age of 89 has decreased from 30 percent in 1990 to less than 6 percent in 2000.

LHH residents have a wide range of physical and mental disabilities. Of the 1054 residents listed on LHH's October 2001 census, approximately 180 residents were identified by LHH as having mental illness and sixteen residents were listed with mental retardation.<sup>15</sup> In addition, LHH identified 283 residents as having off-campus privileges<sup>16</sup> and 124 residents who have

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<sup>15</sup> It is unclear how many residents at LHH have mental illness. There was a large disparity between the information provided by LHH in response to our document request and other published reports indicating that approximately 400 residents at LHH have a psychiatric diagnosis in addition to their medical needs. See Mitchell H. Katz, M.D., Director of Public Health, 2002 State of the City Public Health Address, San Francisco Department of Public Health, April 8, 2002, at 14; LHH Annual Update, FY 2000-2001, at 10. We were not provided with the criteria used in generating either the 180 or 400 figures. Our expert consultants found similar discrepancies in trying to determine the number of residents with mental retardation, identifying at least seven additional residents with mental retardation residing at LHH that were not identified by LHH itself.

<sup>16</sup> LHH residents with off-campus privileges are able to leave the facility unattended. In most cases, these residents use public transportation without any assistance.

expressed an interest to return to the community.

In December 2001, our expert consultants evaluated 115 residents, a little more than 10 percent of the residents of the facility. Our sample included residents with mental illness, with mental retardation, and with off-campus privileges; residents who expressed an interest in returning to the community; and, residents from the general census list. Our consultants concluded that a significant number of these residents do not require skilled nursing care in an institutional setting.

Of the 115 records reviewed, our experts identified 52 residents who could live in the community based upon the type of home and community-based supports and services currently provided in San Francisco. Of these, seven clearly expressed opposition to community placement at the time of our evaluation. The remaining 45 can be categorized as follows:

- 12 residents plainly meet the requirements for community placement under Olmstead as evidenced by a documented recommendation from their treating professionals that community placement is appropriate, and the resident does not oppose such placement;
- 10 additional residents are without a documented recommendation from their treating professionals that community placement is appropriate, but those individuals' needs and functioning levels as determined by LHH treating professionals indicate they could be served in the community with appropriate supports and services. These residents do not oppose community placement.
- 23 remaining residents have medical needs and functioning levels as determined by their treating professionals that indicate a potential for community placement, but there is no indication in the residents' charts regarding the individuals' preferences with respect to community living.<sup>17</sup>

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<sup>17</sup> We were unable to interview every resident during our tours. Because LHH does not maintain aggregate data for all residents regarding their discharge potential or preference to return to the community, or collect such information on an individual basis in a resident's chart, in many cases residents'



These individuals included residents with disabilities who require minimal supports and services; persons with developmental disabilities; and persons with mental illness. Some residents are unnecessarily isolated at LHH after plainly meeting the requirements of Olmstead. Others are not appropriately identified for community placement based on the deficiencies and, in some instances, violations of applicable federal regulations, which we discuss below, all of which contribute to the unnecessary isolation of qualified residents in the institution.

## **B. OLMSTEAD ANALYSIS**

### **1. First Prong of Olmstead - Treating Professionals' Assessment for Community Placement**

The Supreme Court held that States are required to provide community placements "when the State's treatment professionals determine that such placement is appropriate..." Olmstead, at 607. The Court explained that "[c]onsistent with these [ADA] provisions, the State generally may rely on the reasonable assessments of its own professionals in determining whether an individual 'meets the essential eligibility requirements' for habilitation in a community-based program." Olmstead, at 602. In the case of the 12 residents identified above, LHH treating professionals clearly documented their recommendation for community placement.

Almost five years ago, we notified San Francisco that "LHH professionals were not conducting meaningful assessments of most residents to determine whether the nursing home is the most integrated setting to meet their needs." See May 6, 1998 Findings Letter at 14. For many LHH residents, that is still the case. LHH's assessment process fails to assess consistently and effectively whether the residents meet eligibility requirements for community supports and services. Therefore, where treating professionals failed to make an Olmstead assessment for residents, our experts relied on the residents' medical needs and functioning levels, as assessed by LHH's treating professionals, to determine whether community placement was appropriate.<sup>18</sup> In preference for community living was unknown.

<sup>18</sup> Federal statutes governing the operation of nursing homes mandate that each resident of a nursing facility, upon admission and periodically thereafter, be provided with a

making these determinations, we found the following deficiencies that contribute to the unnecessary isolation of LHH residents.

**a. Preadmission Screening and Resident Review for Persons with Mental Illness or Mental Retardation.**

For individuals with serious mental illness or mental retardation, federal and state laws require that preadmission screening be conducted of all applicants to and residents of Medicaid-certified nursing facilities. 42 U.S.C. §§ 1396r(b)(3)(F)(i), 1396r(e)(7)(A)&(B); 42 C.F.R. §§ 483.112, 483.128, 483.132, 483.134, & 483.136. These laws were enacted to prevent the unnecessary admission and confinement of persons with psychiatric and developmental disabilities to nursing homes.<sup>19</sup> Preadmission Screening and Resident Review ("PASRR") is a two-stage process that, if properly implemented, should ensure that persons with psychiatric and developmental disabilities are not unnecessarily placed in nursing homes. The first step is an assessment to identify the applicants and residents who have a serious mental illness or mental retardation. If an individual is found to meet the criteria for having serious mental illness or mental retardation at the Level I stage, the individual should be referred for Level II screens to determine whether the individual requires the level of services that can only be provided in a nursing facility and whether specialized services

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comprehensive assessment of his/her functional capacity, including potential for discharge. 42 U.S.C. § 1396r, and its implementing regulations, 42 C.F.R. § 483, Subpart B. In addition to federal law, the admission criteria for LHH are outlined in its Placement at LHH and Rehabilitation Center Memo issued by LHH's Director of Admissions and Eligibility. The inclusion criteria specify that admission is contingent upon the existence of a primary medical condition requiring nursing facility services.

<sup>19</sup> "If the State mental health or mental retardation authority determines that an applicant for admission to a nursing facility does not require nursing facility services, the applicant cannot be admitted. Nursing facility services are not a covered Medicaid service for that individual, and further screening is not required." 42 C.F.R. § 483.118. See also 42 C.F.R. § 483.126 (appropriate placement); Office of Inspector General, U.S. Department of Health and Human Services, Younger Nursing Facility Residents With Mental Illness: Preadmission Screening and Resident Review (PASRR) Implementation and Oversight, No. OEI-05-99-00700, at i-ii (Jan. 2001) (discussing Olmstead decision and intent of PASRR process).

are needed.

The PASRR process that is implemented by the City violates federal regulations because it fails to identify properly persons with mental disabilities.<sup>20</sup> With respect to the Level I PASRR assessments that are conducted prior to admission to LHH, we found individuals (for example, Colleen S., Scott W., Helen W.) who have a history of mental illness, but who were not identified as having a mental illness on their PASRR Level I evaluations. These individuals clearly needed a Level II evaluation of their mental illness but did not have one conducted. Based upon the histories contained in the records, it was not clear how these diagnoses could have been missed on the initial assessment. Without a more comprehensive Level II review, it is unclear whether the individuals require the level of skilled nursing care that would warrant confinement in a nursing home.

**b. Admission and Utilization Review Processes.**

LHH admission and utilization review processes fail to identify and screen out individuals who do not need nursing care in an institutional setting. 42 C.F.R. § 456.1 (requiring State Medicaid Plans to provide methods and procedures to safeguard against unnecessary utilization of care and services). According to LHH's 2001 Utilization Management Plan, LHH's utilization review process is intended to monitor the appropriateness and clinical necessity of admissions, continued stays, and supportive services for people referred to and living at LHH. Skilled nursing needs are determined using objective criteria, as set forth by federal and state regulations. See 42 C.F.R. § 483, Subpart B (Medicaid); 42 C.F.R. 409.31 (Medicare); 42 C.F.R. 409.33 (Medicare); Cal. Code Regs. tit. 22 § 51124 (Medi-Cal); Cal. Code Regs. tit. 22 § 51335(j) (Medi-Cal). Based upon a review of resident records, we found that some LHH residents do not have the kinds of medical needs that meet the level of care provided by a skilled nursing facility or which make LHH the most integrated treatment setting.

For example, June M. is a 60-year-old woman who was admitted to LHH in November 1991.<sup>21</sup> She is diagnosed with congenital

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<sup>20</sup> 42 U.S.C. § 1396r(e)(7)(B)(i),(ii); 42 C.F.R. § 483.20(m).

<sup>21</sup> The names of LHH residents referred to in this letter have been changed to protect the privacy of the individual. We

blindness and chronic back pain. She entered the facility more than a decade ago because of difficulty in finding a housekeeper to assist her. During our December 2001 site visit, we spoke with June and she indicated a very strong preference to return to the community. The discharge assessment form in her record included positive indications that she was ready for discharge, including ambulation, medical stability, frequent passes to the community, potential for independent living, and the desire to be discharged. Her annual medical review reports that "[s]he has no skilled nursing needs."

Similar to other LHH residents, June has no medical needs being supported by LHH. Indeed, LHH documents indicate that she requires no assistance in her activities of daily living (ADL). She interacts with the community on a regular basis. She wants to reside in the community and could do so if provided assistance with cooking, housekeeping, and transportation.

Also, it appears that some LHH residents were admitted based upon their caretakers' need for skilled nursing services as opposed to the individual's own medical need. For example, Leona M., a 32-year-old resident, was admitted to LHH so that she could be near her mother who was residing at the facility. Additionally, Steve B. was admitted for respite care so that his primary caretaker, his father, could have knee surgery. In both cases, records indicate that these individuals remained at the facility for an extended period of time. Leona stayed at LHH after her mother's death and Steve has now been at LHH for over four and a half years although hospital policy limits respite stays to eight weeks per year.

**c. The Timely Assessment of Residents' Discharge Potential To a More Integrated Setting.**

LHH fails to conduct timely assessments in order to determine discharge potential and ensure placement in the most integrated setting appropriate to meet the needs of LHH residents.<sup>22</sup> First, LHH's assessment process departs from

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will provide, under separate cover, a key to City attorneys that will identify the actual names of the residents discussed in this letter.

<sup>22</sup> Comprehensive resident assessments of resident's needs and functioning levels are required upon admission and periodically thereafter. 42 C.F.R. § 483.20(b)(2)(i) (within 14

generally accepted professional standards because staff fail to assess an individual's discharge potential at the time of admission. LHH does not view discharge planning as an ongoing process that begins at admission. Individual goals for physical functioning, self-care, and behavioral strategies for successful transitions to the community are not identified at the time of admission. For example, Barbara P. wants to return to the community, and according to her interdisciplinary team, she has good potential to do so. She was admitted on November 19, 2001. At the time of our visit, more than one month later, the team had not started to develop a discharge plan. This should have started immediately upon admission. Another example is Mary L. She was admitted to LHH for observation in August 1998. At the time of admission, it was noted that Mary had a preference to live in the community. Additionally, it was reported in the record that Mary "disliked nursing homes." More than three years after admission for observation, there was no short- or long-term discharge plan indicated in the record for this resident.

Second, LHH's ongoing assessment process also fails to determine and document accurately a resident's potential for discharge when his/her circumstances may change. There were many LHH residents who made significant progress while at LHH and no longer need care in an institutional setting. However, LHH's ongoing assessment process fails to identify and document in a timely manner when a resident no longer requires skilled nursing care. Accordingly, many individuals remain at LHH for too long.

For example, LHH resident Jennifer K. is 77 and was transferred to LHH from San Francisco General where she had been hospitalized for a broken arm. Besides the broken arm, Jennifer was diagnosed with arthritis and Parkinson's Disease. Her discharge form, completed one month after admission, indicates that she should be discharged to the community. One year and five months later, however, no further discharge notes could be found in the file. Before being hospitalized for a broken arm, Jennifer was living successfully in the community at a senior citizen hotel and had a case manager at a senior center. Another LHH resident, Shanika R., is 80 and was originally admitted to LHH for leg ulcers. Shanika had no skilled nursing needs at the time of our review. Her primary diagnosis is developmental delay, not otherwise specified ("NOS"). She requires only minimal assistance with dressing and grooming, and has off-ground

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days of admission); 42 C.F.R. § 483.20(b)(2)(iii) (ongoing reviews at least annually).

privileges. Although she has indicated a preference to live in the community, Shanika had been at LHH for one year and five months in December 2001.

**d. The Use of the Assessment and Care Planning Process to Promote Greater Independence, Including Placement in a More Appropriate Integrated Setting.**

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Federal law requires that nursing facilities "provide services and activities to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care." 42 U.S.C. § 1396r(2). LHH's care plans do not reflect a coordinated, interdisciplinary effort designed to increase patients' independence and improve functioning. As a general matter, staff were not observed attempting to engage residents in activities or to teach residents new skills.<sup>23</sup> Very often, treatment planning and rehabilitation goals are viewed separately from discharge planning. In some cases, discharge goals were inconsistent with treatment and rehabilitation goals. For example, in Ann S.'s record there was a notation: "Well enough to leave [LHH]." That same day, a social worker noted in Ann's chart that the social worker was working with Ann to get her to accept living at LHH long term.

Many residents' care plans do not identify clearly their needs or their individualized criteria for, and barriers to, discharge.<sup>24</sup> LHH care plans often do not identify the care, training, and/or rehabilitation goals/objectives to address residents' needs and to support their return to the community. Moreover, residents' care plans often do not include the methods that staff should utilize to facilitate residents' acquisition of skills or the data that staff need to collect in order to measure

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<sup>23</sup> See 42 U.S.C. § 1396r(4)(A)(i) ("To the extent needed to fulfill all plans of care, a nursing facility must provide, or arrange for the provision of, nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."). See also 42 C.F.R. § 483.20(k).

<sup>24</sup> "The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment." 42 C.F.R. § 483.20(k)(1).

the progress that residents are making. In addition, LHH care plans fail to identify clear action steps designed to overcome barriers to discharge.

**e. LHH Discharge Plans.**

LHH fails to develop and implement appropriate discharge plans to ensure that each person residing at LHH is served in the most integrated setting appropriate to meet the individual's needs.<sup>25</sup> The discharge process is unduly cumbersome and prolonged, resulting in many LHH residents remaining in the facility long after their level of medical acuity would dictate transfer to a lower level of care.

According to generally accepted professional standards, discharge plans should be based upon the capacities and needs of the individual and whether community services can meet those needs. In many instances, we found that LHH professionals fail to make recommendations for discharge based upon an individual's needs. Rather, it appears that they are making recommendations for people to remain at LHH based upon the perceived lack of community alternatives available. The result is that there are LHH residents who remain at LHH because of limited community capacity or the perception of limited community capacity, not because of skilled nursing needs. For example, June M., a 60-year-old woman with congenital blindness, has been at LHH for over 10 years. June routinely leaves LHH during the day to visit friends. She takes public transportation and reportedly needs little, if any, assistance from LHH staff. She requires no skilled nursing care, and indicates a strong preference to return to the community. Her most recent discharge note (March 2002) coded her discharge potential as uncertain. In her record, the documented barriers to discharge are housing and personality issues. There is a letter in the file to June from Mayor Willie Brown stating that: "Unfortunately the City does not have any program through which you may receive a financial supplement to live elsewhere. I have forwarded your letter to managers at Laguna, with hopes that they may find more opportunities for you to feel connected and comfortable. Remember that a change in attitude can make all the difference."

**2. Second Prong of Olmstead - The Individual Does Not Oppose Community Placement**

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<sup>25</sup> See 42 C.F.R. § 483.20(k) (care plans).

The Court in Olmstead set forth its second prong by holding that community placement is required when "the affected persons do not oppose such treatment..." Olmstead, at 607. The Court noted that there is not "any federal requirement that community-based treatment be imposed on patients who do not desire it" in the ADA. Olmstead, at 602.<sup>26</sup> As noted above, 22 of the 52 residents we identified as appropriate for community living expressed a preference to live in the community. It is unclear how many additional LHH residents who are eligible for community placement do not oppose such placement. However, based on the deficiencies identified below, we believe additional residents could meet the second-prong requirement for community placement under Olmstead.

**a. LHH's Role to Inform Residents of Community Options.**

In addition to the ADA's preamble cited in Olmstead, federal regulations relating to waiver services and services provided to persons with mental illness require that public agencies inform individuals contemplating institutionalization of community alternatives.<sup>27</sup>

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<sup>26</sup> "Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept." 28 C.F.R. § 35.130(e)(1). The Court also cited Title II's preamble which reads: "[P]ersons with disabilities must be provided the option of declining to accept a particular accommodation." 28 C.F.R. Part 35, App. A, p. 450.

<sup>27</sup> When home and community-based waiver services are offered under Medicaid (as they are in California), public agencies must ensure that "when a recipient is determined to be likely to require the level of care provided in a...nursing facility..., the recipient or his or her legal representative will be informed of any feasible alternatives available under the waiver and given the choice of either institutional or home and community-based services." 42 C.F.R. § 441.302(d)(1),(2).

For long-term residents who have resided in a nursing facility for more than 30 months and have been identified through PASRR as requiring specialized services, but not nursing facility services, "the State must, in consultation with the resident's family or legal representative and caregivers [o]ffer the resident the choice of remaining in the facility or of receiving



Based upon a review of individual resident records, there appears to be no effective policy or procedure that requires LHH staff to explore routinely community alternatives for qualified residents and provide meaningful information to residents about those alternatives. Several cases illustrate this finding.

For example, Leona M. has a diagnosis of cerebral palsy and severe mental retardation. She is dependent on staff for bathing, is incontinent, and needs assistance in transfers and supervision with other activities of daily living. Her discharge plan does not list any barriers to discharge. Leona came to LHH at the request of her family so that she could be closer to her mother who was a patient at LHH. Her mother recently passed away. She currently receives no special services for her developmental disability from LHH. According to the record, her grandparents are exploring other placement options. This person presents several challenges in that her original admission to the institution was highly unusual. Moreover, although there are no identified barriers to discharge, LHH staff have failed to explore viable community options.

Ronald L. is a 55-year-old man who has resided at LHH for four years. He has traumatic brain injury and a seizure disorder. The primary service being provided by LHH for this man is 24-hour supervision. He needs to be monitored for the possibility of wandering. He needs limited assistance with shaving and bathing. This type of supervision could be provided in a community setting. According to current professional standards of discharge planning, it would be appropriate to determine if Ronald could benefit from a targeted program in the community that serves persons with traumatic brain injury. However, such services have not been offered to Ronald.

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services in an alternative appropriate setting; and [i]nform the resident of the institutional and noninstitutional alternatives covered under the State Medicaid plan for the resident." 42 C.F.R. § 483.118(c)(1)(i), (ii). For similar residents who have resided in a nursing facility for less than 30 months, "the State must, in consultation with the resident's family or legal representative and caregivers [a]rrange for the safe and orderly discharge of the resident from the facility in accordance with § 483.12(a); [p]repare and orient the resident for discharge; and [p]rovide for, or arrange for the provision of, specialized services for the mental illness or mental retardation." 42 C.F.R. § 483.118(c)(2)(i), (ii), (iii).

Helen A. has been at LHH for over 20 years. She requires moderate assistance with eating, washing, and dressing. Her diagnoses are developmental delay, ulcers, coronary artery disease, hypertension, and depression. Her discharge plan concludes that community placement is inappropriate. There is no indication in her record, however, that her interdisciplinary team explored appropriate community alternatives. The fact that her current disabilities do not present any problem for attending programming in the community is a good indication that Helen can successfully live in the community.

For example, Shelly W. has a diagnosis of profound mental retardation, spastic hemiplegia, and hypertension. She feeds herself and needs assistance with showering and dressing. Shelly's discharge plan is to remain at LHH due to her cognitive impairments and her need for assistance with activities of daily living. She attends community programming four days a week. Many individuals like Shelly live successfully in the community.

Another example is Steve B. He was admitted for a one-month respite on August 19, 1997. Four and a half years later, Steve is still a resident at LHH. He serves as a volunteer for the Arc, a community program for people with developmental disabilities, four days a week. His diagnoses include cerebral palsy, seizure disorder, spastic quadriplegia and mental retardation. He feeds and bathes himself and is able to position himself and ambulate using a wheelchair. There is no indication in the record that LHH has presented Steve with realistic community alternatives. Without such structured exposure to community alternatives, it is perhaps understandable why Steve indicates that he prefers to remain at LHH and why his father is supportive of this arrangement.

**b. Impact of LHH Discharge Planning on Resident Choice of Placement.**

The LHH discharge planning process does not meet generally accepted professional standards because staff fail to plan actively for residents who have the potential for discharge and want to leave. For those LHH residents who indicated a desire to return to the community, very few records documented effective discharge planning efforts to locate appropriate community alternatives to meet their needs. For example, Sam M. is a 60-year-old man who has been at LHH for over three years. He has organic brain disease and a bilateral above-the-knee amputation.

He ambulates using a wheelchair. Sam expressed an interest to be discharged to the community. He leaves LHH during the day to go to a senior center located in the community. The discharge summary says that he will remain at LHH until he can secure an SSI rate, non-ambulatory board and care facility. There is no indication in the record that LHH staff are making any proactive attempts to help this man return to the community.

We found a substantial number of LHH residents who, at the time of admission, indicated a preference to return to the community. However, after a prolonged stay at LHH, these residents appear to have become so accustomed to institutionalization that LHH records reflect that they have lost interest in moving to the community. An individual can become so institutionalized that discharge to an appropriate community placement becomes unnecessarily challenging.<sup>28</sup> For these individuals, professional standards and federal regulations related to discharge planning dictate that staff make efforts to prepare residents for discharge.<sup>29</sup>

For example, Shelly L. came to LHH for a three-week respite on February 9, 2001. Since then, her husband died, and she lost her home. She had previously been employed as an apartment manager. Her diagnoses include back pain, COPD-Oxygen dependent, history of intravenous drug use, and opiate dependence. Shelly requires assistance with bathing but is independent with transfers, dressing, and eating. Her discharge plan indicates that she has decided to stay at LHH because she has frequent episodes of shortness of breath and is oxygen dependent. She has been placed on a public assistance voucher program housing list ("Section 8") that has a wait time of several years. In addition to housing, Shelly will need in-home medical supports, substance abuse treatment, and personal care services. Because the only housing option the interdisciplinary team is exploring is Section 8 housing, Shelly is likely to be institutionalized for at least

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<sup>28</sup> These views are consistent with those expressed by Dr. Mitchell Katz, Director of San Francisco's Department of Public Health, regarding LHH who reported that "the best time for community placement is prior to individuals spending substantial time in a long-term care institution. Once residents have lost their home, community ties and survival skills for living independently, alternative placement is substantially more difficult." Katz, LHH Options Paper, supra n.12, at 17.

<sup>29</sup> "A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility." 42 C.F.R. § 483.12(a)(7).

three to five years.

Brian Y., 45, has been at LHH since June 1991. He was admitted to LHH from a hospital after a motor vehicle accident that left him a quadriplegic. He is very independent and requires little, if any, assistance from LHH staff. He leaves LHH daily to work and attend community meetings and social events outside of the facility. He takes public transportation without any assistance from LHH staff. While he is at LHH, he uses his computer. Detailed social work notes dating back to 1992 noted the resident's "unrealistic expectations" and determined that it was likely that he would "[s]tay at LHH for long term care." In 1993 and 1994, a community placement was explored, and Brian's name appeared at the top of the wait list for housing. Whenever Brian's name abruptly appears on the housing list, he does not appear to be mentally prepared to make a decision and has declined housing. Documentation of counseling aimed at mental readiness for discharge was absent. Although Brian is very independent and needs very minimal support, he remains at LHH because he has become afraid to live in the community. LHH is what he has known for so long.

**3. Third Prong under Olmstead - The Community Placement Can Be Reasonably Accommodated**

Once an institutionalized individual meets the first two prongs in Olmstead, the Court held that States are required to provide community-based treatment when "the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with...disabilities." Olmstead, at 607.<sup>30</sup> In further holding that unjustified isolation in an institution is properly regarded as discrimination based on disability, the Court in Olmstead noted that "States must adhere to the ADA's nondiscrimination requirement with regard to the services they in fact provide." Olmstead, at 603, n.14.

San Francisco provides a broad range of long-term care

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<sup>30</sup> The Court relied on 28 C.F.R. § 35.130(b)(7) which reads: "A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7) ("reasonable-modifications regulation").

services for people with disabilities in institutional, home, and community-based settings.<sup>31</sup> Among its home and community-based programs are optional and waiver services included in California's State Plan under Medicaid.<sup>32</sup> In some instances, individuals must meet requirements for placement in institutional settings like LHH in order to be eligible for alternative community placements. This is particularly true of Medicaid waiver programs.

California currently has six Home and Community-Based Service (HCBS) waiver programs. These waivers enable persons who are elderly or have disabilities to avoid institutionalization by receiving Medicaid services in the community. Three of these waiver programs are the Multipurpose Senior Services Program (a service option for persons age 65 and over who are certified at nursing home level of care, but who can remain in the community with care management and additional in-home and/or community long-term care services), and Nursing Facility and Model Waivers, both of which are aimed at persons who would otherwise need nursing facility care for 90 days or longer. To receive approval for these types of waivers, the California Department of Health Services or the designated state department must provide a letter

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<sup>31</sup> During our December 2001 and March 2002 tours of LHH and community providers, we found that San Francisco had many examples of excellent programs in the community, but sufficient capacity does not exist for a variety of essential programs. Community programs that we visited include, but are not limited to: In-Home Supportive Services; Single Room Occupancy Hotels (Windsor Hotel); Residential Care Facilities (Autumn Glow); Adult Day Centers (On-Lok Senior Health Center, Presentations House); Supportive Housing (Bethany Center, Broderick); and Mental Health Community Centers (Westside Community Mental Health Center). In general, our consultants found that the community programs provided quality services.

<sup>32</sup> Medicaid statutes require that participating States provide a specified set of medical assistance services. See 42 U.S.C. § 1396d. Optional services may also be offered under Medicaid. In California, these options include personal care services, such as California's In-Home Supportive Services program, and the Program of All-Inclusive Care for the Elderly ("PACE" or "On Lok" as it is referred to in San Francisco).

The waiver program provides Medicaid reimbursement to States for the provision of community-based services to individuals who would otherwise require institutional care, upon a showing that the average annual cost of such services is not more than the annual cost of institutional services. See 42 U.S.C. § 1396n(c).

of support or endorsement to individual counties who apply for certain grants or Medicaid waivers.

The State can expand the above waivers to meet the needs of LHH residents who are appropriate for less restrictive levels of care but who still require supports and health services. It appears that the City and the State could take advantage of home and community-based waiver programs to target groups at LHH that could be served appropriately in the community but are currently not eligible for funded services. Thus, there appear to be federal funding sources the State of California and the City of San Francisco could seek to provide for home and community-based services for LHH residents. Currently, San Francisco has a wide array of community placements and supports, but they do not exist in adequate numbers to ensure that LHH residents who are clinically capable of living in less restrictive community settings and who do not oppose living in the community, are able to do so. The number of less restrictive placements for younger individuals in San Francisco is particularly insufficient and may account for the dramatic increase in this population group at LHH over the last ten years.

As previously stated, there are numerous residents of LHH for whom the facility is not the most integrated setting. Many of these residents have remained at the facility for long periods of time and are not being returned to the community at a reasonable pace. The City has a wide array of community services that, if expanded, could meet the needs of many of the individuals currently housed at LHH. The array of community services available in San Francisco, for example, would be adequate and appropriate to serve all of the sampled residents identified by our consultants who remain at LHH not because they require skilled nursing services, but because of limited community capacity.

One example of harm due to the limited community settings is the case of Jocelyn P. who desires discharge to the community and has been recommended for discharge by her interdisciplinary team. She remains at LHH because there are limited appropriate community settings. Jocelyn is enrolled in a lottery for placement at Broderick House, a facility that provides adult residential care to individuals with mental health and substance abuse disorders. The lottery is being used because there are more people who request admission than the facility can serve. The facility only has 24 long-term beds and 10 respite beds. Staff at Broderick House reported the total operating cost per

bed was \$120 per day, or approximately \$43,200 a year, compared to \$126,655 per year at LHH.

San Francisco's limited capacity is evident in several service categories, including: 1) residential services for people with physical disabilities as well as individuals with mental health and/or substance abuse disorders; 2) housing and housing services for people with mental health and/or substance abuse disorders; 3) assertive community treatment teams; and 4) vocational services and day treatment programs. The City has not taken adequate steps to expand these services.

In 1998, the Long-Term Care Pilot Project Task Force reported that "San Francisco has an uncoordinated array of long-term care services offering health, medical, social and other support services. Unfortunately, more than four years later, the current focus of long-term care is on institutional care."<sup>33</sup> This situation continues to exist for individuals with mental health, substance abuse, and developmental disabilities as evidenced by many of the examples we cite above.

Further, expanded opportunities for integrated community living could be constrained by the plan to construct a new replacement facility for LHH. The new 1,200-bed facility is to cost \$401 million to construct, or \$300,000 per bed. See supra n.10. The new facility is likely to cost at least as much to operate as LHH currently does. At \$347 per day, each bed costs nearly \$127,000 per year to operate. See supra n.7. The City subsidizes one third (33.7%) of that annual cost per bed, with the remaining cost primarily paid for by federal and state funds under Medicaid. See supra n.8. Consumption of that amount of capital and operating resources, particularly when federal, state, and local budgets are tight, is likely to constrain San Francisco's ability to continue expansion of more appropriate integrated community resources.

Remedying the ADA violation does not preclude San Francisco from rebuilding some portion of Laguna Honda for residents who would be appropriately served in a skilled nursing facility. Indeed, some of the well-needed structural changes that will be made should address our May 1998 Finding that "LHH is not

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<sup>33</sup> The Long-term Care Council, which issued the report, was established by California legislation, AB 452 (Chapter 895 Statutes of 1999) to coordinate policy and operations for long-term care.

providing residents with an adequate and appropriate living environment." See May 1998 Findings Letter, at 13. However, there does not appear to be any documented need for the City to rebuild all 1,200 beds. San Francisco might reconsider its funding allocations in meeting its obligations under the ADA. As the Court cautioned in Olmstead, a State may satisfy its obligations under the ADA "if the State were to demonstrate that it had a...waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated...(emphasis added)," Olmstead, at 606. The cost-savings produced by building a smaller facility could fund much-needed community services. Indeed, if even a fraction of the cost of the currently-budgeted rebuild were to be spent on integrated community living opportunities as opposed to replacing the entire nursing facility, not only would the inappropriately isolated residents of LHH benefit, but persons at risk of being institutionalized now and in the future would benefit, too.

A recent study in New York City found that the cost of serving homeless people with serious mental illness and substance abuse in the community averaged approximately \$50,000 per person per year - including subsidized housing and primary medical care. The cost of a similar array of services for these very difficult and complex individuals is likely to be equivalent in San Francisco. Thus, the funds spent on two beds at LHH for a year could be used to serve five people in integrated community settings with a full array of services and supports.

By way of further explanation, we discuss a community-based service scenario. According to information published by the U.S. Department of Housing and Urban Development, the 2003 fair market rent for an affordable efficiency apartment in San Francisco is \$1,185 per month.<sup>34</sup> Assuming that 30 percent of an individual's income should be spent on housing, an individual on SSI in San Francisco could pay about \$225 per month for that apartment. Thus, the subsidy needed for that unit would be just over \$960 per unit month or \$11,520 per year. If \$50,000 per person per year were available for supported community living, \$38,480 would be left for support services and medical care costs after the housing subsidy was paid.

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<sup>34</sup> Fair Market Rents for Fiscal Year 2003, 67 Fed. Reg. 189, 61382 (Sept. 30, 2002) (as revised by errata, Oct. 22, 2002).



These calculations are not intended to cast judgment on the capital or per bed year costs of LHH. Rather, they suggest that for people who meet the clinical level of care criteria for community placement, and who want to live in the community, community integrated options could be provided at a fraction of the cost of staying in LHH. If the City wishes to assure that citizens have access to integrated community living as opposed to institutional care that they neither need nor choose, then the resources and the opportunities are readily available.

### **III. MINIMAL REMEDIAL MEASURES**

In order to remedy these deficiencies and to protect the rights of LHH residents to be free from unnecessary isolation, LHH and San Francisco need to implement, at a minimum, the following measures:

#### **A. ASSESSMENT PROCESS**

1. Conduct timely, adequate, and periodic assessments to determine whether Laguna Honda is the most integrated setting to meet residents' needs.
2. Conduct timely and adequate quarterly reviews to determine whether each resident of Laguna Honda continues to require care in a skilled nursing facility.
3. Train and supervise staff regarding LHH admission criteria so as to ensure that individuals admitted to LHH meet skilled nursing criteria.
4. Review and develop admission criteria for short-stay acute nursing services and respite care to ensure that individuals are not maintained at the institution longer than is necessary.
5. Review and develop appropriate utilization review procedures to ensure that admissions to and continued stays at LHH are appropriate.
6. Review, revise and/or develop LHH admission criteria that identify clear medical standards and criteria that distinguish short-term acute and rehabilitative services from long-term care components of the hospital.

7. Develop organizational guidelines that identify the LHH staff who are responsible for identifying alternative community placements and commencing discharge planning immediately upon admission to the facility.
8. Regularly assess, advise, and educate residents regarding discharge potential and home and community-based long-term care options.
9. Ensure that the PASRR process complies with federal requirements. At a minimum, improve the PASRR Level I screening process to ensure that individuals with mental illness and/or mental retardation are identified consistently. In addition, when Level II evaluations indicate the need for the provision of specialized services, LHH and San Francisco should provide or ensure the provision any such specialized services and any other treatment or habilitation to patients who are determined to need them in a timely and adequate manner.
10. Ensure that all appropriate staff receive competency-based training regarding PASRR requirements.

**B. DISCHARGE PLANNING PROCESS**

1. Develop and implement discharge policies and procedures that comply with professional standards and ensure that LHH residents are discharged to appropriate community placements in a timely manner.
2. Ensure that discharge plans describe in sufficient detail the specific characteristics of the most integrated, appropriate setting based on the patients' needs, including the type, duration, and frequency of services necessary for appropriate discharge to the community.
3. Ensure that discharge plans include sufficient detail and accountability to facilitate discharge or overcome barriers to discharge.
4. Ensure that all existing skill acquisition plans, at a minimum, include the following: i) detailed objectives; ii) methods staff should use to collect

data; and iii) a description of the type of data staff should collect.

5. Ensure that specific goals and objectives set forth in individual treatment plans and discharge plans are consistent, and are designed to facilitate discharge, where appropriate.
6. Ensure that all treatment and discharge plans identify individual behavioral and physical/health-related milestones for measuring progress toward discharge.
7. Develop and implement a process that ensures that goals related to rehabilitation promote greater independence, including placement in a more integrated, appropriate setting to meet residents' needs.
8. Ensure that residents receive meaningful, active programming that is related directly to assisting residents to develop the skills and physical capabilities associated with living in the most integrated, appropriate setting to meet their needs.
9. Develop and implement policies that require social workers to track relevant data regarding discharge planning.
10. Create a central database that tracks relevant data regarding discharge planning.
11. Ensure that active discharge planning occurs according to professional standards, by reducing the caseload of social workers, if necessary.
12. Develop and implement policies and procedures that ensure that teams address any concerns of LHH residents regarding discharge.
13. Follow-up with discharged residents to ensure that recommended services are being provided and are adequate to address their needs.
14. Take appropriate actions to alert community providers when services are found to be inadequate.

**C. COMMUNITY SUPPORTS AND SERVICES**

1. Allocate adequate funding for, or otherwise provide home and community-based services to ensure that LHH residents are not unnecessarily isolated at LHH.
2. Develop and implement a system-wide assessment of various subcontracted community programs to identify network gaps as well as areas of highest demand, and to provide a basis for comprehensive planning, administration, and resource targeting in San Francisco.
3. Establish and implement a policy to preserve housing for individuals who are temporarily hospitalized or placed in short-term rehabilitation at LHH by taking steps necessary to maintain and make accessible, as needed, the residents' housing until and when they return home.
4. Expand the following community-based services: residential services for individuals with mental health or substance abuse disorders, housing and housing supports, housing and residential programs for individuals who have physical as well as mental disabilities, assertive community treatment, vocational services and day treatment programs.
5. Increase the number of case managers providing services to persons served in the community. Increase coordination of intensive case management in the San Francisco community to prevent institutionalization.
6. Conduct a comprehensive needs assessment to determine how many LHH residents can receive and do not oppose care in a community-based setting that will be appropriate to meet their needs. At a minimum, this assessment should identify any, and all, supports and services each resident is receiving at LHH and what services each resident will need to support him in the community. Utilize the results of this needs assessment to reconsider the need to rebuild 1,200 beds at LHH.
7. Based upon the results of this needs assessment, San Francisco should review its current budget to determine

how expenditures can be appropriately allocated to ensure that LHH residents are not unnecessarily isolated.

8. Create and maintain a complete inventory of housing options in San Francisco that will be utilized by LHH residents.

In making the foregoing findings, and identifying appropriate remedies, we recognize that the City has made progress in remedying some of its long-standing deficiencies with respect to conditions of care at Laguna Honda. This progress can be attributed to the efforts of City and facility officials to address proactively problems they identified at the facility. These efforts evidence a commitment to improving the facility.

In light of the City's cooperation in this matter, we will be sending our consultants' reports under separate cover. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration of the issues discussed in this letter and offer practical assistance in addressing them.

Pursuant to CRIPA, the Attorney General may institute a lawsuit to correct deficiencies of the kind identified in this letter. We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to do so in this case. Civil Rights Division lawyers will be contacting your office to discuss these remedial measures.

Sincerely,

/s/ Ralph F. Boyd, Jr.

Ralph F. Boyd, Jr.  
Assistant Attorney General

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