Enclosed you will find several documents that relate to SF DPH

Document 1
SB 1045 Legislation, as currently written, with pertinent area highlighted.

Document 2
A list of Psych patients currently in med-surg beds, who are awaiting psych placement

Document 3
A draft of a petition written by RN's who work at SFGH in the ED. This petition outlines deficiencies in care and leadership in the ED, and outlines why patient care and leadership overlap and matter. We will present a copy with signatures at the hearing.

Document 4
California Health and Safety Code 1442.5 – Beilenson Hearings, with pertinent area highlighted.

Document 5 (attached separately)
Prop Q legislation, with pertinent area highlighted.

Document 6 (attached separately)
A letter composed in 2014 by RN's who work in SFGH ED.

Document 7 (attached separately)
Proposition C, voted on and approved by 76% of SF Voters in 1987, with pertinent area highlighted.

SB1045, Prop Q, ED RN letter, Prop C 1987.

* The documents being included in this packet have been chosen for their relevance. SB1045 is a state law, now codified which dictates the creation of a program that allows people to be forced into psych and drug treatment. I've included the legislation and highlighted portions which say that the program must be implemented with "adequate resources."
* Prop Q is a piece of legislation codified in 1988 which mandates that all private hospitals that reduce services must first come to the SF Board of Supervisors with a proposal and impact study. This took place before St. Lukes closed its SNF unit last year. It seems that SF DPH is holding itself to a different standard than we hold private institutions, because this ARF reduction was made in secret and is only now getting public scrutiny because of press coverage and direct action by workers.
* Letters written by RN's who work in the emergency room at SFGH outlining departmental issues which have led to the ED being a place where providing care based on best practices is not supported by management.
* Prop C legislation from 1987 detailing the overwhelming support for the bond measure to build the SF BHC, home to the ARF and outlining reasons why the SF Health Commissioners in 1987 unanimously supported the building of this site.

Today's problem

On July 22, SFDPH admin sent a letter informing SEIU 1021 and SF BHC workers that the ARF population will be shrinking. All but 14 permanent beds at the ARF are being closed to allow for an expansion of the Hummingbird's shelter beds. The ARF's capacity will shrink from 55 to 14, 41 permanent beds will be lost to accommodate this change. Closing permanent beds to expand temporary shelter beds is bad math. In addition to our residents being displaced, SFDPH is also displacing city workers.

It's no accident that beds are open at the SFBHC, the most recent admission to the ARF took place on September 6, 2018, almost one year ago. The last admission to the RCFE was April 1, 2019, four months ago. It seems the beds have been vacated and held empty to make room for the Hummingbird expansion. This, however is ethically reprehensible when the SFGH inpatient psych unit at SFGH is at capacity and patients are waiting for beds. Beds they are told do not exist but are actually sitting empty, just across the parking lot.

These practices are unethical and also unfathomable in the face a growing homeless population, many of whom are suffering with mental illness. The current residents at the ARF are facing double risks. One risk is having their long-term permanent housing

destabilized, the other risk is that they could be pushed into a psychiatric decompensation due to stress related to changes in care and the stress of a big transition.

Add to this SFGH ED was on diversion 58% of August, PES has been on diversion more than 33% of every month this year! SF DPH is the provider of care for all San Franciscans who need care provided by our social safety net. Diversion is an artifact of inadequate supplies in capacity in each emergency setting but also indicates a lack of capacity in setting patients should be moving into after receiving emergency care. When these emergency settings are too full to take on new cases, people are forced to seek treatment elsewhere, soften in settings that are inadequately equipped to handle their needs.

The residents at the ARF are vulnerable people who have serious and persistent mental illnesses and cannot live independently. People who cannot prepare their own food, do their own laundry nor manage their own money. They also cannot manage their medications, without which they would return to suffering major psychiatric crises on a regular basis and would cycle through the city's ER's and psychiatric emergency room. As if all these changes weren't egregious enough, the SF BHC administration told staff to keep this change secret from the residents. Staff feel intimidated by their management and do not feel they can properly care for their residents because they have been forbidden from guiding their residents through a thoughtful and caring transition. Staff at the SF BHC have been caring for these residents for years, some since the facility opened and the first residents moved in. The people who live at the SF BHC say they feel like part of a family, a family who lives and works at the SF BHC. The ARF is their home and they should continue to live there.

The ARF should not lose any beds. The ARF should be filled to capacity. The ARF staff should be given appropriate resources to continue to provide high quality care and a loving home like environment to residents.

Document 1

Senate Bill No. 1045
CHAPTER 845

An act to add and repeal Article 7 (commencing with Section 5555) of Chapter 6.2 of, and to add and repeal Chapter 5 (commencing with Section 5450) of, Part 1 of Division 5 of the Welfare and Institutions Code, relating to conservatorship.

[Approved by Governor September 27, 2018. Filed with Secretary of State September 27, 2018.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1045, Wiener. Conservatorship: serious mental illness and substance use disorders.

(1) Existing law establishes a procedure for the appointment of a conservator for a person who is determined to be gravely disabled as a result of a mental health disorder or an impairment by chronic alcoholism, as specified, pursuant to a petition to the superior court by an officer conducting an investigation and concurring with a recommendation of conservatorship. Existing law also establishes a procedure for the appointment of other types of conservatorship or a guardianship as ordered by the probate court.

Existing law, the Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law, until January 1, 2022, grants each county the authority to offer certain assisted outpatient treatment services for a person who meets specified criteria, including, among others, that the person is suffering from a mental illness, that the person has a history of lack of compliance with treatment for the person's mental illness, and that the person is in need of assisted outpatient treatment, as specified. Laura's Law authorizes designated persons to request the county behavioral health director to file a petition in the superior court for an order for assisted outpatient treatment.

This bill would establish a procedure, for the County of Los Angeles, the County of San Diego, and the City and County of San Francisco, if the board of supervisors of the respective county or city and county authorizes the application of these provisions subject to specified requirements, for the appointment of a conservator for a person who is incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, as specified, for the purpose of providing the least restrictive and most clinically appropriate alternative needed for the protection of the person. The bill would prohibit a conservatorship from being established under these provisions if a conservatorship or guardianship exists under the above-described provisions.

This bill would make the establishment of a conservatorship pursuant to these provisions subject to, among other things, a finding by the court that the behavioral health director of the county or the city and county has previously attempted by petition to obtain a court order authorizing assisted outpatient treatment pursuant to Laura's Law for the person for whom conservatorship is sought, that the petition was denied or the assisted outpatient treatment was insufficient to treat the person's

mental illness, and that assisted outpatient treatment would be insufficient to treat the person in the instant matter in lieu of a conservatorship.

This bill would require a conservatorship initiated under these provisions to automatically terminate one year after the appointment of the conservator by the superior court, or shorter if ordered by the court, except as specified.

This bill would authorize the Judicial Council to adopt rules, forms, and standards necessary to implement these provisions.

(2) This bill would require the County of Los Angeles, the County of San Diego, and the City and County of San Francisco, subject to the county's or city and county's election to apply these provisions, to establish a working group, comprised of representatives of local agencies and disability rights advocacy groups, among others, to conduct an evaluation of the effectiveness of the implementation of the conservatorship provisions described above in addressing the needs of persons with serious mental illness and substance use disorders. The bill would require each working group to prepare and submit a preliminary report to the Legislature on its findings and recommendations no later than January 1, 2021, and a final report no later than January 1, 2023.

(3) This bill would repeal, on January 1, 2024, all of the provisions relating to the new conservatorship procedure and the working group, as described above in paragraphs (1) and (2).

(4) This bill would make legislative findings and declarations as to the necessity of a special statute for the County of Los Angeles, the County of San Diego, and the City and County of San Francisco.

DIGEST KEY

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

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BILL TEXT

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1.

Chapter 5 (commencing with Section 5450) is added to Part 1 of Division 5 of the Welfare and Institutions Code, to read:

CHAPTER 5. Housing Conservatorship for Persons with Serious Mental Illness and Substance Use Disorders

5450.

(a) Until January 1, 2024, this chapter shall apply only to the County of Los Angeles, the County of San Diego, and the City and County of San Francisco if the board of supervisors of the respective county or city and county, by resolution or through the county budget process, authorizes the application of this chapter and makes a finding that no voluntary mental health program serving adults, no children's mental health program, and no services or supports provided in conservatorships established pursuant to Division 4 (commencing with Section 1400) of the Probate Code or conservatorships established pursuant to Chapter 3 (commencing with Section 5350), including availability of conservators, may be reduced as a result of the implementation of this chapter.

(b) (1) Before the county board of supervisors may authorize the application of this chapter, the county mental health department, the county welfare department, and, if one exists, the county department of housing and homeless services shall do both of the following:

(A) Develop a plan to implement this chapter in consultation with representatives of disability rights advocacy groups, a provider of permanent supportive housing services, the county health department, law enforcement, labor unions, and staff from hospitals located in the county or the city and county.

(B) Present before the county board of supervisors on the plan and available resources for the implementation of this chapter.

(2) In order to approve authorization of the application of this chapter, the county board of supervisors shall determine, after a public hearing, based on materials presented, that all of the following services are available in, at a minimum, sufficient quantity, resources, and funding levels to serve the identified population that the county board of supervisors intends to serve, within the county or city and county for utilization in connection with the application of this chapter:

(A) Supportive community housing that provides wraparound services, with adequate beds available.

(B) Public conservators trained on the specifics of how to assess and evaluate individuals for the new form of conservatorship described in this chapter.

(C) Outpatient mental health counseling.

(D) Coordination and access to medications.

(E) Psychiatric and psychological services.

(F) Substance use disorder services.

(G) Vocational rehabilitation.

(H) Veterans' services.

(I) Family support and consultation services.

(J) A service planning and delivery process that includes all of the following:

(i) Plans for services that contain evaluation strategies, which shall consider cultural, linguistic, gender, sexual orientation, age, and special needs of minorities and those based on any characteristic listed or defined in Section 11135 of the Government Code in the target populations. Provision shall be made for staff with the cultural background and linguistic skills necessary to remove barriers to mental health services as a result of having limited-English-speaking ability or cultural differences.

(ii) Provision for services to meet the needs of persons who are physically disabled.

(iii) Provision for services to meet the special needs of older adults.

(iv) Provision for family support and consultation services, parenting support and consultation services, and peer support or self-help group support, if appropriate.

(v) Provision for services to be client-directed and to employ psychosocial rehabilitation and recovery principles.

(vi) Provision for psychiatric and psychological services that are integrated with other services and for psychiatric and psychological collaboration in overall service planning.

(vii) Provision for services reflecting special needs of women from diverse cultural and socioeconomic backgrounds.

(viii) Provision for housing for clients that is immediate, transitional, permanent, or all of these.

(ix) Provision for services reflecting special needs of lesbian, gay, bisexual, and transgender (LGBT) individuals.

(K) The individual personal services plan ensures that a person subject to conservatorship pursuant to this chapter receives age-appropriate, gender-appropriate, disability-appropriate, and culturally appropriate services, to the extent feasible and when appropriate, that are designed to enable those persons to do all of the following:

(i) Live in the most independent, least restrictive housing feasible in the local community, and, for clients with children, to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as is appropriate.

(ii) Engage in the highest level of work or productive activity appropriate to their abilities and experience.

(iii) Create and maintain a support system consisting of friends, family, and participation in community activities.

(iv) Access an appropriate level of academic education or vocational training.

(v) Obtain an adequate income.

(vi) Self-manage their illnesses and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives.

(vii) Access necessary physical health benefits and care and maintain the best possible physical health.

(viii) Reduce or eliminate the distress caused by the symptoms of mental illness.

(3) The county or the city and county shall not seek to conserve any individual pursuant to this chapter unless there is funding and available resources to provide all of the services set forth in paragraph (2).

5451.

In the County of Los Angeles, the County of San Diego, and the City and County of San Francisco, subject to Section 5450, a conservator of the person may be appointed for a person who is incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, as evidenced by frequent detention for evaluation and treatment pursuant to Section 5150. The procedure for establishing, administering, and terminating a conservatorship under this chapter shall be the same as provided for in Division 4 (commencing with Section 1400) of the Probate Code, except as follows:

(a) The court may appoint the public conservator in the county of residence of the person to be conserved and the person to serve as conservator if the person requesting the appointment establishes, and the court makes an express finding, that it is necessary for the protection of the

proposed conservatee and the granting of the conservatorship is the least restrictive alternative needed for the protection of the conservatee.

(b) (1) The person for whom conservatorship is sought shall have the right to demand a court or jury trial on the issue of whether the person meets the criteria for the appointment of a conservator of the person under this chapter. Demand for court or jury trial shall be made within five days following the hearing on the conservatorship petition. If the proposed conservatee demands a court or jury trial before the date of the hearing as provided for in Section 5465, the demand shall constitute a waiver of that hearing.

(2) Court or jury trial shall commence within 10 days of the date of the demand, except that the court shall continue the trial date for a period not to exceed 15 days upon the request of counsel for the proposed conservatee.

(3) This right shall also apply in subsequent proceedings to reestablish a conservatorship.

(c) Conservatorship investigation shall be conducted pursuant to Chapter 3 (commencing with Section 5350) and shall not be subject to Section 1826 of, or Chapter 2 (commencing with Section 1850) of Part 3 of Division 4 of, the Probate Code.

(d) Notice of proceedings under this chapter shall be given to a guardian or conservator of the person or estate of the proposed conservatee appointed under the Probate Code and as otherwise provided in Section 5350.2.

(e) As otherwise provided for in this chapter.

(f) A conservatorship pursuant to this chapter shall not be established if a conservatorship or guardianship exists under Division 4 (commencing with Section 1400) of the Probate Code or under Chapter 3 (commencing with Section 5350).

5452.

For purposes of this chapter, the following definitions apply:

(a) "Frequent detention for evaluation and treatment" means eight or more detentions for evaluation and treatment in the preceding 12 months.

(b) "Evaluation" consists of multidisciplinary professional analyses of an individual's medical, psychological, educational, social, financial, and legal conditions as they may appear to constitute a problem. Persons providing evaluation services shall be properly qualified professionals and may be full-time employees of an agency providing face-to-face, which includes telehealth, evaluation services or may be part-time employees or may be employed on a contractual basis.

(c) "Intensive treatment" consists of such hospital and other services as may be indicated. Intensive treatment shall be provided by properly qualified professionals and carried out in facilities qualifying for reimbursement under the Medi-Cal program as set forth in Chapter 7 (commencing with Section 14000) of Part 3 of Division 9, or under the federal Medicare Program as set forth in Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act and regulations thereunder. Intensive treatment may be provided in hospitals of the United States government by properly qualified professionals. This chapter does not prohibit an intensive treatment facility from also providing 72-hour evaluation and treatment.

5453.

The purpose of conservatorship under this chapter is to provide the least restrictive and most clinically appropriate alternative needed for the protection of a person who is incapable of caring for

the person's own health and well-being due to a serious mental illness and substance use disorder, as evidenced by frequent detention for evaluation and treatment pursuant to Section 5150. If the court determines that the person needs to be moved from the person's current residence, the placement shall be in supportive community housing that provides wraparound services, such as onsite physical and behavioral health services, unless the court, with good cause, determines that such a placement is not sufficient for the protection of that person.

5454.

In the County of Los Angeles, the County of San Diego, and the City and County of San Francisco, subject to Section 5450, the board of supervisors of the respective county or city and county shall designate the agency or agencies to provide conservatorship investigation as set forth in this chapter, and those investigations shall comply with the requirements of Section 5354. The governing board may designate that conservatorship services be provided by the public guardian or agency providing public guardian services.

5455.

(a) (1) The county sheriff may recommend an evaluation for conservatorship to the officer providing conservatorship investigation in the county of residence of the person if the sheriff determines that a person detained in a jail is incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, as evidenced by frequent detention for evaluation and treatment pursuant to Section 5150. The county sheriff may delegate this authority to make a determination and recommendation to the health care service providers in the county jail.

(2) The director of a county mental health department or a county department of public social services may recommend an evaluation for conservatorship to the officer providing conservatorship investigation in the county of residence of the person if the director determines that a person is incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, as evidenced by frequent detention for evaluation and treatment pursuant to Section 5150.

(3) The professional person in charge of an agency providing comprehensive evaluation or a facility providing intensive treatment may recommend an evaluation for conservatorship to the officer providing conservatorship investigation in the county of residence of the person if the professional person in charge of the agency providing comprehensive evaluation or the facility providing intensive treatment determines that a person in the professional's care is incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, as evidenced by frequent detention for evaluation and treatment pursuant to Section 5150.

(b) If the officer providing conservatorship investigation, upon conducting an evaluation for conservatorship, finds that the person meets the criteria for conservatorship and the conservatorship is the least restrictive alternative, the officer shall petition the superior court in the county of residence of the person to establish conservatorship.

5456.

The establishment of a conservatorship pursuant to this chapter is subject to a finding by the court that the behavioral health director of the county or the city and county has previously attempted by petition to obtain a court order authorizing assisted outpatient treatment pursuant to Article 9 (commencing with Section 5345) of Chapter 2 for the person for whom conservatorship is sought, and that both of the following conditions exist:

(a) The petition was denied or the assisted outpatient treatment was insufficient to treat the person's mental illness.

(b) Assisted outpatient treatment would be insufficient to treat the person in the instant matter in lieu of a conservatorship.

5457.

(a) The officer providing conservatorship investigation shall investigate all available alternatives to a conservatorship under this chapter, including a conservatorship under Division 4 (commencing with Section 1400) of the Probate Code or a conservatorship under Chapter 3 (commencing with Section 5350), and shall recommend conservatorship to the court only if no less restrictive alternatives exist and it appears that the person does not qualify for a conservatorship under Division 4 (commencing with Section 1400) of the Probate Code or a conservatorship under Chapter 3 (commencing with Section 5350). This officer shall render to the court a written report of investigation prior to the hearing. The report to the court shall be comprehensive and shall contain, in addition to the elements required under Section 5354, all relevant aspects of the person's medical, psychological, financial, family, vocational, and social condition, and information obtained from the person's family members, close friends, social worker, or principal therapist. The report shall also contain all available information concerning the person's real and personal property. The facilities providing medical treatment, or intensive treatment or comprehensive evaluation, the sheriff, and the director of the county mental health department or the county department of public social services shall disclose any records or information that may facilitate the investigation. If the officer providing conservatorship investigation recommends a conservatorship, the officer shall explain why all less restrictive alternatives are not sufficient, and if the officer recommends against a conservatorship, the officer shall set forth all alternatives available. When confidentiality and client privacy laws permit, a copy of the report shall be transmitted to the individual who originally recommended conservatorship, and the information shared shall be compliant with state and federal laws governing protected health information. The court shall receive the report in evidence and shall read and consider the contents of the report in rendering its judgment.

(b) The report of the officer providing conservatorship investigation shall contain the officer's recommendations concerning the powers to be granted to, and the duties to be imposed upon, the conservator, the legal disabilities to be imposed upon the conservatee, and the proper placement for the conservatee pursuant to Section 5460, and shall explain why each of these items is the least restrictive alternative. The report to the court shall also contain an agreement signed by the person or agency recommended to serve as conservator certifying that the person or agency is able and willing to serve as conservator.

5458.

Except as otherwise provided in this chapter, the person recommended to serve as conservator shall promptly notify the officer providing conservatorship investigation whether the person recommended to serve as conservator will accept the position if appointed. If notified that the person or agency recommended will not accept the position if appointed, the officer providing conservatorship investigation shall promptly recommend another person to serve as conservator.

5459.

(a) A person or agency shall not be designated as conservator whose interests, activities, obligations, or responsibilities are such as to compromise the person's or agency's ability to represent and safeguard the interests of the conservatee. The conservator has a fiduciary duty to protect and care for the conservatee.

(b) If a public guardian is appointed conservator, the public guardian's official bond and oath as public guardian are in lieu of the conservator's bond and oath on the grant of letters of conservatorship. A bond shall not be required of any other public officer or employee appointed to serve as conservator.

5460.

When ordered by the court after the hearing required by this chapter, a conservator appointed pursuant to this chapter shall provide the least restrictive and most clinically appropriate placement for the conservatee, which shall be the conservatee's residence or a community-based residential care setting in supportive community housing that provides wraparound services, such as onsite physical and behavioral health services, unless the court for good cause orders otherwise.

5461.

(a) At any time, a conservatee or any person on the conservatee's behalf with the consent of the conservatee or the conservatee's counsel, may petition the court for a hearing to contest the powers granted to the conservator under Section 5460.

(b) A request for hearing pursuant to this section shall not affect the right of a conservatee to petition the court for a rehearing as to the conservatee's status as a conservatee pursuant to Section 5464. A hearing pursuant to this section shall not include trial by jury.

5462.

(a) Conservatorship initiated pursuant to this chapter shall automatically terminate one year after the appointment of the conservator by the superior court, or shorter if ordered by the court. If upon the termination of an initial or a succeeding period of conservatorship the conservator determines that conservatorship is still required, the conservator may petition the superior court for the conservator's reappointment as conservator for a succeeding one-year period or any shorter period.

(b) Any program in which a conservatee is placed shall release the conservatee at the conservatee's request when the conservatorship terminates. A petition for reappointment filed by the conservator or a petition for appointment filed by a public guardian or public conservator shall be transmitted to the program at least 30 days before the automatic termination date.

5463.

(a) The clerk of the superior court shall notify each conservator, the conservatee, the person in charge of the program in which the conservatee receives services, and the conservatee's attorney, at least 60 days before the termination of the one-year or shorter period. Notification shall be given in person or by first-class mail.

(b) If the conservator does not petition to reestablish conservatorship at or before the termination of the one-year or shorter period, the court shall issue a decree terminating conservatorship. The decree shall be sent to the conservator and the conservatee by first-class mail.

(c) The Judicial Council may adopt rules, forms, and standards necessary to implement this chapter.

5464.

(a) At any time, the conservatee may petition the superior court for a rehearing as to the conservatee's status as a conservatee.

(b) If a conservatee appeals a court's decision to establish a conservatorship, the conservatorship shall continue unless execution of judgment is stayed by the superior court or the appellate court.

5465.

A hearing shall be held on all petitions under this chapter within 30 days of the date of the petition. If the conservatee or proposed conservatee is not represented by counsel, the court shall appoint the public defender for the conservatee or proposed conservatee within five days after the date of the petition at the county's or city and county's expense. A hearing or trial shall not occur under this chapter unless the conservatee or proposed conservatee is represented by counsel.

5466.

This chapter shall remain in effect only until January 1, 2024, and as of that date is repealed.

SEC. 2.

Article 7 (commencing with Section 5555) is added to Chapter 6.2 of Part 1 of Division 5 of the Welfare and Institutions Code, to read:

Article 7. Housing Conservatorship Working Group

5555.

(a) The County of Los Angeles, the County of San Diego, and the City and County of San Francisco, subject to Section 5450, shall establish a working group to conduct an evaluation of the effectiveness of the implementation of Chapter 5 (commencing with Section 5450) in addressing the needs of persons with serious mental illness and substance use disorders in the county or the city and county. The evaluation shall include an assessment of the number and status of persons who have been conserved under that chapter, the effectiveness of these conservatorships in addressing the short- and long-term needs of those persons, and the impact of conservatorships established pursuant to that chapter on existing conservatorships established pursuant to Division 4 (commencing with Section 1400) of the Probate Code or Chapter 3 (commencing with Section 5350) and on mental health programs provided by the county or the city and county. The working group shall be comprised of representatives of disability rights advocacy groups, the county mental health department, the county health department, the county social services department, law enforcement, labor unions, staff from hospitals located in the county or the city and county, and, if one exists, the county department of housing and homeless services.

(b) Each working group shall prepare and submit a preliminary report and a final report to the Legislature on its findings and recommendations regarding the implementation of Chapter 5 (commencing with Section 5450). The preliminary report shall be submitted to the Legislature no later than January 1, 2021, and the final report shall be submitted to the Legislature no later than January 1, 2023, in compliance with Section 9795 of the Government Code.

5556.

This article shall remain in effect only until January 1, 2024, and as of that date is repealed.

SEC. 3.

The Legislature finds and declares that a special statute is necessary and that a general statute cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances of the County of Los Angeles, the County of San Diego, and the City and County of San Francisco.

Document 3

San Francisco General Hospital
Emergency Department Care Staff
1001 Potrero Ave. San Francisco, CA 94110

To All Concerned:

As members of the patient care team at San Francisco General Hospital & Trauma Center Emergency Department, we feel compelled to alert you to the trends of chronic poor staffing; severe overcrowding; potential violations of our MOU with The City and governmental regulations; and actions by management that are shrouded in secrecy, with nonexistent collaboration with experienced Emergency/trauma RNs. These changes have resulted in negative impacts on patient care, unsafe patient conditions and concerns regarding employee safety.

The following list of concerns, although lengthy, is not all inclusive:

1. QUESTIONABLE MANAGERIAL PRACTICES
   a. Our Administration, including Chief Executive Officer (CEO), Sue Ehrlich and Chief Nursing Officer (CNO), Terri Dentoni, have failed to provide consistent, experienced and ethical leadership for the Emergency Department.
      i. As a Level One Trauma Center, SFGH ED serves over 1 million people. The need for consistent direction and organization has been overlooked since the ED has been functioning under a revolving panel of 'interim' Nursing Directors for over 10 years.
      ii. The current ED Nursing Director, Be-verlyn Navarro, was hired in February, 2018. Since May 2019, 50% of the ED leadership team have resigned their positions. Their reasons include, but are not limited to,
         1. Lack of involvement in the development of new programs that directly affect patient care.
         2. Implementation of new programs against the direct objections of the nursing staff and nursing leadership.
         3. Intimidation by management to remain silent on issues that affect patient safety.
         4. Exclusion of the front-line nurses in development of patient care programs and procedures.
         5. Intimidation by this Director if questioned in regards to procedures and policies.
      iii. The leadership style at San Francisco General Hospital has created a culture of intimidation so severe that employees fear advocating for their patients and avoid interactions with management whenever possible. This hostile work environment is having detrimental effects on the mental health of the staff. Conflict and tensions are so high that there is no chance for members of the health care team to collaborate in the way they must in order to provide comprehensive and compassionate care to our most vulnerable populations.
   b. Qualifications of the Nursing Director and some of the management staff are in question. These individuals appear to have been hired without the necessary skills needed to function in our department and have not been trained or certified to perform the work they supervise. They also step into clinical care roles for which they have not received the appropriate training or validated competencies. Not all of their positions were publicly posted, giving qualified internal candidates an opportunity to apply. The CNO often places her own choices for staff into 'interim' positions and those individuals are eventually made 'permanent'.

. "A supervisor must have validated competencies in order to provide care for patients on a unit, or to assign other personnel to care for that group of patients" https://www.nationalnursesunited.org/sites/default/files/nnu/files/pdf/supervisor-competency.pdf

c. Nurses report regular incidents of intimidation and retaliation. If they point out concern for patient safety they are being approached by their managers and questioned as to whether they can manage their job, are too stressed out, need an assignment change or perhaps "need a vacation." This type of intimidation is a clear violation of their Whistleblower rights, protected under the United States Department of Labor.

.The Whistleblower Protection Programs | Whistleblower Protection Program

d. Ancillary Staff (Medical Evaluations Assistants) were threatened with insubordination when they expressed concerns about transporting behavioral patients across the large open air campus, alone, at times in the middle of the night.

e. Internal positions are awarded without transparency and without consistent process. This occurs departmentally and in the facility at large. Nurses may or may not be informed about open positions. Nurses may or may not be asked to engage in the interview process. Those who do participate in the process have their feedback disregarded when it comes to hiring. This lack of transparency leads to concerns of nepotism.

f. Administration's focus is entirely on data, which they can easily manipulate when reporting it to commissions and regulatory bodies. For instance, a great deal of focus is spent on reducing the Left Without Being Seen (LWBS) rate in our department. Patients that are LWBS cannot be billed for a full Emergency Room visit, as they have not been assessed by a provider. Once seen by a provider their billing status changes, regardless of whether they have received treatment or if their overall wait for that treatment has been reduced. We believe the laser focus on changing the designation of these pts (from LWBS to AWOL) is disingenuous. It is not leading to improved patient care, it is not decreasing overall lengths of stay, it is not leading to safer conditions for our patients or our staff. It creates the appearance of quality when in fact the reality is much different.

2. UNSAFE STAFFING. Loss of experienced emergency/trauma nurses, chronic short staffing and excessive use of temporary contract workers/RNs.

a. Experienced RNs are leaving at unprecedented rates; new nurses are being funneled through trauma and triage training far earlier than professional associations recommend. On any given day, temporary or per diem RNs outnumber permanent staff; reliance on traveler RNs and per diems amounted to almost one million hours of temporary workers last year.

b. There are strong correlations between staff exhaustion or burn out and poor patient outcomes, including death. Our department has suffered staffing levels that have been worsening for almost 10 years. Due to poor leadership, our morale is declining at a rate that we can no longer compensate for or justify silence. We speak out because we know we can be and do better...we know people matter more than "numbers".

3. OVERCROWDING. Patient numbers within the Emergency Department are climbing at an alarming rate, with a 20% increase each year for the last 3 years (2016).

a. Since 2016 our patient throughput has increased by 20% annually. This throughput increase has not been met with a comparable increase in staff. Our situation becomes more tenuous as the patient population grows, the support for behavioral health patients decreases and the percentage of contract, temporary, or inexperienced RNs increases.

b. The Medical Director's constant pressure to 'eliminate divert' leads to a critical mass of patients daily. This increase results in a patient load similar to disaster scenarios. Charge Nurses advocate for the patients enduring exceedingly long wait times in the waiting room, only to be told 'the waiting room doesn't count'. The incidence of Nurse to Patient Ratio violations are too numerous to track.

c. The department's Resuscitation area is designed to house 6 critically ill or injured patients, with 3 primary RNs assigned to the area. Yet the patient numbers often exceed that, up to 10 or 12 and even as high as 17. Patients are not in line of sight of nursing staff. Hallway beds have battery operated monitors. Privacy is violated with only rolling screens dividing patients. Coaches are not available for high fall risk or behavioral patients. We believe this increasingly common situation places the patients at extremely high risk and violates a number of articles in Title 22, including Title 22 Division 5 70207, 70209, 70805, 70809(c,d), 70213 (e). Title 22, Division 5, tenet 70217(a)(8).

d. The ER regularly boards 20+ admitted patients, for all or a large portion of their admission. Many admitted patients are discharged from the emergency room, having never been transferred to an inpatient room. Yet while ⅓ of the department may be boarding admitted patients, the Emergency Department is continually pressured to receive more patients from the community.

e. The increasing number of patients with behavioral health issues is not being matched with an increase in appropriately trained staff to monitor and support their needs.

i. Behavioral health patients are often cohorted in rooms with only a rolling screen to separate them.
ii. Once the rooms are full, patient gurneys are lined up in the hallways and in front of the clerking desks.
iii. Patients are monitored by a patient care associate at a bank of video monitors, leaving one patient care associate to respond to the physical needs of as many as 8 or 12 patients.
iv. Patient care associates are not trained to manage the needs of acute psychiatric patients.
v. There are no dedicated psychiatric health professionals assigned to the Emergency Department and these patients are often required to wait several hours for a psychiatric assessment.
vi. The administration does not provide consistent security staffing, often stating understaffing of SFSD officer's as a reason for leaving staff vulnerable to assaults or responsible for elopements.
vii. The unit does not have locked facilities to protect patients and staff.

4. CONCERNING CLINICAL PRACTICES. The institution of the CARESTART program in the ED has created unsafe patient care conditions.

CARESTART programs have been successfully implemented in some Emergency Departments. However, our program was implemented so poorly that it constantly struggles. Nurses were disingenuously invited to participate in a workshop on the programs' development. However, it was clear the program was already laid out and Nurse's input was discouraged and completely disregarded. Not only do we not have the staff to maintain this program, we lack the physical space to manage the program. This results in intimate pt care, physical exams, EKGs, and personal medical histories occuring in the hallways or literally elbow to elbow with other patients. In addition, department leadership failed to address the safety of this program in its current state. The risk management team has confirmed (as recently as 9/23/2019) that this places undue liability on every nurse, nurse practitioner and provider who participates in the program. Administration has thus far offered no solution. CARESTART is not a solution to our ED overcrowding. Data has proven that decreasing the door to provider time has not decreased the overall length of stay.

a. The CARESTART program entails the active treatment of patients in the waiting area.

b. There are no clear institutional policies surrounding the operation of this program, with the priorities constantly changing.

c. Front line Nurses feedback was disregarded in the development of this program, which is in violation of Title 22, Division 5, tenet 70211 (c) (2), 70213 (a) (1), 70213 (b)(d).

d. No Nurses are 'assigned' to the patients in the waiting area, which means the patients are not receiving a full nursing assessment; the patients are not receiving regular and timely reassessments; the patients are not receiving monitoring after medicating or procedures. This is in violation of Title 22 Division 5, tenet 70215(a) (1), 70217(a).

e. Nurses managing the CARESTART program are instructed to perform a 'Nursing Assessment' only if the patient will be discharged from the waiting room. However, there is no direction by administration as to how, when, or where this 'assessment' is to occur.

f. There is one Nurse tasked with the management of the CARESTART program each shift. Meaning this one Nurse is held responsible for providing medication or coordinating the care for up to 20 different patients, all of whom remain in the waiting room. Risk Management was clear at a recent meeting that the nurses are required to provide the same level of monitoring of these patients as they would be for any other patient receiving treatment in the ED.

g. Many nurses have expressed concern related to the lack of nursing ratios for patients being treated through the CARESTART program and been informed by the Nursing Director that 'patients in the waiting room have no ratios'.

i. Title 22 indicates "the licensed nurse-to-patient ratio in an emergency department shall be 1:4 or fewer at all times that patients are receiving treatment." Title 22, Division 5, tenet 70217 (a) (8).

In summary, we are deeply concerned about the hospital administrations' increasingly dismissive and combative approach to leadership. We believe the above examples demonstrate a pattern of questionable intentions, doubtful competence and intimidating practices designed to silence patient advocates. Under these conditions our facility cannot hope to provide competent and compassionate care that we believe the residents and visitors to San Francisco deserve. We believe it is the responsibility of the Department of Public Health to address these concerns and improve these conditions.

Respectfully,

The staff of San Francisco General Hospital Emergency Department and Trauma Center

HEALTH AND SAFETY CODE - HSC

DIVISION 2. LICENSING PROVISIONS [1200 - 1797.8]

(Division 2 enacted by Stats. 1939, Ch. 60.)

CHAPTER 2.5. County Medical Facilities [1440 - 1498]

(Chapter 2.5 added by Stats. 1961, Ch. 1993.)

ARTICLE 1. Administration [1440 - 1462]

(Article 1 added by Stats. 1961, Ch. 1993.)

1442.5.

(a) Prior to (1) closing , (2) eliminating or reducing the level of medical services provided by, or (3) the leasing, selling, or transfer of management of, a county facility, the board shall provide public notice, including notice posted at the entrance to all county health care facilities, of public hearings to be held by the board prior to its decision to proceed. The notice shall be posted not less than 14 days prior to the public hearings. The notice shall contain a list of the proposed reductions or changes, by facility and service. The notice shall include the amount and type of each proposed change, the expected savings, and the number of persons affected.

(b) Notwithstanding the board's closing of, the elimination of or reduction in the level of services provided by, or the leasing, selling, or transfer of management of, a county facility subsequent to January 1, 1975, the county shall fulfill its duty to provide care to all indigent people, either directly through county facilities or indirectly through alternative means.

(1) Where the county duty is fulfilled by a contractual arrangement with a private facility or individual, the facility or individual shall assume the county's full obligation to provide care to those who cannot afford it, and make their services available to Medi-Cal and Medicare recipients.

(2) Where the county duty is fulfilled by alternative means, the facility or individual providing services shall be in compliance with Sections 441.18 and 1277.

(3) The board shall designate an agency to provide a 24-hour information service that can give eligible people immediate information on the available services and access to them, and an agency to receive and respond to complaints from people eligible for services under this chapter. The designated agency may be the agency that operates the facility. This subdivision applies only in instances in which there is (1) a closing of, (2) an elimination or reduction in the level of services provided by, or (3) the leasing, selling, or transfer of, a county facility.

(4) The board shall arrange for all facilities or individuals contracting to provide services to indigent people to be listed in the local telephone directory under county listings, and shall specify therein that the facilities or individuals fulfill the obligations of county facilities.

(5) Section 25371 of the Government Code does not relieve the county of the obligation to comply with this section.

(Amended by Stats. 1999, Ch. 83, Sec. 101. Effective January 1, 2000.)

COMMUNITY HEALTH CARE PLANNING ORDINANCE

When is the ordinance in effect?

This ordinance was passed by the voters on November 8, 1988, and became effective as of December 8, 1988.

Who implements this ordinance?

The Health Commission (charged with "managing and controlling…all matters pertaining to the preservation, promotion, and protection of the lives, health, and mental health of the inhabitants of the City and County….")

What does this ordinance require?

A) Private hospitals shall provide public notice prior to closing a hospital inpatient or outpatient facility, eliminating or reducing the level of services provided, or prior to the leasing, selling or transfer of management.

This ordinance applies to general acute care hospitals and acute psychiatric hospitals, as defined in California Health and Safety Code (HSC) Sections 1250 et seq., other than public hospitals. This ordinance also applies to the clinics of these hospitals. This ordinance does not apply to facilities providing a lower level of care, such as skilled nursing facilities, congregate living health facilities, and intermediate care facilities.

When a general acute care hospital or an acute psychiatric hospital closes a hospital inpatient or outpatient facility, eliminates or reduces the level of service provided in such a facility, or leases, sells or transfers management of such a facility, it is required to provide public notice.

The reference to "hospital" throughout these procedures shall mean hospitals and their clinics.

To "reduce services" shall mean to make a substantial reduction in the level of clinical services.

It shall refer only to a reduction that the hospital anticipates will remain in effect for a period of three (3) months or longer.

B) The hospital shall provide public notice, including a notice posted at the regular public and employee entrances, and Emergency and Admitting entrances.

1. The public notice shall contain a detailed list of the announced or proposed reductions or changes and the expected number of patients and employees affected by both facility and service. The notice shall include the sentence, "The Health Commission will hold a hearing on this proposed change; for information as to date, time, and place, call the Health Commission at 554-2666."

2. The public notice required by the ordinance shall include, at a minimum the posting of a notice and the mailing of notice to the Secretary of the Health Commission at least 90 days before the intend date of action. Compliance with these minimum requirements shall be deemed compliance with the public notice requirements of the ordinance.

3. The public notice from the hospital is to be sent to the Secretary to the Health Commission, 101 Grove Street, Room 311, San Francisco, CA 94102.

4. The public notice should be minimally 8-1/2" x 11" in size and legible.

5. The notice shall be posted in two languages in addition to English. The two languages shall be chosen in a manner designed to provide notice to those non-English-speaking persons who predominate among the hospital's client and employee population. The hospital may provide the notice in additional languages if it chooses.

C) Except in the case of remodeling/construction, a temporary reduction or elimination of services of three months or more requires the 90 days' public notice as set forth herein. With respect to remodeling/construction, the 90 days' public notice is required if the work will require a reduction or elimination of services of six months or more. If it will require a reduction or elimination of services of less than six months, the 90 days' public notice and a public hearing are not required if the hospital provides written notice to the Secretary of the Health Commission before the work begins.

D) If the Health Commission determines that the proposed action will be detrimental, the Health Commission shall further explore in these public hearings what alternative means are available in the community to provide the service or services to be eliminated or curtailed.

E) Pursuant to a statement of intent included in the ordinance, the meaning and effect of the ordinance is to be construed consistent with the purpose and construction of California Health and Safety Code Sections 1442 and 1442.5 and consistent with applicable state and federal law.

What are the procedures of the Health Commission?

A) The Secretary to the Health Commission will schedule a public hearing during the period of time between the date that the hospital gives notice of the proposed or announced change and the date that the change is to occur.

B) The Health Commission may elect to have a sub-committee to conduct the public hearing; the sub-committee would report on the evidence received in the public hearing and make a recommendation to the full Commission.

C) In preparation for the hearing, the following information would be requested from the hospital:

- Name, address, phone number and contact person for the institution.
- Description of the proposed project.
    - Utilization, financial and staffing information.
    - Timeframe and schedule for implementation.
- Alternatives considered to the project

D) During the hearing, the hospital whose action is the subject of the hearing shall be afforded an opportunity to present any information relating to its proposed action and to respond to matters raised by any other persons during that hearing. Members of the public who cannot attend the hearing are encouraged to send written testimony to the Health Commission prior to the hearing. This testimony shall become part of the record of the record before the Health Commission.

E) At the conclusion of the public hearing the Health Commission shall make findings based on evidence and testimony from the public hearings and submitted written material that the proposed action will or will not have a detrimental impact on health care service of the community. The Health Commission can schedule a subsequent hearing if further information is required, and make findings at a subsequent meeting.

F) The Health Commission will send out notices to the hospital and those persons who have asked in writing to be on the mailing list for notice of hearings under this ordinance four (4) weeks prior to the scheduled hearing for any change that the hospital proposes after the adoption of these procedures.

G) If a hospital fails to comply with the public notice requirements of the ordinance, the Health Commission may request the City Attorney to seek a court order restraining the hospital from implementing the intended action until the hospital so complies.

Any person/organization may notify the Health Commission in writing of the intention of a hospital to substantially reduce or eliminate services of which the Health Commission may not be aware. Such notification shall include reasonable substantiation of the facts; and it shall then be the obligation of the Health Commission and the Department to make prompt inquiries as to the information provided.

H) Upon the adoption of or amendment to these procedures by the Health Commission, the Secretary shall distribute copies to general acute care and acute psychiatric hospitals, the press, and those persons on the mailing list for notice of hearings under this ordinance.

These procedures were adopted on a temporary basis on May 3, 1989, with the understanding that they can be amended at a future public hearing. These procedures were amended by the Health Commission on November 18, 2008.

To: Dave Staconis, Pat Carr. Terry Dentoni & Sue Currin,

The San Francisco General Hospital Emergency Department Nursing Staff would like to once again express our concerns for the severity of safety and staffing issues that continue to exist in our department. Our concern stems from the real shift-by-shift threats to patient and staff safety and to the actual injuries sustained in our department (see attached: ADO's from Friday February 14th, 2014; Mary Perez Incident). The current staffing levels in the ED are dangerous for the following reasons: they directly compromise the delivery of safe patient care and hinder adherence to ENA's Emergency Nursing Standards of Practice (2011), while also frequently violating Title 22 state staffing ratios which call for 1:1 (or better) nursing ratio for critical patients. Standards promote and ensure safe nursing practice. They are a measure by which the public views nursing performance and accountability. Thus, the current hazardous SFGH Emergency Department staffing situation is alarming for our patients and remains a huge liability for the entire hospital. Furthermore, the environment is tremendously threatening to our individual Registered Nurse Licenses and is dismantling our safe nursing practice.

Request for Action.
We expect SFGH Emergency Department Management and SFGH Hospital Administration to provide staffing levels that reflect the needs of our acuity level and quantity of patients. This will allow for a healthy and humane level of skilled nursing care.

1. Zone 1 staffing should consistently have one Circulating Nurse, four Primary Nurses, two Acuity Nurses, and one designated Break Nurse. According to the MOU, our department, prior to the CDU opening, was staffed with nineteen Registered Nurses plus one Charge Nurse. Since the opening of the CDU, the Emergency Department should have been provided with two additional RNs. However, currently we now have two fewer RNs in the main Emergency Department. Newly mandated (and not in writing) by our CNO: at all times 1-2 RNs must remain in the CDU regardless if any patients are in the CDU census. This is a serious patient and staff safety issue, is financially irresponsible and is extremely wasteful staffing for the Emergency Department.

2. Increase ancillary staffing to meet the guidelines in our MOU (clerks and MEA's dedicated to specific ED Zones). Additionally, provide ancillary staffing for all patients on 5150 holds or requiring close/constant observation. (See attached letter: Dated June 22, 2012, written by Terry Dentoni, MSN, RN, CNL, Nursing Director.)

3. Develop and implement a written policy with a safe and controlled designated area for psychiatric patients while in the Emergency Department. One example is to consider staffing Zone 3 with TWO Nurses, ONE designated MEA (or Psych Tech) and ONE Deputy at all times. (See attached example: Violence Prevention Worksheet Documentation: Management of Combative, Disruptive, 5150 and Suicidal Patients. Highland Hospital Emergency Department, Oakland, CA.)

We would appreciate your feedback and support in our efforts to continue to provide safe and effective Emergency Care for the community we serve at San Francisco General Hospital. Unlike the most recent attempts (see attached letters and emails submitted to the Emergency Department Management) we now ask for a written response of acknowledgment to this letter within seven days of receipt. In this written response please comment on the proposed changes and plan of action as described above. Should there be a failure to respond to this letter within seven days, our concerns and recommendations will be brought to a higher level in the SFGH and Department of Public Health chain of command.

We, as San Francisco General Hospital Emergency Department Nurses, are dedicated and proud to serve our community. However, patient care and the safety of our work environment are severely compromised. (See Attached: ENA Position Statement: Violence in the Emergency Care Setting.) It is imperative that we collaborate together to improve the serious issues at hand. As a Department, we must continue the SFGH Value of "patient and staff safety" and maintain the SFGH Mission of "providing quality health-care and trauma services with compassion and respect."

Sincerely,
San Francisco General Hospital & Trauma Center: Emergency Department, Nursing Staff

Health Facilities Bonds

PROPOSITION C

PUBLIC HEALTH FACILITIES SYSTEM IMPROVEMENT BONDS, 1987. To incur a bonded indebtedness of $26,000,000 for the improvement of the public health facilities within the City and County of San Francisco.

YES 98 ➡
NO 99 ➡

Analysis

by Ballot Simplification Committee

THE WAY IT IS NOW: San Francisco must under State Law provide hospital care for mental health patients who cannot afford private care. Because of the lack of a facility in San Francisco for mental health patients who need long-term care, the City must now pay other counties to take care of some of these patients.

THE PROPOSAL: Proposition C would authorize the City to borrow $26,000,000 by issuing general obligation bonds. This money would pay for the construction of a 185-bed facility for long-term mental health care at San Francisco General Hospital. The interest and principal on general obligation bonds are paid out of tax revenues. Proposition C would require an increase in the property tax.

A YES VOTE MEANS: If you vote yes, you want San Francisco to issue general obligation bonds totaling $26,000,000 to build a 185-bed facility for long-term mental health care at San Francisco General Hospital.

A NO VOTE MEANS: If you vote no, you do not want San Francisco to issue bonds to build this facility.

Controller's Statement on "C"

City Controller John C. Farrell has issued the following statement on the fiscal impact of Proposition C:

"Should the proposed bond issue be authorized and when all bonds shall have been issued on a fifteen (15) year basis and after consideration of the interest rates related to current municipal bond sales, in my opinion, it is estimated that approximate costs would be as follows:

Bond Redemption	$26,000,000
Bond Interest	13,728,000
Debt Service Requirement	$39,728,000

Based on a single bond sale and level redemption schedules, the average annual debt requirement for fifteen (15) years would be approximately $2,648,000 which amount is equivalent to seventy-four hundredths ($0.0074) of one cent in the tax rate."

THE LEGAL TEXT OF PROPOSITION C APPEARS ON PAGE 118

Health Facilities Bonds

ARGUMENT IN FAVOR OF PROPOSITION C

Daily, the City confronts mental illness ... spaced-out youngsters on street corners, mumbling derelicts in our parks, seniors locked in silent fantasies in tiny rooms. All desperately need help, but San Francisco has no long-term care facility for the City's mentally ill. We are forced to keep our mentally ill in acute psychiatric beds at facilities outside San Francisco at excessive costs.

Proposition C will provide $26 million for the construction of a 185 bed facility at San Francisco General Hospital, including a desperately needed unit for adolescents.

This long-term care facility will permit patients to remain near friends and families, and provide care responsive to ethnic and linguistic diversity of our City, all of which will help hasten recovery.

VOTE YES ON PROPOSITION C

The lack of adequate local facilities causes overcrowding of emergency psychiatric and acute services. At times, this results in the early release of many of our mentally disturbed.

For many mentally ill, their only refuge is a doorway along the street or under shrubs in a park. It has been estimated that some 40% of the homeless are mentally ill. Mental illness afflicts families in all walks of life, and proper care within the City is desperately needed.

The facility itself will be secured and will provide medical and psychiatric care at a daily cost of $140 per bed as compared to the $400 now paid to facilities out-of-town.

Saving from reducing acute hospital costs and reduction of contracts with out-of-county facilities will more than cover operating costs in the new facility.

Long-term care with a first-rate medical staff, addresses the problem of mental illness in our City compassionately and cost effectively, and fills a major gap in the City's mental health care system.

Please vote "YES" for this urgently needed facility.

Dianne Feinstein, Mayor

ARGUMENT IN FAVOR OF PROPOSITION C

We do not have a long-term care facility for our City's mentally ill, a major gap in our mental health care system. We are forced to keep our mentally ill at facilities located outside of San Francisco at excessive per day costs to the City.

Proposition C will provide $26 million for the construction of a 185-bed long-term care facility, including an adolescent unit, at San Francisco General Hospital.

This long-term care facility will permit patients to remain near friends and families facilitating recovery and providing care responsive to the ethnic and linguistic diversity of our City.

Because we currently do not have a facility for the long-term care of our mentally ill, our emergency psychiatric and acute care facilities are overcrowded, sometimes resulting in the early release of our mentally ill.

Proposition C will provide a long-term mental health care facility where patients can be appropriately served less expensively. Savings from reduced care costs and from the reduction in the use of out-of-county facilities will more than cover operating costs of this new facility.

Please vote YES for Proposition C for this urgently needed facility.

SUBMITTED BY THE BOARD OF SUPERVISORS

ARGUMENT IN FAVOR OF PROPOSITION C

I don't take bond issues lightly. They should be carefully considered before promulgation. There must be a specific need for the bond issue. This bond issue has been carefully considered. It is much needed.

San Francisco currently does not have a facility for providing long-term psychiatric care. Indeed, the City now spends approximately $3,250,000 per year for the care of San Francisco residents in out-of-county mental health facilities.

VOTE YES ON PROPOSITION C.

This bond issue to finance the construction of a community mental health facility at San Francisco General Hospital is a prudent and timely investment in the health and well-being of San Franciscans and a correct project for the future of our City.

Please join me in voting Yes on Proposition C. I support it wholeheartedly.

State Senator Quentin L. Kopp

ARGUMENT IN FAVOR OF PROPOSITION C

One measure of a compassionate society is how we treat those in need of mental health treatment. Skilled psychiatric nursing care is one important factor in helping to restore mental health. Proposition C would allow the City to construct a 185 bed mental health facility so our residents can have access to improved psychiatric treatment. Proposition C helps fulfill our duty to the mentally ill. PLEASE VOTE YES ON PROPOSITION C.

Supervisor Jim Gonzalez

Arguments printed on this page are the opinion of the authors and have not been checked for accuracy by any official agency.

Health Facilities Bonds

ARGUMENT IN FAVOR OF PROPOSITION C

VOTE YES on Proposition C to save money by caring for long term psychiatric needs. Currently San Francisco pays over $3 million a year to other counties to care for indigent psychiatric patients because we lack facilities of our own. Transportation cost to places like Napa and other counties will also be eliminated.

VOTE YES ON PROPOSITION C and make effective use of your mental health dollars.

John H. Jacobs
Executive Director, San Francisco Chamber of Commerce

ARGUMENT IN FAVOR OF PROPOSITION C

As San Francisco's Health Director, I personally appeal to each and every voter to vote YES ON PROPOSITION C.

Proposition C would allow us to build a greatly needed long-term psychiatric facility in San Francisco. Patients with severe mental illness or emotional upset would have a suitable environment for convalescence and rehabilitation before returning to home and community.

The new facility will be constructed next to S.F. General Hospital in order to provide medically sound and cost-effective services in a secure setting.

Currently, there is no such facility in San Francisco. As a consequence, family and friends of our San Francisco patients must go to other counties to visit them. Our staff cannot closely supervise the patients and best determine their needs.

The facility would pay for itself, with Medi-Cal and private insurance payments.

Please vote Yes on C. It is a wise investment in the health of our City.

David Werdegar, M.D., M.P.H., Director of Health

ARGUMENT IN FAVOR OF PROPOSITION C

Three good reasons to vote "yes" on Proposition C:

The establishment of a skilled nursing facility will provide an important and necessary program currently not available which should be incorporated in the range of mental health services in San Francisco.

We can keep San Francisco residents in the City, closer to family members and friends, when they need this level of care.

It will cost the City less than we now spend to send people out of the county for treatment.

Members of the Mental Health Advisory Board of San Francisco:
Erma Brim
Dionne Helmer, R.N., Ph.D.
Byron Ho
Walter Maciak
Murray Persky, M.D.
Donna J. Rowles
Rich Samples
Gerald Veverka
Supervisor Nancy G. Walker

ARGUMENT IN FAVOR OF PROPOSITION C

The physicians of the San Francisco Medical Society endorse this bond issue for a subacute, locked facility for the mentally ill. It is long overdue and represents the most appropriate way to provide more humane and cost effective care for the mentally ill who may be dangerous or unable to care for their own needs.

Presently over 200 San Francisco patients are placed in locked nursing facilities **out of county** — away from family and community support — at great expense to the County. Because no appropriate facility exists, our police department spends hundreds of hours responding to over 20,000 emergency psychiatric assistance calls yearly.

A locked facility will help prevent suicides by adolescents, end neglect and costly hospitalization of the elderly mentally ill and care for some of the homeless mentally ill.

Vote "yes" on Proposition C.

R. Eugene Tolls, M.D., President, San Francisco Medical Society
Jean E. Hayward, M.D., **President,**
San Francisco Psychiatric Chapter

ARGUMENT IN FAVOR OF PROPOSITION C

As San Francisco parents, spouses, children and friends of the mentally ill, we are painfully aware of their needs. Right now many of them are institutionalized out of their home county, suffering not only from their illnesses, but also from a disjointed system that places them far from their families and reduces their chances of recovery.

PROPOSITION C will provide a humane and secure environment for a rehabilitation-oriented program that will encourage family involvement. It was designed with input from doctors, hospital staff, clients and interested persons like ourselves, and will provide services where they are needed — in San Francisco. In addition, the program will cost less than what is currently being spent to place our loved ones in facilities out-of-county.

Please help us assist those who need it the most — VOTE YES ON C.

Gerald Veverka and Members
San Francisco Family Alliance for the Mentally Ill

Arguments printed on this page are the opinion of the authors and have not been checked for accuracy by any official agency.

Health Facilities Bonds

ARGUMENT IN FAVOR OF PROPOSITION C

The Problem:

—An estimated 33% of the 6,000 to 8,000 homeless people in the city are mentally ill.

—Police report that they received 19,500 calls involving psychiatric concerns in 1986 and that the number will be twice as high this year.

—The City's publicly-supported psychiatric emergency rooms are sometimes so crowded that patients must wait there for days.

—Huge budget increases have been spent on providing hospital beds at a cost of $400 per day for patients who could be appropriately served in a less acute setting, if beds were available.

—There are no long-term care psychiatric beds available in San Francisco. The beds are currently located in facilities outside San Francisco County. These other counties have discouraged our use of the beds in their communities. Future availability of these services is uncertain.

The Answer:

San Francisco NEEDS a LOCAL Skilled Nursing Center:

—To provide more effective and humane treatment

—To enable the family to visit and be part of the treatment process

—To reduce the cost of acute hospital care

—To fill a gap identified over the last 20 years as most critical in completing the mental health system of care.

Hilda Bernstein
Jacqueline Cohen
Margarete Connolly
Dr. Graeme Hanson
Sheriff Michael Hennessey
Tom Maravilla
Bonnie McGregor
Stephen McNeil
Linda Post
Dr. Richard A. Shadoan
Louise Swig
Phillip E. Sowa, Executive Director, S.F. General Hospital
Dr. Reiko True, Deputy Director, Community Mental Health Services

ARGUMENT IN FAVOR OF PROPOSITION C

San Francisco needs to spend its mental health dollars more effectively.

—We need to stop spending money on facilities in other counties. Over $1.5 million a year is spent in other counties and the state is charging us another $1 million a year for our use of Napa State Hospital.

—We need to take the appropriate patients out of expensive emergency and acute care facilities—where the cost of care is over $400 a day—and put them into the most cost-effective level of care.

—We need to consolidate our services to be able to administer them more efficiently.

We need a long-term care psychiatric facility in San Francisco. WE NEED PROPOSITION C.

Lee Dolson, General Manager, Downtown Association
John H. Jacobs, Executive Director, S.F. Chamber of Commerce

ARGUMENT IN FAVOR OF PROPOSITION C

As professionals concerned with the health of San Franciscans we see first hand the sad stories of the City's mentally disturbed. These patients need humane, effective care in a secured facility. They need to be near their families and physicians. They need **Proposition C.**

VOTE YES ON PROPOSITION C for the health of our City.

Past Presidents, S.F. Medical Society:
Dr. David W. Allen
Dr. Edward A. Chow
Dr. Brad Cohn
Dr. David D. Sachs
Dr. Jean K. Haddad, President-elect
Dr. Michael E. Abel
Dr. Donald I. Abrams
Dr. Edward S. Ballis
Dr. Samuel H. Barondes
Dr. Frederick H. Berman
Dr. Robert B. Cahan
Dr. Daniel S. Chaffin
Dr. Melvin D. Cheitlin
Dr. James W. Dilley
Dr. Donald L. Fink
Dr. Sidney E. Foster
Dr. Roger Friedenthal
Dr. Eugene L. Gottfried
Dr. Alan Greenwald
Dr. Moses Grossman
Carolyn B. Hallowell
Dr. Stuart E. Heard
Dr. Frank A. Johnson
Dr. Sally Kaufmann
Dr. James H. Kauth
Dr. James Krajeski
Dr. Stephen M. Krause
Dr. Robert C. Larsen
Dr. Bert S. Levenson
Dr. Frank Lewis
Dr. Arthur E. Lyons
Dr. Peter Mandell
Dr. Gary Mizono
Dr. Stephen C. Pardys
Dr. Richmond Prescott
Shirley A. Reece
Dr. Morton Rosenblum
Dr. Joan Saxton
Dr. Richard M. Schlobohm
Dr. John B. Sikorski
Dr. Richard L. Sweet
Donald Traunor
Dr. Paul Volberding
Dr. W.L. Warner
Dr. Laurel Ann Waters
Dr. Thomas O. Wildes

ARGUMENT IN FAVOR OF PROPOSITION C

We support Proposition C for better mental health care in San Francisco.

Art Agnos
Roger Boas
John L. Molinari
Louise H. Renne

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Health Facilities Bonds

ARGUMENT IN FAVOR OF PROPOSITION C

As the policy-setting body of the Department of Public Health, we as Health Commissioners unanimously and enthusiastically support Yes on Proposition C.

Proposition C will enable San Francisco to build a long-term care facility next to San Francisco General Hospital, thus keeping patients in the community near family and support systems as opposed to transferring patients to more costly, out-of-county facilities. This 185-bed facility, which includes a 15-bed unit for adolescents, will focus on rehabilitation and re-entry into the community with an emphasis on vocational education and sensitivity to culture and language.

Vote YES on Proposition C which will ultimately be a cost-saving measure of benefit to the community. This facility is essential for adequate care for the mentally ill of San Francisco.

Members of S.F. Health Commission:
Phillip R. Lee, M.D., President
Naomi Gray, Vice-President
John Blumlein
James Foster
Richard Sanchez, M.D.
Y. Clement Shek, D.D.S.
Rosabelle Tobriner

ARGUMENT IN FAVOR OF PROPOSITION C

San Francisco needs a better mental health care system. We need a long-term mental health care facility:

– so that the San Francisco patients who are being turned away by facilities in other counties have a treatment facility where they can be supervised and cared for;

– so that the City can stop spending thousands of dollars to place patients in other counties;

– so that the City can better care for the disturbed youth and desperate adults that roam our streets.

The City needs a long-term mental health facility. VOTE YES ON PROPOSITION C.

Citizens Committee for Proposition C:
Philip R. Lee, M.D., Chair
John L. Blumlein, Treasurer
Robert Aaron, M.D.
George Bach-y-Rita, M.D.
Judith E. Ciani
Patricia F. Costello
Valerie C. Gilmore
Naomi Gray
Charlene Harvey
Davis Ja
Enola D. Maxwell
Carole Migden
Donna Rowles
Santiago "Sam" Ruiz
Richard Sanchez, M.D.
R. Eugene Tolls, M.D.
Paul Varacalli
Yori Wada
A. Cecil Williams

ARGUMENT IN FAVOR OF PROPOSITION C

Currently, Latinos needing long-term mental health care are being separated from their families and children when placed in out-of-county facilities. Having patients outside the county drains our resources. We need to have sub-acute facilities in the Latino community.

This facility will also be a resource for employing people from our community.

Yolanda Alcantar
Luiz Buitrago
Carlota Texidor del Portillo
Wilma L. Espinoza
Yolanda E. Gallegos
Dr. Luz-Mary Harris
Ricardo Hernandez
Carmen Herrera
Ralph Hurtado
James Morales
Emilio Nicolas, Jr.
Robert A. Reveles
George Suncin

ARGUMENT IN FAVOR OF PROPOSITION C

The Black Community wholeheartedly supports the building of a community mental health facility on the campus of San Francisco General Hospital. The facility, to serve adults and adolescents, is desperately needed to meet the increasing need for treatment and rehabilitation services to help patients make the transition from an acute, crisis situation before being discharged back into the community. Far too many of our patients have to be treated at out-of-county facilities, costing taxpayers more than it would if we could keep our people at home close to family and friends who can contribute to the recovery process.

We view this facility as a charitable endeavor because it will help to facilitate the treatment process which will allow the patient to return more quickly to family, friends, and jobs. The citizens of San Francisco will benefit from having this type of facility in our own county.

Dr. Abner J. Boles, Chair, Black Mental Health Coalition
Dr. Amos C. Brown
Dr. Michelle O. Clark
Eugene Coleman, President, Bay Area Association of Black Social Workers
Dr. George W. Davis
Dr. John L. Dupre, President, Black Psychiatrists of Northern California
Valerie Gilmore
Father James Goode
Zuretti L. Goosby
Naomi Gray
Jim Jefferson
Supervisor Willie B. Kennedy
Enola Maxwell
Lulann S. McGriff
Dr. Samuel E. Miller
Carol E. Tatum
Cheryl Towns, President, New Bayview Committee
Arnold G. Townsend
Supervisor Doris M. Ward
A. Cecil Williams
Dr. Sodonia M. Wilson

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ARGUMENT IN FAVOR OF PROPOSITION C

The Asian American community supports the building of a community mental health facility in San Francisco. Located on the grounds of San Francisco General Hospital, the facility will serve adults and adolescents who desperately need treatment and rehabilitation services. These patients are attempting to make the transition in recovery from an acute crisis situation towards functioning and being integrated into the community.

Most of our patients have been treated outside of San Francisco in facilities that are neither bilingual nor culturally-sensitive. Furthermore, these out-of-county costs are significantly higher than if we kept our patients in San Francisco close to their families and friends who can contribute to and support their recovery.

Dr. Bart Aoki
Noriko Bridges
Edward de la Cruz
Yo Hironaka
Supervisor Tom Hsieh
David Ishida
Dr. Davis Ja
Dr. Gordon Juan
Tom Kim
Jeff Mori
Sandy Mori
Sally S. Osaki
Anita H. Sanchez
Dr. Y. Clement Shek
Dr. Sanford S. Tom
Yori Wada
Ron Wakabayashi
Herbert Z. Wong

ARGUMENT IN FAVOR OF PROPOSITION C

We support this universally needed long-term care mental health facility in San Francisco. This facility will be sensitive to the needs of our diverse communities and will promote a supportive and secure approach to treatment.

Supervisor Harry Britt
Diana Christensen
Greg Day
Dr. James W. Dilley
James Foster
Jerry de Jong
Phyllis Lyon
Del Martin
Carole Migden
Fran Miller
Louise A. Minnick
Connie O'Connor
Tim Wolfred

ARGUMENT IN FAVOR OF PROPOSITION C

We believe that persons suffering with serious mental illness are entitled to:

- the best, most appropriate care possible
- receive care in their own community, close to loved ones
- opportunities for rehabilitation to be productive members of society
- have a place to be cared for, as older children, other than a State Hospital

If you agree, vote **YES on Proposition C**, to provide a local mental health skilled nursing facility at San Francisco General Hospital.

Basil Plastiras, President
Mental Health Association of San Francisco

ARGUMENT AGAINST PROPOSITION C

A bond issue for $26,000,000 interest $13,728,000 for another 15 years.

This is for additions and improvement of public health facilities, i.e. mental health.

In the past 15 years more money has been poured into the City's mental health program, with very little results. I should know having been a volunteer in mental health for that many years.

The improvements needed is the personnel.

Vote NO on Proposition C.

Marguerite Warren

Apply for Your Absentee Ballot Early
Application must reach the Registrar at least 1 week before election

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