



**Metropolitan Chicago
Healthcare Council**



Illinois Hospital Association

To: Chief Executive Officers, Member Hospitals

Please route to: Emergency Department Medical and Administrative Directors;
Behavioral Health Directors and Psychiatric Triage Teams; and Social
Service Directors

From: MaryLynn M. Clarke, Senior Director, Behavioral Health Constituency
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Subject: Implementation of Revised Policies and Procedures for the Assessment
and Transfer of a Patient with Mental Illness from an Emergency
Department to a State-Operated Hospital

Illinois hospital emergency departments (ED) have served a large and growing number of patients with mental illnesses in recent years, paralleling national trends. A recent IHA survey indicated an almost 50% increase in ED presentations between 2002 and 2004 of patients with mental illnesses; a 2005 national survey of EDs indicated a 60% increase. Persons with mental illnesses seek care in the ED primarily because other appropriate alternatives are unavailable or unaffordable; and there are too few acute care facilities to meet demand. As a consequence, many patients with mental illness wait a long time for an acute care bed to become available, twice as long as other medical patients according to the IHA survey. And, if the patient was going to be transferred to a state-operated hospital (SOH), they have waited an average of 15 hours in one urban hospital (a time period reported by many hospitals); other hospitals reported patients waiting as long as 20 or 30 hours for transfer. Once in an ambulance, these same patients were waiting, at times, several hours in the parking lots of the SOHs for admission. The risks to patient safety warranted immediate attention.

Facilitated by both the Illinois Hospital Association and the Illinois Division of Mental Health, an interdisciplinary task force of health care professionals convened initially in October 2006 and thereafter for two years to address not only the immediate problem of reducing wait times in ambulances, but also the need to look at the systems in which the patients were evaluated, assessed for transfer to a SOH, transported to the SOH, and admitted to the SOH. Representing the Illinois College of Emergency Physicians (ICEP), the Metropolitan Chicago Healthcare Council, community mental health centers, ambulances, and the Division of Mental Health, they joined forces to create a patient-centered environment in which the patient experienced a

respectful as well as a clinically appropriate process. (Note that NAMI was apprised of the work and progress of the group throughout the process and its input has been solicited.)

This collaborative effort is embodied in the attached report: “Recommendations to Improve the Assessment, Treatment, and Transfer of Psychiatric Patients to State-operated Hospitals.” This report describes their deliberations and sets forth a series of concrete recommendations to improve several facets of the assessment and transfer processes.

We are pleased to report that DMH has taken several steps to implement the recommendations in this report. Many of these positive steps are described in an addendum to the report. Among the significant accomplishments of this group has been (1) a significant reduction in wait times in ambulances—from hours to minutes; (2) implementation of several steps to improve communication between SOHs and hospitals, including a process to reach SOH administrators 24 hours a day; (3) several new protocols have been implemented to streamline the intake process; and (3) the agreement of the private and SOH physicians on standardized “medical clearance” criteria. These criteria will be used by physicians and intake personnel in all of the state hospitals, effective June 1, 2008.

These criteria are found in the attached two forms: The “Psychiatric Medical Clearance Checklist” and “Contraindications for Admission to the Illinois Division of Mental Health Hospital”. The Medical Clearance Checklist is similar to a list that was developed 10 years ago, but has been updated to reflect current practice. The Contraindications form reflects suggestions from emergency department nurses as well as the broader task force. You may use both forms as guides in your evaluation and assessment of a patient with mental illness who is being considered for transfer to a state-operated hospital.

Medical leadership at the Division of Mental Health has reviewed and approved both forms. Physicians working in all of the state-operated hospitals have agreed to abide by them. As was agreed by the task force, hospitals will perform four lab tests (blood count, electrolytes, pregnancy test and drug screen), with patient consent, and the SOH physicians will not request additional lab tests simply on the basis of an abnormal value. That is, the ED physician will perform follow-up tests based on his or her clinical judgment. When there is a question or disagreement with a SOH physician's decision to not admit a patient, there will be physician to physician communication.

To assist in the implementation of the criteria and protocols and to monitor our progress in reducing patient wait times in the ED and in ambulances, we will ask you to record your experience with the new processes on the attached “Monitoring” form. You should record the information requested for each patient transferred to a SOH. You will retain the detailed information so that you can compare your data to that of the SOH, which is also collecting similar data, should the need arise. In addition, the Task Force will meet on a quarterly basis and will address concerns related to this process during these meetings. The availability of data will inform this discussion and the resolution of issues. You may choose to send to me the monitoring forms at the end of each month or when you experience a problem you wish to bring to our attention. We do ask, however, that you send to IHA at the end of each month the

summary data on the time periods a patient spends in your ED: time of presentation to ED and time patient leaves for SOH.

SOH staff will also collect similar data for the same patients and will provide the forms to Raul Almazar, Deputy Director. Instructions for sending the data are described on the attached forms. The data as well as issues that arise in the implementation of these new protocols will be reviewed by the Patient Assessment and Transfer task Force on a quarterly basis. At the end of the year, recommendations will be made to make adjustments, if and as warranted.

As part of the implementation of these criteria and protocols, training will be provided to EMS and ambulance personnel. The Illinois College of Emergency Physicians (ICEP) and the Emergency Nurses Association (ENA) will inform its members of the new protocols, as will IHA and MCHC. We are also working with the Community Behavioral Health Association (CBHA) and the Illinois Association of Rehabilitation Facilities (IARF) to communicate these new protocols to its members, many of whom are pre-screeners.

If you have any questions about the attached materials, please contact MaryLynn Clarke at mclarke@ihastaff.org or 217-541-1154. Or, you may contact Raul Almazar at Raul.Almazar@illinois.gov or 847 742-1040 Ext. 2010.

Thank you for your many efforts to improve patient care for persons with mental illnesses.

Attachments:

- The Psychiatric Patient Assessment, Treatment, and Transfer Task Force Report: “Recommendations to Improve the Assessment, Treatment, and Transfer of Psychiatric Patients to State-Operated Hospitals”
- Psychiatric Medical Clearance Checklist
- Contraindications for Admission to the Illinois Division of Mental Health Hospital
- Psychiatric Patient Emergency Department Assessment and Transfer to SOH Monitoring Form



**Psychiatric Patient Assessment, Treatment, and
Transfer Task Force Report:**

**“Recommendations to Improve the
Assessment, Treatment, and Transfer of
Psychiatric Patients to State-Operated
Hospitals”**

**By The Illinois Hospital Association
in behalf of the IHA/DMH Psychiatric Patient
Assessment, Treatment, and Transfer
Task Force**

November 2007-revised March 2008

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I. Background

Because there are fewer treatment options available than are needed in Illinois, persons with mental illnesses in increasing numbers are seeking care in hospital emergency departments (ED). A recent Illinois Hospital Association (IHA) survey noted a 47.6% increase in ED presentations by persons with mental illness in the two year period of 2002-2004. An American College of Emergency Physicians (ACEP) national survey in 2005 documented an over 60% increase in ED presentations by persons with mental illness.

Because both state and private hospitals in the last decade have closed several inpatient psychiatric beds while demand for these resources has not abated, patients in need of inpatient care are waiting several hours in the Emergency Department to find bed placement. Respondents in both the IHA and ACEP surveys indicated the lack of available psychiatric acute care beds as the primary reason for ED overcrowding and long waits for disposition. Patients with a mental illness wait on average twice as long as other medical patients in the ED for disposition, according to the IHA ED survey. Patients waiting for transfer to a state psychiatric hospital wait longer than any other patient for disposition.

A major Chicago academic medical center reported that in 2007, a patient waited an average of 15 hours from ED presentation to transfer to a SOH, an increase of several hours over 2006. Similarly, a suburban hospital reported an average of 11.6 hours from ED presentation to SOH transfer, with some patients waiting 17 hours. A Chicago community hospital reported that three patients remained in their EDs for more than 24 hours in December, awaiting transfer to an SOH. Between September 2 and October 29 of 2007, this hospital's prescreening agency tracked the time of the patient's arrival in the ED to their departure in an ambulance to a SOH. Their data indicate that patients spent a minimum of 7 hours in the ED and as many as 30 hours awaiting transfer to a SOH. Of 46 patients screened in this time period, 16 spent more than 20 hours in the ED. Data collected from a group of private hospitals in November and December 2007 measured three components of the patient process: time spent for the hospital to evaluate the patient in the ED; time spend to negotiate with the SOH; and time it took for the SOH to accept the patient. The data indicates that as much or more time is spent negotiating and interacting with the SOH about the patient's transfer than is spent assessing the patient. See Appendix A.

Because there are insufficient resources and inadequate procedures to process the volume of patients that flow through SOH intake locations, patients being transferred to a state psychiatric hospital, are not only waiting several hours in the ED, they also are waiting in an ambulance to be admitted to the SOH. Patients being transferred to state hospitals frequently must remain in the ambulance on the grounds of the SOH while they await intake. Data from one Chicago-area ambulance company shows significant increases between 2006 and 2007 in the times patients are waiting in ambulances to be accepted by Madden or Chicago Read SOHs. Fourteen patients remained in an ambulance on the grounds of one of these two hospitals for more than 90 minutes in September of 2007. Five patients remained longer than 90 minutes in October of this year. The attached chart shows ambulance wait times for the months of September and October in 2006 and 2007. See Appendix B.

Long waits in the ED while the patient waits for an SOH to identify an available bed are inconsiderate of the patient's medical condition and his or her dignity. Long waits in an ambulance on the grounds of an SOH are not only inconsiderate, but unsafe.

The following Report describes the work over the past two years of a group of health care providers working in the public and private sectors to identify ways in which to improve processes associated with the assessment and transfer of a person with a mental illness to a state hospital. It contains specific recommendations related to medical clearance protocols, medical contraindications for admittance to a SOH, as well as recommendations to improve SOH intake processes. These recommendations should improve the patient's experience in the ED as well as SOH by standardizing required lab tests; identifying in advance conditions that cannot be treated in a state hospital and those that should be treated in a private hospital; making consistent across the state criteria used for SOH admission. The recommendations address procedural improvements that should result in shorter ED throughput times.

The causes of the large and growing number of patients with mental illness seeking care in our EDs are complex and beyond the scope of this Report, but are discussed in the recently published report of the IHA Behavioral Health Steering Committee's Best Practices Task Force, "Best Practices for the Treatment of Persons with Mental and Substance Use Illnesses in the Emergency Department." Their resolution will depend on the development and financial support of appropriate and sufficient treatment options -- a challenge that must be solved.

Background

The Illinois Hospital Association in 2006 convened a meeting with health care providers and the Division of Mental Health to address patient issues that required immediate attention: excessively long patient wait times in hospital emergency departments, delays in obtaining approval to transfer a patient to a state-operated hospital (SOH), and long ambulance wait times at SOHs. (Patient volume and wait times had increased for several reasons, but the centralization of intake into one SOH appeared to contribute to even longer delays than were attributable to other causes. An attempt by DMH to schedule ambulance arrivals in overcrowded EDs was met as being unacceptable, for patients and providers.)

The group consisted of representatives of the Illinois Department of Human Services Division of Mental Health (DMH), including SOH physicians, psychiatrists and administrators; the Illinois Hospital Association and the Metropolitan Chicago Healthcare Council (MCHC), including their member managers of hospital psychiatric programs, psychiatrists and emergency department physicians; community mental health centers, including SOH prescreeners, private ambulance service providers and the Illinois College of Emergency Physicians. Their names and affiliations are listed in this report.

The group met several times between February 2006 and October 2007 to identify ways to improve the processes associated with the assessment and transfer of psychiatric patients from hospital emergency departments to a state-operated hospital. They also considered ways in which processes could be improved for transfers to a private psychiatric hospital or a hospital with a dedicated psychiatric unit. This multi-disciplinary group of clinicians and advocates initially addressed lengthy patient wait times in emergency departments and in ambulances. Although they focused primarily on

hospitals in the Chicago metropolitan area, it was their intent to craft recommendations that could be implemented statewide, as appropriate. Through their discussions, the committee expanded the scope of its deliberations and attention to consider the context within which these delays occurred, acknowledging the futility of ‘blaming’ any party for the failures of decades of strained resources.

Principles and Goals of the Committee

Early in the discussion, the group agreed to the following guiding principles and goals for the mental health system: to provide care to patients in the most appropriate setting for his or her condition; to provide safe care to our patients and thus that it is unsafe for patients to remain in an ambulance for any time beyond that which it takes to transport; that resources are strained and must be improved in private emergency departments as well as in state hospitals; that it is not in the best interest of our mutual patients to subject them to policies and protocols that delay treatment and disposition; and that every patient should be treated with respect and dignity.

Medical Clearance Standards

One of the causes of patient delays in transfer to a SOH has been requirements of the SOH related to “medical clearance.” Requests for multiple and additional lab and other diagnostic tests, often times in succession; inconsistent standards between SOHs; and lack of clarity about SOH expectations were viewed as contributing unnecessarily to delays. Physicians in both the private and state hospitals agreed that a commonly agreed objective standard would be useful and appropriate.

A Medical Clearance Subcommittee of the group was formed and met during the past year and one-half to make recommendations regarding medical clearance criteria and protocols. Under the leadership of Dr. James Brunner, DMH, and Dr. Jerold Leikin, Evanston Northwestern Healthcare, and with input by emergency department physicians, psychiatric nurses, and psychiatrists, this group has reviewed the criteria currently used by DMH, criteria recommended by a committee convened about ten years’ ago for the same purpose, and reached agreement on all but one issue: whether or not lab tests should be performed on all patients, regardless of presenting symptoms. On this issue, the emergency department and private hospital psychiatrists had suggested a standard that would have required tests for patients whose clinical presentation warranted lab testing, and for patients who are experiencing a first “break.” It has been their contention that false positives associated with PRN labs cause unnecessary testing and do not, of themselves, improve care or result in better outcomes. State physicians have been more comfortable with standardized lab tests, suggesting three (now four) tests be done on all psychiatric patients: urine toxicology screen, CBC, and basic blood chemistry profile, urine pregnancy test.

This issue was resolved at our October 4th meeting with a compromise offered by Dr. Leikin: hospitals, with patient or his or her representative’s consent, will perform a limited set of agreed upon lab tests but SOHs will not require “chasing” of findings. That is, the ED physician will perform follow-up labs based on his/her clinical assessment of the patient. The SOH physician will not override the ED physician’s judgment. The committee agreed this was reasonable. They suggested data collection and evaluation of these protocols at the end of 12 months, to determine the value of the tests and the patient implications of the protocols.

II. Recommendations

Recommendations to Improve the Patient Assessment and Transfer Process

The following recommendations were made by the group to improve the processes related to the transfer or admittance of a patient to a SOH:

1. SOH physicians should, to the extent possible, process each transfer request as it is received to avoid both delays and “bunching,” whereby multiple persons are accepted for transfer at one time.
2. SOH staff should communicate to hospitals any anticipated delays in accepting patients to the SOH. This will allow hospitals to develop an appropriate care plan while awaiting the transfer.
3. Ambulance arrivals should be coordinated to the extent possible. As an interim measure, hospitals and SOH staff should communicate about probable delays in processing patients at the SOH intake point so as to prevent a patient from waiting in an ambulance. However, “scheduling” is viewed as a short term, interim measure. It should not be viewed as a resolution of the underlying problems of inefficient processes and too few staff.
4. Intake processes should be streamlined and separated. The search of the patient’s belongings should be separate and discrete from the medical portion of the intake process (history and physical). When a patient is transferred from an ED in which the patient is wearing a gown, his or her belongings have been searched for contraband and dangerous objects, and are contained in a separate container; there is no need to delay the patients’ intake for the SOH staff to repeat this process.
5. A new staffing model to assure continued flow of intake during shift changes should be adopted. Sufficient staff should be added to accommodate times of the day during which there are more patients presenting for admission. As with any hospital, patients present in larger numbers at certain times of the day. Flexible staffing during these peak hours is necessary. Moreover, private hospitals are available 24 hours a day, seven days a week. SOHs should also be available to receive patients on the same basis.
6. Support of EMS professionals should be provided in the following areas:
 - a. EMS Guidelines should be developed to assist EMS professionals on how to handle a situation when they are waiting too long in an ambulance. It was noted that this will require the project medical director’s approval.
 - b. Training is necessary to assist private ambulance EMS personnel carrying out their responsibilities related to the transfer of a patient with a mental illness. This training could include representatives of DMH, Department of Transportation, Homeland Security, and the medical directors overseeing specific geographic areas. It was noted that DMH currently trains police officers, and this training could be modified to address the EMS professionals. This training should be standardized across the state to the extent practical.

7. Evaluate paperwork related to the transfer of patient including any forms filled out by the hospital, EMS personnel, or SOH staff. Use electronic forms if possible. If not, insure all parties understand their respective obligations and complete all paperwork in a timely manner.

A. Medical Clearance

1. Use the Medical Clearance form that has been approved by the group.
2. Hospitals provide agreed upon baseline screening labs. Any additional testing is performed according to the clinical judgment of the treating physician in the ED. SOH physicians do not require chasing of abnormal findings. Of course, any testing is performed with patient consent, or consent of his or her representative. Collect this data for a twelve month period and reexamine at the end of that period.
3. Develop an algorithm for the process of requesting/approving a transfer.
4. Write down the medical contraindications on the back of the medical clearance form. These contraindications should be revised based on the recommendations of this and other relevant committees during the past year and one-half.
5. Documentation sent with the patient should show that everything on the checklist was done.
6. In the event a patient transfer is declined because a medical condition or lab finding, the treating physician has the option to speak directly with the physician who denied the request for transfer. A transfer request cannot be declined by a screener or SOH staff person, only a SOH physician.

B. The contraindication list should be revised as discussed. (attach)

C. Timeline

1. The medical clearance checklist, including information on the labs with a “no chasing” requirement, should be adopted by hospitals as soon as possible.
2. A target rollout would be first quarter 2008 with EMS and ICEP working together to identify training needs and opportunities. DMH will provide training. IHA and MCHC will provide information on their websites as well as communication to hospitals in the state about the protocols agreed to by this group, training opportunities, and sources of information.

Long term strategies to improve the system within which the patient with mental illness must navigate

In addition to the opportunities outlined above, other recommendations will require longer-term implementation strategies. To improve the psychiatric patient’s experience with all of us -- hospitals, ambulance staff, state hospital staff, community mental health screeners, physicians, nurses, social workers — requires our commitment to tackle the big issues, among them:

- Private psychiatric hospitals and units in general hospitals have been closing and downsizing, primarily as a result of inadequate private and public payment for psychiatric disorders. Medicaid inpatient psychiatric base rates remain where they were in 1992, a fraction of a provider’s costs.

- At the same time, our state psychiatric hospitals have been closed and reduced in size due to cost cutting measures, without first ensuring there were adequate and available acute care and outpatient services to provide the care for the persons who previously accessed SOH services.
 - We didn't shift some of the savings of closing the state hospitals into these private hospitals.
 - We didn't shift some of the resources of closed hospitals into building a stronger outpatient care system either.
- Waiting lists are common in community mental health centers that have not seen an increase in rates or funding for the past several years. A patient in crisis needs attention immediately, not in a month. There needs to be an ability on the part of the CMHC or other outpatient providers to see a patient within 24 hours if this patient is deflected from a private emergency department or the SOH. Preferably the patient should be seen by psychiatrist if indicated but at a minimum by a qualified mental health professional.
- There are not enough psychiatrists who are either willing or able to care for the number of persons with mental illnesses who need this level of expertise. Medicaid pays psychiatrists a rate that is so far below costs it would be virtually impossible for a psychiatrist to serve only Medicaid patients and remain in practice. If we want psychiatrists to be available, they need fair compensation. If Medicaid is unable to fix their rates, DMH needs to pay them.
- Many psychiatric patients use the emergency department because they can not afford to remain on the medications their conditions require. This is exacerbated by an inability to access an outpatient provider, either a psychiatrist or a community mental health provider, in a timely manner. Without appropriate medication and early intervention patients are doomed to a cycle of trips in and out of the ED and hospital.
- Patients with co-morbid substance use and psychiatric conditions also are using EDs in large numbers because our system of care is unable to provide appropriate treatment options. Most hospitals do not provide dedicated substance use programs. The publicly funded substance abuse treatment community is generally unable to care for patients who require any type of medical intervention, including use of medication. The state hospitals are not designed to care for persons with substance use disorders, if they are considered "primary"
- We have not clearly articulated the respective roles of state and private hospitals in a way that supports both settings of care. The IHA Behavioral Health Steering Committee in 2005 set forth a set of principles and recommendations about the role of state and private hospitals in terms of the types of patient conditions mental health clinicians believed were best treated in each setting. The following is an excerpt from that report:

“Articulate criteria regarding which patients are most appropriate for a private hospital and which are most appropriate for a SOF.

We believe that the SOF is appropriate for patients who are not successfully treated in community hospitals. These patients often exhibit the following characteristics: they are treatment resistant and/or have had multiple (three or more) admissions in the

previous twelve months, and/or may require a longer length of stay (beyond 10 days). And, they may be unmanageably violent.

Private hospitals are appropriate for patients who present medical complexities that benefit from access to multiple specialties; patients who need to be stabilized and treated within the shortest time frame; and patients who will benefit from the diagnostic and other therapeutic resources of an acute care setting.

Patients with co-occurring disorders are caught between narrowly construed regulatory and public financing schemes that do not support access to appropriate services. For example, the state SOFs reluctantly accept patients with a primary diagnosis of substance abuse; Medicaid does not reimburse a private hospital for substance abuse treatment or rehabilitation, but only detoxification services, leaving the addicted person no access to treatment for their addiction in an acute care setting. The Illinois Department of Alcoholism and Substance Abuse licenses and pays for “sub-acute” Medicaid services, not acute services such as those needed by a substance abuse patient who has attempted suicide or has a psychiatric condition. Thus, the State financing of behavioral services lacks a comprehensive and coordinated rehabilitative focus, and thus leaves gaps that perpetuate expensive relapse and readmission.

Patients with developmental disabilities with mental illness also have few options for acute treatment available to them today. Given that the private sector cannot generally treat these individuals on an acute basis, they pose a natural population of citizens for which the State should assume responsibility. At a minimum, the State must fund, either directly or by arrangement, services that effectively meet the complex needs of these individuals.”

The Metro South Restructuring Committee adopted these principles in its report to the Secretary of Human Services Carol Adams. There has not been any formal follow-up to these recommendations.

This Report recommends several short and long term actions that will improve a patient’s experience with the mental health system. Although it’s principal and immediate purposes are to improve patient throughput from ED to SOH, we hope it will serve as a platform for systematic improvement. Until we define the number and type of primary and acute care psychiatric services needed in Illinois and who will provide these services, for whom; until we provide and support those defined services, and until we establish a reasonable and adequate Medicaid payment rate and funding for psychiatrists, hospitals, and community mental health providers, we will continue to see thousands of persons with mental illnesses rotate through the stopgap revolving doors of our emergency departments. And, they will continue to wait for us to build a system of care that meets their needs.

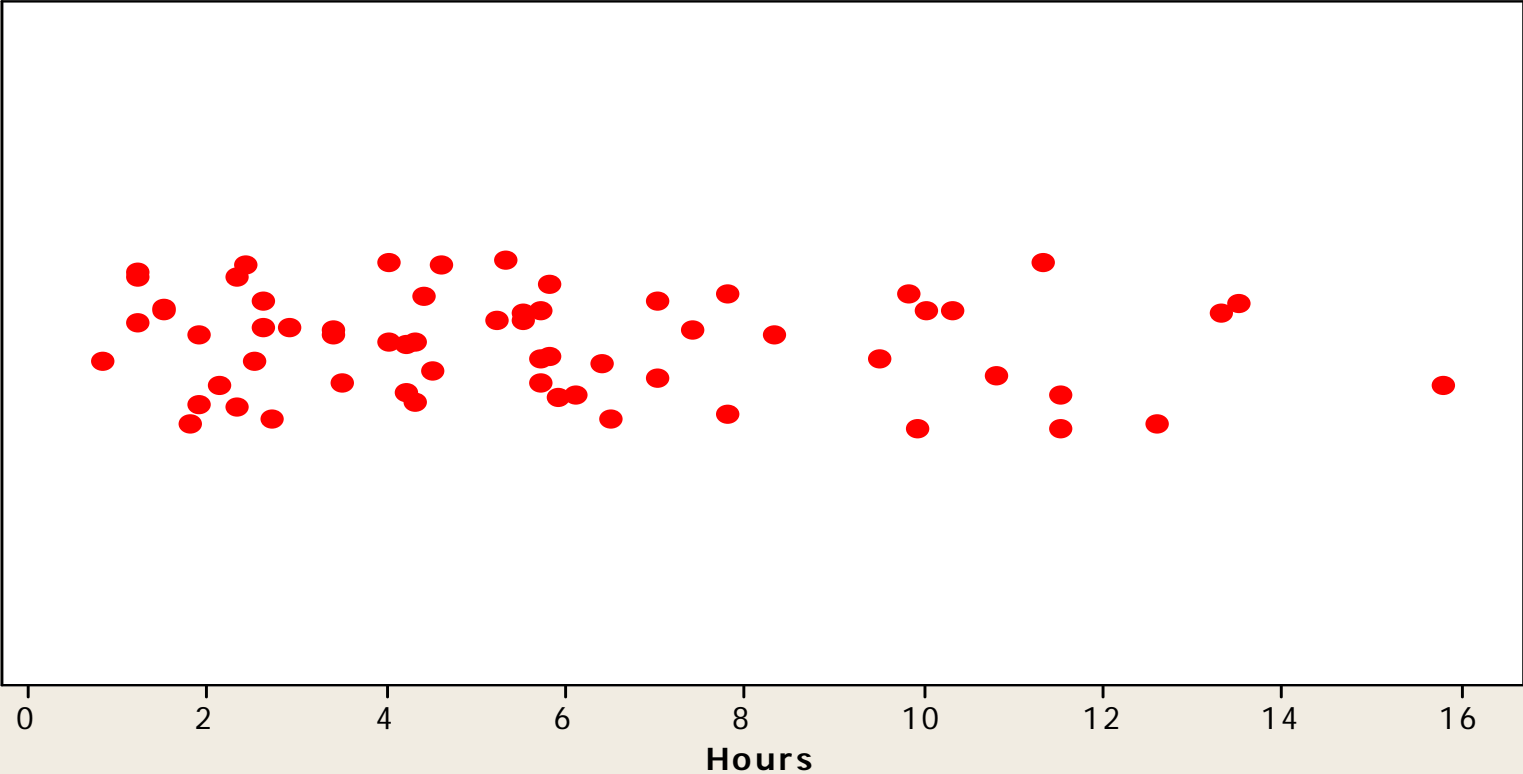
CONTRAINDICATIONS for Admission to DMH Hospital**February 2008**

1. Patient not able to do activities in daily living. Examples include: requiring skilled nursing care; limited feeding capacity; assistance ambulating
2. Patient with swallowing problem
3. Patient requiring catheter
 - a. Foley
 - b. Feeding tubes, or N/G tube
 - c. Central lines
4. Patient requiring dialysis
5. Patient requiring medications not available in DMH formulary
6. Patient requiring physical therapy
7. Patient requiring CPAP
8. Patient requiring post-surgical care and follow-up
9. Patient at risk of medically significant complications due to recent major medical trauma (Meets State requirements for trauma)
10. Patient with acute neurological symptoms, including unstable seizure disorders
11. Patient with cancer that needs work-up or treatment expeditiously
12. Patient with possible new onset of psychosis, where work-up has not been done
13. Patient with active MRSA, or VRE resistance
14. Patient requiring Peripheral IV line or IV injection
15. Patient requiring nebulizer treatment
16. Patient requiring oxygen
17. Patient requiring EKG monitoring/telemetry
18. Patient requiring urgent surgery
19. Patient at risk of medically significant complications due to drug withdrawal (e.g., seizures and/or DT's)
20. Patient with medically significant bleeding
21. Patient with draining wounds that require nursing care
22. Patient with communicable diseases requiring isolation
23. Patient with acute drug inebriation
24. Patient with delirium or altered levels of consciousness
25. Patient with primary dementia without other psychiatric or Axis I symptoms
26. Patient with methadone dependency, unless in an accredited methadone program
27. Patient with toxic levels of medication or who are at risk to become toxic (i.e., acetaminophen)
28. Pregnant patients who are 36 weeks or greater or with a high risk pregnancy

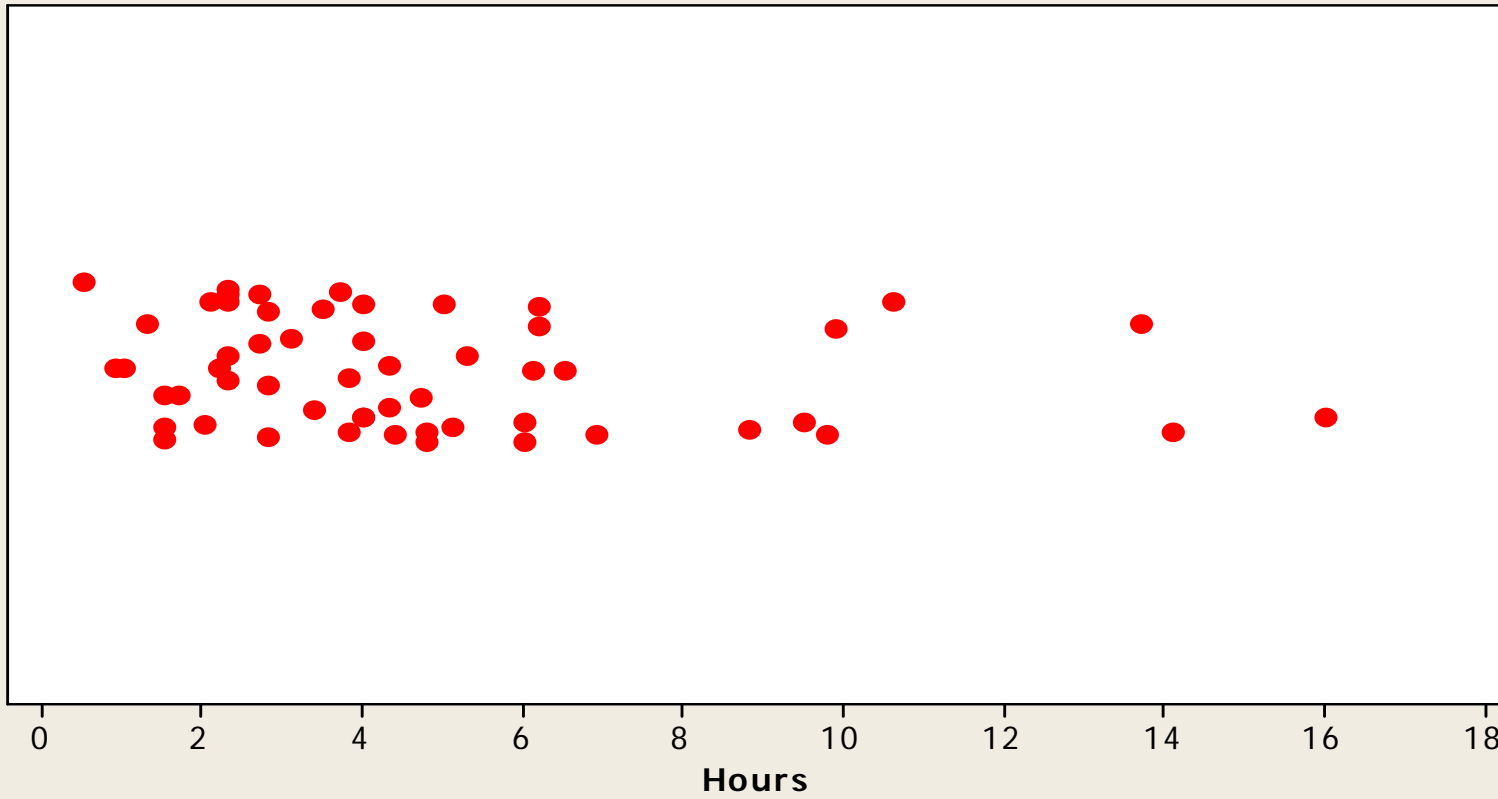
Descriptive Statistics

Process Step	Cases	Median Hrs	Mean Hrs	Min. Hrs	Max. Hrs	Range Hrs
Time Spent to Process Person in ED	62	5.25	5.7	0.8	15.8	15
Time Spent to Negotiate with SOF	55	4	4.7	0.5	16	15.5
Time SOF Takes to Accept Person	78	1.75	3.1	0.3	20	19.7

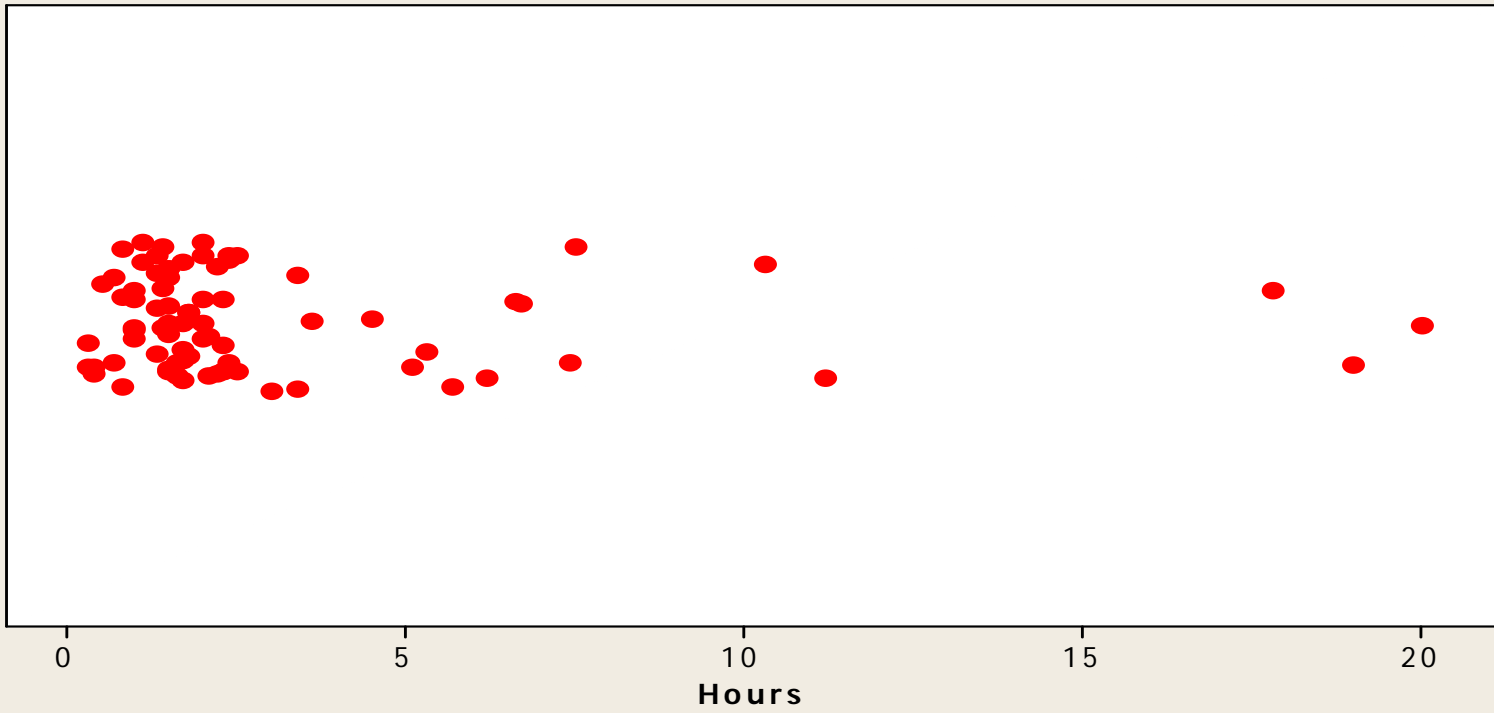
Time to Process Patient in ED



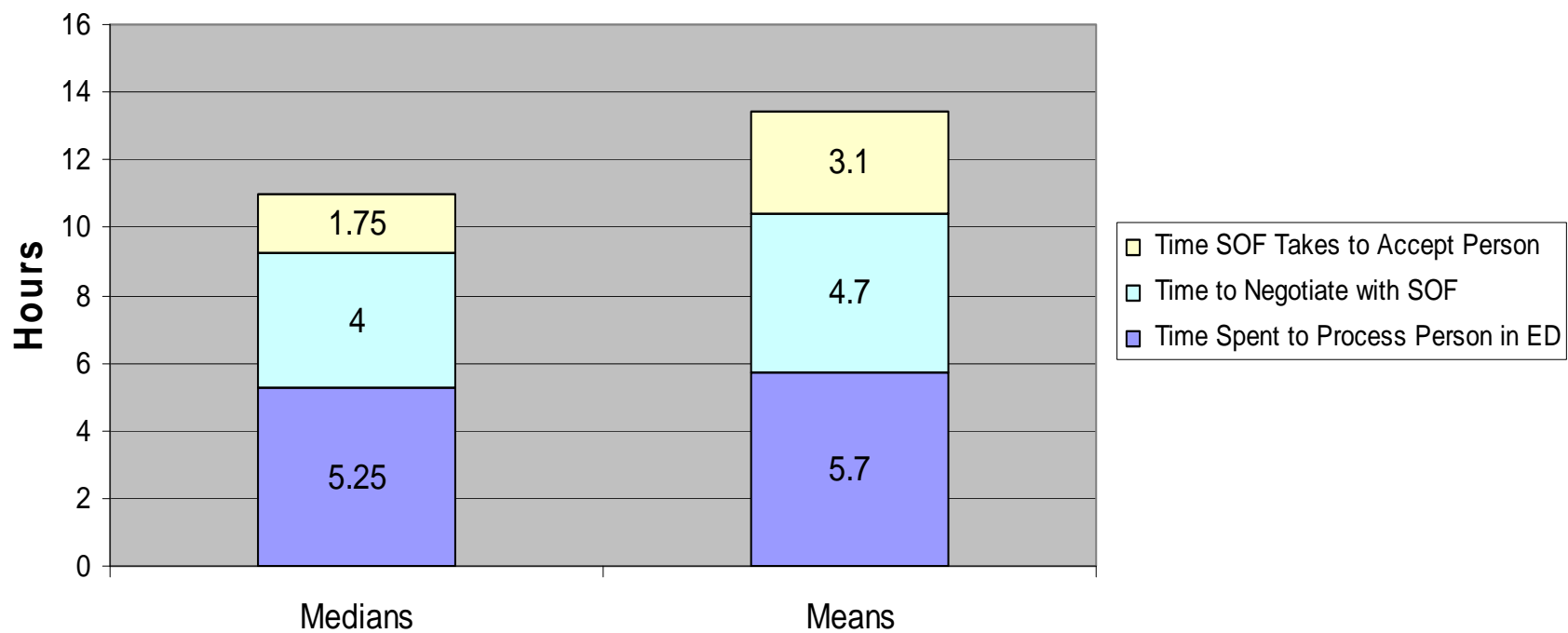
Time to Negotiate with SOF



Time for SOF to Accept Patient



Time for Assessment and Transfer from Community Hospital ED to SOF November and December, 2007



Appendix II

Ambulance Data September & October 2006 & 2007

MADDEN AND REED AMBULANCE WAIT TIMES FOR MEDICAL EXPRESS AMBULANCE SERVICE

comparison of September and October Date for 2006 and 2007

(wait time defined as time of ambulance arrival at DOH destination until cleared destination minus 20 minutes for paperwork and return to service)

	MIN	Sep-06		Sep-07		% increase '06 to '07
		n=47	n=64	#	%	
Combined (Madden and Read)	wait time > 20 minutes	20	43%	58	91%	48%
	wait time > 30 minutes	15	32%	48	75%	43%
	wait time > 45 minutes	12	26%	33	52%	26%
	wait time > 60 minutes	8	17%	23	36%	19%
	wait time > 90 minutes		0%	14	22%	22%
Madden	MIN	n=15		n=34		
	wait time > 20 minutes	9	60%	33	97%	37%
	wait time > 30 minutes	8	53%	27	79%	26%
	wait time > 45 minutes	7	47%	22	65%	18%
	wait time > 60 minutes	5	33%	16	47%	14%
wait time > 90 minutes	0	0%	10	29%	29%	
Reed	MIN	n=32		n=30		
	wait time > 20 minutes	11	34%	25	83%	49%
	wait time > 30 minutes	7	22%	21	70%	48%
	wait time > 45 minutes	5	16%	11	37%	21%
	wait time > 60 minutes	3	9%	7	23%	14%
wait time > 90 minutes	0	0%	4	13%	13%	

	Oct-06		Oct-07		% increase '06 to '07
	n=50	n=59	#	%	
	24	48%	39	66%	18%
	18	36%	33	56%	20%
	10	20%	26	44%	24%
	4	8%	15	25%	17%
	1	2%	5	8%	6%
	n = 14		n=17		
	7	50%	9	53%	3%
	5	36%	8	47%	11%
	3	21%	7	41%	20%
	1	7%	4	24%	16%
0	0%	3	18%	18%	
	n = 36		n=42		
	17	47%	30	71%	24%
	13	36%	25	60%	23%
	7	19%	19	45%	26%
	3	8%	11	26%	18%
1	3%	2	5%	2%	

Medical Express Ambulance Service March 2008

<u>Date</u>	<u>Run #</u>	<u>At Dest.</u>	<u>Clear Dest.</u>	<u>Time Elapsed</u>	<u>Destination Facility</u>
2008-03-01	12,544	05:24:14	05:47:53	23.65	CHICAGO READ MENTAL HEALTH CEN
2008-03-01	12,557	09:06:58	10:00:37	53.65	CHICAGO READ MENTAL HEALTH CEN
2008-03-02	12,642	03:35:42	03:54:08	18.43	CHICAGO READ MENTAL HEALTH CEN
2008-03-03	12,772	11:05:56	11:29:58	24.03	MADDEN MENTAL HEALTH HOSPITAL
2008-03-03	12,775	11:06:57	11:51:54	44.95	CHICAGO READ MENTAL HEALTH CEN
2008-03-03	12,809	13:04:34	14:15:00	70.43	CHICAGO READ MENTAL HEALTH CEN
2008-03-03	12,810	12:49:53	13:25:14	35.35	CHICAGO READ MENTAL HEALTH CEN
2008-03-03	12,909	19:47:00	21:24:53	97.88	MADDEN MENTAL HEALTH HOSPITAL
2008-03-04	12,943	00:10:14	00:52:50	42.60	CHICAGO READ MENTAL HEALTH CEN
2008-03-04	13,019	11:30:40	12:29:59	59.32	CHICAGO READ MENTAL HEALTH CEN
2008-03-05	13,196	01:36:58	02:11:33	34.58	CHICAGO READ MENTAL HEALTH CEN
2008-03-05	13,202	04:29:14	04:56:30	27.27	MADDEN MENTAL HEALTH HOSPITAL
2008-03-05	13,380	19:50:33	20:09:17	18.73	CHICAGO READ MENTAL HEALTH CEN
2008-03-06	13,422	02:05:10	02:35:37	30.45	CHICAGO READ MENTAL HEALTH CEN
2008-03-06	13,484	11:11:00	12:32:51	81.85	CHICAGO READ MENTAL HEALTH CEN
2008-03-06	13,516	13:51:37	14:39:25	47.80	MADDEN MENTAL HEALTH HOSPITAL
2008-03-06	13,657	00:18:14	00:47:16	29.03	MADDEN MENTAL HEALTH HOSPITAL
2008-03-07	13,675	07:45:35	08:38:06	52.52	MADDEN MENTAL HEALTH HOSPITAL
2008-03-07	13,695	09:30:06	10:19:00	48.90	CHICAGO READ MENTAL HEALTH CEN
2008-03-07	13,737	11:42:48	12:34:48	52.00	CHICAGO READ MENTAL HEALTH CEN
2008-03-07	13,741	12:44:32	13:46:36	62.07	CHICAGO READ MENTAL HEALTH CEN
2008-03-08	13,903	13:41:32	14:32:15	50.72	CHICAGO READ MENTAL HEALTH CEN
2008-03-09	13,974	03:40:10	03:57:32	17.37	MADDEN MENTAL HEALTH HOSPITAL
2008-03-09	14,001	16:33:00	17:00:20	27.33	MADDEN MENTAL HEALTH HOSPITAL
2008-03-10	14,151	14:44:21	15:27:15	42.90	MADDEN MENTAL HEALTH HOSPITAL
2008-03-10	14,209	17:59:57	19:04:37	64.67	CHICAGO READ MENTAL HEALTH CEN
2008-03-10	14,251	03:08:23	03:23:34	15.18	MADDEN MENTAL HEALTH HOSPITAL

2008-03-12	14,495	03:39:48	04:12:49	33.02	CHICAGO READ MENTAL HEALTH CEN
2008-03-13	14,720	05:50:26	06:32:56	42.50	CHICAGO READ MENTAL HEALTH CEN
2008-03-13	14,746	10:36:52	11:05:18	28.43	MADDEN MENTAL HEALTH HOSPITAL
2008-03-13	14,798	12:44:01	15:26:42	162.68	CHICAGO READ MENTAL HEALTH CEN
2008-03-13	14,974	23:33:51	23:57:04	23.22	CHICAGO READ MENTAL HEALTH CEN
2008-03-14	14,986	07:55:31	08:40:42	45.18	CHICAGO READ MENTAL HEALTH CEN
2008-03-14	15,019	10:00:21	11:05:08	64.78	CHICAGO READ MENTAL HEALTH CEN
2008-03-14	15,134	15:50:44	17:09:16	78.53	CHICAGO READ MENTAL HEALTH CEN
2008-03-15	15,241	10:15:37	11:00:51	45.23	MADDEN MENTAL HEALTH HOSPITAL
2008-03-15	15,317	19:14:43	19:32:37	17.90	MADDEN MENTAL HEALTH HOSPITAL
2008-03-17	15,396	03:54:31	04:12:47	18.27	CHICAGO READ MENTAL HEALTH CEN
2008-03-17	15,577	20:06:46	20:23:10	16.40	CHICAGO READ MENTAL HEALTH CEN
2008-03-18	15,750	15:22:38	16:26:39	64.02	CHICAGO READ MENTAL HEALTH CEN
2008-03-19	15,851	04:03:14	05:29:38	86.40	CHICAGO READ MENTAL HEALTH CEN
2008-03-20	16,302	19:25:42	20:20:25	54.72	CHICAGO READ MENTAL HEALTH CEN
2008-03-20	16,323	23:55:00	01:18:29	83.48	MADDEN MENTAL HEALTH HOSPITAL
2008-03-23	16,639	05:34:24	06:30:27	56.05	CHICAGO READ MENTAL HEALTH CEN
2008-03-23	16,640	06:36:19	06:52:49	16.50	MADDEN MENTAL HEALTH HOSPITAL
2008-03-24	16,861	17:45:48	18:15:45	29.95	MADDEN MENTAL HEALTH HOSPITAL
2008-03-24	16,914	23:55:56	00:23:36	27.67	CHICAGO READ MENTAL HEALTH CEN
2008-03-26	17,171	07:18:09	08:08:48	50.65	CHICAGO READ MENTAL HEALTH CEN
2008-03-26	17,264	13:53:50	15:20:20	86.50	CHICAGO READ MENTAL HEALTH CEN
2008-03-26	17,385	21:07:11	21:38:28	31.28	CHICAGO READ MENTAL HEALTH CEN
2008-03-27	17,410	07:42:48	08:42:15	59.45	CHICAGO READ MENTAL HEALTH CEN
2008-03-28	17,830	18:13:59	18:46:57	32.97	MADDEN MENTAL HEALTH HOSPITAL
2008-03-29	17,879	09:30:11	09:49:22	19.18	MADDEN MENTAL HEALTH HOSPITAL
2008-03-29	17,893	14:11:33	15:22:50	71.28	CHICAGO READ MENTAL HEALTH CEN
2008-03-30	17,968	09:18:53	10:01:15	42.37	MADDEN MENTAL HEALTH HOSPITAL
2008-03-30	18,055	22:07:13	22:22:06	14.88	MADDEN MENTAL HEALTH HOSPITAL

Average Time to Clear
(min): **46.02**

Addendum

Illinois Division of Mental Health's Implementation of Recommendations

DMH has responded positively to the numerous issues and concerns raised by Emergency Departments, pre-screening agents, and ambulance companies as they relate to the activities of Central Intake, in particular and SOHs in general. DMH has expressed it positively as follows: "We embrace each issue as serious, and as such are attempting to identify proactive systems changes to streamline and/or alleviate problematic areas. Our goal is to achieve best work practices with hospitals and pre-screening agents on behalf of the population that we serve. It is not our intent to become an obstacle to hospital staff seeking to access public inpatient psychiatric mental health services."

The following are activities that have been addressed as of March 2008:

- DMH has redirected admissions of a Chicago Southside catchment area from Madden Mental Health Center back to Tinley Park Mental Health Center. This will ease the volume in referrals/presentations to Madden from Emergency Departments to Madden.
- Each State Hospital has designated staff, across the three shifts, who are directly responsible for tracking arrival times of ambulances and initiation of the intake processes.
- Ambulance wait times exceeding a threshold of 30 minutes are flagged and brought to the attention of the Medical Director during business hours or the Administrator On Duty in off hours for immediate resolution.
- DMH is collecting data across all three hospitals to establish thresholds for all Central Intake activities and use this information to monitor Central Intake processes work productivity and response times.
- A protocol for notification to Emergency Rooms when paperwork is not complete was implemented. Dr. Robert Sharpe, Medical Director, Madden Mental Health Center, sent a January 25, 2008 correspondence to Central Intake staff and Madden's Chief of Social Work with instructions that Central Intake is to assume responsibility to contact Emergency Room departments immediately when paperwork received is incomplete and/or requires re-faxing.
- Madden re-implemented a policy, effective February 1, 2008, that patient's belongings will not be searched upon arrival, but will be secured and searched after the patient is admitted. This has been recognized as a major rate-limiting factor that increases ambulance wait times.
- Dr. Sharpe has directed Central Intake staff that communication/feedback with Emergency Departments is not to be relegated only to the RN, but whomever is identified as the assigned communication link between the local hospital and Central Intake. This will decrease wait times in receiving confirmation for transport from the Emergency Department.

- To address the issue of Emergency Departments not receiving timely calls, necessitating repeat attempts to get feedback information from Central Intake and concerns about rudeness during these repeat calls. The State Hospitals' Medical Directors, Directors of Nursing, Chiefs of Social Work will complete training of staff on professional communication and best acceptable communication techniques and demeanor by March 30, 2008.
- Hospitals have expressed concern that there were inappropriate overrides of medical clearance decisions intentional delays of transfers when there 'appears' to be no underlying medical clearance issue. Dr. Sharpe assumed responsibility to work with Madden's medical staff to ensure better consistency in determinations made based on the Medical Clearance Protocol and the operation practices of Central Intake.
- Regarding the use of assistive devices and concern that Central Intake staff will not consider patients for admission who use a wheelchair, Dr. Sharpe clarified that patients are not considered appropriate for admission if they need to have assistive devices to ambulate, i.e.s, cane, walker, crutches, nor can have a cast. It was stated that if the need exist; patients will be assigned a wheel chair for mobility as long as they can ambulate with assistance.
- There was concern that there are inconsistent time frames indicated across the State Hospitals for transfer from a medical/surgery unit. DMH Medical Directors issued a written protocol for handling transfers and the time frame for transfer, by March 10, 2008.
- The Implementation of the Variance Form (used by Region 1 Central), DMH is reevaluating the effectiveness of this form. A decision to use it or not will be made at a later date.
- Release of Medical Clearance Protocol, DMH has worked with medical staff input from local hospitals to reach agreement on the language contained in the Medical Clearance Protocol and contraindication checklist. This document has been approved and will be implemented June 2008.

Division of Mental Health - State Operated Hospital Contact Numbers Region One*

Brenda Hampton	Tinley Park	708-614-4001
After Hours - Administrator on Duty		708-614-4000
James Brunner, MD	Tinley Park	708-614-4015
Robert Sharpe, MD	Madden	708-338-7280 708-426-8739
Dan Wasmer	Read	312-363-7097

*These Region One numbers were provided by the State Operated Hospital Administrators. Other State-Operated Hospitals numbers are provided at the DHS website: <http://www.dhs.state.il.us/page.aspx?item=32535>

Hospital Monitoring Form

Please provide the following information about the assessment, evaluation, and transfer or admission of a psychiatric patient who presents for care in your emergency department. This information will be used to monitor the implementation of the new SOH transfer protocols.

	Name of Hospital:															
	Location:															
	Name of person providing data:															
	Contact Information for person providing data:															
	Patient's Initials:															
➔	Date and time patient with a mental illness presents to your emergency department:															
	Time you contact SOH to arrange a transfer to SOH:															
	<small>Provide name of SOH you contact. If patient will be transferred to a SOH other than the SOH contacted for intake, please name SOH: (Medical clearance is assumed to have occurred by this time)</small>															
	Lab tests performed: (Please Circle)															
	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Blood count</td> <td style="width: 30%;">YES</td> <td style="width: 30%;">NO</td> </tr> <tr> <td>Drug screen</td> <td>YES</td> <td>NO</td> </tr> <tr> <td>Pregnancy test</td> <td>YES</td> <td>NO</td> </tr> <tr> <td>Electrolytes</td> <td>YES</td> <td>NO</td> </tr> <tr> <td>Other: (Please Specify)</td> <td>YES</td> <td>NO</td> </tr> </table>	Blood count	YES	NO	Drug screen	YES	NO	Pregnancy test	YES	NO	Electrolytes	YES	NO	Other: (Please Specify)	YES	NO
Blood count	YES	NO														
Drug screen	YES	NO														
Pregnancy test	YES	NO														
Electrolytes	YES	NO														
Other: (Please Specify)	YES	NO														
	Date and Time SOH agrees to accept transfer of patient to SOH:															
➔	Date and Time patient leaves your ED for SOH:															
	Patient denied acceptance to SOH ___ Yes ___ No Please Identify Reason Denied:															
	Patient Denied acceptance by SOH															
	Please indicate Patient disposition: _____ Admitted to hospital psychiatric unit _____ Admitted to hospital medical unit _____ Transferred to another psychiatric facility _____ Other: (Please specify)															
➔	Please note any difficulties associated with patient assessment and transfer process:															

Please retain this form for your records. Send summary data (see data fields marked by arrows) regarding time patient presents to ED and leaves ED for SOH at end of each month to MaryLynn Clarke at 217-541-1166 (fax) or email: mclarke@ihastaff.org. You may call 217-541-1154 or email with questions. You also may send the entire form to Ms. Clarke at the numbers indicated.

State-Operated Hospital Monitoring Form

Please provide the following information about the assessment, evaluation, and transfer or admission of a psychiatric patient who presents for care in a private hospital emergency department then is transferred to your State Operated Hospital. This information will be used to monitor the implementation of the new SOH transfer protocols.

Name of State Operated Hospital:															
Location:															
Name of person providing data:															
Contact Information for person providing data:															
Patient's Initials:															
Time SOH was contacted to arrange a transfer to SOH:															
<small>(Medical clearance is assumed to have occurred by this time)</small>															
Date and time patient with a mental illness presents to your SOH:															
Lab tests performed at Private Hospital: (Please Circle) <table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Blood count</td> <td style="width: 30%;">YES</td> <td style="width: 30%;">NO</td> </tr> <tr> <td>Drug screen</td> <td>YES</td> <td>NO</td> </tr> <tr> <td>Pregnancy test</td> <td>YES</td> <td>NO</td> </tr> <tr> <td>Electrolytes</td> <td>YES</td> <td>NO</td> </tr> <tr> <td>Other: (Please Specify)</td> <td>YES</td> <td>NO</td> </tr> </table>	Blood count	YES	NO	Drug screen	YES	NO	Pregnancy test	YES	NO	Electrolytes	YES	NO	Other: (Please Specify)	YES	NO
Blood count	YES	NO													
Drug screen	YES	NO													
Pregnancy test	YES	NO													
Electrolytes	YES	NO													
Other: (Please Specify)	YES	NO													
Date and Time SOH agrees to accept transfer of patient to SOH:															
Patient was admitted to SOH ___Yes ___No If not, please answer the following questions: Patient was transferred to another facility for medical care ___Yes ___No Patient was transferred within 24 hours to another facility, including back to ED*, for medical care ___Yes___No															
Please note any difficulties associated with patient assessment and transfer process:															

*If patient returned to the ED within 24 hours, please fax form to Raul Almazar, RS, MA, Interim Deputy Director, Division of Mental Health, at 847-429-4910. Otherwise, email this form to Raul Almazar at Raul.Almazar@illinois.gov. You may call him at 847-742-1040, ext. 2010.