Illinois Department of Human Services

Rod R. Blagojevich, *Governor*

Carol L. Adams, Ph.D., *Secretary*

100 South Grand Avenue, East Springfield, Illinois 62762
401 South Clinton Street Chicago, Illinois 60607

January 9, 2009

Mr. Dan R. Long
Executive Director
Commission on Government Forecasting
and Accountability (CGFA)
703 Stratton Office Building
Springfield, IL 62706

Dear Mr. Long,

Please find enclosed the responses from the Divisions of Developmental Disabilities and Mental Health to your most recent questions regarding the closure of Howe Developmental Center and the transformation of the Tinley Park Mental Center, respectively.

We appreciate your continued concern and recognize the complexity and importance of this decision.

Sincerely,

Carol L. Adams
Secretary

Division of Mental Health, Illinois Department of Human Services

Executive Summary

Responses to Questions from the Committee on Government Forecasting and Accountability

The information that follows responds to the questions posed by members of the Commission on Government Forecasting and Accountability and other esteemed members of the General Assembly with an interest in this proposed initiative. The Division has consistently supported an open and "transparent" process in developing this and remains available to answer any additional questions and receive other comments and suggestions that could improve the proposal as we strive to improve the delivery of acute psychiatric inpatient care to the residents of the Southland.

It is important to note that this planning process began over three years ago and has involved a wide range of stakeholders, including members of the General Assembly, policy and clinical professionals, consumers of care and the workforce. All have been acutely aware that the current Tinley Park hospital structure is largely in a state of disrepair and has been sited for many life-safety/ code violations that are expensive if not impossible to address. The hospital has also been decertified by the Center for Medicare and Medicaid Services and continues to await a recertification survey.

There is little disagreement that the Southland continues to need this public service and in fact, due to the population growth in Will and South Suburban Cook counties, additional capacity for inpatient psychiatric care is projected. Further, all agree that the Southland would benefit greatly from the improvements associated with a new state-of-the-art psychiatric hospital. After reviewing public policy studies and models in other states, it was determined that the fastest, most efficient approach to achieving this goal is through leveraging relationships with the private sector. Through those relationships, a new hospital could be constructed in 2 years and the state would be the beneficiary of innumerable other technological and organizational enhancements.

The Division of Mental Health would be happy to provide citations of studies in this area, policy white papers and data from other systems that have moved forward using similar strategies. We look forward to a continued dialogue on this proposal and thank you for your interest.

Division of Mental Health, Illinois Department of Human Services

Responses to Questions from the Committee on Government Forecasting and Accountability

Responses to COGFA

1) Tinley Park Mental Health Center has also lost its Medicaid certification. According to an article in the Chicago Tribune of October 2006, there was an administrator at TPMHC named Khalil Shalabi, what was Mr. Shalabi's role at TPMHC? What were Mr. Shalabi's qualifications to hold this position at TPMHC?

While Mr. Shalabi was housed in an office located on the grounds of TPMHC, he was never an employee of the TPMHC and therefore had no duties or responsibilities to DMH or the TPMHC. He did not have any work products under the auspices of DMH, nor did he report to any staff employed by DMH. Mr. Shalabi reported solely to the Office of Administrative, Clinical, and Program Support (OCAPS).

2) Why did TPMHC lose its certification? Was it because of the inability of TPMHC to keep accurate medical records which was also noted by CMS on three separate inspections?

Tinley was in fact decertified because of a medical records issue that occurred on three separate Center for Medicaid & Medicare Services (CMS) visits.

Additionally, there were other issues during those visits. Problems with TPMHC's lack of compliance with current regulatory standards, poor adherence to life safety standards, and the lack of patient-related environmental supports at the hospital resulted in TPMHC being placed on preliminary denial of accreditation by the Joint Commission, an independent not-for-profit organization that accredits and certifies more than 15,000 health care organizations and programs nationwide.

Earlier in 2007, TPMHC was decertified by CMS; as a result, the State has been unable to bill the federal government for Medicare and Medicaid patients, an estimated $300.9K annually based on FY07 reimbursement. The state is still awaiting a CMS survey for recertification. TPMHC has since been reaccredited by the Joint Commission after substantial time and cost to the State to make repairs and modifications to the facility.

3) What are the "life safety" concerns at the TPMHC? The commission requests all documents related to the de-certification of TPMHC.

As cited in reports from the Joint Commission and Peter Kwasnik, a certified sanitarian contracted by the state to inspect facilities, life safety concerns at TPMHC include:

- Hot/Cold faucets in the showers provide a risk for patients using them as anchors to hang from; they are very costly and problematic to replace because they are imbedded in plaster walls.

- Also the bathtubs in the shower areas present a safety risk as well, but removal is also very involved and very costly.
- The recessed walls at the service elevator location present a blind spot where patients can hide, which is safety concern for staff.

There are also other safety concerns including line of sight issues, no viewing panels in the patient doors, etc. but DMH was not cited for those concerns.

See Joint Commission Survey Findings (Attachment A) & Peter Kwasnik Survey Finding (Attachment B).

4) DHS states that there is a difficulty in recruiting and retaining professional staff at TPMHC. Will a new hospital in the same area solve that problem? What will DHS do differently to recruit staff once the new hospital is built?

DHS announced its intent to close Tinley Park Mental Health Center in 2004. As a result of that announcement, and the uncertainty of the future of Tinley Park in the ensuing years, Tinley Park MHC lost a significant number of staff and had difficulty attracting staff. The fact that DMH has declared its intent to remain in full operation during the transition and building of a new hospital should inspire confidence and some certainty in prospective applicants and the present staff.

Recruitment and retention of professional staff and physicians may become the responsibility of the contractor/vendor (pending union negotiations). This will allow greater flexibility during the recruitment process, such as not being controlled by state hiring processes, standards or hiring restrictions; providing different salary and benefit structures that are not available to the state; greater utilization of temporary employees during recruitment period; and ability to use recruitment tools not available to state. If the vendor is contractually responsible for professional staff, DMH would not have an active role in recruitment or retention. DMH will insert specific payment penalties should vacancies exceed a particular timeframe. This will provide a greater incentive for the vendor to recruit and fill open positions.

Additionally, one of the criteria DMH will utilize in selecting an alternative site is access to a major medical center for patient support and access. Establishing an ongoing relationship with a major academic hospital may enhance recruitment efforts to ensure adequate professional opportunities and potential training programs for their staff.

5) During the testimony regarding TPMHC the department states that they <u>will</u> consolidate all mental health operations into two buildings. Hasn't that already been done?

Currently, TPMHC operations are in the Maple Building and the Administration Building; however, Oak, Mimosa, Pine, the power plant, and various other buildings remain open to provide food, medicine, and other services necessary for TPMHC to function.

In the spring of 2009, the existing facilities on the TPMHC campus will be consolidated into a single building, the Maple Building. This is necessary in order to streamline and reduce costs, enhance security, and vacate all other campus buildings that will no longer serve a function or operate in support of DHS TPMHC.

6) The new hospital won't be completed until 2012. Will the department wait to sell the current property until the hospital is completed?

CMS controls surplus property not DHS/DMH. Upon the consolidation of TPMHC into Maple, continuing the usage of the power plant and roadways, the remainder of the Tinley Park/Howe campus will be deemed as surplus state property. This designation will trigger the formal CMS process to dispose of the property.

7) There was a committee established to make recommendations as to the future of TPMHC. What was the recommendation of the committee? Who served on that committee?

The Task Force report is attached at the end of this document. See Attachment C. Additional comments may be found in question #4 of Senator Harmon's questions.

Responses to Senator Harmon

1) ***If Howe stays open, is the replacement of Tinley Park MHC still a viable option?***
   - ***If the new hospital will not open until 2012, why do the operations need to be changed at this time?***
   - ***If the Tinley proposal is allowed to move forward, what recourse will COGFA have if the new facility never opens?***

Regardless of the future status of Howe, the TPMHC (1) no longer adheres to 21st century clinical standards of care; (2) is in extremely poor condition and not conducive to consumer (patient) and staff safety; (3) lacks adherence to current and projected regulatory standards; (4) fails to be environmentally supportive to the principles of recovery as known today; and (5) would require the investment of vast amounts of money and resources by the State to maintain.

The public private partnership model (including the vendor taking over management of the facility in September 2009), leverages the strengths of the public system, and those of private system, to establish an integrated service delivery system that includes the full array of public and private health expertise while minimizing additional costs to the State. (For specifics on this model see question #7 below.)

If the new facility "never opens", the State has the option of investing in the current facility to bring it up to code and into regulatory compliance in addition to significant rehab to allow 21st century treatment to be available to residents in need of DMH services.

2) ***Please provide detail on how the proposal will reduce or eliminate services from Tinley Park. Provide details outlining the present service levels and expected service levels throughout the interim period until the new facility is brought online.***
   - ***What impact on service is expected as a result of the proposed consolidation into the Maple Building?***
   - ***Please provide as a comparison, the number of beds for inpatient care currently available at Tinley Park Mental Health Center, the number of the same during the consolidation phases, and the number proposed at the new facility.***

TPMHC will not reduce or eliminate any services during the interim period. The consolidation into the Maple Building will have no impact on services. Currently, there are 75 staffed beds. During the interim period there will also be 75 staffed beds. The new facility will have 100 beds (as recommended by Navigant Consulting, an independent consulting firm contracted to conduct a longitudinal analysis of prior admission patterns against current and future trends and population growth figures.)

3) What impact will the consolidation and replacement plan have on staffing levels at Tinley Park MHC?

- ***In written record DHS has declared 'Until negotiations with bargaining units proceed and are completed, the full and correct determination of staffing patterns in FY10, or beginning in July 2009, are unclear." Please clarify what negotiations to which you are referring in this statement.***
- ***Further, please describe how will the staffing levels, service levels, bargaining unit negotiations, and proposed plan will interconnect.***

As of September 30, 2008, there were 205.5 budgeted employees and 197.3 on-board employees at the Tinley Park Mental Health Center (TPMHC). In accordance with the collective bargaining agreement between AFSCME Council 31 and the State of Illinois, DHS is required to provide AFSCME with reasonable advance notice in writing, which shall not be less than forty-five (45) days prior to the issuance of a Request For Proposal (RFP). DHS and AFSCME will then meet for the purpose of discussing the reasons for the RFP. During this discussion, the Union will be provided all reasonably available and substantially pertinent information in conformance with applicable laws and be granted reasonable requested opportunities to meet with DHS for the purposes of reviewing the employer's contemplated action and proposing alternatives to the completed subcontract. The outcome of these discussions will determine which staff positions will be employed by the vendor versus those that remain employees of the State.

The RFP will include the State's preferred staffing model. However, in addition to bidding on the State's model, the Division of Mental Health (DMH) anticipates allowing the respondent to bid an alternative staffing model (with the rationale, risk and benefits of the alternative). All this will be considered by DMH during the review and scoring process of the solicitation.

DHS will ensure that all represented employees will be afforded their contractual rights and will make every attempt to minimize the adverse impact on employees during this process. At the same time, DMH will strive to ensure that the current level of patient care and services remain in place.

4) I understand Dr. Adams convened the Metro South Mental Health Planning Task Force in 2005, which produced a final report. Please provide a copy of the final report and describe in what ways the current proposal for replacement of the Tinley Park MHC is consistent with or contradicts the Task Force report.

- ***As I understand it, the Task Force recommendation with respect to the operation of the facility is for it to remain a publicly operated facility. In what ways does the proposal for a public-private partnership recognize this recommendation?***

See 2005 Task Force Report (Attachment C).

In September 2004, the Secretary of DHS appointed a task force to create a vision for the mental health service delivery system for the Metro South region. The Secretary called for a "bold" vision; a vision that represented the best efforts of the Task Force to think creatively and long-term about an optimal mix of inpatient and outpatient mental health services and about the community supports deemed necessary for facilitating recovery and resilience for consumers in the region.

In May 2005, after nine months of work, the Task Force presented their "vision" to the Secretary. As a result, the following mission and vision statements were developed.

MISSION: *Through collaborative and interdependent relationships with system partners, it is the Mission of the DMH, the State Mental Health Authority, to assure the provision of a recovery-oriented, evidence-based, community-focused, value-dedicated and outcome-validated mental health service system, in order to build the resilience and facilitate the recovery of persons with mental illnesses.*

VISION: *It is the vision of the DMH that all persons with mental illnesses recover, and are able to participate fully in life in the community. We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports essential for living, working, learning, and participating fully in the community*.

The TPMHC replacement plan was developed to be consistent with the stakeholder mission and vision for the Division of Mental Health. The redesigned facility and overall goals of the project include:

- The construction of a new 100-bed replacement hospital that will expand access for the growing Southland region. The bed size was determined by a comprehensive analysis of bed need;

- Utilizing a public/private partnership model to leverage the strengths of the public system and those of private system by offering an alternative to the present service delivery and financing model. This new model could establish an integrated service delivery system that includes the full array of public and private health expertise while minimizing additional costs to the State;

- Attempt to ensure that all staff will remain employed and to provide new employment opportunities for the Southland region;

- Project will occur in phases to minimize disruption in access to services during construction;

- Foster inpatient care that is consumer-focused, builds on the strengths of a public hospital system of care, and ensures that consumers discharged from the new hospital are successfully connected with community-based treatment options;

- Provide consumers and their families with high quality information about their treatment and offer programs that support customer engagement, peer-led recovery methods and general education;

- A location with easy access to public transportation for consumers, their families, and staff;

- Ready access to a major medical center for patient support and access to a major academic setting with healthcare programs to ensure adequate professional recruitment opportunities and potential training programs; and

- No net loss to the region in dollars or services.

- ***Have the members of the Task Force been contacted or asked to weigh in on the current proposal in any venue?***

DMH fully intends to engage our community partners – consumers, advocacy groups, families, and other mental health providers – to move forward in the implementation of our plan. It is our belief that by moving forward with a public private partnership DMH will accomplish goals, including:

- The strengthening of our quality of care and best practices through innovative private sector ideas that can be more quickly implemented in an environment that is nimble and flexible enough to respond to patient needs and state needs and aligned with best and evidence based practices;

- Increasing the efficiencies which will result in higher rates of consumer satisfaction, the ability to serve more patients, improved staff productivity and retention, and effective use of State dollars;

- Continued planning with families and residents to better respond to their needs; and

- Reduction of the State's long-term obligation to maintain aging infrastructure.

Specifically, our timeframe for engaging members of the Task Force is:

- Attend the Region 1 South Advisory Council Meeting on January 16, 2009. The Advisory Council is made up of Executive Directors of hospitals and community agencies providing mental health services in the southland region.
- Before the end of January 2009, a special stakeholder group is being convened to provide input. There will be representatives from the following groups: NAMI, Mental Health America and Mental Health America Summit, Equip for Equality, Illinois Mental Health Planning and Advisory Council, Illinois Hospital Association and union representatives.

5) What will be the state's role under the current proposal to replace the Tinley Park MHC? Please provide details on the State's role in the following capacities

- ***Construction and operation of the new facility***

- ***Ownership, control, and maintenance of the land on which the facility is built***
- ***Funding of the construction***
- ***Funding of the services***
- ***Revenue for any related funding obligations related to the new facility***
- ***Estimated Medicaid reimbursement at the new facility, in relationship to current Medicaid funding for the TPMHC***

Through an open RFP process, DMH will solicit potential bidders to construct a new privately owned facility for TPMHC.

- The state will not be paying for or financing the construction of the new hospital. The awarded vendor will be required to propose to DMH in their proposal how they would finance the construction. Upon occupancy the vendor will be the sole owner of the building and operator of the hospital with DMH contracting for the delivery of care to our consumers. Their financing will be backed by the awarded contracted that the vendor secures from the DMH. The state will be under no other obligation under the terms of the vendor's contract or towards the financing itself. The vendor is obligated to secure the financing most attractive to them and DMH.
- The hospital will be a privately owned entity. The state is renting or leasing the availability of those services of the hospital for its sole use for as long as the vendor remains compliant to the terms of the contract. Under these terms the state assumes NO risk for the financing or construction costs of the building, these cost are significant and not currently in any appropriations or obligation. The state bears no obligation for the continued maintenance and upkeep of that building freeing the capital and general revenue fund resources of the state up for this burden.

The states role:

- Construction and operation: DMH will manage and monitor the performance of the vendor to meet the terms of the contract.
- Ownership, control, and maintenance: DMH will manage and monitor the performance of the vendor to the meet the terms of the contract.
- Funding of construction: No state obligation.
- Funding of services: No increase beyond current GRF appropriation.
- Revenue: Will revert to DMH under terms of contract.
- Estimated Medicaid revenue: As "IMDs", the Medicaid revenue projections remain the same, and under Medicaid regulations, limiting accessible reimbursement. However, since the claiming process will be under vendor control, DMH plans to place specific performance expectations upon the vendor to secure all appropriate payment reimbursement streams. The expected outcome should result in increased reimbursement, especially related to Medicaid claiming. Based on FY07 Medicaid reimbursement: $300.9K.

6) In 2005, I understand that private hospitals in the Southland advocated against the closing of Tinley Park MHC because they could not or did not want to provide the mental health services to DHS clients. Has DHS been in contact with these surrounding hospitals regarding the current willingness to provide such services to DHS clients?

- ***Do you have commitments from local private hospitals to provide inpatient mental health services? If so, which hospital? If not, what steps are you taking to ensure such partnerships during the proposed replacement?***
- ***Please identify any hospitals which have expressed an interest in building a new mental health hospital in the Southland area during the RFI process.***

Tinley currently has CHPs beds at Ingalls and at St. Joseph's. The plan is to invest in CHPS throughout the region beginning in FY10.

The objection in 2005 against the closing of Tinley Park MHC does not apply to today's plan. Tinley Park will remain in full operation during the construction of the new facility and will increase capacity in the new hospital.

Additionally, DMH engaged in preliminary discussions with area hospitals and providers to share information about what the division intends to do. DMH staff met with the CEO's and Directors of Behavioral Health of South Suburban area hospitals, co-led by the Illinois Hospital Association, on December 9, 2008. The feedback received, based on the current plan, is that they do not expect any untoward effect on their operations. In deference to CGFA statutory language, DMH have not taken additional steps that would likely be perceived as DHS DMH "taking actions to close." The DMH plan is to engage in further discussions with area hospitals after CGFA files its advisory recommendation. It should be noted, however, that several area hospitals and community providers have continually approached DMH with proposals and/or expressed active interest in engaging in substantive discussions with DMH to enhance or expand their inpatient and outpatient behavioral health services at their sites.

Hargrove Hospital-Chicago, a wholly owned subsidiary of Universal Health Services, responded to the RFI released in November of 2008. However, this does not guarantee that Hargrove will be one of the bidders responding to the RFP to construct a new privately owned facility.

7) Do you have plans to privatize the facility management in July 2009? If so, what is the rationale for such a change? Further, what is the rationale for privatizing the operation of the new hospital?

- ***Why is the proposal to privatize a safety-net facility good public policy?***

DMH anticipates entering into a management agreement with a vendor in September 2009. Utilizing a public/private partnership model to leverage the strengths of the public system, and those of private system, will offer an alternative to the present service delivery and financing model. This new model could establish an integrated service delivery system that includes the full array of public and private health expertise while minimizing additional costs to the State. Specifically, this model is based on the following assumptions.

- Private providers have experience and cutting edge expertise in the areas of information management including the use of an electronic medical record system, with features such as
  - computer-based order entry
  - computer-based laboratory test retrieval systems
  - real time tracking mechanism for quality management
  - more sophisticated case history retrieval

All of these features would both increase efficiency but have also consistently shown to reduce medication errors and enhance patient care and quality management.

- Foster inpatient care that is consumer-focused, builds on the strengths of a public hospital system of care, and ensures that consumers discharged from the new hospital are successfully connected with community-based treatment options;

- Provide consumers and their families with high quality information about their treatment and offer programs that support customer engagement, peer-led recovery methods and general education;

- No net loss to the region in dollars or services

8) Under the proposal to replace Tinley Park MHC, please provide a timeline of certain major events in the process by projected dates.

- ***The consolidation begins?***
- ***The RFP drafted?***
- ***The RFP published?***
- ***The Contractor chosen?***
- ***The construction begins?***
- ***The construction completed?***
- ***The Medicaid certification process begins?***
- ***The Medicaid certification process completed?***
- ***The new facility opens?***
  (Please include other major components to the proposed timeline not identified here.)

Projected Timeline:

- RFP Drafted: Present − February 2009
- RFP Published: March 2009
- Contractor Chosen: August 2009
- Consolidation Begins/Vendor Assumes Management of TPMHC: September 2009
- Health Care Facilities Planning Board-CON Application Submitted: October 2009
- Construction Begins: February 2010
- Construction Completed: February 2012
- New Facility Opens: March 2012
- Medicaid Certification Process: The state is currently awaiting a CMS survey for recertification at current facility. Vendor will be required to submit application for certification for new facility within three months of opening of new facility.

9) Where will the new facility be located, specifically? When will the final decision be made? And when will it be made public?

Currently, DMH is involved in evaluating potential sites for the new replacement hospital, sites that respond to and maintain the mission, vision and goals outlined earlier in this document. State owned property is under consideration as well as the identification of existing privately owned facilities and land that might be suitable for retrofitting. DMH is involved in sensitive due

diligence discussions and has not been given authorization to disclose the involved parties and/or site locations. All potential sites are within 17 miles of the existing TPMHC. One or two potential sites will be included in the RFP (release anticipated early March 2009).

Responses to Representative Mautino

1) A full listing of the capital improvements and the associated costs made/completed at TPMHC (R&M, PIF, etc.) for the past 10 years.

1999 - $174,000 to upgrade electrical distribution system
236,000 to upgrade lighting in Spruce Hall
81,000 to replace roofing on Sycamore & Spruce Halls
2000 - $510,000 to upgrade parking lots in Spruce, Oak & Willow
2002 - $310,000 to upgrade life safety system at Oak Hall
300,000 for tuck pointing Maple Hall
245,000 to upgrade energy management
2003 - $230,000 to upgrade accessibility for Spruce Hall

A total of $2,086,000 has been expended in capital projects within the last 10 years.

2) A summary of all citations which occurred that resulted in CMS de-certification

See CMS Survey Findings (Attachment D).

Attachment A: Tinley Park Mental Health Center Joint Commission Survey Findings 3/19/2007 – 3/21/2007

Tinley Park Mental Health Center

7400 West 183rd Street

Tinley Park, IL 60477

Organization Identification Number: 1577

Date(s) of Survey: 3/19/2007 - 3/21/2007

PROGRAM(S)

Hospital Accreditation Program

SURVEYOR(S)

Jay S. Flocks, MD
Virginia J. Jordan, MSN, RN

Executive Summary

Your organization's survey findings have met the criteria for Conditional Accreditation. These findings will be presented to the Accreditation Committee for a final disposition of your organization's accreditation decision. Your organization is required to submit corrective Evidence of Standards Compliance (ESC), due 45 days from the date that these survey findings were posted to your organization's extranet site, for all Requirements for Improvement that are contained in this report. The corrective Evidence of Standards Compliance will not impact the survey findings. However, they are required in order to document the action that your organization has taken to come into compliance with the standards since the time of survey.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Credentialed Practitioners

Standard: MS.4.60

Program: HAP

Standard Text: The organized medical staff provides oversight for the quality of care, treatment, and services by recommending members for appointment to the medical staff.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C
3. The organized medical staff uses the criteria in appointing members to the medical staff and appointment does not exceed a period of two years.

Surveyor Findings

EP 3
Observed in Medical Credentialing at Tinley Park Mental Health Center site.
A physician was noted to have a credentialing expire in 2005. The MD was never recredentialed after that, although active on the staff.

Observed in Medical Credentialing at Tinley Park Mental Health Center site.
Another MD was found also to have privileges expire in 2005. The MD was never recredentialed, though active.

Observed in Medical credentialing at Tinley Park Mental Health Center site.
Another MD was found also to have privileges expire in 2005. The MD was never recredentialed, though active.

Standard: MS.4.10

Program: HAP

Standard Text: The hospital collects information regarding each practitioner's current license status, training, experience, competence and ability to perform the requested privilege.

Secondary Priority Focus Area(s): Organizational Structure

Element(s) of Performance

Scoring Category : A
6. The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information:

The applicant's current licensure at time of initial granting, renewal, and revision of privileges, and at the time of license expiration
The applicant's relevant training
The applicant's current competence

Surveyor Findings

Requirement(s) for Improvement

EP 6
Observed in Medical Credentialing at Tinley Park Mental Health Center site.
In a review of three MD active staff charts, in no cases were there ANY credentialing activities as listed in this standard from 2003 o the present. In each case, the credentialing expired 1n 2005 and there was no attempt o recredential any of these quite active staff MD's after the expiration in 2005.

Standard: MS.4.15

Program: HAP

Standard Text: The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidenced-based process.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
1. The hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of the following are included in the criteria:

Current licensure and/or certification, as appropriate, verified with the primary source.

The applicant's specific relevant training, verified with the primary source.

Evidence of physical ability to perform the requested privilege*.

Data from professional practice review by an organization(s) that currently privileges the applicant (if available).

Peer and/or faculty recommendation.

When renewing privileges, review of the practitioner's performance within the organization.

*Organizations should consider the applicability of the Americans with Disabilities Act (ADA) to their credentialing and privileging activities, and, if applicable, review their medical staff bylaws, policies, and procedures. Federal entities are required to comply with the Rehabilitation Act of 1974.

Surveyor Findings

EP 1
Observed in Medical Credentialing at Tinley Park Mental Health Center site.
A Chart of a physician was reviewed or credentialing. She is an active staff internist. Her last credentialing expired n 2005. There was no credentialing initiated after that. In essence, then, none of the duties of credentialing have been performed by the Medical Staff since 2003. This same finding applies to at least two other physicians reviewed. In conversation with the Medical Director and President of the Medical Staff, I was assured that I would find the same dereliction in most of the other MD charts.

Standard: MS.4.20

Program: HAP

Requirement(s) for Improvement

Standard Text: The organized medical staff reviews and analyzes all relevant information regarding each requesting practitioner's current licensure status, training, experience, current competence, and ability to perform the requested privilege

Secondary Priority Focus Area(s): Organizational Structure

Element(s) of Performance

Scoring Category : C
3. The organization completes the credentialing and privileging decision process in a timely manner.

Scoring Category : A
8. Privileges are granted for a period not to exceed two years.

Surveyor Findings

Requirement(s) for Improvement

EP 3
Observed in Medical Credentialing at Tinley Park Mental Health Center site.
A physician was noted to have a credentialing expire in 2005. The MD was never recredentialed after that, although active on the staff.

Observed in Medical Credentialing at Tinley Park Mental Health Center site.
Another MD was found also to have privileges expire in 2005. The MD was never recredentialed, though active.

Observed in Medical credentialing at Tinley Park Mental Health Center site.
Another MD was found also to have privileges expire in 2005. The MD was never recredentialed, though active.

EP 8
Medical Credentialing Tinley Park Mental Health Center A Chart of a physician was reviewed or credentialing. She is an active staff internist. Her last credentialing expired n 2005. There was no credentialing initiated after that. In her file her license to practice expires in 2005. In fact, a check with the State of Illinois, performed in my presence shows she is currently licensed. She has been practicing unprivileged and uncredentialled for 2 years. That this happened is a failure of leadership at the highest level.

Medical Credentialing Tinley Park Mental Health Center A Chart of a physician was reviewed for credentialing. He is an active staff psychiatrist. His last credentialing expired n 2005. There was no credentialing initiated after that. In his file his license to practice expires in 2006. In fact, a check with the State of Illinois, performed in my presence shows he is currently licensed. He has been practicing unprivileged and uncredentialled for 2 years. That this happened is a failure of leadership at the highest level.

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Another MD was found also to have privileges expire in 2005. The MD was never recredentialed, though active.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Infection Control

Standard: IC.4.10

Program: HAP

Standard Text: Once the hospital has prioritized its goals, strategies must be implemented to achieve those goals.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
1. Interventions are designed to incorporate relevant guidelines* for infection prevention and control activities.

*Examples of guidelines include those offered by the CDC, Healthcare Infection Control Practices Advisory Committee (HICPAC), and National Quality Forum (NQF).

Surveyor Findings

EP 1
Observed in Dietary Department at Tinley Park Mental Health Center site.
Tour observation noted a large floor fan which was in operation. The blades of the fan were coated with a thick black residue of dust and was blowing in the direction of food preparation tables and several clean trays used for patient food. (Food was not present at the time of the observation).

Observed in Radiology Department at Tinley Park Mental Health Center site.
Tour observation noted a desk fan in the main office area of the Radiology Department. The open-weave mesh net that covered the fan was heavily coated with a residue of dust.

Observed in Laboratory at Tinley Park Mental Health Center site.
Tour observation noted an orange-topped test tube with an expiration date of 1/07.

Observed in Laboratory at Tinley Park Mental Health Center site.
Tour observation noted test tubes with 7/06 expiration dates.

Observed in Laboratory at Tinley Park Mental Health Center site.
Tour observation noted test tubes with expiration dates of 11/06.

Observed in Maple 4 at Tinley Park Mental Health Center site.
During tracer activity, the surveyor observed the barber cutting a male patient's hair in the Visitors Room. The barber was using a comb and electric clippers. When the barber completed the hair cut, he began cutting another patient's hair. The barber used the same clippers and comb without cleaning or sanitizing them.

Observed in Maple 4 at Tinley Park Mental Health Center site.
The surveyor observed the barber cutting the hair of a third male patient. The barber did not clean or sanitize the clippers or comb that were used to cut the hair of the previous two patients as noted above.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Information Management

Standard: IM.6.10

Program: HAP

Standard Text: The hospital has a complete and accurate medical record for patients assessed, cared for, treated, or served.

Secondary Priority Focus Area(s): Credentialed Practitioners

Element(s) of Performance

Scoring Category : C
5. The author authenticates either by written signature, electronic signature, or computer key or rubber stamp the following:

The history and physical examination
Operative reports
Consultations
Discharge summary

Scoring Category : B
11. The medical record delinquency rate averaged from the last four quarterly measurements is not greater than 50% of the average monthly discharge (AMD) rate and no quarterly measurement is greater than 50% of the AMD rate.

Note: The score for this Element of Performance will result from the condition described below.

The medical record delinquency rate averaged from the last four quarterly measurements is the following:

Not greater than 50% of the AMD rate and no single quarterly measurement are greater than 50% of the AMD rate-- the score is 2 -Compliance.

Not greater than 50% of the AMD rate but one or more quarterly measurements is greater than 50% of the AMD rate-- the score is 1 -Partial Compliance.

Greater than 50% of the AMD rate but less than twice (that is, 200%) the AMD rate-- the score is 0 – Insufficient Compliance.

Equal to or greater than twice (that is, 200%) the AMD rate-- the score is 0 – Insufficient Compliance and a decision of Conditional Accreditation: see DECISION RULE CON05.

Surveyor Findings

Requirement(s) for Improvement

EP 5
Observed in Maple 2 at Tinley Park Mental Health Center site.
During a patient tracer, it was noted that an assessment (history) on this patient was signed in cursive by the MD whichwas unreadable by everyone who saw it in the room. He/she then, in the space provided for printing one's name, printed an unreadable name.

Observed in Maple 2 at Tinley Park Mental Health Center site.
During a patient tracer, it was noted that a patient physical assessment was signed by the MD in a completely unreadable fashion and no other identifier, e.g., a printed name or identifying number was appended to identify the author.

EP 11
The medical record delinquency rate averaged from the last four quarter was greater than 50% of the average monthly discharge rate.

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Medication Management

Standard: MM.4.50

Program: HAP

Standard Text: The hospital has a system for safely providing medications to meet patient needs when the pharmacy is closed.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
3. This process is evaluated on an on-going basis to determine the medications accessed routinely and the causes of accessing the pharmacy after hours.

Surveyor Findings

EP 3
Observed in Maple 2 at Tinley Park Mental Health Center site.
During a patient tracer, medications were examined in the medication refrigerator. There was one vial of Tbc Antigen and two vials of Novolin Insulin not labelled with the date of opening. Since it was impossible to tell, then the expiration date (28 days after opening) this represents a very dangerous storage practice.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Organizational Structure

Standard: LD.3.20

Program: HAP

Standard Text: Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
1. Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.

Surveyor Findings

EP 1
Observed in Maple 4 at Tinley Park Mental Health Center site.
Tracer activity included review of physician orders for routine blood work at the time of admission of a patient. The patient was transferred from a local medical-surgical hospital on 3/9/07, a Friday. The phlebotomist works Monday to Friday. By the time the patient was admitted, the phlebotomist was not on duty. The next day that the phlebotomist was on duty to draw the patient's blood was 3/13/07 (Tuesday) due to a hospital holiday on 3/12/07. On 3/13/07, the patient refused to have her blood drawn. As of the day of survey, 3/19/07, the patient had not had her blood drawn, nor was there documentation in the medical record to indicate additional attempts by the phlebotomist to obtain a blood specimen. Patients who are admitted during the regular work days of the phlebotomist have their blood drawn by the next day. Patients admitted on the weekends or holidays with orders for routine blood tests need to wait until the next regular scheduled work day of the phlebotomist.

Observed in Maple 4 at Tinley Park Mental Health Center site.
Tracer activity noted that a patient was admitted 3/17/07, a Saturday. Laboratory specimens were drawn by the phlebotomist 3/20, a Tuesday.

Observed in Maple 4 at Tinley Park Mental Health Center site.
Tracer activity noted another patient admitted 3/16/07, Friday at 9 PM. Laboratory specimens were drawn by the phlebotomist 3/20/07, a Tuesday.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Patient Safety

Standard: Requirement 2C

Program: HAP

Standard Text: Measure, assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

Secondary Priority Focus Area(s): Communication

Element(s) of Performance

Scoring Category : A
1. The organization defines critical tests and critical results/values.

Scoring Category : A
2. The organization defines the acceptable length of time between the ordering of critical tests and reporting the test results and values.

Scoring Category : A
3. The organization defines the acceptable length of time between the availability of critical results/values and receipt by the responsible licensed care giver.

Scoring Category : A
4. The organization collects data on the timeliness of reporting critical results/values.

Scoring Category : A
5. The organization assesses the data and determines whether there is a need for improvement.

Scoring Category : A
6. The organization takes appropriate action to improve and measure the effectiveness of those actions.

Surveyor Findings

Requirement(s) for Improvement

EP 1
Observed in Planning Session at Tinley Park Mental Health Center site.
During a planning session, a policy was provided titled Policy #308 Medical Laboratory Results And Follow-up. A policy was also provided titled "University of Illinois Medical Center at Chicago Management Policy and Procedure". This was clearly a policy of the contract laboratory and not of this HCO. Nowhere in the TPMHC policy was there an attempt to define or reference to critical tests or results/values.

EP 2
Observed in Planning session at Tinley Park Mental Health Center site.
During a planning session, a policy was provided titled Policy #308 Medical Laboratory Results And Follow-up. A policy was also provided titled "University of Illinois Medical Center at Chicago Management Policy and Procedure". This was clearly a policy of the contract laboratory and not of this HCO. Nowhere in the TPMHC policy is there a mention of acceptable timing for critical values, nor for that matter is there a use of the term "critical value"

EP 3
Observed in Planning session at Tinley Park Mental Health Center site.
During a planning session, a policy was provided titled Policy #308 Medical Laboratory Results And Follow-up. A policy was also provided titled "University of Illinois Medical Center at Chicago Management Policy and Procedure". This was clearly a policy of the contract laboratory and not of this HCO. Once again, the TPMHC policy does not address the issue of timing, in this instance, between availability and receipt of critical data.

EP 4
Observed in Staff interviews at Tinley Park Mental Health Center site.
Although data on critical test values were requested, none could be produced for the previous 12 months.

EP 5
Observed in Staff interviews at Tinley Park Mental Health Center site.
In staff interviews it was noted that since no data could be produced, there was no data to assess.

EP 6
Observed in Staff interviews at Tinley Park Mental Health Center site.
Although information regarding this requirement was requested, none could be produced since the baseline data was not available.

Standard: Requirement 8A

Program: HAP

Standard Text: There is a process for comparing the patient's current medications with those ordered for the patient while under the care of the organization.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C
2. The medications ordered for the patient while under the care of the organization are compared to those on the list and any discrepancies (e.g., omissions, duplications, potential interactions) are resolved.

Surveyor Findings

Requirement(s) for Improvement

EP 2
Observed in Maple 2 at Tinley Park Mental Health Center site.
Tracer activity and staff discussions indicated that a process for medication reconciliation was not in place.

Observed in Maple 2 at Tinley Park Mental Health Center site.
Discussion with a staff nurse revealed that a process for medication reconciliation had not been implemented at the organization.

Observed in Maple 2 at Tinley Park Mental Health Center site.
During a patient tracer, it was noted that no effort was made, nor was there a process in place to compare the patient's medications with the medications prescribed and note the reason for starting new medications. No attempt was made by the MD to develop a comprehensive medication list.

Observed in Maple 4 at Tinley Park Mental Health Center site.
During a patient tracer, it was noted that two of the patient's medications were discontinued from his medication list and other medications in the same therapeutic class were substituted. No reason, i.e., reconciliation was noted. It is well to note here that due to compliance issues, in ten days the patient was back on his initial medication which is its own argument for proper reconciliation.

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Physical Environment

Standard: EC.9.10

Program: HAP

Standard Text: The hospital monitors conditions in the environment.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
4. Each of the environment of care management plans are evaluated at least annually.

Surveyor Findings

EP 4
Observed in Environment of Care Session at Tinley Park Mental Health Center site.
The annual evaluation of the environment of care plans for the period 7/1/05 - 6/30/06 was written during the survey. Staff attested to the fact that a draft copy had been completed, however, the final document was completed during the survey.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Quality Improvement Expertise/Activities

Standard: LD.4.60

Program: HAP

Standard Text: The leaders allocate adequate resources for measuring, assessing, and improving the hospital's performance and improving patient safety.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
4. Staff is trained in performance improvement and safety improvement approaches and methods.

Surveyor Findings

EP 4
Observed in Data System Tracer at Tinley Park Mental Health Center site.
During the Data Tracer, it was noted that there was not the skill set in leadership to perform meaningful, yet simple data analysis. A number of PI projects were presented which, although well thought out, lacked any plan for analysis to show that they worked, did not work, or made things worse.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Assessment and Care/Services

Standard: PC.2.130

Program: HAP

Standard Text: Initial assessments are performed as defined by the hospital.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : C
1. Each patient is assessed per hospital policy.

Surveyor Findings

EP 1
Observed in Maple 2 at Tinley Park Mental Health Center site.
During a patient tracer, it was noted that an incomplete physical exam, missing key elements of a minimally acceptable examination, was placed on the chart by an MS3 medical student. However, it was countersigned by an attending MD with no corrections, additions, or comments.

Observed in Maple 2 at Tinley Park Mental Health Center site.
During a patient tracer, it was noted that there was a history on the chart signed by an attending physician, but, as agreed by all observers, not written in his handwriting. The actual author was not identified as required.

Standard: PC.8.10

Program: HAP

Standard Text: Pain is assessed in all patients.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : C
1. A comprehensive pain assessment is conducted as appropriate to the patient's condition and the scope of care, treatment, and services provided.

Surveyor Findings

Supplemental Findings

EP 1
Observed in Maple 2 at Tinley Park Mental Health Center site.
During a patient tracer, it was noted that neither the MD or RN assessment detailed a pain assessment comprehensive enough to satisfy hospital policy. The MD did not rate pain, and the RN did not answer the questions about pain in the past or what has helped in the past required by the standard admitting form.

Observed in Maple 4 at Tinley Park Mental Health Center site.
During a patient tracer, it was noted that neither the MD or RN assessment detailed a pain assessment comprehensive enough to satisfy hospital policy. The MD rated pain as "0", and both the RN and MD did not answer the questions about pain in the past or what has helped in the past required by the standard admitting form.

Observed in Maple 2 at Tinley Park Mental Health Center site.
During a patient tracer, it was noted that a comprehensive pain assessment was not done, in that previous experience with pain was not detailed. Additionally, the patient was noted to complain of an earache on admission but the pain is noted as 0/10. This disparity is never explained.

Standard: PC.16.40

Program: HAP

Standard Text: Policies and procedures governing specific testing-related processes are current, approved, and readily available.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : B
4. Current and complete policies and procedures are readily available to the person performing the test.

Surveyor Findings

EP 4
Observed in Maple 4 at Tinley Park Mental Health Center site.
Hospital policy does not address the procedure for indicating the date that the control vials for accu-check quality control testing were opened. Surveyor inspection of the two opened control vials did not contain dates when they were opened. Manufacturer guidelines state that opened vials expire 90 days after they are opened.

Observed in Maple 2 at Tinley Park Mental Health Center site.
Two control vials used for the quality control procedure of the accu-check machine were observed. The box that contained the vials was labeled with the date that the vials were opened, however, the individual vials were not labeled with a date that indicated when they were opened. Manufacturer guidelines state that opened vials expire 90 days after they are opened.

Standard: PC.12.180

Program: HAP

Standard Text: The hospital collects data on the use of restraint and seclusion.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Supplemental Findings

Scoring Category : B
3. Data on all restraint and seclusion episodes are collected from and classified for all settings/units/locations by the following:

Shift
Staff who initiated the process
The length of each episode
Date and time each episode was initiated
Day of the week each episode was initiated
The type of restraint used
Whether injuries were sustained by the patient or staff
Age of the patient
Gender of the patient

Surveyor Findings

EP 3
Observed in Data System Session at Tinley Park Mental Health Center site.
Staff discussions and review of data for use of restraint revealed that the following data had not been collected: staff who initiated the process; length of each episode; type of restraint used; whether injuries were sustained by patient or staff; age of patient; and gender of the patient.

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Equipment Use

Standard: PC.16.50

Program: HAP

Standard Text: Quality control checks are conducted on each procedure.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : C
5. For instrument-based waived testing, quality control procedures are performed at least once each day on each instrument used that day for patient testing.

Surveyor Findings

EP 5
Observed in Maple 4 at Tinley Park Mental Health Center site.
Hospital policy states that accu-check machines are "tested" once a week. Log records confirmed that quality control procedures for the accu-check machines had been consistently performed once a week by the night nursing staff. Neither hospital policy nor nursing practice indicated that quality control procedures had been completed at least once a day when the instrument was used for patient testing.

Observed in Maple 2 at Tinley Park Mental Health Center site.
As noted above, weekly quality control procedures are consistently carried out for the accu-check machines. Staff interviews revealed that a process for daily calibration of the accu-check machines when they are used for patient testing had not been implemented.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Infection Control

Standard: IC.2.10

Program: HAP

Standard Text: The infection control program identifies risks for the acquisition and transmission of infectious agents on an ongoing basis.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : B
1. The hospital identifies risks for the transmission and acquisition of infectious agents throughout the hospital based on the following factors:

The geographic location and community environment of the hospital, program/services provided, and the characteristics of the population served
The results of the analysis of the hospital's infection prevention and control data
The care, treatment, and services provided

Surveyor Findings

EP 1
Observed in Infection Control Session at Tinley Park Mental Health Center site.
The risk analysis for the transmission and acquisition of infectious agents did not include the following: geographic location, community environment of the hospital, and program/services provided.

Standard: IC.4.15

Program: HAP

Standard Text: Immunization against influenza is offered to staff* and licensed independent practitioners.

*The requirements in standard IC.4.15 do not apply to students.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : B
4. The hospital annually evaluates vaccination rates and reasons for non-participation in the hospital’s immunization program

Surveyor Findings

Supplemental Findings

EP 4
Observed in Infection Control Session at Tinley Park Mental Health Center site.
The State of Illinois designated one day for each state hospital to administer influenza vaccination to hospital saff. Out of approximately 200 staff, 19 received the influenza vacinne on the designated day in 8/06. In staff discussion, the limited amount of time for staff to receive the vaccine was a major factor in the organization's non-participation in this immunization program. This does not meet the principle of good process design specifically, consistency with the organization's mission, values, and goals.

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Patient Safety

Standard: LD.3.50

Program: HAP

Standard Text: Services provided by consultation, contractual arrangements, or other agreements are provided safely and effectively.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : B
6. The hospital evaluates the contracted care and services to determine whether they are being provided according to the contract and the level of safety and quality that the hospital expects.

Surveyor Findings

EP 6
Observed in Radiology Department at Tinley Park Mental Health Center site.
Staff discussion indicated that the contracted radiologist comes to the hospital once a week on Wednesdays. X-rays of patients who had x-rays on Thursdays were not read for six days. This does not reflect the principle of good process design, specifically, use of currently accepted practices (doing the right thing, using resources responsibly, using practice guidelines).

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Staffing

Standard: HR.2.20

Program: HAP

Standard Text: Staff and licensed independent practitioners, as appropriate, can describe or demonstrate their roles and responsibilities relative to safety.

Secondary Priority Focus Area(s) N/A

Element(s) of Performance

Scoring Category : C
4. Staff and licensed independent practitioners as appropriate, can describe or demonstrate reporting processes for common problems, failures, and user errors.

Surveyor Findings

EP 4
Observed in Maple 2 at Tinley Park Mental Health Center site.
Surveyor discussions with a staff member revealed that the staff member was not aware that she could contact The Joint Commission. This information is provided during orientation of new employees, however, a system to inform current employees had not been uniformly implemented.

Observed in Maple 2 at Tinley Park Mental Health Center site.
Surveyor discussion with a staff RN revealed that the nurse did not know the expiration time for a control solution vial used for calibration of the accu-check machine once the vial was opened.

Observed in Maple 2 at Tinley Park Mental Health Center site.
During an interview with a staff nurse, she had no idea that she could call The Joint Commission, if an unresolvable issue came up. The HCO presented evidence that there was one PowerPoint slide in the orientation and in-service curriculum, but the nurse had no recollection of this.

Attachment B: Peter Kwasnik Survey Findings 8/4/2007

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
1. CMS requires that the hospital maintain written evidence of regular inspection and approval by State or local fire control agencies. However, the Illinois State Fire Marshals Office by agreement with the Illinois Department of Public Health will not inspect health care facilities that are regulated or inspected by that agency. In addition, it was reported that previous requests for inspections by the local fire department have not been honored. It is suggested that the facility resubmit a written request for a site visit to the local fire authority.	Entire facility	Contact, in writing with TP Fire Department	Tom Hamilton	Letter sent to TPFD asking for a fire safety review of the facility. Awaiting a response. The Illinois State Fire Marshals' Office declined to conduct a fire safety inspection of the facility saying that" Public Health has the responsibility to conduct inspections in Health Care facilities".

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
This effort, in conjunction with copies of fire safety reports by Globetrotter and other qualified fire safety experts, should satisfy this requirement.				
2. Reportedly, there are no records verifying that functional tests of the emergency lighting system had been conducted. A functional test should be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. Battery-operated systems (if any) require an additional annual test of at least 1½-hour duration.	Entire facility	Engineering to conduct testing	Dan Sullivan, Tom Hamilton	Completed on 5/19/07 **Documentation on File**
3. Light fixtures that provide emergency lighting are not distinguishable from other light fixtures.	Entire facility	Engineering to mark fixtures	Dan Sullivan, Tom Hamilton	Completed on 5/19/07

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
To facilitate functional testing of the emergency lighting system, and for prioritizing work orders, light fixtures that are part of the emergency lighting system should be made easily identifiable by label (sticker) or other visual means.				
4. There is no documentation available indicating that window curtains are flame resistant. Documentation attesting that curtains and draperies are flame resistant (as demonstrated by testing in accordance NFPA 701, *Standard Methods of Fire Tests for Flame Propagation of Textiles and Films*) should be obtained from the manufacturer or distributor of such items.	Elevator lobbies in Maple Hall	Curtains to be replaced with window coverings that meet flame resistant standards	Janine Gudac, Tom Hamilton	Window curtains in the passenger elevator lobbies have been removed. Curtains in patient bedrooms have been replaced and documentation certifying to their flame resistance (NFPA 701) is available. **All documentation is on file.**

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
5. Not every unit employee is familiar with his/her responsibility during an emergency. For example: One of the two employees questioned did not know what to do in the event of a bomb threat and had difficulty in identifying the key and opening the fire alarm box. Two of the two employees questioned had difficulty locating the emergency response manual. Access to a portable fire extinguisher was impeded with movable equipment. Staff should be provided with additional emergency response training. They should be asked to demonstrate their knowledge as part of the hospitals system of self-inspections and/or as	Entire facility	1. In addition to the CBL's, Training Coordinator will do on location training of a minimum of 10 employees per week. On location training will include asking staff and students, volunteers where Emergency Manuals are located, opening of locked fire pull stations with appropriate key, and describing the response to various emergencies. Names and dates of employees tested will be recorded in employee training file. 2. Training Coordinator will provide training in the use of fire extinguishers to all staff by actual demonstration annually.	Ruby Powell, Tom Hamilton	Wall mounted holders have been purchased and installed on each of the Residential Units, the Maple 3 Unit, and Security. The Facility Emergency Planning Manuals have been placed in these holders. A preliminary draft of a staff training outline has been reviewed by the Safety Committee and suggested changes/additions have been forwarded to Ms. Lee. With Ms. Lees' transfer, Ms. Powell has assumed the Training Coordinators duties. She is currently working on updating the staff training outline which will be used for this required training.

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
part of the regularly scheduled fire drills.				
6. Reportedly, the quantity of emergency drinking water supply is not based on calculations of anticipated need. The emergency drinking water supply should be of a quantity that is equivalent to ½ gallon (preferably 1 gallon) per person per day for a predetermined duration to allow for replenishment by the purveyor. This calculation should include inpatients, staff, and other persons that come to the hospital during emergencies. A letter of understanding (not necessarily a contract) with the purveyor that indicates the quantity of emergency water that is to be delivered should be kept on file.	Patient units (Maple Hall)	Drinking water supply will be calculated to determine amount of drinking water that should be on hand for emergencies.	Tom Hamilton	We have a current agreement with Hinckley Spring for Emergency water, dated 2/2/07 The WA Howe Center has a skid of water stored should the need arise at either facility. It has been determined that a two day supply of water on-hand (87 cases) would be adequate to allow for Hinckley- Spring to re supply us in an emergency. 87 cases of water are on order for TPMHC which will be stored in the General Stores for emergencies. **Documentation is available showing receipt of 87 cases.**

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
7. Reportedly, there is no mechanism for evaluating the safety of employee-owned electrical appliances that are used in patient care environments. A mechanism for evaluating the safety of electrical appliances (including extension cords) that are brought into the facility by staff should be developed and implemented. Items that have been evaluated and approved for use in a specific location should be labeled/tagged with the date of approval and be rechecked annually.	Entire facility	Safety Committee will develop a policy and procedure on evaluating the safety of employee owed electrical appliances used in patient care areas including inspection, tagging and annual inspections of equipment.	Tom Hamilton,	The Facility Electrical Policy was approved by the Safety Committee at the May 17, 2007 meeting .Has been forwarded to Leadership for final approval and dissemination. As of 8/7/07, the Policy has not been approved or issued **All proposed elements are contained in the policy.**
8. There are a variety of conditions that could be used to facilitate a self-injurious act. Examples of obvious patient hazards are as follows: -Patient room doors could easily be barricaded with furniture. -Vent diffusers in patient rooms have missing slats and constitute an anchoring point. -Beds could be turned on end and	Patient Units (Maple Hall)	Safety Committee will conduct a risk assessment on each of the areas to determine level of risk	Mike Ally	Risk Assessment last completed in 2003. Has to be scheduled with a committee yet to be determined. **Nursing now inspects**

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
serve as an anchoring point. -There are various anchoring points in the toilet and shower rooms. -The alcove by the service elevator is 'out-of-the-way' and not under the visual control of staff. -Changing-booth curtain rods could be removed and used as a weapon A risk assessment should be performed by clinical and administrative staff (including safety and security) of these and any other known or discovered conditions. Facilitators deemed hazardous by this committee should be abated.				**the units on a regular basis and completes written reports. The Safety Committee will review these reports quarterly.**
9. Time sensitive supplies are not always removed from stock upon expiration. This finding was wide spread and included commercially prepared sterile supplies, defibrillator pads and batteries, and vacutainers. Time dated supplies should be removed from stock in a timely manner. This system is dependent upon a monthly (preferably weekly) review of storage facilities for such	Patient units, Clinical Lab and Wellness Center	Weekly focused inspections will be conducted by Nursing staff to verify that time sensitive supplies are removed from stock. Reports of the weekly inspections will be submitted to DON for corrective actions.	Delores Ward R.N. and Clinical Nurse Managers	Weekly inspections are completed by Nursing staff. Any discrepancies noted are addressed immediately by the DON or CNM

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
supplies.				
10. The integrity of the packaging of a significant number of sterile supplies were found to be compromised. For example: In various locations of the hospital, sterile packs were found with punctures, or were crushed or torn. Policies and procedures should be developed and implemented that will require a review of the condition of commercially prepared sterile supplies. These should include a definition of an event that may cause a sterile pack to be or suspected of being compromised and provide clear direction that the final inspection of the package and ultimate decision to use its contents rests with the clinician.	Patient units, Clinical Lab and Wellness Center	Weekly focused inspections will be conducted by Nursing staff to verify that time sensitive supplies are removed from stock. Reports of the weekly inspections will be submitted to DON for corrective actions.	Delores Ward R.N. and Clinical Nurse Managers	Weekly inspections are completed by Nursing staff. Any discrepancies noted are addressed immediately by the CNM

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
11. Medications and sterile supplies were stored under less than sanitary conditions in the employee food refrigerator in Suite 126. In addition, the controlled medications therein were not secured by double lock. This refrigerator should be cleaned and dedicated for storing either food or medication.	Wellness Center	Weekly focused inspections are conducted by Nursing staff to verify that all medications and sterile supplies are stored properly. Reports of the weekly inspections will be submitted to Dr. Yokley for corrective actions.	Sharon Yokley	Weekly inspections are completed by Nursing staff. Any discrepancies noted are addressed immediately by Dr. Yokley
12. The activated gluteraldehyde (Metricide28) used in Suite 126 was not labeled with the date of activation. The bottle as well as the soaking tray should be labeled with the date of activation and, upon expiration, disposed according to label instructions.	Wellness Center	Weekly focused inspections will be conducted by Nursing staff to verify that the sterilizing solution used by the podiatrist displays the activation date and has not expired.	Sharon Yokley	Weekly inspections are completed by Nursing staff. Any discrepancies noted are addressed immediately by Dr.Yokley

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
13. Not all spray bottles are labeled to identify their content. Unless its identity is unmistakable, small working containers of bulk cleaning agents, disinfectants, etc. should be individually labeled for easy identification of content.	Patient Units, Housekeeping, Wellness Center, Clinical Lab	Weekly focused inspections are conducted by Nursing staff to verify that all spray bottles are properly labeled. Reports of the weekly inspections will be submitted to DON for corrective actions.	Delores Ward R.N. and Clinical Nurse Managers, Mr. Malone	Weekly inspections are completed by Nursing staff. Any discrepancies noted are addressed immediately by the CNM
14. The emergency response kits lacked an inventory of supplies. The kits were not sealed. The emergency response kit should be sealed whenever it is not in actual use. Whenever the seal is broken or missing, the kit should be re-inventoried to ensure that it contains the required supplies.	Patient Units and Wellness Center	Policy and procedure regarding Emergency Kits will be revised to include sealing of kits	Delores Ward R.N. and Clinical Nurse Managers	Weekly inspections are completed by Nursing staff. Any discrepancies noted are addressed immediately by the CNM
15. The logs for defibrillators, oxygen tanks, and refrigerator	Patient Units, Wellness Center, Clincial Lab	Weekly focused inspections will be conducted by Nursing staff and Dr. Yokley to verify	Delores Ward, Sharon Yokley	Weekly inspections are completed by Nursing staff. Any

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
temperature checks are not always being maintained. Staff responsible for these checks should be reminded of the importance of conducting these checks. Completed logs should be reviewed and, if necessary, critiqued by the person in charge of that area/department.		that these logs are being maintained properly. Reports of the weekly inspections will be submitted to DON or Dr. Yokley for corrective action.		discrepancies noted are addressed immediately by the CNM or Dr. Yokley.

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
16. The Med Rooms on the 4th and 2nd floor were excessively hot (85ºF at 21% R.H. and 81ºF at 24% R.H. respectively). The air handling system should be adjusted or modified to accommodate the Med Rooms with ambient air temperatures that are within the seasonal comfort zone. (Note: Minor temperature fluctuations for short duration are permitted during seasonal transition periods.)	Med Rooms on Maple 2 and 4	Engineering will review air handling system and make necessary adjustments.	Dan Sullivan, Tom Hamilton	The required cooling units were purchased at the end of FY07 and received in mid July. E-mail dated August 7, 2007 to Mr. Sullivan and his response indicated that theywould be able to begin installation of the units later this week (8-8 thru 8-10-07) **08/20/07, Dan Sullivan indicated that this project should be started within the next few weeks**
17. Oral glucose tolerance beverage and employee food was	Clinical Lab, Wellness Center	Monthly focused inspections will be conducted by Dr. Yokley to verify that items	Sharon Yokley	Weekly inspections are completed by Dr. Yokley. Discrepancies

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
stored in what appeared to be the Laboratory's specimen refrigerator. A 'clean' refrigerator should be provided for products that are ingested by the patient. The specimen refrigerator should be labeled with the bio-hazard symbol.		stored in the specimen refrigerators are appropriate.		noted are addressed immediately by her.
18. Employee food was often mingled with patient food in refrigerated facilities. Food from unknown or unapproved sources should not be mingled with food intended for consumption by patients. Employee food and food brought in by patients' families may be placed in a designated area of a food refrigerator or other food storage location in a way that would not result in the contamination of	Patient Units	Weekly focused inspections will be conducted by Nursing staff to verify that employee and patient food are not placed in the same refrigerators. Reports of these weekly inspections will be submitted to DON the corrective actions.	Delores Ward R.N. and Clinical Nurse Managers	Weekly inspections are completed by Nursing staff. Any discrepancies noted are addressed immediately by the CNM

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
facility-issued food. These designated areas should be clearly identifiable by sign, label, or other effective means.				
19. Most cabinets, drawers, and similar storage locations were unorganized, cluttered, and in need of cleaning. A system for cleaning and organizing cabinets, drawers, and similar storage spaces should be developed and implemented. Supplies should be store according to type. Incompatible supplies should never be mingled. Employee personal property should not be stored with patient care equipment, supplies, medications and food. Sterile and clean supplies should be stored in clean facilities that are used for	Nursing Stations, Treatment/Exam Rooms, Clinical Lab, Wellness Center, Janitor's Closets	1. A facility policy will be implemented requiring that all drawers, cabinets and other storage containers will be labeled as to the contents. 2. Weekly focused inspections will be conducted by selected staff to verify that cabinets, drawers and storage locations are organized and uncluttered. Reports of the weekly inspections will be submitted to Ms. Ward , Dr. Yokley and Mr. Malone for corrective actions.	Delores Ward, Sharon Yokley, Larry Malone	Weekly inspections are completed by Nursing staff. Any discrepancies noted are addressed immediately by the responsible staff. **Policy # 241, Nursing Environmental Surveys which addresses the above, was adopted on August 20th.** **Larry Malone Support Services Supervisor, inspects all janitorial closets to ensure appropriate storage of supplies and cleanliness of same.**

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
no other purpose. Whenever possible, medications should be stored in the following manner: Injectibles above ingestibles; ingestibles above topicals. If space limitations make such storage impractical, then the following storage arrangements should be considered: Sterile supplies above clean supplies; clean and food-related supplies above ordinary supplies; ordinary supplies above disinfectants; liquids below dry/non-liquids, etc.				
20. Most handwashing sinks were not readily available for use due to a lack of hand-washing supplies and obstructions. All handwashing facilities	Medication Rooms, Treatment Rooms, Washrooms, Clinical Lab, Wellness Center	Weekly focused inspections will be conducted by Nursing staff to verify that hand washing facilities are properly maintained. Reports of these weekly inspections will be submitted to the DON for	Delores Ward, Sharon Yokley, Larry Malone	Weekly inspections are completed by Nursing staff. Any discrepancies noted are addressed immediately by the responsible staff.

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
should be provided with single service soap, disposable towels that are offered form a dispenser, and a trash container that is convenient to the handwashing sink. Access to the sink should be kept unimpeded. Handwashing sinks should not be used for any purpose other than handwashing.		corrective action.		
21. Many of the sanitation and safety defects are the direct result of mingling employee personal property and activities with that of the hospitals. For example; employee food was stored on the laboratory table with the centrifuge; med and patient food refrigerators are used for storing personal food, pursed and clothing are stored on surfaces, in cabinets, closets, and drawers containing patient care equipment and supplies. As it pertains to the patient units, employees should be offered and make use of the lockers that are located in rooms near the elevator corridor on the 2nd and 4th floors. If administration chooses, these rooms could also serve as break areas and be equipped with an adequately-sized	Patient Units, Wellness Center, Clinical lab	Weekly focused inspections will be conducted by Nursing staff to verify that employee personal property and Hospital functions and property are not inter-mingled. Reports of the weekly inspections will be submitted to DON and Director, Medical Ancillary Services for corrective actions.	Delores Ward, Sharon Yokley,	Weekly inspections are completed by Nursing staff. Any discrepancies noted are addressed immediately by the responsible staff

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
table, chairs, cabinet, refrigerator and microwave oven. The use of these appliances should be limited to reheating food and beverages (not for cooking). Since there are no opportunities for dishwashing, only disposable eating utensils should be stored on the premises. Employee-owned reusable eating utensils, dishes and food containers that are brought in and taken home at the end of the shift may be permitted. As for the laboratory and suites 116 and 126, these areas should be cleaned and organized to provide physical and procedural separation between clinical and personal activities.		Weekly focused inspections will be conducted by Dr. Yokley to verify that personal and clinical activities are kept separate.	Dr. Yokley	Areas have been re-organized to provide separation between clinical and personal activities Completed 00/00/07
22. Reportedly, there is no policy or written procedure for the receiving, handling, and issuing of donated clothing. Such a policy and procedure should be developed with the participation of the facility's infection control professional and safety officer.	Patient Units	Policy and procedure for donated clothing will be written	Janine Gudac, Tom Hamilton	Final draft sent to Delores Ward and Dr. Brunner on 7/31/07. It was requested that it be sent to the next level for approval and implementation. **Awaiting presentation of policy to Governing Body**
23. Self-closing, metered	Patient units	Weekly focused inspections	Engineering	

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
faucets do not always provide an uninterrupted flow of water for a minimum duration of 15 seconds. Metering faucets should be adjusted or repaired to provide a flow of water for at least 15 seconds without the need for reactivation.		will be conducted by selected Administrative staff to verify that time sensitive supplies are removed from stock. Reports of the weekly inspections will be submitted to DON and Director, Medical Ancillary Services for corrective actions.		Work Order sent in to check the operation of the metered faucets. Completed: 4/9/2007
24. Several pieces of furniture were rusted, torn, and with similar imperfections. The facility should establish a system for the timely refurbishing or replacement of damaged furniture. Furniture in residential and clinical areas should be cleanable and capable of being disinfected by wet methods.	Entire hospital	1. Property Control will conduct weekly inspections of patient units and other areas to identify equipment which needs to be replaced. 2. Furniture for the patient and other clinical areas will be cleanable and able to be disinfected.	Sherri Miller	Waiting for permanent replacement for Property Control Coordinator. Function not occurring at this time. Weekly inspections by Nursing are currently filling this void. New furniture which can be disinfected was purchased for all patient processing rooms on Maple 2&4.

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
25. The underside of the unit ice dispensers needed cleaning. The ice dispensing machines should be cleaned and maintained in a sanitary condition.	Nursing stations	Underside of Ice Machines were cleaned.	Mr. Malone Delores Ward	Completed. This will be an on-going compliance issue.
26. The following are sanitation defects in the 4th and 2nd floor kitchen areas: a. The temperatures of food on a test tray (which was represented as just having been rethermalized according to standard procedures) were as follows: Mashed potatoes……..127ºF Roast Beef…… 140ºF Spinach……. 111ºF Foods that have been cooked and then refrigerated should be reheated to 165ºFor higher throughout before being served. To minimize the risk of scalding, it is suggested that the hot food be permitted to cool down to a temperature of approximately 140ºF before being served. The dietary manager or her representative should establish and participate in a quality assurance program for the satellite kitchens that emphasizes critical control points in food safety. b. Food service staff did not wear hair restraints. Employees should wear effective hair restraints to prevent the contamination of food and food-contact surfaces.	Patient units	Purchase new digital thermometers to improve accuracy of readings and ease of use. Re-train staff on proper procedures.	Mr. Hamilton Ms. Medina	Digital thermometers have been received Ms. Medina has distributed them to the Maple 2&4 units. Documented training has been completed with the Maple 2 and Maple 4 staff. Completed on 4/21/07.

Finding	Areas Impacted	Action(s) Taken	Responsible Person	Follow up
c. Wiping cloths were not stored in a sanitizing solution between uses. Moist clothes used for wiping kitchenware and utensils should be stored in a sanitizing solution between uses. Since laundry bleach is the sanitizer of choice, the solution should be formulated to a concentration not less than 100 ppm (twice the minimum permitted) and not more than 200 ppm available chlorine. A test strip should be available and used to verify the concentration of the solution with each formulation. d. Dried food splash accumulations were on the upper surfaces of the 2nd floor microwave cavity.		Purchase pre-mixed sanitizing solution for use through-out the facility.	Mr. Hamilton Mr. Malone	Pre-mixed sanitizing solution has been received. New product is Cavicide. Product will be dispensed from Central Supply. Completed on May 9,2007. Completed. 4/18/07
27. Gather policies and procedures related to environmental and safety protocols shared with Howe, and make them collectively available at Tinley for the upcoming survey process.	Clinical Lab, Dental Suite,	Develop inspection protocol for Clinical Lab and Dental Suite.	Tom Hamilton, Sharon Yokley	Inspection protocol for surveying the Dental suite and Phlebotomy lab have been written by Dr. Yokley and have been put into effect. Completed on 4/4/2007
28. Have all key restricted areas accessible to supervisory staff to facilitate regularly scheduled monitoring.	Wellness Center, Clinical Lab,		Rennie Smith	Completed

Attachment C: 2005 Task Force Report

A VISION FOR MENTAL HEALTH SERVICES
IN THE METRO SOUTH REGION
METRO SOUTH MENTAL HEALTH PLANNING TASK FORCE

May 5, 2005

Convened by Dr. Carol Adams, Secretary, Illinois Department of Human Service

Introduction

In September 2004, the Illinois Department of Human Services (IDHS), under the direction of Secretary Carol Adams, convened a special planning task force in the Metro South Region of Chicago to discuss and come to consensus around a renewed vision for mental health services in the area currently served by the Tinley Park Mental Health Center (TPMHC). The charge was that mental health services should be re-designed such that the region would provide future consumers with the best that the discipline has to offer-- drawing from best practices in use locally and nationally. The Secretary called for a bold vision.

While this planning process has been prompted by the State's budget crisis and discussions that have included a proposal to close TPMHC, the Secretary has advised the Metro South Mental Health Task Force (Task Force) that it should research and recommend alternate solutions that may include a public hospital option as well as other innovations. This plan represents the best efforts of the Task Force to think creatively and long term about optimal mental health services for the region.

Vision Statement

We envision mental health services in the Metro South Region that fosters a future when everyone with a mental illness will recover, a future when mental illness can be prevented, treated or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatments and supports-essential for living, working, learning and participating fully in the community. [1]

Locally, we envision a system of care that is adequately funded, consumer and family driven, and geographically accessible. This system should continue to include state operated psychiatric beds seamlessly linked with community-based mental health services including the full spectrum of available in-patient and out-patient services. These mental health services will be guided by evidence based research and practice. Services will be linked to other community resources critical to stabilization and recovery, including but not limited to primary health care, affordable housing and employment services.

[1] Adapted from the New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in American. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003. www.Mentalhealthcommission.gov. For free copies call 1-800-789-2647.

Goals

To achieve this vision in our region we will strive towards achievement of these goals:

1. Achieve adequate funding for mental health service enhancement and expansion in the Metro South region.

Context: Historically, mental health services in the Metro South region have not been fully funded; and thus, gaps in services exist. If the service delivery system is to be reconfigured in any way, it is essential that no funds be lost to the region and that reimbursement levels be raised to cover the real costs of ensuring the highest quality mental health services to consumers.

a. Achieve adequate funding levels for all needed mental health services in the region.

b. Explore ways to increase funding for mental health services through increased federal match.

c. Ensure adequate reimbursement rates for community mental health services and private hospitals for services such as: in-patient care, mental health court costs, post-discharge medications; substance abuse services etc.

d. Funds resulting from the full or partial sale of TPMHC lands should remain in the Metro South region to support short-term and long-term infrastructure and service needs as determined by this plan. There should be no net loss to the region in dollars or services.

e. Determine and maintain a reasonable number of state operated beds located in the region.

f. Identify gaps in community based services and ensure funding for those services.

2. Make prevention and consumer education central to a realigned mental health system in the Metro South region.

Context: Current evidence based research supports a best practice model that includes active consumer education as critical to prevention of mental illness and essential to stabilization and recovery.

a. Build strong communities that foster “collective efficacy” or the notion that strong formal and informal social networks and controls make for healthier communities.

b. Ensure strong linkages among the array of health and human service providers, law enforcement, housing and employment resources and services.

c. Facilitate access to affordable primary health care, affordable housing and employment that pays a living wage.

d. Provide consumers and their families with high quality information about their treatment options and about the full constellation of community resources available to assist them in stabilization and recovery.

3. Foster inpatient care that is consumer focused and community based while building on the strengths of a public hospital system of care.

Context: Historically, TPMHC has been a critical anchor in the region. While providers and consumers value community based approaches to mental health, they also recognize that there is merit in having a public hospital in the mix to serve those who have exhausted their private insurance or who are uninsured. Such a hospital is also critical in serving severely mentally ill consumers who are a threat to themselves or others or who may be brought to the facility in lieu of criminal prosecution. At times, a public hospital is the most appropriate resource for the most seriously mentally ill. Once lost, it may never be replaced. While the short-term gains associated with the sale and closing of the state hospital may be attractive, they represent a one time revenue source, at a time when IDHS is being asked to expand services without continuing appropriations.

a. Maintain a public hospital presence in the region, highly targeted to consumer needs as necessitated by behavioral management issues or functional impairment that may not be met by private hospitals such as:

   - longer term care and rehabilitation;
   - special services for mentally ill substance abusers (MISA);
   - special services for those with a dual diagnoses of mental illness and developmental disability;
   - special services for consumers who need court ordered treatment;
   - special services for consumers diverted by law enforcement from criminal to mental health services.

b. Future planning for mental health services in Metro South should be based on a thorough study of the availability of private psychiatric beds and expected consumer demand over time. Public solutions should be innovative, fully funded, and in place *before* any closure or downsizing of TPMHC.

c. Differentiate the roles of the state operated hospital and private hospitals by clearly defining roles and responsibilities, core services, definitions of acute and chronic care, and criteria for admissions and deflections to public and private hospitals.

d. Requirements that ensure that consumers discharged from private hospitals are successfully connected with community based treatment options similar to those currently provided by state hospitals.

e. Explore alternative public/private service and financing models that leverage the strengths of the public system and those of private system.

f. Strengthen collaborative partnerships among all providers in the region's mental health continuum of care.

4. **Enhance and expand upon evidence based best practices in the delivery of out-patient mental health treatment and services.**

   Context: The components of known evidence-based best practice in community mental health are widely known to include at minimum: crisis intervention and pre-screening; mental health linkage case management and intensive case management; psychiatric evaluation and psychotropic medication management; medication management and prevention services; psycho social rehabilitation and skill acquisition; Mentally Ill Substance Abusers (MISA) services; supervised residential services; Assertive Community Treatment (ACT); consumer advocacy and education; employment/vocational training and placement; consumer involvement; cultural competence; research and evaluation of outcomes.

   a. Metro South will strive to make its constellation of services and resources as diverse and comprehensive as possible, filling any gaps that may currently exist.

   b. Support customer engagement, peer-led recovery methods, and general education.

5. **Establish an integrated service delivery system that includes the full array of public and private health and human services, law enforcement and courts, housing, jobs and economic development agencies that support mental health consumers, adequately funded.**

   Context: Mental health services alone do not meet all consumer needs. Stabilization and full recovery require ancillary services and resources located in the consumer's community. Providers of these other services must be accessible and appropriate to the needs of the mental health consumer.

   a. Increase training and funding for local law enforcement on mental health issues.

   b. Increase training for primary health care providers on mental health issues.

   c. Establishment and enhancement of MISA services.

   d. Integration of services provided by state agencies to consumers e.g. Department of Alcohol and Substance Abuse (DASA) and Division of Mental Health etc.

   e. Ensure that the mental health court system becomes accessible to private and public providers.

   f. Increase coordination with state employment services and supported employment opportunities.

   g. Increase connections with sources of affordable housing.

6. Establish standardized mental health outcomes for the region and systematically track and monitor these outcomes.

Context: The IDHS Division of Mental Health (DMH) operates state mental health facilities and sets standards for and monitors utilization of its continuity of care agreements with private hospitals and other community mental health providers.

a. This standard setting and monitoring role should continue and be enhanced such that data collected can be actively used to evaluate and improve the overall system of mental health services in the region.

b. Maintain DMH's role as Network Manager particularly with regard to setting standards of care, monitoring and enforcing those standards.

c. Develop a local outcome tracking system.

Metro South Mental Health Planning Task Force

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Attachment D: CMS Survey Findings

Jul 31-Aug 2, 2006; Oct 16-18, 2006; Jan 22-24, 2007

TINLEY PARK CMS SURVEYS

Tag #	July 31-Aug 2, 2006 Survey	Plan of Correction	Oct 16-Oct 18, 2006 resurvey	Plan of Correction	Jan 22-Jan 24, 2007 Resurvey	Plan of Correction
B 103 - degree and intensity of treatment provided	1. Presence of contraband	All visitors to be search with metal detector	1. Treatment plans need to include alternative approaches and interventions to reduce use of restraint and seclusion	1. Introduction and implementation of Personal Safety Plan ***(1/16/07)*** 2. Review of use of restraint and seclusion in the next treatment team meeting ***(ongoing)*** 3. Training to RN's and Tech regarding alternatives to restraint and seclusion. ***Gail Bluebird Training 7/24&26/07.*** ***CPI Training Fair Scheduled for September. All staff to review Restraint/ seclusion PPD at that time.***	1. Non-English speaking patient did not have interpreter services present during psychiatric evaluation 2. Secure interpreter services to facilitate treatment measures for non-English speaking patients	Facility policy has been revised to include on site interpreters for patients ***(Policy 213 revised 6/4/07) Doctors, Nursing, SWs trained. Hospital Service Plan updated 8/1/07. Contracted on-site services in place and in use since 2/07.(All mono-lingual Spanish speaking patient referrals only to Read or Madden.)***
B 103 - degree and intensity of treatment provided	2. Hallways not monitored as a nursing assignment	Unit assignments modified to assign staff to monitor hallways as well as 30 minute face checks (reduced from 1 hour)	2.Restraint/ seclusion policies regarding standard of imminent risk and face to face evaluations was not always met per documentation	1. Refresher training for all staff on restraint and seclusion policies and the face to face evaluations 2. Retraining of all direct care staff on emergency vs non-emergency situations ***Gail Bluebird Training 7/24&26/07.*** ***CPI Training Fair Scheduled for September. All staff to review Restraint/ seclusion PPD at that time.***		

Tag #	July 31-Aug 2, 2006 Survey	Plan of Correction	Oct 16-Oct 18, 2006 resurvey	Plan of Correction	Jan 22-Jan 24, 2007 Resurvey	Plan of Correction
B 103 - degree and intensity of treatment provided	3. Failure of staff to follow policies, i.e., searching patient after visits	retraining of all staff on searching patients post visits	3. Ensure all active treatment measures would enable a patient to move toward discharge	1. Patient will participate in assignment of treatment modalities (groups) and receive a copy of their treatment plan *Interventions Addendum (11/3/06)allows for patient choice and allows for a variety of needs.offered. Revised schedule 6-07 , with more on-unit groups.. Copies of Addendum given beginning 11/8/06. Tx Plan Signature sheets revised to indicate patient choice and copy of Plan offered.* 2. Treatment plan will be reviewed by patient and treatment team on weekly basis and patient will receive copy of revised treatment plan. *Staffings changed to 14-Day. Treatment Plan Review Form revised. Signature sheet revised to indicate patient choice and copy of Plan offered.* *Mandatory Retaining of nursing staff scheduled for 8-23 and 8-27/07 on personal safety plan/de-escalation/alternatives managing emergencies.*		
B 103 - degree and intensity of treatment provided	4. Searching of visitors	All visitors to be search with metal detector				

Tag #	July 31-Aug 2, 2006 Survey	Plan of Correction	Oct 16-Oct 18, 2006 resurvey	Plan of Correction	Jan 22-Jan 24, 2007 Resurvey	Plan of Correction
B 108 - Social Service Assessments	1. Social assessments not present in all records within facility timeframes	Director of Social Work to conduct concurrent reviews and report findings to Quality Council. ***Concurrent audit of Social Assessments began with 8/16 admissions and are ongoing; monthly reports through 12/06. Quarterly Reports beginning 1/07.***	Social Assessments did not specify the social worker's role in treatment and discharge planning	Director of Social Work will conduct concurrent reviews of all social assessments to ensure documentation of social worker's role in treatment and discharge planning ***Audit of Section #14e began with 11/5/06 admissions and has been ongoing and a part of all reports of the Concurrent audits of Social Assessments. Also monitored by Social Work Peer Review beginning 11/07.***		
B 110 - Psychiatric Evaluation					Psychiatric evaluation was conducted without an interpreter for non-English speaking patient	See plan for B 103 ***(Policy 213 revised 6/4/07) Doctors, Nursing, and SWs trained. Hospital Service Plan updated 8/1/07. Contracted on-site services in place and in use since 2/07.(All mono-lingual Spanish speaking patient referrals only to Read or Madden.)***

Tag #	July 31-Aug 2, 2006 Survey	Plan of Correction	Oct 16-Oct 18, 2006 resurvey	Plan of Correction	Jan 22-Jan 24, 2007 Resurvey	Plan of Correction
B 118 - Individualized Treatment Plans	1. Asthmatic condition not included on treatment plan	1. Retraining of all staff on writing individualized treatment plans *(9/28/07Central Office Training)* 2. Medical staff indicator that all medical problems will be noted as problem in treatment plan 3.RN's will initiate initial treatment plan including all medical issues identified through assessments 4. Daily Nurse Shift report was expanded to include patient risks, i.e., contraband found, requests for discharge, medical issues and distribution will include all clinical staff as well as Pharmacy and posted on Nursing Station 5. Physicians will have written shift report				

Tag #	July 31-Aug 2, 2006 Survey	Plan of Correction	Oct 16-Oct 18, 2006 resurvey	Plan of Correction	Jan 22-Jan 24, 2007 Resurvey	Plan of Correction
B 122 - Specific modalities in treatment plan	1. Psychotic symptoms listed as problem	1. Clinical Leadership will be retrained to improve treatment plan problem identification and observe and monitor treatment teams *(9/28/07Central Office Training)* **Concurrent monitoring of Treatment Plans by clinical leadership began 10/31/06 and ended after Jan. CMS survey. (Reports filed for Nov. and Dec reviews). Treatment Planning workgroup (4/24/07 -present) developed new Treatment Team Monitoring Checklist 8/14).**	Same as B 103	1. All restraint seclusion orders will be reviewed on a daily basis by Medical Director and DON to ensure completeness and clinical appropriateness 2. A psychologist will participate in all treatment team meetings following use of restraint/ seclusion to ensure review of treatment plan and modification of plan as necessary. *Clinical Psychologist participation began 11/06 and is ongoing. Data collected from all restraint review staffings. Psychologist participation in Witnessing began 8/09.* *Mandatory training for nurses 8/23 and 8/27/07. Subject: individualization of Tx modalities including assessment, re-assessment and documentation of patients' progress towards goals.*		
B 122 - Specific modalities in treatment plan	2. Intervention listed was just "meds" and was not specific as to type/dosage of medication	1. Clinical Leadership will be retrained to improve treatment plan problem identification and observe and monitor treatment team. *(See previous B122 entry)*				

Tag #	July 31-Aug 2, 2006 Survey	Plan of Correction	Oct 16-Oct 18, 2006 resurvey	Plan of Correction	Jan 22-Jan 24, 2007 Resurvey	Plan of Correction
B 122 - Specific modalities in treatment plan	3. Nursing interventions listed as "monitor on routine observation" which was not specific	1. Clinical Leadership will be retrained to improve treatment plan problem identification and observe and monitor treatment teams ***(See previous B122 entry)***				
B 122 - Specific modalities in treatment plan	4. Medical problems noted on H & P did not always appear as a problem on the treatment plan	1. Clinical Leadership will be retrained to improve treatment plan problem identification and observe and monitor treatment teams ***(See previous B122 entry)***				
B 122 - Specific modalities in treatment plan	5. Use of group "track" system and assignment to groups non-specific in treatment plan	1. Review patient characteristics of patients served **(9/06)** 2. Based upon evaluation, group interventions will be modified to include appropriate skill sets **Revised Group Programming Schedule and discontinued Track Assignments (9/28/07)**				

Tag #	July 31-Aug 2, 2006 Survey	Plan of Correction	Oct 16-Oct 18, 2006 resurvey	Plan of Correction	Jan 22-Jan 24, 2007 Resurvey	Plan of Correction
B 125 - Active treatment is documented	See findings under B 103	See correction under B 103	See findings B 103	See correction for B 103	Failure to secure an interpreter for to facilitate necessary treatment measures for non-English speaking patient	See plan for B 103 ***(Policy 213 revised 6/4/07) Doctors, Nursing, SWs) trained. Hospital Service Plan updated 8/1/07. Contracted on-site services in place and in use since 2/07.(All mono-lingual Spanish speaking patient referrals only to Read or Madden.)***
B 133 - Discharge planning	1. Discharge Summaries, page 3, were not completed within the facility time frames	Facility policy regarding Discharge Summaries, page 3, was revised to completion within 5 working days of discharge per continuity of care agreement	Discharge Summaries, page 3 were not completed within 5 working days of discharge per continuity of care agreement	On daily basis, Medical Director or designee will review status of Discharge Summaries, page 3 for completion; overtime will be used as requested; also ordered computer software so physician can dictate into computer an no transcription is needed	Discharge Summaries, page 3 were not completed within 5 working days of discharge per continuity of care agreement	1. Facility policy has been revised as of 2/15/07 completion date of 30 days post discharge 2. Overtime is being used to reduce backlog 3. Dictation service may be used
B 144 - Medical Staff	1. Ensure safety and security of all residents	1. See response in Tag # 103	See B 103	See plan for B 103	1. See B 103	

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B 144 - Medical Staff	2. Ensure that physicians develop individualized, non-generic treatment plans	See response to tag # B 118	Ensure violence screening questionnaire is completed on all admissions	Staff to be retrained on the use and completion of the Violence Screening Questionnaire	2. See B 133	See Plan for 133
B 144 - Medical Staff	3. Ensure active treatment for all patients	See correction under tag # 122				
B 148 - Nursing Services	1. Prevent the presence and use of contraband on units	See correction under B 103	MD order for restraints was altered by RN	Daily review of all restraint and seclusion orders by Medical Director and DON to ensure completeness and no presence of alternation to order	See B 103	
B 148 - Nursing Services	2. Ensure proper monitoring of patients	See correction under B 118	Same as B 103	See plan for B 103		
B 148 - Nursing Services	3. Ensure incorporation of nursing interventions in treatment plans	See correction under B 118				

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B 148 - Nursing Services	4. Failure to provide medication to patient	See correction for B 103				