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March 28, 2014

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Mr. Michael Constantino
c/o Illinois Health Facilities and
Services Review Board
525 West Jefferson
Springfield, IL 62761

RE: Written Comments
Project 13-076, Holy Cross Hospital

Dear Mr. Constantino:

Please accept this letter as “written comments” on the above-referenced proposed project, as well as a response to comments made in opposition to the above-referenced project at the Public Hearing conducted on March 4, 2014.

Some hospitals appeared at the Public Hearing, and testified that they had the capacity to accept the patients proposed to be admitted to the planned acute mental illness (“AMI”) unit at Holy Cross Hospital (“HCH”). While the hospitals’ occupancy rates would suggest that capacity exists, that capacity does not appear to be accessible by the patients served by Sinai Health System (“SHS”) and living in the neighborhoods surrounding Holy Cross Hospital, many of which are without any form of insurance coverage or are Medicaid recipients.

Please accept the following in support of that position:

1. SHS is a primary provider of health care services to residents of the West and South sides of Chicago that are without any insurance coverage, or are Medicaid recipients. An analysis of patients treated in Holy Cross Hospital’s Emergency department during 2013 with psychiatric diagnoses revealed that 78.5% were either uninsured or Medicaid recipients (42.3% were categorized as charity care and additional 36.2% were Medicaid recipients). It is anticipated by SHS that the patients to be admitted to the proposed unit will include a similarly

disproportionately-high share of charity care patients, and it is the intent of SHS to admit patients to the proposed AMI unit, based exclusively on the patients' clinical needs, without regard for payment source.

The table below identifies the percentage of inpatient admissions categorized as charity care by each of the hospitals that have indicated concern over the proposed project.

Loretto Hospital*	8.6%
Ingalls Memorial Hospital*	6.1%
Jackson Park Hospital	6.1%
South Shore Hospital	6.0%
Swedish Covenant Hospital*	5.7%
St. Bernard Hospital	4.3%
Roseland Community Hosp.**	3.9%
Chicago Lakeshore Hospital*	3.0%
UHS Riveredge Hospital	2.0%
Norwegian American Hospital*	1.7%
Mercy Hospital and Medical Center	0.7%
UHS Hartgrove Hospital*	0.3%
UHS Streamwood Hospital*	0.0%

*located in excess of 30 minutes (MapQuest, adjusted)
from Holy Cross Hospital

**provides adolescent exclusively, which HCH
will not provide

Source: 2012 IDPH *Hospital Profiles*

In contrast, during 2012 12.5% of the patients admitted to SHS's two acute care hospitals were categorized as "charity care".

1. Patients initially seen in the Holy Cross Hospital Emergency Department and requiring admission to an AMI unit often experience long delays awaiting transfer. As documented in the CON application, during the 12-month period ending June 30, 2013 there were 513 such patients. 80-90% of the patients seen in the hospital's ED with a psychiatric diagnosis are brought to the ED by the Chicago Police Department or Chicago Fire Department, and as noted above, 42.3% are categorized as "charity care". Once an ED physician determines that a patient has been medically cleared for transfer to an AMI provider, an RN is assigned to locate a hospital with 1) an available bed and 2) a willingness to accept the patient. This process typically requires multiple phone calls and FAXs. The process is

initiated with a transmission of the patient's name, date of birth, social security number and insurance coverage. The initial call, since Holy Cross' joining SHS, is made to Mount Sinai Hospital. If a bed is not available there, the next call is to Madden Mental Health Center, if the patient qualifies for admission to that facility. Then, if the patient is without insurance coverage; or if the patient has third party coverage (Medicaid or any other form), other AMI providers that have demonstrated a willingness to accept patients are contacted. These other hospital providers often advise HCH representatives that they do not have a bed available, are holding patients in their own EDs for transfer to another hospital, or are unable or unwilling to accept the patient for other reasons. In addition, Madden accepts no patients between Friday afternoon and Monday morning, and other hospitals, to a lesser extent, have periods during which they will not accept patients. In those instances, HCH is forced to admit the patient to one of its own medical units, with a 24-hour "sitter" until a transfer can be arranged.

It is estimated that approximately 90% of the time when a patient has no third party coverage, HCH is unsuccessful in its efforts to secure a bed for the patient's transfer other than to Mount Sinai or Madden.

Holy Cross Hospital tracked all patients evaluated in the hospital's Emergency Department, and subsequently transferred to another hospital's AMI unit during February 2014. Fifty-five such patients were identified, and there were significant difficulties in the timely transfer of patients, both in terms of the number of phone calls that needed to be made by Holy Cross staff to arrange a transfer, and the delays incurred from the time a decision was made to transfer the patient until the patient left the Holy Cross ED. Those findings are summarized below:

- Average number of calls required to arrange transfer: 3.87
- Patients transferred within 2 hours: 7%
- Transfers delayed 6+ hours: 29%
- Transfers delayed 10+ hours: 18%
- Transfers delayed 12+ hours: 13%

In addition, the transfer of AMI patients from HCH to another hospital is very costly, and this cost is passed on to the patient/insurance provider, including Medicaid. Approval of the proposed project would eliminate these expenses.

From the perspective of the hospital, delays in the transfer of patients result in a number of difficulties, particularly in the ED, including: 1) an ED treatment station being unnecessarily occupied for hours, while a patient is being held, 2) the staff time often needed to make numerous phone calls and send numerous FAXs, attempting to identify a hospital that will accept the patient, 3) disruptions to the orderly treatment of other patients caused by difficult psychiatric patients, 4)

the need to assign a “sitter” to monitor each psychiatric patient, and 5) the need to attend to the concerns of a patient’s family over an extended period.

Mount Sinai Hospital operates a 28-bed AMI unit, with virtually all admissions to that unit being initiated through the hospital’s Emergency Department. As is the case with Holy Cross Hospital’s ED, a high percentage of the AMI patients seen in the Mount Sinai Hospital ED are without insurance. During the 12-month period ending June 30, 2013 416 patients were transferred from Mount Sinai’s ED to another hospital for admission to an AMI unit because no beds were available on Mount Sinai’s AMI unit. Mount Sinai Hospital’s ED regularly experiences difficulties, similar to those of Holy Cross Hospital, when attempting to transfer a patient, and it is anticipated that the proposed unit will eliminate many of those inefficient, non-therapeutic and costly delays. As discussed in the CON application, expansion of the MSH AMI unit is not feasible for facility-related reasons.

2. A letter of opposition to the proposed project was filed by the Association of Safety-Net Community Hospitals, suggesting that safety net hospitals would be financially harmed by the proposed project. This position echoed the Public Hearing testimony of management representatives of three member hospitals---that they would be financially harmed by HCH’s project. While each of these providers discussed the potential financial impact of the proposed project on their own hospital, the difficulties experienced by Holy Cross Hospital patients needing to access inpatient acute mental illness services was not mentioned a single time by any of the presenters, nor were the difficulties experienced by family members when a patient is hospitalized outside of their home community or the difficulties associated with accessing follow-up care when hospitalized outside of the home community.

Eleven AMI providers are identified in the CON application as being within a 30-minute drive of Holy Cross Hospital. Driving time, however, is not a reflection of accessibility for many community residents that look to HCH for care—and particularly the most financially disadvantaged components of the patient population—those that rely on public transportation (please see attached map). In addition, as is the case with Mount Sinai Hospital, a vast majority of AMI admissions will occur through HCH’s Emergency Department, making drive times for this service a poor predictor for analyzing accessibility.

Patient origin data included in ATTACHMENT 12 of the CON application confirms that HCH’s patient population is concentrated in a small geographic area surrounding the hospital. The table below compares driving time to the time required to travel from HCH to the eleven hospitals via public transportation. As can be seen, no providers are located with 30 minutes, if public transportation is to be used. As a result, the desirable continuity of care associated with accessing

follow up care when a patient is hospitalized outside of their home community is virtually impossible if a patient is treated in these AMI units.

From Holy Cross Hospital to:	Driving Time (minutes)*	Public Transportation (Minutes)**	Public Transportation (Mode)**
St. Bernard Hospital	11	38	2 buses
South Shore Hospital	22	70	2 buses
Roseland Community Hosp.	22	71	2 buses, 1 train
Mercy Hospital	20	64	2 buses, 1 train
Jackson Park Hospital	17	61	2 buses
St. Anthony Hospital	19	40	1 bus
Rush University Med. Ctr.	23	62	1 bus, 1 train
Mount Sinai Hospital	21	43	1 bus
Advocate Christ Medical Ctr.	13	61	3 buses
Little Co. of Mary Hospital	11	40	2 buses
MetroSouth Medical Center	23	57	2 buses

Sources:
 *MapQuest, adjusted
 **CTA Trip Planner (3/12/14 10AM)

3. The Association’s letter cited St. Bernard Hospital as an example, noting that St. Bernard “anticipates a loss of 5-10 AMI patients per day and approximately \$1.5 million in revenue annually.” The documentation provided in HCH’s CON application absolutely contradicts this and estimates that St. Bernard will “lose” approximately 130 patients a year. IDPH data identifies St. Bernard’s 2012 AMI average length of stay as 7.5 days, which results in a lost average daily census of 2.67 patients (130 x 7.5 ÷ 365), rather than 5-10 patients. Also, because of the high number of HCH patients that are uninsured (charity care), the financial impact on St. Bernard Hospital will be a fraction of the estimated \$1.5M. We believe this to be the case for other listed hospitals. It is hard to believe that an inpatient AMI unit at HCH will actually cause other safety net hospitals to close doors and/or curtail services, particularly given that the payer mix of the population to be served , and that these same hospitals refuse many AMI transfers from HCH’s ED.
4. The same hospitals opposing the proposed project called for more outpatient mental health programming, as opposed to AMI beds, to treat the area’s growing demand for mental health services. SHS fully acknowledges the critical role of outpatient services in the spectrum of mental health services that must be made available to the community, and it is likely that few, if any other area general

hospitals provide the scope or volume of outpatient mental health programs that is currently provided by SHS, including an outpatient mental health clinic operating at Holy Cross Hospital, providing a variety of services five days a week.

All of SHS's outpatient mental health programs are tri-lingual—English, Spanish, and American sign language. In total, during 2013, SHS' outpatient mental health programs provided over 79,000 treatments, and approximately 240 new patients are accessing these services on a monthly basis. Among SHS' current mental health services, in addition to the HCH clinic, are the following programs provided both on the Mount Sinai campus and in the community:

- psychological evaluations and rehabilitation
- medication management
- individual, group and family therapies
- residential services at Pioneer House
- bilingual *Under the Rainbow* program (targeting the community's youth)
- programming that targets the community's youth and adults that are deaf
- case management
- programming through Interfaith House and Chicago Public Schools
- screenings at Stroger Hospital and Cook County Jail

It is SHS's intent to expand its mental health outpatient programming based at HCH to provide a greater continuum of care including: a 24/7 crisis stabilization program with the goal of limiting transfers to inpatient programs, psychiatric screenings and assessments, a medications management program, individual and small group therapies, and after care services for adults, following discharge from an inpatient program. In addition, discussions are now underway with community representatives to identify optimal sites and receive permission to locate small mental health clinics in selected area schools.

However, and importantly, the community access that SHS provides to outpatient programming does nothing to reduce the difficulties that area residents in need of inpatient care are experiencing. There is no avoiding the fact that inpatient psychiatric care is a necessary component of the continuum of care, and outpatient programs do not prevent this (as valuable as they are). Further, the number of accessible AMI beds, particularly for the most financially-challenged component of the service area's population, has diminished over the past decade as a result of the closure of State-operated inpatient facilities.

5. The suggestion was made at the Public Hearing that SHS would be better served if it were to use the funds proposed for the HCH project to upgrade Mount Sinai Hospital's facilities and replace equipment at MSH. A significant portion of the

project's funding is the result of a State capital grant. Those dollars are designated for capital projects at HCH, and cannot be used for other purposes by SHS.

The capital dollars at SHS's disposal are very limited, due in major part to the System's commitment to the provision of uncompensated services and its high percentage of uninsured patients and Medicaid recipients. Decisions on the allocation of those limited capital dollars are driven by a number of factors, paramount of which is community need. The fact that SHS has decided to use capital resources to fund the expansion of its commitment to address the mental health care needs of its community underscores not only that commitment but its understanding that access to inpatient services for the patients traditionally served by SHS is lacking and must be improved.

6. The U.S. Health Resources and Services Administration (HRSA) has designated Holy Cross' community area as a mental health shortage area, with that designation being originally made on July 11, 2003 and last confirmed on November 25, 2013.
7. Freestanding psychiatric hospitals designated by CMS as Institutions for Treatment of Mental Diseases are not allowed to admit/receive reimbursement for the care of adult Medicaid recipients. (Some are participating in a pilot program allowing them to do so, on a temporary basis.) Four of the opposing hospitals (Chicago Lakeshore Hospital, UHS Hartgrove Hospital, UHS Riveredge Hospital and UHS Streamwood Hospital) are freestanding psychiatric hospitals, and together are approved to operate 668 AMI beds. 25.05% of the patients admitted to Holy Cross Hospital in 2013 were Medicaid recipients, and 36.2% of the patients seen in HCH's Emergency Department with psychiatric diagnoses are Medicaid recipients.
8. Certain hospitals provide inpatient AMI services only to selected age groups. For example, Roseland Community Hospital's AMI unit operates as an adolescent unit, and per South Shore Hospital's Public Hearing testimony, their 15-bed AMI unit operates as a geropsychiatry unit. The proposed HCH service will not be providing child and adolescent services, and will therefore continue to refer patients to the hospitals that do so.

Sinai Health System's two acute care hospitals meet every definition of and operate as safety net providers. The same holds true for a number of the hospitals voicing concern over the proposed project. In fact, SHS works cooperatively with a number of the concerned hospitals in addressing specific needs within overlapping services areas, and anticipates continuing to do so. Regardless of that mutual respect and generally cooperative nature, great difficulties in accessing needed inpatient acute mental illness care for residents of the neighborhoods served by SHS continue, particularly for the significant uninsured portion of that population.

The proposed project ensures a continuity of care that does not currently exist through the provision of inpatient care in the same community where follow-up outpatient services are provided.

Last, I would like to acknowledge the broad-based level of support that this project has received from Holy Cross Hospital's community, including letters of support or direct Public Hearing testimony from:

- Illinois House Speaker Michael Madigan
- Congressman Bobby Rush
- State Representative Daniel J. Burke
- State Senator Mattie Hunter
- Access Community Health Network
- Metropolitan Family Services
- Chicago Family Health Center
- NAMI (National Alliance on Mental Health) Chicago
- Community Behavioral Healthcare Association
- Southwest Organizing Project
- Neighborhood residents
- Greater Southwest Development Corporation
- St. Rita of Casia Catholic Church
- Cook County Sheriff Thomas Dart
- Chicago Police District Commander David McNaughton

Thank you for the opportunity to make these observations through the Public Comment process.

Sincerely,



Charles Weis
Chief Financial Officer/
Chief Strategy Officer

Attachment (Map)

Cc: C. Avery, IHFSRB

