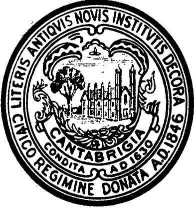

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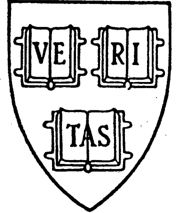

To: Mr. Robert Healy, City Manager April 9, 1982

From: Melvin Chalfen, M.D.; Commissioner of Health and Hospitals MAC

Subject: City Council Request for Psychiatric Admissions Policies of the Cambridge Hospital

In a communication dated March 25, 1982 Mr. Paul E. Healy, City Clerk, forwarded to me a request by Councillor Danehy, Chairman of the City Council Committee on Health and Hospital for a report on "psychiatric admissions customs" of the Cambridge Hospital (copy attached).

Dr. Myron Belfer, Acting Chief of Psychiatry, has reviewed the specific question raised by the petitioner and the broader issue of admissions policies in the Department of Psychiatry. The petitioner's claim that persons seeking psychiatric care are forced to take medications is responded to with an explanation that patients on Cahill IV are informed that in voluntarily agreeing to admission they agree to participate in an active treatment plan which may involve, as one component, the use of medication. No patient is refused active treatment solely because he refuses medication. If refusal of the medication component of a treatment plan results in behavior which cannot be appropriately managed on Cahill IV the patient could be transferred to another facility in the broader Cambridge-Somerville system where such behavior could be managed. Throughout a patient's stay on Cahill IV staff work with patients toward mutually agreement on and participation in an appropriate care plan.

The enclosed memorandum prepared by Dr. Belfer and attached admissions policies details the department's procedures in this area.

cc: Dr. Belfer
Mr. Ryan

1493 Cambridge Street Cambridge, Massachusetts 02139 Telephone (617) 498-1000

RECEIVED
APR 14 12 21 PM '82
OFFICE OF THE
CITY MANAGER

The Cambridge Hospital
Affiliated with
Harvard Medical School

Department of Psychiatry

MEMORANDUM

TO: Mr. Michael Ryan DATE: April 8, 1982
Senior Assistant Director for The Cambridge Hospital

FROM: Myron L. Belfer, Acting Chief MLB
Department of Psychiatry

SUBJECT: Psychiatric Admission Procedures at The Cambridge Hospital--
Memorandum of 3/25/82 from Paul H. Healy, City Clerk to
Dr. Melvin Chalfen, Commissioner of Health and Hospitals

In response to your inquiry regarding the admission criteria to the Cahill 4, Inpatient Psychiatry Service at The Cambridge Hospital and the specific concern of a patient regarding the requirement of the use of medication for admission, I would like to offer the following clarifications.

Some background may be useful. I clearly support the need for the Psychiatry Department to serve all the citizens of Cambridge regardless of their financial resources, or severity of disturbance. We endeavor through our Emergency Service to make our services as accessible as possible. At the same time Cahill 4 is part of a larger network of services, perhaps the most comprehensive, highest quality service network in the Commonwealth, which permits us to tailor treatment services to a particular patient's needs. There are instances where patients or referring individuals, who often are not aware of the network of services, believe that admission to Cahill 4 is the only or best alternative when, in fact, less restrictive or occasionally more restrictive services are indicated.

Cahill 4 is an acute treatment, open, voluntary unit. This implies the use of active treatment and a patient's willingness, however marginal, due to their mental condition, to engage in treatment. Some patients who may be at risk to harm themselves or others cannot make an agreement to be a voluntary patient or engage in active treatment and in an effort to protect the patient or others, we have to recommend involuntary treatment in a closed unit. The latter is clearly an exception. When the latter is the case, the patient is referred to Central Hospital in Somerville which maintains a "closed unit" or to the Cambridge-Somerville Unit at the Metropolitan State Hospital which has a "Special Treatment Unit".

The key to disposition then is the ability to engage in active treatment, not necessarily the use of medication. Sometimes in an effort to explain to patients and families what active treatment is, the example of the use of medication is given. Besides medication, active treatment involves psychotherapy,

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milieu therapy, group work, occupational therapy, work with families, etc. The treatment plan is arrived at by staff, usually with the agreement of the patient and family. Sometimes the patient does not initially agree and staff work with the patient to arrive at a satisfactory plan. No new patient is refused active treatment solely for the reason that they refuse the use of medication while in a disturbed state. This issue is addressed in the decision of the U.S. Court of Appeals case Rogers vs. Okin which was appealed from the U.S. District Court for the District of Massachusetts:

> "In so holding, the district court in effect found that Massachusetts citizens have a constitutional right upon voluntary admittance to state facilities to dictate to the hospital staff the treatment that they are given. The district court cited no authority for this finding, and we know of none. Massachusetts law provides for the voluntary admission of mental health patients who are "in need of care and treatment...providing the admitting facility is suitable for such care and treatment." Mass. Gen. Laws Ann. ch 123 § 10(a). The statute does not guarantee voluntary patients the treatment of their choice. Instead, it offers a treatment regimen that state doctors and staff determine is best, and if the patient thinks otherwise, he can leave. We can find nothing even arguably unconstitutional in such a statutory scheme."

Patients who are known to the system from long-term outpatient care or prior admissions may stop taking the medication that they are on for a variety of reasons. After consultation with their therapist, it may be decided that it is best to try to maintain them outside of the hospital, especially when they are capable of good functioning. They may have stopped taking their medication to test the system or foster a known regression on their part. In that specific instance, where the patient is not at risk to themselves or others, the statement may be made that they need to be back on medication. Treatment is not, in fact, withheld.

Attached is the protocol for admitting patients to Cahill 4 which outlines the procedures that are followed. I would be pleased to answer any questions you might have.

MLB/dmf
Enclosure

ADMISSIONS

POLICIES AND PROCEDURES

I. General Admissions Criteria

1. Cambridge-Somerville patients are given first priority for hospitalization on Cahill IV or Central Hospital. The area Admissions Coordinator, Linda Swain (498-1157), will maintain a waiting list and is responsible for assigning community hospital beds.

2. Priorties are determined on the basis of clinical need with consideration given to appropriate patients who would be sent to Metropolitan State if a community bed were not available.

3. Patients presently on medical units at Cambridge Hospital or Central and in need of psychiatric inpatient treatment and who would otherwise go to Metropolitan State Hospital will be given first priority.

4. Patients without insurance and who have a legal Cambridge-Somerville address are given equal consideration for Cahill IV beds. This will be determined by the Admissions Coordinator in consultation with the referring person and, as always, clinical need will be the primary criterion.

5. When community beds become available the Admissions Coordinator will notify the CCH Emergency Room. If no patient is there awaiting admission and appropriate for the bed a patient will be admitted from the waiting list.

6. Metropolitan State patients will be placed on the list in the order in which the information is received by the Admissions Coordinator and will be given no special priority unless transfer is considered clinically imperative for reasons of treatment or safety.

7. Metropolitan State patients or community patients in need of hospitalization and who have medical needs may be given special consideration for Cahill IV, or Central, especially if their medical treatment has begun.

8. Patients of Cambridge Hospital staff with admitting privileges will be given no special consideration except on the basis of their clinical need. If from out of the area these patients will be considered low priority unless they have been treated previously on Cahill IV or Central.

9. Any and all questions should be directed to the Admission Coordinator. For specific admission requirements and criteria refer to the following pages.

Admission to Metropolitan State Hospital

1. General Procedure

   A. The Admissions Coordinator must be informed of all admissions or transfers. Transfers from Cahill IV or Central must receive prior approval from the Admissions Coordinator or the nursing supervisor at Metropolitan State.

   B. Patients may be admitted directly to Metropolitan State only from the following facilities: Cambridge Hospital Psychiatric Emergency Service, Somerville Mental Health Clinic, Central, Cambridge Court. All others must be referred through Cambridge Hospital Emergency Service.

   C. All patients must be seen for evaluation at one of the above facilities. In rare cases, patients may be approved via telephone by Cambridge Hospital Emergency Service.

   D. The Nursing Supervisor at Metropolitan State Hospital must be notified of admission by the admitting facility before the patient is sent.

   E. The following information must be sent with the patient:

      1. Legal Status (Section 10, 12)
      2. Clinical Evaluation Summary (3 Pages)
      3. Physical Exam
      4. Physician's Orders
      5. A-4 Form

   F. The admitting facility is responsible for insuring that the patient is medically cleared and is not in possession of anything which could be harmful to the patient or others, before being sent to Metropolitan State Hospital.

2. Criteria for Hospitalization

   A. Patient must be in immediate need of treatment and determined to be inappropriate for hospitalization in the community, or 24 hour bed, or unable to wait for a bed.

   B. Patient must be Cambridge or Sommerville resident.

   C. All patients must be considered for community hospitalization, if appropriate, and placed on a waiting list with the Admissions Coordinator.

   D. Any patient with Medicaid/Medicare, BC/BS, or private insurance must be considered for hospitalization in other hospitals if beds are unavailable at Central of Cahill IV, with the exception of a patient who should remain in the catchment area, by prior agreement with Metropolitan State Hospital.

   E. The Admissions Coordinator must be notified of any patient with insurance who may be sent to Metropolitan State.

F. Any patient sent to Metropolitan who is found to be in need of medical care and therefore considered inappropriate may be transferred back to the Cambridge Hospital for treatment. The Psych EW should be notified prior to transfer. Any patient determined clinically inappropriate for admission on psychiatric grounds may be returned to EW provided that that the MSH admitting physician has seen the patient and has discussed the case with the EW before returning the patient.

<u>Admissions to Central Hospital</u>

1. General Proceudre

   A. All admissions or transfers must be approved by the Area Admissions Coordinator.. Patients may only be admitted via the Cambridge Hospital Emergency Service (Cambridge) Somerville Mental Health Clinic (Somerville) or Metropolitan State Hospital. After 5:00 p.m. Monday through Friday and on weekends all Center patients must be seen in the Cambridge Hospital Emergency Service. In rare cases Center patients may be screened by EW via telephone and, if appropriate, admitted directly from another hospital.

   B. Once approved, the referring person (hospital, clinic) will be directed to call the Central Hospital Admissions Coordinator who will do a brief intake and arrange date/time of admission.

   C. Patients may then be admitted directly to Central Hospital and should be sent with all available written material pertinent to the admission; any medical workup, Central Hospital Admission Form, Section 12 (if needed - locked unit only), financial information, Medicaid card, discharge summary (for transfer), physicians orders.

2. Criteria for Hospitalization

   A. Open Unit

      1. Patient must be voluntary.
      2. Patient must have insurance, Medicare or Medicaid <u>currently active</u> (Category 04 will not cover hospitalization).
      3. Minimum age for admission is 13.

   B. Locked Unit

      1. Patient may be on Voluntary or Committment Status (Section 12)
      2. Patients with Court charges pending may be considered appropriate for admission at the discretion of the Admission Coordinator and Central Hospital
      3. Patient must have insurance (see above #2).
      4. Minimum age for admission is 16.

In an effort to keep the Central Hospital Units at full capacity, admissions and transfers must often occur quickly as beds may become available without warning. To facilitate this process, it would be advisable for referring clinicians to prepare all admissions/transfer materials and begin to prepare the patient for admission, as soon as possible after a patient is placed on a waiting list.

IV. Admission to Cahill IV

1. General Procedure - applied to all admissions.

   A. All admission or transfers must be approved by the Admissions Coordinator.

   B. Once approved, the referring person (hospital, clinic) will be directed to call the Chief Resident (or designee) with intake information and arrange date/time of admission.

   C. Admissions to 24 hours bed must go through The Cambridge Hospital Psychiatric Emergency Service and be approved by the Chief REsident.

   D. Elective admission, (scheduled, non-emergency) should plan to arrive on Cahill IV between 10:30 a.m. and noon. Elective patients arriving later than 3:00 p.m. will not be accepted until the following day.

   E. Once the above criteria are established, the patient may be admitted and the following specific procedures must be followed:

      1. Direct Admissions- This privilege is reserved for Cambridge Hospital Psychiatric Emergency Service, SMHC - EW, Schiff Center, Fresh Pond, Metropolitan State, and Central Hospital.

         The following must be done or the patient will be refused admission:

         a. Admission note or discharge summary must accompany patient, including:

            1. Identifing Data (Name, age, Social Security #, address, etc.)
            2. Chief Complaint
            3. History of present illness
            4. Past Psychiatric History
            5. Brief Family and Social History
            6. Mental Status

         b. Admissions or transfer order, and medication orders or documentation of recent medication.

         c. Admitting office must be notified of direct admission and will need:

            1. Name
            2. Age
            3. Admitting physician on Cahill IV
            4. Insurance Information or copy of application for Medical Assistance
            5. Proof of Residency (Cambridge/Somerville)
            6. Admitting diagnosis

      2. Physician's with admitting privileges (M.D.'s on Cambridge Hospital Staff)

         a. Written admitting orders and admission note
         b. Call admitting office to notify of admission or

c. Patient may be seen for evaluation in the Cambridge Hospital Psychiatric Emergency Service, and admitted through there, provided there will be complete admission note from therapist in Cahill IV chart within 24 hours.

3. Private Therapists (not on staff at any of the above facilities) patients must be seen for evaluation in the Cambridge Hospital Psychiatric Emergency Service or Somerville Mental Health.

4. Other Hospitals

   a. Patient must be seen for evaluation by the Cambridge Hospital Psychiatric Emergency Service or Somerville Mental Health 3 days prior to transfer.
   b. On day of admission patient must go through EW or SMHC and referring hospital must send with patient:

      1. Records and or discharge summary
      2. Recent orders including medication orders.

   c. Cahill IV Team Coordinator must be called on the day of admission to confirm transfer.

5. OPD and ACS Staff

   a. Therapist must discuss case with senior clinican. If hospitalization deemed necessary, the admissions coordinator should be contacted.
   b. When the chief resident has approved the admission, it will be the responsibility of the OPD or ACS member to write an admission note. Physicians orders will be written by the OPD or ACS staff psychiatrist.
   c. When the chief resident feels that further evaluation is required, the patient will then be referred to the emergency room for evaluation. It will then be the responsibilty of the emergency service to complete the necessary workup if admission is needed.

6. Cambridge Hospital In-hospital Transfer

   a. Patient must be evaluated by consultation-liaison staff and approved for transfer by Admissions Coordinator and Chief Resident on Cahill IV;

      1. Transfer note
      2. Physician orders
      3. Pertinent medical information (including plans for medical follow up if any)

Note: The above procedures must be followed or patients will be refused admission to Cahill IV. Any question or problems with these procedures should be referred to the Admissions Coordinator.

REV: 3/31/80

THE CAMBRIDGE HOSPITAL

INPATIENT PSYCHIATRIC SERVICE

ADMISSION TO THE INPATIENT PSYCHIATRIC UNIT

Each team will have a person available, each week day for admitting patients to that team. That person will allow for the possibility of being called out of meetings, to see the patients as they arrive on the ward. The nursing personnel covering the ward will be responsible for contacting the team coordinator and the admitting person, in that order. The reasoning for this is to assign an avaluator, who if available will do the admitting.

1. The Nursing Admission/Assessment form (attached) is completed on admission. Parts of this form that must be completed include Section I and the Admission Summary on page two. Additional information on the form is completed when pertinent and expected to be relevant to the patient's hospitalization.

   Under Admission Summary, please include a brief mental status exam and the person's initial behavioral or affective response to admission. Acknowledge having read other clinician's admitting data and add additional information as necessary.

   To reduce the tumultuousness that can surround admission, this information should be obtained in the patient's room.

   Registered nurses must countersign admitting notes completed by Mental Health Workers.

   Patient, at the discretion of the admitting nursing staff member, will be introduced to staff and patients.

2. Person and belongings will be searched for safety of patient and ward.

3. Patient will be informed about the physical exam and the lab work that are required.

4. Patient will be generally introduced to staff, patients and ward lay-out. If appropriate, he will be introduced to the patient ward sponsor and be given a patient orientation guide. He is informed of imminently scheduled groups.

5. The staff member will then obtain patients restrictions and inform appropriate staff of specific concerns.

On Cahill IV patient's privileges are negotiated with, and authorized by, the patient's evaluator. However, there are guidelines that state basic things which a patient must do in order to qualify for each level of privileges. These guidelines, in the form of expectations and matching privileges are listed on the following pages. The staff believes that by meeting certain expectations patients demonstrate their ability to handle responsibility and to constructively use privileges. As patients meet higher expectations, they get more advanced privileges; on the other hand, if they stop meeting these expectations they will lose some, or all of the privileges that go with them. Safety is a primary concern and always the most important factor in deciding on privileges.

Expectation Stage	Privilege
Expectation Stage I.	
A. All Patients first 24 hours patient can remain on ward without behaving in a manner immediately dangerous to himself or others	Area of ward restriction on 15 minute checks
B. All patients second 24 hours. Patient behavior on ward and level of organization indicate the patient is not a danger to himself or others while on the ward	Ward restriction
Expectation Stage II	Cafe

Patient on ward at least 48 hours
Patient cooperative with or without assistance, with basic ward expectations:

Reasonable personal hygiene
8:00 A.M. wake up
Makes bed, linen change once per week
Keeps room neat-possesions in wardrobe and bedside table

Patient attending at least activities planning and community Meetings as well as individual meetings with evaluator
Patient's behavior controlled and appropriate for cafeteria setting
Patient can get to and from cafeteria on his own
Patient signs out, returns promptly, and signs in

Expectation Stage III

Patient on ward at least 72 hours.
Patient meeting all requirements listed above, as well as attending all ward required groups and groups required by individual treatment plans.

Accompanied or Unaccompanied time out

Accompanied time out includes time out with staff or designated family or friends unaccompanied time out starts with ½ hour, gradually increasing to two hours.

Time Out is not to interfere with patients required groups or to extend past 9 P.M. unless previously arranged.

Expectation Stage IV

Patient meets all expectations listed abbve, structures and constructively uses Time Out, and works appropriately on overall treatment, including discharge-aftercare planning

2 hours to uhlimited Time Out
Time Out not to interfere with patient's required groups or to extend past 9 P.M. unless previously arranged

Guidelines for Patient Evaluation on Cahill IV

Donna Moores, M.D.
July, 1981

I. Admissions

A. Documents

1.) Admission Note - including identifying data, chief complaint, history of present illness, immediately relevant past psychiatric history, mental status exam, preliminary diagnosis, preliminary statement of treatment goals for hospitalization.

a.) All admission notes are done in psych emergency room unless it is a direct admit (i.e. State hospital transfer or from Somerville Mental Health Center).

b.) Admission notes from the primary referring clinician are recommended.

c.) All non-physician admission notes must be countersigned by a physician.

d.) All admission after 4 P.M. on week days or on weekends or holidays, must come through the psych emergency room, and the admission notes must be countersigned by the resident on call.

e.) For patients transferred from another floor in Cambridge Hospital, the psych consult/ liason clinician is responsible for a thorough transfer note.

2.) Admission Orders -

a.) Orders are written by the referring MD (Somerville Mental Health, State Hospital or Consult-Liason) or by the doctor in the psych emergency room.

b.) Admissing Orders should include the following:

- Admit to Cahill IV, ________ Team
- Diagnoses (include all Med & Psych)
- Condition (suicide, assault or escape risk or possible withdrawal)
- Allergies

- Restrict to ward for 48 hours (? telephone or visitor restrictions)
- Checks (state frequency)
- Diet (? push fluids, ? I & O)
- Vital Signs (routine means an admit & PRN at nursing staff discretion. You must specify if you want temp, any specific neuro checks, or postural BP & PR. Must outline parametics & signs for medicating & calling H.O. if monitoring for withdrawal).
- (? weights - specify frequency)
- (? sleep chart)
- Activity (must specify any room or wing restrict plan)
- Labs - SMA-12, SMA-6, CBC (?with diff.), urinalysis, RPR (? thyroid functions, toxic screen & ETOH level, CXR, EKG - standard for patients over 40 years old, skull films).
- Meds - standing order for neuroleptic, antidepressant or lithium. PRN of neuroleptic (type, dose, frequency, max daily dose, BP parameters, PRN for what behavior) Anti-Parkinsonian agent (standing order &/or PRN).
  Other frequently used meds (should have PRN for ASA or Tylenol MOM, Maalox) ? vitamins, ? sedative for sleep (should be avoided, possibly use only three days on admit).
  Medication for withdrawal.
  Medication for medical problems

3. Physical Exam

   a.) Must be performed & in chart within 24 hours. To be done by team resident on routine admissions.

   b.) When patient is admitted after 4 P.M. on weekdays or on weekends or holidays, exam is performed by on-call resident.

   c.) Exam is routinely performed in treatment room on Cahill IV or in psych. emergency.

4.) Nursing Staff Responsibilities

a)) Admitting Office or Psych Emergency notifies Cahill IV nursing staff of a patient's readiness to come to the unit. If the patient's behavior is suitable, an admitting office staff member escorts him/her to the unit; if not, a Cahill IV or Psych Emergency staff member escorts the patient.

b) Within four hours a nursing admission note is completed on a standardized form. This must be signed by an R.N. or countersigned by the team resident.

c) Nursing follow-up notes should be completed for each shift over the patient's first 24 hours. This includes a commentary on the patient's mental status and relevant observations about the patient's behavior in the milieu.

d) Admission and progress notes written by mental health workers are countersigned by a registered nurse. All evalaator notes must be countersigned by an M.D. (Team residents generally countersign all non-M.D. notes).

II. Initial Cahill IV Work-UP

A) The Chief Resident must approve all emergency room/direct admissions, transfers and admissions to the 24 hour bed.

1. S/he then notifies the team coordinator, team resident, charge nurse & Ward Clerk.

2. On weekends, the Cahill IV Senior Staff On-Call (Dr. Anscombe & Team consultants) approve these admissions.

B) All patients must be seen by the Team psych resident within one hour of admission on Cahill IV.

1. This is a very brief exam and consultation with the charge nurse.

2. The admitting note and orders should be reviewed and any necessary changes made at this time.

C) Within 12 hours of admission a complete initial work-up must be completed and in the patient's chart.

1. Complete initial work-up consists of admission note, physical exam and mental status exam (including cognitive function).

2) The initial work-up is the responsibility of the team resident.

3) See attached sheets for an outline of an initial work-up.

4) All new admissions are briefly presented during the first morning report following admissions. This is the responsibility of the team coordinator.

D) Team coordinator assigns an evaluator for each admission.

1. If the evaluator is not the Team resident, s/he may be involved with the resident in performing the initial work up.

2. Team coordinator must write a statement assigning an evaluator in the admission work-up.

E) Chief Resident's Note -

a) Chief Resident sees each new admission within 24 hours (unless patient is admitted over a holiday or weekend).

b) A short chief resident's note is included in the initial work-up.

F) Family Work

a) The team social worker is responsible for contacting each patient's family or assigning another team member to do the family work.

b) Families should be contacted within the first 24 hours and initial plans for their attending an admissions conference should be coordinated by the family worker.

G) Nursing Responsibilities

1. Should a patient have concomitant nursing needs, the Team Coordinator determines their presence and plans for addressing them.

2. S/he monitors their inclusion in the treatment plan and their actual and documented progress.

3. Examples of such needs are diabetic management and instructions associated with psychotropic medications.

III The Problem List & Treatment Plan

A) These should be placed in the front of the chart.
B) Their format should follow the guidelines for the problem-oriented medical record.
C) Each problem should be updated on a weekly basis.

IV Admissions Conference

A) This is a meeting of staff, patient and patient's family to outline the goals of the hospitalization and formally to introduce the patient and family to the service.

B) Members present should include the patient's evaluator, family worker & the team resident when deemed appropriate.

C) These meetings should be scheduled by the evaluator and family worker as soon as possible after admission.

D) There must be a note in the chart following the conference, noting members present & briefly summarizing content.

V Progress Notes

A) Frequency of progress notes should be dictated by the patient's clinical condition; however, the minimal is one note per weekday.

B) Progress notes should update & explain the overall problem List & Treatment Plan, should be labeled with the appropriate number and title and should be in the SOAP format.

C) The progress notes should indicate that active treatment is on-going with each problem. It is important to indicate in the record how services given are expected to improve the patient's condition, such as:
   a) Alleviate or control symptoms which necessitated hospitalization
   b) improve level of functioning

VI Present State Exam, Beck Depression Scale, Mini-Mental Status Exam.

These diagnostic tools should be included for appropriate patients; i.e. diagnostic difficulty, questionable organicity or toxicity, etc.

VII The Evaluation Conference

A. The conference is a forum for integrating the material developed during the patient's initial hospitalization and formulating a continued care plan.

1. The initial evaluation conference can be held at any time. However, it should be held no later than a week to ten days after the patient first comes onto the service.

2. It is the responsibility of the evaluator to sign up for an evaluation conference with the team coordinator.

3. The participants in the evaluation conference should include the evaluator, the team coordinator, the social worker, other interested staff, and any outside therapists, if applicable. Team resident should attend when there are medical problems, otherwise, as is possible.

    a. Patient interview is optional

B. The conference presentation should be prepared by the evaluator before the meeting. A chartnote following the conference should include:

1. An updating of the data base. In other words, any further information regarding elements of the data base, such as the history of present illness, past medical and psychiatric history, and past family history. These should be added along with mental status at the time of the evaluation conference.

2. There should be a restating of the problems with a short narrative regarding the status of each problem at the time of the evaluation conference.

3. There should be the presentation of a dynamic formulation. As its name implies, a dynamic formulation presents, in summary form, those forces at play which contribute to the patient's present state. It should take into account the patient's predisposition, including genetic, pathophysiological, environmental, characterologic issues. Against this background the precipitating stresses for the present illness should be brought into focus. Finally, one should present in a meaningful way the underlying wishes or drives, conscious or unconscious and the defensive counterparts which have come together under the aegis of the acknowledged predisposing factors and precipitating stresses to form the chief complaint in presenting symptoms. In other words, this dynamic formulation should be a more succinct overview and derived from previous listing of the patient's problems.

4. There should be a diagnosis in standard DSM III format.

5. There should be a treatment proposal for further hospitalization using the problem oriented approach model on the initial plan.

VIII Discharge Planning Guide (Prepared by Ken Minkoff, M.D.)

At each stage of the hospitalization there are several questions which need to be answered to ensure adequate discharge planning. Most of them are quite obvious, but it is hard to remember all of them unless a specific effort is made to do so. This checklist can be used as a guide for developing discharge plans. But it is important to remember that however thorough a plan seems on paper, something always goes wrong. That is why it is so essential that planning is done early, so that after the initial plan flops, there is still time for an adequate back-up plan to be put in its place.

Stage 1. Evaluation

At the time of the evaluation, the following questions need to be answered with regard to discharge planning:

A. Clinical

(1) What is the clinical and behavioral goal for discharge? At what point (specifically) will the patient be clinically ready to leave the hospital?

(2) What is the expectable level of recovery from the present illness, as judged by patient's premorbid function, diagnosis and level of chronicity? That is, how well will the patient function socially (in terms of daily living skills, interpersonal ability, tolerance of companionship or isolation) and vocationally after discharge?

(3) How long will the patient be in the hospital? How long will it take to reach the above goals?

B. Treatment

(1) Is the patient involved in outpatient treatment at present? If so, how can the outpatient clinicians be involved at the earliest possible occasion in treatment and discharge planning?

F. Vocational

(1) Does patient have a job (school) to return to? If so, what arrangements need to be made with employer (school) to ensure continuation during the period of hospitalization, and to facilitate re-entry and acceptance?

(2) If no job, how will patient best structure his time after discharge? What are his vocational/ educational goals, and are they reasonable? The answer to this relates to A (2) (Expectation of vocational recovery.) If the patient will need Mass. Rehab., CETA, etc. or day treatment, initial application should be made at this time.

After initial answers to these questions are formulated, these issues should be checked out with the patient to see how the "Plan" conforms to his wishes or goals and modified accordingly.

Stage 2 Discharge Formulation

This stage begins about 4 weeks prior to anticipated discharge so as to be completed 2-3 weeks prior to discharge. The purpose of this phase is to finalize a preliminary (in case it flops) discharge plan. (Note that in a brief hospitalization, this phase must begin at the same time as the Evaluation Phase.) In order to prepare the Discharge Plan, all the questions asked in the Evaluation Stage need to be reviewed. By the time Stage 2 is completed, all of the following should be done:

A. Clinical

(1) Criteria for when the patient will be ready for discharge should be specified and agreed upon with the patient.

(2) A timetable for discharge (gradually increasing time out) should be set up.

B. Treatment

(1) Outpatient Treatment Plan should be set (1-1 Group, Day Care).

a. If patient is returning to previous therapist, therapist should be involved in this stage and continuity of care insured.

b. If patient referred to new therapist, patient should have begun meeting with him/her.

c. If patient is referred to clinic/agency, intake should be completed, etc.

(4) Plans for therapy should be sent.

(5) Discharge summary should be completed with evaluation hospital course and copies sent to all outpatient treatment agencies prior to initial contact.

(6) Termination with hospital and hospital therapist should be begun.

(7) Collective decision should be made as to who has primary responsibility for coordinating total outpatient treatment plan.

C. Housing

(1) Living situation should be set, or nearly so, and funding arranged.

(2) Conditions of the living situation (i.e. Halfway house rule, family demands) should be clear to patient and provision for meeting them set.

D. Finances

(1) Patient must have funds available for the time of planned departure.

(2) If SBI or GR pending, interval sources of funding must be sought.

E. Vocational

(1) Plan to return to work should be arranged with employer.

(2) Starting dates for new programs (school, CETA, Mass. Rehab.) should be sentand initial appointments completed.

(3) Day Center initial evaluation should be completed (after SMHC intake) and starting date set to begin about two weeks prior to discharge.

The formulated plan must be checked out with patient and modified accordingly with revision of initial flops.

Stage 3 Termination

During final week of Planned Discharge, and on the day of discharge (especially in a precipitous AMA discharge), it is important to be attentive to specific details to prevent foul-ups

(1) Patient must be clinically ready to go--as tested by time-outs and according to planned criteria.

(2) Outpatient appointments should be set up, written and given to patient, preferably within a few days of discharge. (same for family.)

(3) Any needed medical follow-up appointments must be clearly written out.

(4) Medication appointment given and Sufficient medicines given until appointment.

(5) Patient must know where to go in crisis, at all times.

(6) Patient has money, and checks are arranged to go to correct address.

(7) Patient has place to live, and has coped with living situation satisfactorily during timeouts.

(8) Patient has transportation (or knows bus routes) to various appointments.

(9) Patient has schedule for daily activities via job, school, volunteer work, day center, etc.

(10) Family has been counselled as to what to expect from patient in terms of behavior, symptoms and role performance.

(11) Termination with hospital completed, so patient does not feel rejected or expelled.

(12) Concerns about hospital bill worked out.

IX. Format for Discharge Summary (prepared by Luis Sanchez, MD)

A. Outline

1. Identifying Data (ID)
2. Chief Complaint (CC)
3. History of Present Illness (HPI)
4. Past Psychiatric History (PPSYCHx)
5. Past History (PI)
6. Social History (SH) (optional)
7. Family History (FH)
8. Past Medical History (PMH)
9. Review of Systems (ROS) (optional)
10. Physical Exam (PE)
11. Mental Status (MS)
12. Laboratory Data (lab)

13. Hospital Course (Hosp Course)
14. Discharge Diagnosis (Disch Dx)
15. Discharge Medications (Disch Meds)
16. Discharge Finances (Disch. Fin.)
17. Plan (Plan)
18. Condition on Discharge (Cond)
19. Ability to Work (Ability to Work)

Notes: a. Abbreviations for headings should be used.
b. All headings should be included except for SH, which can be part of PH and ROS, which can be part of PMH.

B. Information to be Included

1. ID at top pf page write patient's name, history number, date of admission and date of discharge. Then in sentence form write number of Cahill IV and Psych admissions, patient's age, marital status, how admitted. Can also include employment status, therapist, previous diagnoses, religion-information which summarizes patient's status.

2. CC in patient's words, short phrase or sentence give as reason for admission.

3. HPI History as relates to reason for admission, given in narrative, chronological form, e.g. can often use the format of 2 mos PTA....leading to day of admission. Past few sentences can summarize patient's presenting symptoms.

4. Psych Hx List chronologically, previous psychiatric hospital admissions or OPD inpatient giving dates, hospital, type of treatment (i.e. ECT). Can also list current psychiatric needs.

5. PH Brief, pertinent description of patient's past history, to include problems, antedating those included in the HPI. Can include birthdays, problems, childhood events, residence changes, family events, marriages, death. listed chronologically.

6. SH can be part of PH. Includes school, employment, military, legal problems, relationships other than family.

7. Order in siblingship. Brief pertinent description of parents, sibs, include ages, pertinent illnesses, quality of relationships.

8. PMH Pertinent illnesses, operations, hospitalizations, allergies, medication. Can often write "unremarkable" if hx not pertinent. Consult with the resident.

9. ROS Can be included in PMN. Include pertinent medical symptoms, and problems not noted in other sections. Consult with the resident.

10. PE Pertinent physical problems. Can often write "unremarkable." Consult with the resident. If problem is important (e.g. Chronic lung disease), should be listed in discharge diagnosis.

11. MS Very important part of the discharge summary. Describe in sentence form pertinent positives and negatives. Usual order includes appearance and behavior; speech; affect; mood; thought content, including hallucinations, delusions, suicidal or homocidal ideation; vegetative signs and symptoms; cognitive functioning, including orientation, memory, concentration, fund of knowledge proverbs, level of insight and judgement.

12. Lab Only pertinent positives; otherwise can write within normal limits work. If data listed, should correlate with PE, PMH, hospital oourse, and possibly discharge diagnosis.

13. Hospital Course Summary of pertinent events during hospitalization to include condition on admission, how lucid (e.g. meds, milieu), how patient responded, results of consults, description of condition at end of hospitalization. Can also list by problems in problem list, but should consolidate problems as determined at time of discharge and describe as to how problem evaluated, treated, and resolved.

14. Didcharge Dx List all diagnoses, including medical problems. These should correlate with diagnoses as listed by resident on patient's face sheet at discharge. First diagnosis often relates to the immediate precipant causing admission (e.g. Chronic Schizophrenia). If not sure of diagnosis, can give Rule Outs R/O after listing the general diagnosis (e.g. Acute Psychotic Episode R/O Schizophrenia, P/O Manic Depressive Deisese. No abbrevaitions can be used. Use Standard DSM III format.

15. Discharge Meds List medications and dosages.

16. Plan Summarize plan, including follow-up, where and with whom.

17. Discharge Finances list what patient has and what is pending (i.e., G.R., SSI)

18. Cond Generally write "improved", but also can say "left AMA." Seldom write unchanged, if planned discharge.

19. Ability to Work Specify if able to work upon discharge. If not, specify for how long disabled and limitations as to type.

C. General Comments

1. Summaries can usually be brief, including only pertinent data. Other details and information can be referred to in the chart; if needed, or found in the complete evaluation summary which can be left in the chart.

2. Remember, nothing damaging to the patient should be included which might be used against the patient legally or in finding employment or attending school.

3. If there are previous admissions and discharges, can write "See old chart" for unchanged data, i.e. SH, PPsych, Hx, etc.

4. Use only recognized abbreviations. Dont make them up.

5. Neatly print proper names, hospitals. The clerk-typist cannot use the context of the sentence in spelling names.

6. Consult the team resident for information in the PMEdHx, ROS, PE, Lab.

7. At the end, print your name, title, and the name of the resident for whom you are dictating.

8. For the benefit of all concerned, including the patient, the summary shall be written within a week of discharge.

9. If patients are being transferred to another facility, summaries shall be written prior to discharge and included with transfer data.

D. Sample Discharge Summaryy (below)

John Smith   Hosp #55-66-55
Admitted 3-10-77   Discharged 4-10-77

1st Cahill Iv, 3rd Psych hosp for this 35 y.o. WMM, father of two children, admitted through the EW on the advice of his therapist, JANE GREEN, R.N. of Somerville Mental Health Center (SMHC) for further evaluation of depression.

CC: "My mind stopped working"

HPI: Patient has been in treatment with Ms. Green for past two years, being seen biweekly, maintained on phenothiazines, with diagnosis of Schizophrenia. Was employed, living with family in usual state of health one month PTA, when patient's mother unexpectedly died of a heart attack. Over next two weeks, pt. became increasingly despondent, and non-talkative two weeks PTA, pt quit his job amd stopped his meals. 1 wk. PTA pt refused to leave his house, stayed in bed, eating little, talking to no one. Day of Admission Ms. Green visited pt's house on advice of his wife, found pt in disheveled state, apparently hallucinating. He was brought voluntarily to the EW for evaluation for admission. Because of his psychosis, severe depression and suicide potential, he was admitted for protection, evaluation and treatment.

PsychHx: 1962, age 20, Westboro State Hospital - 4 mos. for psychosis, treated with phenothiazines.
1970 Glenside 1 month for psychosis, treated with EXT.
1975 until present, SMHC as outpatient.
Medicine: Thorazine 400 mg. p.o. GHS.

PH: Born Somerville. Described by mother as shy child with few friends. High School graduate with average grades. Parents separated when pt 17 y.o. Worked as a laborer. Married at 19 y.o. 1st child at 20 y.o. Hospitalized before birth of child. 2nd hospitalization following birth of 2nd child. Employed for last 5 yrs. with Somerville Maintenance Dept.

FH: 3rd of 4 siblings. Parents divorced when pt. 18 y.o. Father, age 65, unemployed, lives in Somerville. allegedly with alcohol problem. Mother, age 63, died one month ago of M.I. lived in pt's house, described as wonderful by pt. Oldest sib, Betty age 39, with hx of psych hospitalization. No family hx of emotional disorders.

PMH: Rheumatic fever age 11. Penicillin allergy.

ROS: "Heart murmur" for past few years.

PE: Unremarkable except for soft systolic cardiac murmur.

MS: Moderately obese, middle aged, disturbed man with bizarre facial grimaces, speaking is monotone with blunted affect and depresseed mood. Admits to hearing voices of the "devil and spirits."Vague suicidal ideation. Admits to 20 lb weight loss in past month , insomnia, loss of appetite, decreased libido. Oriented and alert with decreased concentration. Proverbs concrete. Insight and judgement poor.

LAB: Routine WNL.

Hosp.Pt's problems were identified and treated as follows:

Course: 1. Psychosis.Pt was restarted on Thorazine, with Doses reaching 1000 mg qd Over 1st wk with gradually resolving of the thought disorder.

2. Depression. With clearing of his psychosis pt was able to grieve his mother's death. As hospitalization progressed, he was able to better utilize individual sessions with his evaluator, but always remained uninvolved in most group activities. He was not encouraged to attend verbal groups, but did utilize task groups.

3. Unemployment Toward end of hospitalization, he regained contact with his employer, and part time hours were worked out.

4. Heart murmur Cardiology consult, diagnosed mild aortic stenosis without need of further treatment at this time.

Disch Dx: I. Schizophrenia, undifferentiated, Chronic 295.92
Major Depression, Psychotic , single episode 296.24

II. None noted
III. Aotic Stenosis , Mild
IV. Psychosocial stressors - 6, extreme death of mother
V. level of functioning- fair-steady job, family.

Disch Finances: SSI.

Meds: Thorazine 400 mg p.o. QHS

Plan: 1. Follow up with SMHC and pt's therapist
2. Medical clinic appointment in six months.

cond: Improved

Ability To work: unable for 2 weeks. Then part time work until pt better compensated, less anxious and as negotiable with his employer.

Frank Smith, MHW
dictating for Mary Evans, M.D.

CITY OF CAMBRIDGE

INTEROFFICE CORRESPONDENCE

RECEIVED
MAR 26 1982
COMMISSIONER
Health & Hospitals

To Dr. Melvin Chalfen, Commissioner of Health & Hospitals

Date March 25, 1982

From Paul E. Healy, City Clerk PEH

Reference

Subject Psychiatric admittance procedures at the Cambridge Hospital

Dear Dr. Chalfen:

Enclosed herewith you will find a copy of a communication recently received by the City Council with regard to psychiatric admittance customs at the Cambridge Hospital. Said communication was referred to the Committee on Health and Hospitals at the Council meeting held on March 15, 1982. Councillor Danehy, the Chairman of the Committee on Health and Hospitals has requested that you submit a report on the psychiatric admissions customs employed by the Hospital for referral to his Committee.

Your kind attention in this matter will be greatly appreciated.

Copy to Councillor Danehy

PEH/mh

Enclosure

i would like to address the cambridge city counsel at its regular monday session march 14 1982 regarding phychiatric (at camb. city hosp.) admittance customs... that a person seeking phychiatric services are forced to take medicine or they will not be ~~helped~~ ~~and~~ admitted there.

Bernard Connors 25 decatur 02139 #2

S-368

Comm. from Paul E. Healy, City Clerk, transmitting comm. from Dr. Melvin Chalfen, Comm. of Health & Hospitals Re: various reports on psychiatric admittance procedures to the Cambridge Hospital.

In City Council,

April 26, 1982