Gatekeeper Reference Document

I. DMHA Website
https://www.in.gov/fssa/dmha/4325.htm

II. State Psychiatric Facility Map
https://www.in.gov/fssa/dmha/files/DMHA_SOFs_and_CMHCs.pdf

III. Certification and Licensure Rules and Indiana Code

You may access rules and regulations through Access Indiana: http://www.in.gov/legislative/

Click on "Law and Administrative Rules," then click on Indiana Code or Indiana Administrative Code for Related Mental Health and Addiction Indiana Code and Administrative Code Sites. Those highlighted reference gatekeeping and SPH. Excerpts are listed below:

www.in.gov/legislative/ic/code/title12

- IC 12-23-18: Methadone Diversion Control and Oversight Program
- IC 12-25: Licensure of Private Mental Health Institutions
- IC 12-27: Rights of Individuals Treated for Mental Illness/Developmental Disabilities

www.in.gov/legislative/ic/code/title16/ar39/index.html

- IC 16-39: Health Records

www.in.gov/legislative/iac/title440.html

- 440 IAC 1.5: Licensure of Free-Standing Psychiatric Inpatient Treatment Facilities
- 440 IAC 4-3: CMHC Mandatory Services
- 440 IAC 4.1: Certification of Community Mental Health Centers
- 440 IAC 4.3: Certification of Managed Care Providers
- 440 IAC 4.4: Certification of Addiction Service Providers
- 440 IAC 5: Community Care
- 440 IAC 5.5: Commitment Report to the Courts for Community Mental Health Centers
- 440 IAC 6: Certification of Residential Care Providers
- 440 IAC 7.5: Residential Living Facilities for Individuals with Psychiatric Disorders or Addictions (includes requirements for Alternative Families for Adults, Semi Independent Living Programs, Transitional Living Facilities, Supervised Group Living Facilities and Sub-Acute Facilities).
- 440 IAC 8: Populations Served by CMHCs and MCPs
- 440 IAC 9: Continuum of Care Minimum Standards for CMHCs and MCPs
- 440 IAC 10: Minimum Standards for the Provision of Services by Opioid Treatment Facilities and Programs

- 440 IAC 10-3 and 4: Minimum Standards for the Provision of Services by Opioid Treatment Facilities and Programs
- 440 IAC 11: Certification of Assertive Community Treatment

What is a Gatekeeper?

440 IAC 9-1-8 "Gatekeeper" defined

Authority: IC 12-21-2-8; IC 12-21-5-1.5

Affected: IC 12-7-2; IC 12-24-12-10; IC 12-24-19-4

Sec. 8. "Gatekeeper" means an entity identified in IC 12-24-12-10 that is actively involved in the evaluation and planning of and treatment for a committed individual beginning after the commitment through the planning of the individual's transition back into the community.

(Division of Mental Health and Addiction; 440 IAC 9-1-8; filed Sep 8, 2000, 10:12 a.m.: 24 IR 373; readopted filed May 10, 2001, 2:30 p.m.: 24 IR 3235; readopted filed Apr 7, 2008, 3:40 p.m.: 20080507-IR-440070745RFA; readopted filed Aug 11, 2014, 11:21 a.m.: 20140910-IR-440140240RFA)

Clarification: A gatekeeper is the agency who conducts the defined activities above. CMHCs may have one gatekeeping liaison or a team of liaisons who function in this role.

440 IAC 5-1-2 Definitions

(4) "Gatekeeper" means the following:

(A) The community mental health center which facilitated the consumer's entry into the state institution after July 1, 1994.

(B) For consumers who entered the state institution before July 1, 1994, the community mental health center which would have been designated to facilitate the consumer's entry into the state institution if the consumer had entered the institution after July 1, 1994.

What is a Gatekeeper's role?

440 IAC 4.1-3-2 Obligations of each community mental health center regarding the exclusive geographic primary service area

Authority: IC 12-21-2-3; IC 12-29-2-1

Affected: IC 12-26-6-8; IC 12-26-7-3

(b) Except for consumers who are enrolled by another CMHC or managed care provider, the CMHC is obligated to provide commitment screening to a state institution administered by the division of mental health and addiction for any individual residing in the CMHC's exclusive geographic primary service area who presents for screening services or is referred for screening services.

(c) Commitment screening to a state institution administered by the division of mental health and addiction shall be done by the CMHC that enrolled them, or by the CMHC with which the managed care provider that enrolled the person has a screening contract.

(d) Notwithstanding subsection (b), the designation of an exclusive geographic primary service area may not limit an eligible consumer's right to choose or access the treatment services of any provider who is certified by the division of mental health and addiction to provide publicly supported mental health services.

440 IAC 5-1-3.5 Gatekeeper's role during the time the individual is in the state-operated facility

Authority: IC 12-8-8-4

Affected: IC 12-24-12; IC 12-24-19

Sec. 3.5. After an adult or child is admitted to a state-operated facility, the gatekeeper shall do the following:

(1) Have a face-to-face meeting with the individual within thirty (30) days of admission and at least every ninety (90) days thereafter, to evaluate treatment progress, and discuss discharge planning.

(2) Communicate with the family or guardian of a child within thirty (30) days of admission and at least every ninety (90) days thereafter, to discuss the treatment plan, evaluate treatment progress, and discuss discharge planning.

(3) Communicate with the treatment team at the state-operated facility within thirty (30) days of admission and at least every ninety (90) days thereafter, to discuss the treatment plan, evaluate treatment progress, and discuss discharge planning.

(4) Provide notice of the date for the planned community placement to the treatment team and the individual at least two (2) weeks prior to the anticipated community placement.

(5) Document face-to-face visits with the individual and contact with the treatment team at the state-operated facility and in the gatekeeper's record.

(Division of Mental Health and Addiction; 440 IAC 5-1-3.5; filed Nov 4, 2002, 12:09 p.m.: 26 IR 747; readopted filed Apr 7, 2008,3:40 p.m.: 20080507-IR-440070745RFA; readopted filed Aug 11, 2014, 11:21 a.m.: 20140910-IR-440140240RFA)

440 IAC 9-2-6 Services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty

Authority: IC 12-21-2-8; IC 12-21-5-1.5

Affected: IC 12-7-2; IC 12-24-12-10; IC 12-24-19-4; IC 12-26

Sec. 6. (a) Services to prevent unnecessary and inappropriate deprivation of a person's liberty include the following:

(1) Review of commitments and gatekeeping into and out of state-operated institutions.

(2) The range of community support program services and crisis service alternatives.

(3) Those administrative and supervisory functions that manage the care provided to make certain that each consumer receives appropriate care.

(b) A utilization management plan, which provides objective guidance that helps direct treatment, external to the clinician/consumer relationship, must be in place and include the following:

(i) The plan shall be an existing system that defines criteria for initiating a course of treatment, transition, and discharge.

(ii) The plan shall be objective, documented, and external to individual clinicians.

(iii) The plan shall cite published literature and research on which the system is based.

(iv) Utilization management may consist of any of the following:

(A) Prior authorization manuals or systems.

(B) Evidence-based treatment systems.

(C) Clinical pathways.

(D) American Society of Addiction Medicine criteria.

(E) Another system of linking need to care.

(5) A provider may contract for utilization management services.

(c) In addition to regular peer review, supervisor review, and treatment plan reviews, the provider shall have an ongoing process to evaluate the utilization of services.

(d) The utilization of services review shall include the following:

(i) The percentage of cases evaluated for each modality of treatment.

(ii) The ongoing system of treatment evaluation.

(iii) Samples of reports from the previous year's treatment review.

(e) The provider shall train staff on the use of the utilization management system and keep records regarding the training.

(Division of Mental Health and Addiction; 440 IAC 9-2-6; filed Nov 30, 2001, 10:58 a.m.: 25 IR 1139; readopted filed Apr 7,2008, 3:40 p.m.: 20080507-IR-440070745RFA; readopted filed Aug 11, 2014, 11:21 a.m.: 20140910-IR-440140240RFA)

IV. CMHC Contract Exhibit

Gatekeeping

A. General Requirements

1) Pursuant to IC 12-26-6-8(c)(1) and IC 12-26-7-3(b)(1), a CMHC shall conduct a face- to-face evaluation of the individuals who are proposed to be committed to a state institution administered by the DMHA and report the findings of the evaluation to the court in which the matter is pending.

2) Pursuant to IC 12-24-12-9 and IC 12-24-12-10(a)(1), a CMHC shall administer within the limits of its service capacity, a continuum of care as required by IC 12-24-19-4 for each individual who meets the following requirements:

a) Has been involuntarily committed under IC 12-26;

b) Is not developmentally disabled; and

c) Has been discharged from a state-operated facility or is placed on outpatient status by a state operated facility under IC 12-26.

B. State-Operated Facility Bed Allocation for the SMI Population

1) IC 12-21-2-3 allows the director of the DMHA to establish, maintain and reallocate long-term care settings and state operated long term care inpatient beds to provide services for patients with long term psychiatric disorders.

2) The total number of approved state operated facility beds allocated by the State for the inpatient care of Adults who are Seriously Mentally Ill for the period from 7/01/xx through 12/31/xx, as well as the corresponding number of Bed Days allocated by the State for this purpose, are identified in the DMHA spreadsheet "Bed Allocation for Indiana CMHCs," dated January 1, 202x, which is hereby incorporated by reference.

3) The total number of approved state operated facility beds allocated by the State for the inpatient care of Adults who are Seriously Mentally Ill (SMI) for the period from 1/01/2x through 6/30/2x as well as the corresponding number of Bed Days allocated by the State for this purpose, are identified in the DMHA spreadsheet "Bed Allocation for Indiana CMHCs," dated January 1, 20xx.

4) The Contractor shall not use more than the allocated number of beds nor allow more of its consumers to receive SOF inpatient services during any given month, unless the Contractor has received authorization from the DMHA that the Contractor is permitted to enter into an agreement and intends to utilize the unused SOF beds of another Community Mental Health Center.

5) In order to borrow a bed the Contractor must obtain prior approval from the DMHA through submission of a "Borrowed Bed Request and Authorization Form."

6) The Contractor further acknowledges that the provision to Contractor by the DMHA of the use of borrowed beds as described above is valuable consideration provided to Contractor by the DMHA under this Exhibit.

7) At no time shall a Contractor exceed a limit of five (5) borrowed beds.

8) If the Contractor determines an extension of an individual agreement is needed, the Contractor must submit a new "Borrowed Bed Request and Authorization Form" requesting reauthorization for the individual to the DMHA for prior approval. The request must be received by DMHA a minimum of 14 business days prior to the expiration of the agreement and must be accompanied by a justification statement for the request and a plan outlining measures that will be implemented by the Contractor to transition the individual to an allocated bed of the Contractor.

9) The Contractor borrowing the bed shall notify the DMHA, in writing, when an agreement has been (a) terminated, (b) the individual has been discharged, or (c) the individual has been transitioned to an allocated bed of the Contractor before the 90-day agreement expiration.

10) The DMHA will communicate in writing to the Contractor the number of bed days used by the Contractor each calendar month. Beds borrowed but not used will not be used in the calculation of bed days.

V. CMHC Bed Allocation

CMHC allocations are determined by the population of the CMHCs geographic service area, the number of clients being served, and the severity of those individuals served. Bed Buy Backs are deducted for the final number of allocated beds.

CY2X	01.01.2X	Allocation prior to buy back	Current Buy Back $3,822,300	Allocation effective Jan 1 202X	SMI Percentage
401	Eskenazi	59	10	49	8.627%
402	Lifespring	26	2	34	3.767%
403	Vincennes	16	-	16	2.309%
404	Southwestern	37	-	37	5.468%
405	Hamilton	39	9	30	5.711%
407	Howard Community	10	4	6	1.458%
409	Oaklawn	41	5	36	5.954%
410	Swanson	11	1	10	1.580%
413	Lawrenceburg	12	-	12	1.823%
414	Grant-Blackford	18	3	15	2.673%
415	Wabash Valley	32	9	23	4.739%
416	Gallahue	26	14	12	3.767%
418	Porter-Starke	13	3	10	1.944%
419	Park Center	36	6	30	5.225%
421	Edgewater	19	-	19	2.795%
422	Muncie	30	4	26	4.374%
423	Bowen	21	6	15	3.038%
424	Southlake Regional	33	9	24	4.860%

CY2X	01.01.2X	Allocation prior to buy back	Current Buy Back $3,822,300	Allocation effective Jan 1 202X	SMI Percentage
426	Northeastern	18	5	13	2.673%
427	Four Co.	15	-	15	2.187%
428	Cummins	20	5	15	2.916%
429	Adult and Child	19	10	9	2.795%
430	Aspire	46	17	29	6.683%
431	Centerstone	76	15	61	11.179%

V.(a) CMHC Bed Buyback

Some CMHCs "sold" allocated beds back to DMHA. DMHA purchased these beds for $27,900 which is paid to the CMHCs annually in their SMI funds under their service contract.

ID	Provider	Beds Sold Back to DMHA	$27,900 per bed per year (Rolled into SMI Allocation)
401	Eskenazi	10	279,000
402	Lifespring	2	55,800
403	Samaritan	-	
404	Southwestern	-	
405	Hamilton	9	251,100
407	Howard Community	4	111,600
409	Oaklawn	5	139,500
410	Swanson	1	27,900
413	Lawrenceburg	-	
414	Grant-Blackford	3	83,700
415	Valley Oaks	9	251,100
416	Gallahue	14	390,600

ID	Provider	Beds Sold Back to DMHA	$27,900 per bed per year (Rolled into SMI Allocation)
418	Porter-Starke	3	83,700
419	Park Center	6	167,400
421	Edgewater	-	
422	Meridian	4	111,600
423	Bowen	6	167,400
424	Southlake Regional	9	251,100
426	Northeastern	5	139,500
427	Four Co.	-	
428	Cummins	5	139,500
429	Adult and Child	10	279,000
430	Aspire	17	474,300
431	Centerstone	15	418,500
	Total	**137**	**3,822,300**

V.(b) Master Allocation Spreadsheet Sample – Monthly Use of Beds

See reference report.

V.(c) Bed Borrowing Form

SOF Borrowed Bed and Authorization Form

Name of Requesting CMHC _____

Agency Address _____

Designated Contact _____ _____

Telephone _____ _____

Current # of Allocated Beds in Use by Requesting CMHC _____ _____

Current # of Active Borrowed Bed Agreements Utilized by the Requesting CMHC_____ _____

Name of Lending CMHC _____ _____

Agency Address _____ _____

Designated Contact_____ _____

Telephone _____ _____

Effective Agreement Date(s) Not to Exceed 90 Days: Start _____/_____/_____ Expiration _____/_____/_____

(Request for reauthorization of additional 90 days may be submitted for review prior to expiration)

Is this a Request for Reauthorization? ☐ Yes _☐ No

Agreement Dates of Prior Authorization Start _____/_____/_____ Due to Expire _____/_____/_____

Client Name _____ _____

Last Four Digits of Consumer Social Security Number (for ID purposes)_____ _____

State-Operated Facility to be Utilized for Treatment _____

Anticipated Admission Date _____/_____/_____ ☐ Client Already Placed in SOF

As authorized representative of the requesting CMHC, I verify the requestor shall provide all clinical follow up related to 440 IAC 5-1-3.5 (including the coordination of the admission and transition of the client to the community).

Representative or Designee of Requesting CMHC Date

As authorized representative of the lending CMHC, I acknowledge the bed borrowed will count towards the lending providers' monthly allocation.

Representative or Designee of Lending CMHC Date

Requests for authorization shall be received by the DMHA at least 15 calendar days prior to the effective start date. Send requests to:

Rhonda Bergen
Asst. Deputy Director, Project Manager
Division of Mental Health and Addiction / Indiana State Psychiatric Hospital Network
402 W. Washington Street, Room W-353
Indianapolis, IN 46204-2739

The above request is ☐ Approved ☐ Denied by the Division of Mental Health and Addiction.

Authorizing Representative – Division of Mental Health and Addiction Date

DMHA Use Only - Received: Entry/Verification: Copy to File:

VI. Referral, MRB, and Wait List Process

See PowerPoint presentation and Viewpoint Manual.

VII. Timely Discharge Performance Measure

SFY 202x Performance Measure Definition

Timely Discharge from State Psychiatric Hospitals of All Populations

Program: All Units in State Psychiatric Hospitals, including forensic

Long Title: Quarterly percentage of individuals identified as ready for discharge from a SPH that are discharged within 45 calendar days of readiness determination.

Definition: Timely discharge is defined as the Gatekeepers community placement of a client from the SPH within 45 calendar days from the date the client is placed on the DMHA Pending Discharge List (PDL) by the SPH(s) and determined ready for discharge.

Readiness for discharge is determined when:

- The discharge is appropriate to the individual's unique and individualized needs
- The discharge is in accordance with standards of professional practice and applicable state and federal law
- The SPH clinical treatment team has determined stabilization of psychiatric and behavioral symptoms have occurred
- The individual demonstrates minimal risk towards self or others
- The clinical treatment team has determined maximum clinical benefit from hospitalization has been achieved

Purpose/Importance: It is imperative that clients in the Mental Health Delivery system receive the least restrictive and most appropriate care based on their individual needs. Therefore, timely discharge is critical for the continuing recovery of each individual ready for community placement.

Measure Specific Source of Data: Individual client data will be provided directly by the SPHs to DMHA through the use of an electronic Pending Discharge List and Viewpoint. The Pending Discharge List will continue to run consecutively with Viewpoint. When discharge readiness has been determined the client will be added to the Pending Discharge List and with a pre-discharge packet sent simultaneously to the gatekeeper in Viewpoint. Forensic pre-discharge packets will be forwarded from OGC to the designated future gatekeeper in Viewpoint upon receipt. A report will be sent monthly to the gatekeeper which will include individuals determined to be discharge ready. The report will include the consumers name, population type, admission date, date placed on list, length of time on list measured in calendar days for each consumer.

Method of Calculation: This measure will be calculated quarterly by Gatekeeper by adding the total number of clients enrolled by the gatekeeper AND the total number of future forensic clients determined ready for discharge during the fiscal year quarter. The total number of clients discharged within 45 calendar days or less will be divided by the total number of clients ready for discharge during the fiscal quarter to give the quarterly result.

For providers with four or less individuals on the quarterly pending discharge list, DMHA will allow one individual over 45 days to count towards the target if a thorough discharge plan has been submitted and demonstrates sufficient efforts by the Gatekeeper to address all barriers to transition. The one individual counted may only be waived once and cannot be the same individual in consecutive quarters.

Additionally, the DMHA acknowledges barriers to discharge may occur. The Gatekeeper must submit a written discharge plan to the Division of Mental Health and Addiction for each client who remains in the state institution longer than forty-five (45) calendar days after meeting discharge readiness criteria. The written plan must be submitted within five (5) calendar days after the individual has waited forty-five (45) days; then every fifteen (15) calendar days thereafter until the client is discharged. The plan shall include the client's clinical status, community barriers to transition, how each barrier is being addressed, and specific transitional action steps taken by the Gatekeeper towards the client's discharge. The individual waived due to transitional barriers may only be waived once and cannot be waived in consecutive quarters.

The target performance for each provider is 80% of all individuals determined to be ready for discharge will be discharged to the community within 45 calendar days.

Data Limitations: It has been reported that occasionally a gap in communication between SPHs and Gatekeepers occur when determining the readiness of an individual for discharge. It will be critical that Gatekeepers maintain ongoing monthly contact and consistent communication with SPH treatment teams in order to actively participate in the discharge readiness process. If there are differing opinions regarding readiness for discharge between the SPH and Gatekeeper, it is important all involved work together to exam the concerns and resolve differences in the best interest of the client. If efforts fail, the Community Care Rule (440 IAC 5-1-4) may be invoked in Viewpoint by the Gatekeeper.

When an appeal is made, the practice implemented by the DMHA to review the concern consists of the following steps to facilitate discussion between Gatekeeper and SPH prior to DMHA review:

- Documented discussion between gatekeeping liaison and SPH treatment team
- Documented discussion between gatekeeping medical director and SPH medical director
- Documented discussion between gatekeeping CEO and SPH Superintendent

It will be the responsibility of the Gatekeeper to coordinate and schedule the discussions. If a resolution cannot be reached, written documentation of discussions from each level and the remaining discrepancies may be submitted to the Division of Mental Health and Addiction for review and a final decision on readiness for discharge will be determined. Individuals actively being reviewed under the Community Care Rule will not be counted toward the measure for 15 business days after the date invoked to allow discussion of the individual's readiness between Gatekeeper and SPH.

VIII. Olmstead

The Olmstead Act? What is it?

Olmstead, or Olmstead v. LC, is the name of the most important civil rights decision for people with disabilities in our country's history. This 1999 United States Supreme Court decision was based on the Americans with Disabilities Act. The Supreme Court held that people with disabilities have a qualified right to receive state funded supports and services in the community rather than institutions when the following is met:

1. The person's treatment professionals determine that community supports are appropriate;
2. The person does not object to living in the community; and
3. The provision of services in the community would be a reasonable accommodation when balanced with other similarly situated individuals with disabilities.

The Olmstead lawsuit started with two women from Georgia named Lois Curtis and Elaine Wilson, who both had diagnoses of mental health conditions and intellectual disabilities. Lois and Elaine found themselves going in and out of the state's mental health hospitals dozens of times. After each stay in the hospital, they would go back home; but then, because they did not have help at home, they would start to struggle again and would have to go back to the hospital to get help again. Lois and Elaine asked the state of Georgia to help them get treatment in the community so that they would not have to go live at the state mental hospital off and on. The doctors who treated Lois and Elaine agreed that they were capable of living in the community with appropriate supports. However, Lois and Elaine ended up waiting for years for their community-based supports to be set up.

Sue Jamieson, who was an attorney at the Atlanta Legal Aid Society, filed a lawsuit on behalf of Lois (and then later added Elaine) for supports to be provided in the community. The lawsuit, which is known as "Olmstead v. L.C." or "the Olmstead decision," ended up going to the highest court in the country, the United States Supreme Court. The name Olmstead comes from the name of the Defendant in the case, Tommy Olmstead, who was the Commissioner of the Georgia Department of Human Resources.

The Supreme Court agreed with Lois and Elaine. The Court found that under the Americans with Disabilities Act, or "the ADA," it is against the law for the state to discriminate against a person based on his or her disability. The Court said that the state discriminated against Lois and Elaine by requiring them to live in a mental health hospital. It should have instead provided services for them in the community. By confining them in the hospital, the state was segregating them by requiring them to live with others with disabilities. The Court said that people with disabilities like Lois and Elaine have the right to receive the treatment they needed in an integrated setting if that is what they want, if their doctors agree, and if it doesn't fundamentally change how the state provides services to people with disabilities.

In Olmstead v. L.C., 527 U.S. 581, 119 S. Ct. 2176 (1999) ("the Olmstead decision"), the Supreme Court construed Title II of the Americans with Disabilities Act (ADA) to require states to place qualified individuals with mental disabilities in community settings, rather than in institutions, whenever treatment professionals determine that such placement is appropriate, the affected persons do not oppose such placement, and the state can reasonable accommodate the placement, taking into account the resources available to the state and the needs of others with disabilities. The Department of Justice regulations implementing Title II of the ADA require public entities to administer their services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

The Olmstead Supreme Court decision is cited today, to keep the flow of individuals in institutional placements (people with mental illness and disabilities) transitioning to live in, and benefit from, community settings and participating in community life. The Supreme Court state that "recognition and unjustified institutional isolation of person with disabilities is a form of discrimination reflect[ed] two evident judgements": 1) "Institutional placements of people with disabilities who can live in, and benefit from, community settings perpetuates the unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life"; and 2) "confinement in an institution severely diminishes everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." Olmstead, 119 S. Ct. 2176, 2179, 2187 [emphasis added]. This decision effects not only all persons in institutions and segregated settings, but also people with disabilities who are at risk of institutionalization, including people with disabilities on waiting lists to receive community-based services and supports.

IX. Fast-Track Admission Options and Hospital-to-Hospital Transfers

(a) If fewer than 30 calendar days have passed since the client's discharge from a state psychiatric hospital, the CMHC may request a "Fast-Track" back into the SPH if they feel the client meets admission criteria. Fast-Tracks are not guaranteed to be accepted for admission and follows an MRB review process. The CMHC should send an email request to the admissions coordinator at the SPH from which the client was discharged and cc: Shelby.Hicks@fssa.in.gov. The email should include a summary of everything that has happened since discharge, including services currently provided to the client. The CMHC must attach all intakes, assessments, physician notes, progress notes and medication list that have been produced since discharge from the SPH.

The SPH's MRB staff will review the material submitted and request any additional information needed to decide on accepting the client as a Fast Track admission. The SPH will provide feedback and/or acceptance to CMHC within five working days of the request. If the client is accepted as a Fast Track, they will be placed on the AWL at that time. Fast Tracks should be given priority for admission into the next available appropriate bed.

(b) When a client needs to be transferred from one SPH to another SPH, a request for the transfer should be made to DMHA (Shelby Hicks) via email by the current SPH. The email should include: a referral form, commitment, medication list, psych evaluation, progress notes and a short summary regarding the reason that a transfer is being requested and the preferred SPH. DMHA will forward to the preferred SPH MRB staff for review and feedback. If the client is forensic OGC will also be notified and will provide feedback. Length of the waitlist, acuity, as well as other factors, will be considered. If the transfer is accepted, DMHA will assign the client to the AWL of the preferred SPH. Transfers should be given priority for admission after Forensic clients, at a 2:1 admit ratio, before CMHC clients when an appropriate bed is offered.

X. Gatekeeping Liaison Directory

Subject to updates and changes

CMHC	Last Name	First, MI	Email	Telephone	Population
Adult and Child	Disbro	Jennifer	jdisbro@adultandchild.org;	317-346-5920 x5620	SED
	Moore	Michelle	mmoore@adultandchild.org	317-893-0270	SMI
ASPIRE Indiana	Boswell	Briana	briana.boswell@aspireindiana.org	317-775-4355	SMI/SED
Bowen Center	Havron	Jeff	jeff.havron@bowencenter.org	574-835-1440	SMI/SED
Centerstone	Austin	Angela	angela.austin@centerstone.org	812-523-8184	ESH, MSH
	Fries	JT	james.fries@centerstone.org	812- 337-2267	
	Heichelbech	Jill	jill.heichelbech@centerstone.org	765-342-6616	SED (All SOFs)
	Tegeler	Donna	donna.tegeler@centerstone.org	765-983-8681	SMI (RSH)
	Harleman	Renee	donielle.harleman@centerstone.org	765-983-8684	SMI (LSH)
	Hardin	Samantha	samantha.hardin@centerstone.org	812-314-3595	SMI (MSH)
	Ramp	Missy	missy.ramp@centerstone.org	812-355-6307	SMI (ESH)
Cummins	Hopkins	Pati	phopkins@cumminsbhs.org	888-714-1927 x2038	SMI/SED
Edgewater	Lytina	Barnett	lbarnett@edgewaterhealth.org	219-885-4264 x2480	SMI/SED
Four County	Lund	Teresa	tlund@fourcounty.org	765-469-5841	SMI/SED
Gallahue	Payson	Aryn	apayson@ecommunity.com	317-355-5385	SMI
	Page	Katelyn	kpage2@ecommunity.com	463-206-7276	SED
Grant-Blackford	Faulkenburg	Jon	jon.faulkenberg@cornerstone.org	765-664-7792 x2515	SMI/SED
Hamilton Ctr.	Lowry	Sheri	slowry@hamiltoncenter.org	812-231-8395	SED
	Macke	Virgil	vmacke@hamiltoncenter.org	812-231-8345	SMI
	Green	David	dgreen@hamiltoncenter.org	812-231-8381	SMI
Howard Regional	Taylor	Penny	ptaylor@ecommunity.com	765-776-5660	SMI/SED
	Brown	Laura	lbrown6@ecommunity.com	765-776-5660	SMI/SED
Lawrenceburg/CMHC	Cornett	Stacey	stacey.cornett@cmhcinc.org	812-537-1302	SED

CMHC	Last Name	First, MI	Email	Telephone	Population
	Roszell	Rachel	Rachel.Roszell@cmhcinc.org	812-532-3453	SMI
	Mock	Tracy	tracy.mock@cmhcinc.org	812-537-1302 x3483	SED
Lifespring	Mills	Paige	paige.mills@lifespringhealthsystems.org	812-206-1255	SMI/SED
Meridian	Million	Lori	lori.million@meridianhs.org	765-935-1576	SMI/SED
Eskenazi/Midtown	Neuburger	Maggie	margaret.neuburger@eskenazihealth.edu	317-880-8486	SMI/SED
Northeastern	Johnson	Liz	eljohnson@nec.org	260-347-1553 x134	SMI/SED
Oaklawn	Wagner	Sydney	sydney.wagner@oaklawn.org	574-283-1234x4178	SED
	Skinner	Kelsey	kelsey.skinner@oaklawn.org	574-533-1234	SMI
Park Center	Williams	Alfred	awilliams@parkcenter.org	260-482-9125 x2410	SED – Ft. Wayne
	Broderick	Jinny	jinny.broderick@parkcenter.org	260-824-1071	SED - Bluffton
	Gabet	Ray	rgabet@parkcenter.org	260-482-9125 x8489	SMI
Porter Starke	Moreno	Elizabeth	emoreno@porterstarke.org	219-476-4653	SMI/SED
Southlake Regional	Comsa	Angela	angela.comsa@regionalmentalhealth.org	219-794-2000	SED
	Pellegrini	Anthony	anthony.pellegrini@regionalmentalhealth.org	219-736-7264	SMI
Samaritan Ctr.	Heineke	Emily	eheineke@gshvin.org	812-885-2720	SED
	Abell	Ken	kabell@gshvin.org	812-886-6085	SMI
Southwestern	Thomas	Jenny	thomasj@southwestern.org	812-436-4246	SMI
	O'Keefe Johns	Ashton	okeefea@southwestern.org	812-746-7801	SED
Swanson Ctr.	Jasnieski	Katie	kjasnieski@swansoncenter.org	219-872-8666	SMI/SED
	Oudhuis	Christine	coudhuis@swansoncenter.org	219-872-8666	SMI/SED
Valley Oaks	Tetzloff	Candice	ctetzloff-ne@valleyoaks.org	765-446-6400x6568	SMI/SED