



DIVISION OF MENTAL HEALTH

Region 1 South Crisis Care System Policies and Procedures

Effective March 4, 2013

Contents

I.	INTRODUCTION	4
II.	INTENT	4
III.	PROCESS OVERVIEW	5
IV.	IDENTIFICATION OF POTENTIALLY ELIGIBLE INDIVIDUALS	5
A.	ELIGIBILITY CRITERIA.....	6
B.	EXCLUSIONARY MEDICAL CONDITIONS.....	6
V.	EMERGENCY DEPARTMENT PROCESS	7
VI.	ELIGIBILITY AND DISPOSITION ASSESSMENT (EDA).....	7
A.	EDA PROCESSES AND SERVICES	7
B.	ADDITIONAL REQUIREMENTS FOR HOSPITALS FUNDED AS EDA PROVIDERS:.....	11
VII.	SERVICES AUTHORIZATION.....	11
A.	PROCEDURE.....	12
VIII.	ASSURING CONTINUITY OF CARE.....	13
IX.	DISPOSITION OPTIONS	14
A.	ACUTE COMMUNITY SERVICES.....	14
B.	MENTAL HEALTH CRISIS RESIDENTIAL	15
1.	<i>Medical Necessity Admission Criteria for Mental Health Crisis Residential</i>	16
2.	<i>Service Requirements</i>	16
3.	<i>Discharge and Referral</i>	17
4.	<i>Daily Reporting of Bed Capacity</i>	17
C.	DASA RESIDENTIAL CRISIS STABILIZATION	18
1.	<i>Admission Criteria for DASA Residential Crisis Stabilization</i>	18
2.	<i>Continued Stay/Discharge Criteria for DASA Residential Crisis Stabilization</i>	18
3.	<i>Exclusionary Criteria for DASA Residential Crisis Stabilization</i>	18
4.	<i>Programmatic Requirements for DASA Residential Crisis Stabilization</i>	19
5.	<i>Daily Reporting of Bed Capacity</i>	20
D.	COMMUNITY HOSPITAL INPATIENT PSYCHIATRIC SERVICES (CHIPS)	20
1.	<i>Medical Necessity and Guidelines for Admission for CHIPS Acute Hospital Services</i> Error! Bookmark not defined.	
2.	<i>Guidelines for Continued Stay</i> Error! Bookmark not defined.	
3.	<i>Guidelines for Discharge</i>	Error! Bookmark not defined.
4.	<i>Documentation Guidelines</i> Error! Bookmark not defined.	
5.	<i>Utilization Review and Billing for CHIPS</i>	21
6.	<i>Daily Reporting of Bed Capacity</i>	25
E.	MADDEN MENTAL HEALTH CENTER SERVICES	26
1.	<i>Service Referrals by Madden Intake for Individuals from Region 1 South and 1 Central</i>	26
X.	TRANSPORTATION	27

A.	SERVICES AND SUPPORTS TO BE PROVIDED	27
1.	<i>Range of responsibility</i>	28
B.	VOLUNTARY TRANSPORTATION SYSTEM REQUEST PROTOCOL.....	28
1.	<i>Requesting a Transport</i>	28
2.	<i>Completing the Request Form (in Appendix)</i>	28
3.	<i>Transport Technician</i>	30
XI.	MEDICATIONS	30
XII.	PROCESSES FOR THE REDETERMINATION OF LEVEL OF SERVICES NEEDED	30
A.	PROCESSES	30
B.	ADDITIONAL REQUIREMENTS FOR TRANSFER TO MADDEN	32
XIII.	APPENDIX	34
A.	PSYCHIATRIC MEDICAL CLEARANCE BY _____	35
B.	REGION 1 SOUTH COMMUNITY HOSPITAL PAIRINGS WITH ELIGIBILITY & DISPOSITION EVALUATORS.....	36
C.	CHIPS & DASA RESIDENTIAL CRISIS STABILIZATION PROVIDERS FOR THE REGION 1 SOUTH CRISIS CARE SYSTEM	37
D.	TRANSPORATION REQUEST FORM	38
E.	NOTICE ON PROGRAM FUNDING FOR PSYCHIATRIC INPATIENT SERVICES.....	40
F.	COMMUNICATION AND PROBLEM SOLVING CHANNELS FOR R1S/CCS	41

Region 1 South Crisis Care System

Policies and Procedures

I. Introduction

In order to re-balance the mental health services system in DHS Region 1 South and replace the services previously provided by Tinley Park Mental Health Center, DHS/DMH purchases the following array of services in support of individuals determined eligible as part of the Region 1 South Crisis Care System (R1S/CCS):

Service	Payment Method
R1S/CCS Eligibility and Disposition Assessment	Grant
Transportation	Fee-for-service
Community Hospital Inpatient Psychiatric Services (CHIPS)	Per diem inclusive of psychiatric services
Mental Health Crisis Residential	Grant
DASA Residential Crisis Stabilization	Grant
Acute Community Services	Grant

In addition, for individuals in need of mental health services when the above services are insufficient or unavailable, DHS/DMH will continue to directly provide the services of its inpatient DHS/DMH-operated hospitals, with intake service provided by Madden Mental Health Center and inpatient services provided primarily by Madden Mental Health Center and Chicago-Read Mental Health Center.

As reflected in all DHS contracts, payment for the purchase of the above services is contingent on approved appropriations and funding from the state.

II. Intent

DHS/DMH's intention is to replace the services previously provided by Tinley Park Mental Health Center (TPMHC) with a re-balanced service system that is:

- Focused on individualized, person-centered services aimed at realizing the recovery of each individual receiving services and their integration into their home community;
- Guided by tenets of trauma-informed care;
- Outcome-validated;
- Designed with incentives for intervening in mental health crises or potential crises at the earliest opportunity possible in order to minimize exacerbation of symptoms and problems for the individual as well as system reliance on more restrictive and expensive services.
- More community-based with services provided in the most normalized and least restrictive environment possible, achieving, over time:
 - Reductions in presentation to community hospital emergency departments for mental health/psychiatric services;
 - Reductions in mental health institutional, hospital and residential treatment admissions;

Since all admissions to Tinley Park Mental Health Center were uninsured individuals referred from the emergency departments of community hospitals, the first phase of the re-balanced service system will focus solely on the assessment and intervention of individuals without insurance presenting as in a mental health crisis in the

emergency departments of hospitals in Region 1 South. In later phases, as experience and resources permit, modifications to the system may be made to broaden the scope of assessment and intervention beyond the emergency departments to earlier points of intercepting an individual in crisis, such as with the local police or in the community with landlords, homeless shelters, etc.

Because it is the intention of DHS/DMH to replace and fund services previously provided to uninsured individuals, if an individual initially determined to be eligible for the Region 1 South Crisis Care System is later determined Medicaid eligible or to have other insurance or resources for payment, their eligibility for Region 1 South Crisis Care System services funded by DHS/DMH ceases immediately. From that point forward any services provided to that individual should be billed to Medicaid, insurance or other appropriate entity.

III. Process Overview

Individuals presenting to a hospital emergency department (ED) in Region 1 South who are determined by the ED staff to be experiencing a psychiatric crisis will be assessed for availability of funding for treatment of the psychiatric crisis. For individuals with no such funding, each ED will have an identified entity for “Evaluator” services. These Evaluators will respond on-site to requests from the ED within one hour, and will perform a face-to-face assessment of the individual’s eligibility for the services of the Region 1 South Crisis Care System and their treatment needs related to the presenting crisis. At the conclusion of the assessment, the Evaluator will discuss their eligibility finding, assessment of risk, and suggested level of care recommendation for treatment services with the individual and the ED attending physician.

If information supports eligibility for the Region 1S Crisis Care System’s services, the Evaluator will call the authorizing agent to confirm eligibility and obtain the location of the appropriate and available services. These services include:

- Community Hospital Inpatient Psychiatric Services (CHIPS)
- Mental Health Crisis Residential
- DASA Residential Crisis Stabilization
- Acute Community Services

In addition to the above, as a safety net for individuals with exceptional conditions or treatment needs, the services of the DHS/DMH state hospitals are available.

Once the appropriate level of service with available capacity has been identified and authorized, the Evaluator will arrange for transportation of the individual to the targeted service site, and confirm linkage to the services within 24 hours of transport.

The details of these processes and services are elaborated below.

IV. Identification of Potentially Eligible Individuals

Individuals presenting to a hospital emergency department (ED) in Region 1 South who are determined by the ED staff to be experiencing a psychiatric crisis will be assessed for availability of funding for treatment of the psychiatric crisis, including a determination of Medicaid eligibility (e.g., via the Medical Electronic Data Interchange (MEDI) system maintained by Illinois Healthcare and Family Services Department).

If funding exists, the ED will arrange the appropriate care.

Regardless of whether the individual is being considered for voluntary or involuntary services, if the individual has no resources or insurance for coverage of treatment services for their psychiatric crisis, the ED staff will then proceed to evaluate whether the individual is potentially eligible for the services of the Region 1 South Crisis Care

System (note that if an individual is initially believed or presumed to meet the financial eligibility for this coverage, but is later found to be Medicaid eligible or to have insurance or other resources for payment of care, then the appropriate entity would be billed for services).

A. Eligibility Criteria

Individuals eligible for the enhanced services of the Region 1 South Crisis Care System would have been referred to Tinley Park prior to its closure, and must:

1. Present in an Emergency Department in the defined geographic area of Region 1 South; and,
2. Be uninsured, with no other resource for needed treatment interventions (including Medicaid as confirmed through the MEDI system); and
3. Not be acutely intoxicated or delirious as evidenced by elevated blood alcohol level (>0.08), unstable vital signs, or fluctuating mental status on clinical exam, and
4. Have a preliminary diagnosis of mental illness or mental illness and substance use disorder¹, and
5. The Emergency Department has completed a medical assessment of the individual and found and documented on the "Psychiatric Medical Clearance" form (available in the Appendix) that the individual does not have a current medical illness or condition that makes the person inappropriate for care in a community residential setting or DHS/DMH Hospital as detailed below.

The above criteria must be evaluated and documented as met prior to calling for an Evaluator for an EDA evaluation. EDA evaluation will only occur after acute intoxication, metabolic syndromes, and acute medical issues are evaluated and resolved or stabilized. Behavioral or emotional problems only present during acute intoxication do not require EDA services and do not meet the standards for inclusion in the R1SCCS.

B. Exclusionary Medical Conditions

Medical illnesses or conditions which preclude admission to a community residential setting or a DHS/DMH Hospital include the following:

1. Patient not able to do activities in daily living. Examples include: requiring skilled nursing care; limited feeding capacity; assistance ambulating
2. Patient with swallowing problem
3. Patient requiring catheter:
 - a. *Foley*
 - b. *Feeding tubes, or N/G tube*
 - c. *Central lines*
 - d. *Insulin pump*
4. Patient requiring dialysis
5. Patient requiring medications not available in DHS formulary
6. Patient requiring physical therapy
7. Patient requiring continuous positive airway pressure (CPAP)
8. Patient requiring post-surgical care and follow-up
9. Patient at risk of medically significant complications due to recent major medical trauma (meets state requirements for trauma)
10. Patient with acute neurological symptoms, including unstable seizure disorders

¹ There is no specified disallowance for the individual to also have a mild or borderline intellectual disability.

11. Patient with cancer that needs work-up or treatment expeditiously
12. Patient with possible new onset of psychosis, where work-up has not been done
13. Patient with active MRSA or VRE resistance
14. Patient requiring Peripheral IV line or IV injection
15. Patient requiring nebulizer treatment
16. Patient requiring oxygen
17. Patient requiring EKG monitoring/telemetry
18. Patient with a condition potentially requiring urgent surgery
19. Patient at risk of medically significant complications due to drug withdrawal (e.g. seizures and /or DT=s)
20. Patient with medically significant bleeding
21. Patient with draining wounds that require nursing care
22. Patient with communicable diseases requiring isolation
23. Patient with acute drug inebriation
24. Patient with delirium or altered levels of consciousness
25. Patient with primary dementia
26. Patient with only mental retardation
27. Patient with methadone dependency, unless in an accredited methadone program
28. Patient with toxic levels of medication or who are at risk to become toxic (i.e., acetaminophen)
29. Patients who are pregnant (as pregnant women should be covered by Medicaid)
30. Patients with uncontrolled diabetes
31. Patients with uncontrolled hypertension
32. Patients requiring parenteral pain control

V. Emergency Department Process

ED staff will document that the individual meets the above eligibility criteria and does not have a current medical condition that precludes their eligibility for the DHS/DMH-funded services by completion of the “Psychiatric Medical Clearance Checklist” (provided in the Appendix).

The ED then calls their designated provider of “Evaluator” services (see Appendix) to request a face-to-face evaluation of the individual’s eligibility for the Region 1 S Crisis Care System’s services, documenting the time of the call. Upon arrival of the Evaluator at the ED, ED staff will provide the Evaluator with their completed “Psychiatric Medical Clearance Checklist” for the individual (or the Evaluator should ask that this form be completed by the attending ED physician).

VI. Eligibility and Disposition Assessment (EDA)

DHS/DMH contracts with selected community mental health service providers or community hospitals in the Region 1 South area to provide evaluations of individuals for R1S/CCS eligibility. These individuals present in community hospital emergency departments as experiencing a mental health crisis or in need of immediate, intensive psychiatric services for which the individual would have previously been referred to Tinley Park Mental Health Center (TPMHC) for admission; that is, the individual is in need of intensive inpatient psychiatric or other mental health services and is uninsured with no other resources for needed services.

A. EDA Processes and Services

Funded community mental health service providers are to:

1. Provide the services of a mental health professional at or above the level of a Qualified Mental Health Professional (as defined in the “Medicaid Community Mental Health Services” Rule 132, available at: <http://www.dhs.state.il.us/page.aspx?item=56754>) to serve as an “Evaluator,” with availability on a 24 hour/seven day per week basis.
2. Receive calls requesting a R1S/CCS Eligibility and Disposition Assessment. During the call it should be confirmed that:
 - a. The individual is presenting in an Emergency Department² in the Region 1 South geographic area;
 - b. The individual is experiencing or presenting as in a psychiatric crisis with a preliminary diagnosis of mental illness or mental illness and substance use disorder;
 - c. The individual has no insurance (including Medicaid as confirmed through the MEDI system) or other means of payment for needed services and treatment.
 - d. The individual is not acutely intoxicated or delirious as evidenced by elevated blood alcohol level (>0.08), unstable vital signs, or fluctuating mental status on clinical exam, and
 - e. The Emergency Department has completed a medical assessment of the individual and found and documented on the “Psychiatric Medical Clearance” form (available in the Appendix) that the individual does not have a current medical illness or condition that makes the person inappropriate for care in a community residential setting or DHS/DMH Hospital.
3. Ensure that priority responses are provided to the Emergency Departments of community hospitals in Region 1 South. Ensure that calls for the evaluation of an individual are responded to on-site at the community hospital emergency department within one hour (60 minutes) of the time the call is first received with confirmation by the ED that the individual meets the five eligibility criteria noted above in #2 and further above under “Eligibility Criteria”. The Evaluator is to document the time the call was received and the time reported on-site.
4. Ensure that the qualified professional completes the initial steps of a face-to-face evaluation of the individual presenting as in a mental health crisis in need of services to determine the individual’s eligibility for Region 1 South Crisis Care System services per the eligibility criteria listed above, with the initial steps of the evaluation confirming:
 - a. The date and time the individual was admitted to the ED;
 - b. The individual is apparently uninsured, with no other resources for needed mental health services;
 - c. The individual does not have medical co-morbidities that would make them not eligible for admission to a DHS/DMH hospital or residential service;
 - d. The emergency department staff has completed a psychiatric medical clearance check list (or the Evaluator should ask that this form be completed by the attending ED physician; see Appendix).

² Evaluators are responsible for completing eligibility and disposition assessment requests from Emergency Departments only. For those persons in Medical-Surgical, ICU or other hospital units or departments the hospital LPHA staff is responsible for contacting Madden MHC Intake Department (as under previous protocol) to initiate a transfer request to Madden MHC. Madden MHC, at its sole discretion, may authorize care into R1S/CCS for only those consumers with a home residence in Region 1 South.

5. Following the initial steps of the evaluation, for individuals meeting the conditions listed above, the qualified professional will continue with clinical evaluation of the individual by further interviewing the individual and any other informants and reviewing any relevant available clinical records or other documentation. For individuals with suspected substance abuse involvement, this includes completion of a multidimensional assessment sufficient to inform a placement recommendation per the American Society of Addiction Medicine (ASAM)Patient Placement Criteria, including the following dimensions:
 - a. Degree of intoxication and/or potential for significant withdrawal symptoms;
 - b. Biomedical conditions and complications;
 - c. Emotional, behavioral and cognitive conditions and complications;
 - d. Readiness for change in substance use;
 - e. Relapse, continued use or continued problem potential;
 - f. Available environments supportive of the individual's recovery.

6. On the basis of their assessment, the Evaluator will:
 - a. Determine the individual's mental health and/or substance abuse diagnoses, level of risk for harm, and need for mental health services;
 - b. Complete the Level of Care Utilization System (LOCUS; see: <http://www.dhs.state.il.us/page.aspx?item=32545>) assessment based on the individual's psychiatric presenting condition;
 - c. Document their findings, including the completion of the Uniform Screening and Referral Form (USARF) available at: http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/MentalHealth/CompGuide/USARFofficialIL462-1222.pdf

7. Based on the above information, the qualified mental health professional Evaluator will determine if the individual meets the following additional eligibility criteria:
 - a. Symptoms consistent with a diagnoses of mental illness: Note that admission criteria for Community Hospital Inpatient Psychiatric Services (CHIPS), Mental Health Crisis Residential and referral from an emergency department to Acute Community Services requires one or more of the following mental health diagnoses:
 1. Schizophrenia (295.xx)
 2. Schizophreniform Disorder (295.4)
 3. Schizo-affective Disorder (295.7)
 4. Delusional Disorder (297.1)
 5. Shared Psychotic Disorder (297.3)
 6. Brief Psychotic Disorder (298.8)
 7. Psychotic Disorder NOS (298.9)
 8. Bipolar Disorders (296.0x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90)
 9. Cyclothymic Disorder (301.13)
 10. Major Depression (296.2x, 296.3x)
 11. Obsessive-Compulsive Disorder (300.30)
 12. Anorexia Nervosa (307.1)
 13. Bulimia Nervosa (307.51)
 14. Post Traumatic Stress Disorder (309.81)
 - b. A LOCUS level of care recommendation of 4 or greater.

8. If the individual does not meet the eligibility criteria, inform the individual and referring ED physician and staff of such and, as possible, provide any alternative treatment or

service recommendations, including referral to the DHS/DMH-funded services available for non-Medicaid DHS/DMH eligible individuals.

9. If the individual does meet the eligibility criteria, the Evaluator then determines the individual's status as a resident of Illinois:
 - a. If the individual is not a resident of the Region 1 South geographic area, the Evaluator will refer the individual to Madden Mental Health Center intake (1-866-810-5869) and provide Madden with the relevant information and documentation;
 - b. If the individual is a resident of the Region 1 South geographic area, including the homeless, the Evaluator will formulate a recommended level of care treatment service recommendations, such as:
 - i. Acute Community Services.
 - ii. Mental Health Crisis Residential Services;
 - iii. DASA Residential Crisis Stabilization Services ,or contracted hospitals that meet the standards for CHIPS outlined below and that can certify to DHS/DMH that they have the capability to serve individuals with the co-occurring conditions of mental illness and substance abuse, such as a dual diagnosis integrated service model;
 - iv. Inpatient psychiatric hospitalization (Community Hospital Inpatient Psychiatric Services (CHIPS) or State-operated psychiatric hospitalization);Transportation
10. The Evaluator then determines the individual's willingness to engage in the recommended level of treatment and whether the individual needs transportation to the recommended inpatient or residential treatment sites.
 - a. If the individual is unwilling to engage in the recommended level of service, determine if the individual meets the criteria for an involuntary psychiatric admission and, if so, proceed with the process to execute the involuntary admission;
 - b. If the individual is unwilling to engage in the recommended level of service and does not meet the criteria for an involuntary psychiatric admission, explain to the individual, the ED physician and staff, and other involved parties, this assessment and the individual's choice.
11. If the individual is willing to engage in the recommended level of treatment, discuss the eligibility finding, risk assessment, and suggested level of care recommendation for treatment with the individual and the ED attending physician and obtain the ED attending physician's decision on the recommended level of care for services. The ED staff will be provided with a copy of the USARF, with additional copies made for the service authorization agent and for the Evaluator's records.
12. Once the ED attending physician's decision is reached on the recommended level of care for services for the eligible individual, the Evaluator then calls the Collaborative ACCESS line (866/ 359-7953) as the services authorizing agent to: (a) determine if the recommended level of service is available and, if so, (b) secure approval and the authorization number for the level of service. This authorization number is also used for securing any necessary transportation to an inpatient or residential services site.
13. The Evaluator makes any necessary contacts and arrangements with the targeted service site, including transportation arrangements as necessary.

14. The Evaluator ensures documentation of the evaluation (including the USARF, LOCUS and, if applicable, information supportive of ASAM patient placement criteria), recommendations and disposition outcome for the individual as part of a clinical record for the individual, with this documentation completed prior to the Evaluator's departure from the ED.
15. The Evaluator informs the Collaborative of the individual's accepting treatment provider by calling the ACCESS line prior to the Evaluator's departure from the ED.
16. Through appropriate follow-up within 24 hours, the Evaluator firmly ensure that the individual did reach the planned level of services site (such as calling the site to confirm that the individual has been accepted into services), taking any corrective actions as necessary to establish this firm linkage and documenting this follow-up and related actions in the individual's clinical record.
17. The Evaluator ensures that the individual is registered in the DHS/DMH consumer registration/ enrollment and services encounter information systems per DHS/DMH policy.

B. Additional Requirements for Hospitals Funded as EDA Providers:

1. Once the ED determines the individual meets basic Region 1S eligibility, call their hospital's behavioral health specialists for a detailed evaluation;
2. Complete the activities of # 4, 5, & 6 of EDA listed above;
3. Provide the services of a physician to conduct psychiatric, addictions (as indicated) and comprehensive risk assessments with availability on a 24 hour/seven day per week basis;
4. Ensure that the physician includes all DHS/DMH prescribed assessment elements when determining eligibility of the individual for R1S/CCS;
5. Provide active treatment to include, as clinically appropriate, extended observation, comprehensive medical assessments, medication administration and monitoring, and any needed crisis intervention service (therapy/counseling, psycho-education, family support, etc);
6. Based on the determination of eligibility and clinical evaluation, determine the most appropriate and available level of care, secure authorization for same, make transportation and admission arrangements and provide documentation to the targeted service provider (see # 12 - 14 above);
7. Within 24 hours, ensure the firm linkage of the individual with the authorized level of care;
8. Ensure documentation of the evaluation, treatment, recommendations and disposition of the individual;
9. Submit required registrations and encounters per DHS/DMH policy.

VII. Services Authorization

Once the Evaluator has completed an evaluation and is prepared with a recommendation for the appropriate level of service for the individual, he should contact the Collaborative to obtain authorization and the name, address and contact information of a service provider with availability that is most convenient to the individual's home.

A. Procedure

1. The Evaluator calls The Collaborative at 866-359-7953 to request authorization for the recommended level of care.³
2. The Evaluator will provide the ACCESS Clinical Care Manager (CCM) at the Collaborative with all necessary information to complete a temporary registration and an authorization, including:
 - a. Demographic information (coordinate with Collaborative):
 - i. First and last name;
 - ii. RIN if applicable;
 - iii. Date of Birth;
 - iv. Address (last known address or current location if homeless);
 - v. Gender;
 - vi. Ethnicity.
 - b. Response Time indicators:
 - i. Time of admission of individual to ED;
 - ii. Start time of initial face-to-face contact between the individual and Evaluator.
 - c. Clinical Presentation:
 - i. Presenting problem/crisis;
 - ii. Five Axes Diagnosis;
 - iii. LOCUS dimensions and LOCUS Recommended Level of Care;
 - iv. ASAM dimensions assessments and the Patient Placement Criteria that have been met, if applicable.
 - d. Recommended Disposition – funded treatment options include:
 1. Community Hospital Inpatient Psychiatric Services (CHIPS);
 2. Mental Health Crisis Residential;
 3. DASA Residential Treatment;
 4. Acute Community Services (ACS).

NOTE: Madden Mental Health Center will serve as the safety net for instances when the above services are not available or not appropriate for the needs of the individual.

3. The CCM reviews for medical necessity. If present, then the CCM will authorize care and will provide the Evaluator with:
 - i. A single authorization number which will be used to authorize the medically necessary level of care and (if necessary to access inpatient or residential services) payment for the transportation service for the individual;
 - ii. The location and contact information for the provider with service availability at the approved level of care.

NOTE: in the event that there is no available capacity for the recommended level of a care, the CCM will provide information about available capacity at other levels of care for consideration by the Evaluator, the individual and the ED physician.

4. If the CCM proposes an alternative level of service due to either clinical factors or lack of capacity:
 - a. The Evaluator will discuss the alternative with the ED physician (or designee), the individual and appropriate parties;
 - b. If agreement on the proposed alternative level of service is reached, then authorization will be provided as described in step 3 above;
 - c. If the ED physician or Evaluator cannot accept the proposed alternative level of service, then the CCM will call Madden Mental Health Center (Madden Intake) to initiate an appeal process:

³ Should the Collaborative be unreachable calls should be directed to Madden MHC Intake Department at 1-866-810-5869.

- i. The CCM will provide Madden Intake with details on the clinical presentation, treatment recommendation and resources available, as well as name and phone numbers to contact the Evaluator at the ED;
 - ii. The Madden Intake physician will review the CCM findings and call the ED to discuss the basis of the appeal;
 - iii. The Madden physician contacts the ACCESS CCM and the ED physician with their level of service decision with one hour (60 minutes) of the call from the CCM.
- d. The CCM then contacts the Evaluator to provide the determination of the appeal and authorize services as appropriate, following the process described in step 3 above.

VIII. Assuring Continuity of Care

In order to promote the highest degree of continuity of care DHS/DMH has the following expectations of EDA services / evaluators and ACS providers: "Through appropriate follow-up within 24 hours, the Evaluator (EDA) or ACS ascertains whether the individual did reach the planned level of services site (such as calling the site to confirm that the individual has been accepted into services), taking any corrective actions as necessary to establish this firm linkage and documenting this follow-up and related actions in the individual's clinical record."

To effectively implement this expectation, concerns about personal health information (PHI) or disclosure of confidential mental health or substance abuse information must be addressed.

DHS/DMH provides the following guidance to all EDAs and treatment sites (CHIPs, Madden MHC, MH Crisis Residential, Residential Crisis Stabilization and Acute Community Services (ACS)), on the proper handling of this situation.

1. For mental health treatment sites and the Collaborative communications related to this matter do not require a 'consent to release information' as they are part of "admission, planning, treatment or discharge" activities between DHS contractors as outlined in the Mental Health and Developmental Disabilities Confidentiality Act" (see 740 ILCS 110/9.2 Sec. 9.2 at: <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2043&ChapterID=57>). Community agencies and private hospitals contracted with DHS are explicitly referenced in the statute.
2. For DASA Residential Crisis Stabilization sites DASA has instructed these providers to secure the appropriate release of information from individuals being served in order to effectively assure continuity of care.
3. Prescribed processes:
 - a. EDAs and ACS providers should directly contact the person(s) identified as "Primary contact person for discharge planning" listed on the CHIPs, MH Residential, DASA Residential Crisis Stabilization and ACS information sheets.
 - b. EDAs and ACS providers should identify themselves as seeking follow-up information that solely verifies the admission of the consumer at the Region 1 South Crisis Care System (R1SCCS) treatment site. The EDA or ACS staff should provide the consumer's name and other identifying information as requested PLUS the CCM authorization number provided by the Collaborative as validation of R1SCCS participation.
 - c. The EDA should also assist the treatment site in identifying the ACS providers to ensure immediate discharge planning activities. In many case the EDA provider and the ACS provider will be the same agency.

- d. If not already accomplished, the EDAs should call the Collaborative’s ACCESS line (CCM) to verify the disposition site.
- e. All treatment site providers (CHIPs, MH Crisis Residential and DASA Residential Crisis Stabilization, Madden MHC) are required to call the Collaborative’s ACCESS line (CCM) at the point of discharge to verify the date of discharge and/or update the actual outpatient ACS provider site.

IX. Disposition Options

A. Acute Community Services

It is assumed that the services and supports funded by these contracts will consist primarily of the services of the Medicaid Community Mental Health Services Program (Rule 132), including psychiatric services as mental health assessment and psychotropic medication administration, monitoring and training. For ACT and CST services prior authorization must be obtained; however, due to their availability (especially on off-hours) it may be expedient for ACT and CST staff to assist and briefly serve and report services for these individuals under other service codes, such as community support. Providers may also include any other services or supports they determine will be needed to achieve the recovery goals of the individual, including medications, transportation or substance use disorder services, to avoid more restrictive and expensive services. That is, the provider has the flexibility to determine and enhance the range of services and supports that are best tailored to meet the needs of the individual eligible for the Region 1 South Crisis Care System as indicated by the mental health assessment.

For residents from Region 1 South being discharged from an ED, CHIPS, crisis residential or a DHS/DMH Hospital, and for those discharged from DASA residential crisis stabilization with a co-occurring disorder, contracted community mental health centers must provide Acute Community Services, and must:

1. Initiate treatment within 24 hours of discharge from an ED and within 48 hours of discharge from a hospital or residential service;
2. Evaluate and serve individuals consistent with Rule 132 services;
3. Initiate Medicaid applications (or, if initiated by another R1SCCS entity, follow through and expedite the application process) utilizing the “Best Practices in Medicaid Applications Process.” Training is available on this process, and ACS providers are held responsible for its utilization;

Medicaid application packets must include (but are not limited to) the following elements:

- a. Application for Medical Assistance (Form 2378H)
- b. UBO4⁴ for any Emergency Department Services in prior 90 days
- c. Signed DHS Authorized Representative Form⁵
- d. Proof of SSDI/SSI OR ALL OF THE FOLLOWING DOCUMENTATION:
 - i. Signed/Completed Form 183A (Physician’s Report)
 - ii. Clinician cover letter reviewing disabling characteristics
 - iii. Copy of History and Physical Examination
 - iv. Copy of Psychiatric Evaluation
 - v. Copy of Psychosocial Evaluation/Social History OR 183B

⁴ This is a billing statement that is used by all hospital providers. This will enable immediate activation of approved AABD Medicaid spend down cases.

⁵ If the individual declines to sign, please submit documentation of this. Make sure s/he understands that this is NOT related to whether s/he has a representative payee for any monetary benefits.

- vi. Copy of pertinent lab reports
- vii. Copy of all diagnostic evaluations
- viii. Copy of pertinent progress notes
- ix. Copies of previous psychiatric discharge summaries⁶
- x. Copy of treatment plan
- xi. Copy of special observation/precaution documentation
- xii. Admitting and discharge or current GAF

4. To ensure timely access to needed services, the provider will:
 - a. Make arrangements to ensure that the Evaluators completing eligibility and disposition determinations in the Region 1 South Hospital Emergency Departments can immediately schedule an appointment with a qualified mental health staff member within 24 hours (e.g., provider supplies Evaluators with the times and locations made available for such appointments) These arrangements will include availability of services appropriate to the needs of the individual. For example, if the individual requires psychiatric medication monitoring or evaluation, the appointment scheduled will be with a practitioner who is professionally able to address such needs.;
 - b. Make arrangements to ensure that individuals eligible for the R1S/CCS needing aftercare or follow-up services after being discharged from CHIPS, Mental Health Crisis Residential, DASA Residential Crisis Stabilization or DHS/DMH hospitalization can be scheduled for appointment with a qualified mental health staff member within 48 hours These arrangements will include availability of services appropriate to the needs of the individual. For example, if the individual requires psychiatric medication monitoring or evaluation, the appointment scheduled will be with a practitioner who is professionally able to address such needs.
5. For each individual identified as eligible for R1S/CCS, the single identified Acute Community Services (Program 410) contracted provider remains responsible for services and supports for the individual for the twelve month period following the provider's initial assessment of the individual (and can subcontract with other providers for any additional services that may be needed).
6. Individuals who are determined to be Medicaid eligible should convert to regular Medicaid services as soon as possible and will no longer be eligible for the Region 1 South Crisis Care enhanced services.
7. Providers are also required to submit reports on expenses, deliverables and performance measures as outlined in the DHS Contract Exhibit for this program.
8. The community mental health services provider ensures that each individual determined to be eligible for R1S/CCS and to receive enhanced Acute Community Services is appropriately registered with the designated identifier in the DHS/DMH consumer registration/enrollment information system.

B. Mental Health Crisis Residential

DHS/DMH mental health crisis residential is for individuals evaluated as having a primary need for intense, residential mental health treatment.

These services focus on the unique mental health crisis stabilization needs presented by the individual through the provision of 24 hour, seven days a week crisis beds and residential supports designed to provide short-term

⁶ If individual declines permission for re-release of this information, this must be documented.

continuous supervision and active treatment in a provider controlled facility. The goal of the program is to help the referred individual stabilize symptoms and refer the individual to necessary follow-up services upon discharge.

1. Medical Necessity Admission Criteria for Mental Health Crisis Residential

1. Individual has symptoms consistent with a diagnosis of one of the following mental illnesses:
 - Schizophrenia (295.xx)
 - Schizophreniform Disorder (295.4)
 - Schizo-affective Disorder (295.7)
 - Delusional Disorder (297.1)
 - Shared Psychotic Disorder (297.3)
 - Brief Psychotic Disorder (298.8)
 - Psychotic Disorder NOS (298.9)
 - Bipolar Disorders (296.0x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90)
 - Cyclothymic Disorder (301.13)
 - Major Depression (296.2x, 296.3x)
 - Obsessive-Compulsive Disorder (300.30)
 - Anorexia Nervosa (307.1)
 - Bulimia Nervosa (307.51)
 - Post Traumatic Stress Disorder (309.81);
2. The individual has been assessed with a LOCUS level of care recommendation of 5 or higher;
3. The individual's condition affirms the need for continuous monitoring and supervision due to the onset of a psychiatric crisis;
4. The individual's usually sufficient skills to maintain an adequate level of functioning in daily living and social skills or community/family integration is disrupted by the psychiatric crisis;
5. The individual's response to current treatment reflects that a less intensive or less restrictive psychiatric treatment program would not be adequate to provide safety for the individual or others or to improve the individual's functioning; **and**
6. It is expected that the resources and techniques associated with this level of care will lead to successful discharge into the community.

2. Service Requirements

1. The Mental Health Crisis Residential (MHCR) provider receives the authorized referral from an Eligibility and Disposition Assessment Evaluator. The MHCR provider will begin serving the individual upon arrival.
2. Care is provided by a minimum of one Mental Health Professional (MHP) as defined in 59 IL Adm. Code 132 who is awake and available on-site at all times.
3. Care is supervised by a Qualified Mental Health Professional as defined in 59 IL Adm. Code 132 who is immediately available for clinical supervision and consultation with the MHP on duty.
4. There is 24 hour access to nursing services and on-call psychiatric services.
5. The estimated length of stay following an authorized referral is typically less than seven days.

6. Initiate Medicaid applications (or, if initiated by another R1SCCS entity, follow through and expedite the application process) utilizing the “Best Practices in Medicaid Applications Process.” Training is available on this process, and ACS providers are held responsible for its utilization.

Medicaid application packets must include (but are not limited to) the following elements:

- a. Application for Medical Assistance (Form 2378H)
- b. UBO4⁷ for any Emergency Department Services in prior 90 days
- c. Signed DHS Authorized Representative Form⁸
- d. Proof of SSDI/SSI OR ALL OF THE FOLLOWING DOCUMENTATION:⁹
 - i. Signed/Completed Form 183A (Physician’s Report)
 - ii. Clinician cover letter reviewing disabling characteristics
 - iii. Copy of History and Physical Examination
 - iv. Copy of Psychiatric Evaluation
 - v. Copy of Psychosocial Evaluation/Social History **OR** 183B
 - vi. Copy of pertinent lab reports
 - vii. Copy of all diagnostic evaluations
 - viii. Copy of pertinent progress notes
 - ix. Copies of previous psychiatric discharge summaries¹⁰
 - x. Copy of treatment plan
 - xi. Copy of special observation/precaution documentation
 - xii. Admitting and discharge or current GAF

3. Discharge and Referral

1. A plan for discharge must be developed within 48 hours of admission.
2. The client’s choice of a provider of Acute Community Services (ACS) must be respected whenever possible. The MHCR provider will inform the client of the available ACS providers.
3. The MHCR provider will develop the plan for discharge with the ACS provider.
4. The plan for discharge will include the expected discharge date.

4. Daily Reporting of Bed Capacity

MH Crisis Residential providers are to report per the DHS/DMH protocol bed utilization and capacity each day of the week (including weekends and holidays) utilizing the Collaborative’s web-based reporting system. The Collaborative will then make this information available to the Clinical Care Managers of the ACCESS line for their use as part of the services authorization process. In addition, the Collaborative will report to DHS/DMH any providers who have not submitted an available bed capacity report.

⁷ This is a billing statement that is used by all hospital providers. This will enable immediate activation of approved AABD Medicaid spend down cases.

⁸ If the individual declines to sign, please submit documentation of this. Make sure s/he understands that this is NOT related to whether s/he has a representative payee for any monetary benefits.

⁹ If your agency does not collect any element listed below, print “NC” on the checklist, legibly. Do not use “NC” if your agency routinely collects this information but it simply isn’t handy.

¹⁰ If individual declines permission for re-release of this information, this must be documented.

C. DASA Residential Crisis Stabilization

The DASA Residential Crisis Stabilization (RCS) program is designed to meet the unique needs of individuals with Substance Use Disorders (SUD's) seeking assistance at an emergency department (ED), state hospital, or other healthcare facility. In addition to active SUD's, these patients are often experiencing acute distress associated with mental illness, medical conditions, and psychosocial/environmental problems. While retaining the six dimensional assessment format described in the 2001 ASAM PPC-2R, the primary goals of DASA RCS are assessing, stabilizing and preparing patients for necessary follow-up treatment or ancillary services upon discharge. The short term nature of RCS (approximately 5-10 days) targets the stabilization of problems related to detoxification, biomedical, emotional, behavior, or cognitive conditions as described in ASAM Dimensions 1-3. Problems associated with readiness to change, relapse or continued use, and recovery environment (ASAM Dimensions 4-6) should be addressed in the RCS treatment planning process, but are generally not justification for continued stay once the patient is stable and able to be referred to additional alcohol and other substance abuse treatment services.

When requesting authorization for services and if approved, the Collaborative will refer the patient to the most appropriate RCS program based on the clinical needs of the patient and the program location. The RCS is responsible for planning and executing follow-up services, including contacting follow-up service providers upon discharge from the residential program.

1. Admission Criteria for DASA Residential Crisis Stabilization

The patient must be assessed by the designated Evaluator from a community mental health center or community hospital, determined appropriate for admission to RCS, and agrees to engage in this level of care and treatment process. Specifically:

1. The patient has symptoms consistent with the diagnosis of a SUD.
2. The individual has been assessed with a LOCUS level of care recommendation of 5 or higher.
3. The patient's condition requires the need for continuous monitoring and supervision. A less intensive service would not provide adequate stabilization from their SUD.
4. Chronic medical problems are sufficiently stable and acute medical problems have been adequately treated to allow the patient to participate in the RCS program.
5. It is expected that the resources and techniques associated with this RCS will lead to successful discharge and referral for additional needed services.

2. Continued Stay/Discharge Criteria for DASA Residential Crisis Stabilization

Continued stay in RCS is indicated as long as the patient continues to meet admission criteria justifying placement in the RCS. The patient will be discharged from the RCS when admission criteria are no longer met.

3. Exclusionary Criteria for DASA Residential Crisis Stabilization

An individual is not eligible for DASA RCS as part of the R1S/CCS if:

1. Assessment indicates the patient may experience acute substance withdrawal that cannot be managed safely by the provider at this level of care (i.e. acute or unstable medical or psychiatric symptoms of withdrawal not yet stabilized by medical treatment).

2. Assessment indicates the patient may experience acute medical symptoms that cannot be managed safely by the provider at this level of care (i.e. medical instability of acute or chronic medical conditions).
3. Assessment indicates the patient may experience acute psychiatric symptoms that cannot be managed safely by the provider at this level of care (i.e. acute psychosis, acute risk of danger to self or others, marked functional impairment, marked cognitive impairment).

4. Programmatic Requirements for DASA Residential Crisis Stabilization

1. A current physical examination must be completed and forwarded to the RCS program from a qualified medical professional or one must be completed within 24 hours of admission to the RCS.
2. If the patient has a confirmed psychiatric diagnosis or the patient begins to display psychiatric symptoms, an initial psychiatric assessment must be completed by a licensed physician, clinical psychologist, clinical social worker, or clinical professional counselor within 48 hours of admission to the RCS or no later than 24 hours after the symptoms present. This assessment will be used in treatment planning, determining the need for further assessment by a licensed psychiatrist, and discharge planning.
3. An initial treatment plan must be developed by professional staff trained and credentialed to assess and monitor the medical and psychiatric status of patients admitted to the RCS. At a minimum, the initial treatment plan must address the presenting problems justifying admission (ASAM Dimensions 1, 2, and 3) and be confirmed by a physician within 48 hours of admission to the RCS.
4. Each patient shall have a planned regimen of care of at least 3 hours of treatment services per day if assessed as capable. This shall include at least one individual contact per day with a professional staff. Treatment services must focus on stabilization of the patient's presenting problems as well as engagement and motivation for additional needed services.
5. Discharge/Transition planning shall begin at admission and must include coordination with follow-up providers to ensure a firm referral and linkage to additional services.
6. As clinically appropriate, initiate Medicaid applications (or, if initiated by another R1SCCS entity, follow through and expedite the application process) utilizing the "Best Practices in Medicaid Applications Process." Training is available on this process, and ACS providers are held responsible for its utilization.

Medicaid application packets must include (but are not limited to) the following elements:

- a. Application for Medical Assistance (Form 2378H)
- b. UBO4¹¹ for any Emergency Department Services in prior 90 days
- c. Signed DHS Authorized Representative Form¹²
- d. Proof of SSDI/SSI OR ALL OF THE FOLLOWING DOCUMENTATION:¹³
 - i. Signed/Completed Form 183A (Physician's Report)

¹¹ This is a billing statement that is used by all hospital providers. This will enable immediate activation of approved AABD Medicaid spend down cases.

¹² If the individual declines to sign, please submit documentation of this. Make sure s/he understands that this is NOT related to whether s/he has a representative payee for any monetary benefits.

¹³ If your agency does not collect any element listed below, print "NC" on the checklist, legibly. Do not use "NC" if your agency routinely collects this information but it simply isn't handy.

- ii. Clinician cover letter reviewing disabling characteristics
- iii. Copy of History and Physical Examination
- iv. Copy of Psychiatric Evaluation
- v. Copy of Psychosocial Evaluation/Social History **OR** 183B
- vi. Copy of pertinent lab reports
- vii. Copy of all diagnostic evaluations
- viii. Copy of pertinent progress notes
- ix. Copies of previous psychiatric discharge summaries¹⁴
- x. Copy of treatment plan
- xi. Copy of special observation/precaution documentation
- xii. Admitting and discharge or current GAF

5. Daily Reporting of Bed Capacity

DASA Residential Crisis Stabilization providers are to report per the DHS/DMH protocol bed utilization and capacity each day of the week (including weekends and holidays) utilizing the Collaborative's web-based reporting system. The Collaborative will then make this information available to the Clinical Care Managers of the ACCESS line for their use as part of the services authorization process. In addition, the Collaborative will report to DHS/DMH any providers who have not submitted an available bed capacity report.

D. Community Hospital Inpatient Psychiatric Services (CHIPS)

The Community Hospital Inpatient Psychiatric Services (CHIPS) program is intended to serve those persons experiencing a psychiatric crisis diagnosed with serious mental illnesses (SMI) who exhibit acute behaviors or symptoms requiring the immediate services of an inpatient setting. To maximize State resources, funds used to reimburse these services are used only after all other appropriate sources of reimbursement have been exhausted, and only for those Illinois residents meeting clinical eligibility requirements and in specific financial need, defined as under 200% Federal poverty level (FPL) as found at: <http://aspe.hhs.gov/poverty/12poverty.shtml>.

It is not the intent or purpose of this CHIPS program to replace or reimburse services for all or part of indigent or non-insured psychiatric services historically provided by this Provider, including services previously rendered by the Provider as "charity care." DMH reserves the right to request from the Provider historical data concerning the level to indigent care, including but not limited to numbers of admissions, patient days, previously provided by the vendor for their psychiatric inpatient services to assess adherence to this section.

Staff providing the services of the R1S/CCS Eligibility and Disposition Assessments, including those of a community hospital with a psychiatric inpatient unit, must request authorization for DHS/DMH payment for this level of service by contacting the DHS/DMH authorizing agent (such as the Collaborative). If approved, the authorizing agent will provide the name, address and contact information for a CHIPS provider with available capacity that is most convenient to the individual's home.

The CHIPS program is responsible for:

- Thorough diagnostic evaluation;
- Delivery of individualized active treatment;
- Planning and executing follow-up services, including contacting follow-up service providers upon discharge from the hospital to ensure linkage;
- Initiate Medicaid applications (or, if initiated by another R1SCCS entity, follow through and expedite the application process) utilizing the "Best Practices in Medicaid Applications Process." Training is available on this process, and ACS providers are held responsible for its utilization.

¹⁴ If individual declines permission for re-release of this information, this must be documented.

Medicaid application packets must include (but are not limited to) the following elements:

- a. Application for Medical Assistance (Form 2378H)
- b. UBO4¹⁵ for any Emergency Department Services in prior 90 days
- c. Signed DHS Authorized Representative Form¹⁶
- d. Proof of SSDI/SSI OR ALL OF THE FOLLOWING DOCUMENTATION:¹⁷
 - i. Signed/Completed Form 183A (Physician's Report)
 - ii. Clinician cover letter reviewing disabling characteristics
 - iii. Copy of History and Physical Examination
 - iv. Copy of Psychiatric Evaluation
 - v. Copy of Psychosocial Evaluation/Social History OR 183B
 - vi. Copy of pertinent lab reports
 - vii. Copy of all diagnostic evaluations
 - viii. Copy of pertinent progress notes
 - ix. Copies of previous psychiatric discharge summaries¹⁸
 - x. Copy of treatment plan
 - xi. Copy of special observation/precaution documentation
 - xii. Admitting and discharge or current GAF

1. Medical Necessity and Guidelines for Admission for CHIPS Acute Hospital Services

The provider will maintain written documentation that the admission for acute hospital services is provided as active treatment, including that:

1. Individual has symptoms of one of the following mental illnesses:
 - Schizophrenia (295.xx)
 - Schizophreniform Disorder (295.4)
 - Schizo-affective Disorder (295.7)
 - Delusional Disorder (297.1)
 - Shared Psychotic Disorder (297.3)
 - Brief Psychotic Disorder (298.8)
 - Psychotic Disorder NOS (298.9)
 - Bipolar Disorders (296.0x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90)
 - Cyclothymic Disorder (301.13)
 - Major Depression (296.2x, 296.3x)
 - Obsessive-Compulsive Disorder (300.30)
 - Anorexia Nervosa (307.1)
 - Bulimia Nervosa (307.51)
 - Post Traumatic Stress Disorder (309.81), **and**
2. The individual has been assessed with a LOCUS score of 6, **and**
3. The individual's condition affirms the need for required specialized resources and/or a structured environment in a selected facility for diagnosis, evaluation, or treatment, **and**

¹⁵ This is a billing statement that is used by all hospital providers. This will enable immediate activation of approved AABD Medicaid spend down cases.

¹⁶ If the individual declines to sign, please submit documentation of this. Make sure s/he understands that this is NOT related to whether s/he has a representative payee for any monetary benefits.

¹⁷ If your agency does not collect any element listed below, print "NC" on the checklist, legibly. Do not use "NC" if your agency routinely collects this information but it simply isn't handy.

¹⁸ If individual declines permission for re-release of this information, this must be documented.

4. The individual's response to current treatment reflects that a less intensive or less restrictive psychiatric treatment program would not be adequate to provide safety for the individual or others or to improve the individual's functioning, **and**
5. An individualized treatment program is completed and on file that specifically addresses the therapeutic needs of the individual and, where appropriate, family involvement, **and**
6. Care is supervised and evaluated by a licensed physician who has completed an accredited psychiatric residency i.e., Accreditation Council for Graduate Medical Education or Accreditation of Colleges of Osteopathic Medicine, **and**
7. An expectation that the resources and techniques associated with this level of care will lead to successful discharge into the community or transfer to a less intensive or restrictive treatment program.

Exclusion Criteria:

1. Significant medical conditions which are poorly controlled or potentially life threatening;

2. Guidelines for Continued Stay

The provider will maintain written documentation that the Severity of Illness (SI) and Intensity of Service (IS) criteria are met as indicated below:

SEVERITY OF ILLNESS (SI) demonstrated by meeting at least **two** of the following criteria:

1. The individual requires continuous skilled psychiatric observation, planned psycho-therapeutic services, and/or planned and controlled psychotropic drug management;
2. The individual exhibits an inability to care for self due to an interaction of mental and other physical disorders creating incapacitating symptoms or behaviors;
3. The individual poses significant suicide risk, including meeting any of the following:
 - feeling hopelessness and/or worthlessness; or,
 - history of unpredictable behavior, agitation, impulsivity, or poor judgment; or,
 - individual history of previous suicide attempts; or,
 - persistent insomnia with deterioration in mood or cognition; or,
 - individual history of noncompliance with treatment recommendations in the past; or,
 - family history of suicide attempts or completed suicide; or,
 - individual history of abusing drugs that could lead to impulsiveness or poor judgment; or,
 - significant changes in mood or behavior; or,
 - individual history of recent loss (e.g., job, relationship, family member); or,
 - preoccupation with suicidal thoughts; or,
 - presence of a suicide plan with reasonable expectation for completion;
4. The individual shows a history of assaultive or serious self-mutilative behavior or reported evidence of danger to self or others;
5. The individual exhibits homicidal ideation accompanied by psychiatric disorder;

6. The individual exhibits impaired reality testing accompanied by disordered behavior (e.g., bizarre, delusional, illogical thinking, hallucinations, manic behavior).

INTENSITY OF SERVICE (IS) need demonstrated by meeting at least **two** of the following criteria:

1. Complex treatment necessitated by co-existing conditions requiring concurrent treatment (e.g., an insulin-dependent diabetic who is neglecting diabetic care due to major depression, chronic respiratory or cardiovascular insufficiency, etc.);
2. A need for a controlled environment to protect self and others (e.g., suicide precautions, instituted isolation, etc.);
3. Special treatment modalities available only in the hospital due to need for special environment, equipment, or ancillary services (e.g., planned and controlled psychotropic drug management);
4. There is a high potential for readmission within 30 days (e.g., documented history of recent admission or high risk behavior, poor adherence to last hospitalization's discharge plan, family's or significant other's incapacity to support the treatment plan, or identified need for specialized outpatient milieu); for individuals meeting this criterion the medical record must reflect efforts taken to address these issues to prevent further readmissions.

3. Guidelines for Discharge

Once an individual meets any of the criteria below, no further concurrent authorizations will be provided:

1. The individual no longer poses a risk of harm to self or others;
2. As indicated by a psychiatrist, the presence of signs and symptoms at a level sufficient to allow for functioning outside of the hospital setting;
3. No evidence supporting a reasonable expectation of significant psychiatric improvement with continued inpatient treatment;
4. Failure to complete an initial therapeutic plan by the attending physician within 24 hours of admission or the multidisciplinary treatment plan if the individual remains in the hospital two days or longer, or both;
5. The multidisciplinary treatment plan is not reviewed and updated or revised as necessary on a weekly basis.
6. When it is determined that an individual is appropriate for discharge, the hospital must supply the ACCESS line CCM with information related to the discharge, including but not limited to: discharge date, discharge diagnosis, aftercare arrangements and medications prescribed.
- 7) Failure to attempt to initiate or fully engage the identified ACS provider in the formulation of a post discharge care plan.

4. Documentation Guidelines

The following components of an individual's medical record have been defined to assist the admitting psychiatrist and ancillary staff in providing the necessary documentation indicative of active psychiatric service. The record must contain sufficient documentation for each item.

1. Within 24 hours of admission, a psychiatric assessment (including the reason for admission, mental status examination, determination of diagnosis, identification of behaviors/symptoms

that need clinical intervention, and initial therapeutic plan based on identified needs) must be documented in the medical record by an attending physician;

2. Other medical history and physical examination must also be completed within 24 hours of admission;

3. If an individual remains in the hospital more than two days, a multidisciplinary treatment plan should be documented in the medical record by the attending physician, with input from other members of the treatment team on the 2nd day of hospitalization. The multidisciplinary treatment plan should be implemented on the 2nd day of hospitalization and include:

- a. Clinical activities designed to enhance the individual's functioning sufficient for the individual to be transferred to a less restrictive care environment with a decreased likelihood of readmission;
- b. Estimated timeframes to achieve therapeutic goals;

4. If a multidisciplinary treatment plan is warranted, progress toward the therapeutic goals must be documented **at least weekly**, and include a re-evaluation if progress is insufficient, with changes and amendments or revisions to the plan as required;

5. Regular progress notes should be completed by non-nursing, non-physician clinicians **at least weekly**;

6. Physician involvement consistent with the **acuity/complexity** of the case requires documentation in the form of a progress note. Attending physician's orders (written or verbal) or signature on the treatment plan are not substitutions for adequate physician involvement and documentation. The **usual and customary standard is 6 progress notes per 7 day period/week**. In order to reflect adequate attending physician involvement, resident physician documentation must reflect that the individual was seen and the clinical interventions discussed with the attending physician;

7. Skilled psychiatric nursing must be reflected in the medical record **daily** and must contain an appropriate sample of clinical nursing observations and interchanges between the individual and nursing staff. In addition, an assessment of the individual for therapeutic and side effects of medications should be documented;

8. Discharge planning needs and efforts must be documented **weekly** in the medical record, should be part of the team's weekly evaluation of progress toward therapeutic goals, and include appropriate and timely follow-up arrangements, such as scheduled follow-up appointments;

9. By the time of discharge, follow-up appointments should be documented or the explanation of why such could not be arranged, as well as an individual's refusal of recommended follow-up appointments and alternative arrangements suggested;

10. Discontinuance of therapy for a period of time, or a period of observation as preparation for or follow-up to therapy, while maintenance of protective services, should be explained as to why these are essential to the overall plan of active treatment;

11. For individuals with a high potential for readmission within 30 days (e.g., documented history of recent admission or high risk behavior, poor adherence to last hospitalization's discharge plan, family's or significant other's incapacity to maintain the treatment plan, or identified need for specialized outpatient milieu), the medical record must reflect efforts taken to address these issues to prevent further readmissions.

12) For all cases and as included in the multi-disciplinary treatment plan and /or progress notes, documentation shall indicate the attempt by the hospital to fully engage the identified ACS provider in the formulation of a post discharge care plan.

5. Utilization Review and Billing for CHIPS

The Provider shall cooperate with the DHS/DMH Regional Office or DHS/DMH contractor Utilization Review process, with treatment limited to continuous inpatient hospitalization, as authorized, per episode. The concurrent approval by the DHS/DMH Regional Office or contractor is needed to qualify for payment under this CHIPS program. Requests for extensions of hospitalization must include the clinical rationale from the Provider.

If an individual is still hospitalized when the initial authorization timeframe is up, a concurrent review and authorization is required for continued DHS/DMH funding of the hospitalization. Twenty-four hours before the expiration of the initial authorization (or on the preceding Friday if a weekend), the attending physician or designee is to contact the Collaborative (1-866-359-7953) to request the authorization for continued hospitalization stay (requests for continued authorizations must be done during regular business hours, Monday through Friday between 8 am and 5 pm).

For any further continuing stay reviews, the Provider is to fax to the CCM prior to the review, the psychiatric assessment, psychosocial assessment all progress notes since the last review and multidisciplinary treatment plan documents developed according to the CCS manual. The content of these documents is to be considered in addition to the verbally reported evidence of continuing stay criteria and should be sent via HIPAA secure:

Fax: **312-453-9003** or email: IllinoisPCI@valueoptions.com

The Collaborative will review the clinical information provided against the “severity of illness” and “intensity of services” criteria, guidelines for discharge, documentation guidelines detailed above. If approved, a concurrent authorization will be provided. If there is a difference of opinion concerning a request for extending the length of stay a Physician Advisor (PA) from the Collaborative will review. If the difference of opinion remains after the first PA review, a second level of review will be conducted by another Collaborative physician. If the second level of reconsideration review remains unresolved, then DHS/DMH will make the final determination.

CHIPS providers must complete a UB-04 CMS 1450 (see: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1104CP.pdf>) and a DMH Funding Notice (see Appendix). Completed forms may be either faxed to DMH at 217-785-3066 Attn: Fiscal Services or mailed to:

Department of Human Services
Division of Mental Health
Attn: Fiscal Services
319 E Madison St., Suite 3B
Springfield, IL 62701

The billing forms are to be submitted within 15 days of close of the month in which inpatient services were provided.

6. Daily Reporting of Bed Capacity

CHIPS providers are to report per the DHS/DMH protocol bed utilization and capacity each day of the week (including weekends and holidays) utilizing the Collaborative’s web-based reporting system. The

Collaborative will then make this information available to the Clinical Care Managers of the ACCESS line for their use as part of the services authorization process. In addition, the Collaborative will report to DHS/DMH any providers who have not submitted an available bed capacity report.

E. Madden Mental Health Center Services

Madden Mental Health Center will serve as the safety net for instances when the above services are not available or not appropriate for the needs of the individual. Specifically, Madden MHC intake department should be contacted (at 1-866-810-5869) under the following circumstances for additional help in the assessment process and to evaluate for potential DHS/DMH hospital admission:

1. The individual has a history suggesting a need for extended inpatient treatment, such as a history of lengthy previous state hospital admissions;
2. The individual presents challenges in discharge placement from an inpatient setting, such as being homeless;
3. The individual has a co-occurring substance abuse diagnosis requiring medical observation that exceeds the capability of available community inpatient psychiatric services¹⁹;

Referrals to Madden are reviewed by a Madden MHC physician for consideration of placement at:

- Madden MHC;
- Chicago Read MHC;
- Another DHS/DMH operated state hospital;
- A community hospital inpatient psychiatric unit (CHIPS) or community mental health or substance abuse residential program when authorization from the Collaborative has been obtained.

Services at Madden MHC include not only inpatient services, but also the services of the Madden Crisis Stabilization Unit for individuals that can be stabilized quickly.

If an individual is admitted to a state hospital, the state hospital is to begin discharge planning within 48 hours of admission, including contact and coordination with potential post-discharge service providers. The state hospital is responsible for planning and executing post-discharge follow-up services, including contacting follow-up service providers upon discharge from the inpatient state hospital program and assuring a firm linkage to these providers through follow-up contacts within two business days of the discharge.

1. Service Referrals by Madden Intake for Individuals from Region 1 South and 1 Central

In addition to the above services, to ensure available service capacity at Madden MHC, the Madden Intake Department also manages the following referrals:

- For an individual from Region 1 Central that presents at the ED of one of the four DHS/DMH-contracted CHIPS hospitals in Region 1C (i.e., Mt. Sinai Hospital, University of Illinois at Chicago Hospital, St. Anthony's Hospital, Vanguard MacNeal Hospital) and is determined to not have insurance or resources for needed treatment:
 - If the ED evaluates the individual as in need of inpatient psychiatric services, mental health crisis residential, or DASA residential crisis stabilization:
 - The ED may call Madden Intake and request authorization for the assessed needed level of care;
 - if Madden Intake concurs with the ED's assessed need for services for the individual they will call the Collaborative to obtain the appropriate service authorization and provide this authorization information to the referring ED;

¹⁹ Riverside Hospital in Kankakee and Advocate Christ Medical Center in Oak Lawn have this capability.

- If Madden Intake does not concur with the ED's assessed need for services they will engage in a physician-to-physician discussion resulting in: (a) referral to an alternative level of care; (b) admission to a DHS/DMH-operated hospital; or (c) denial of authorization for services at the requested level of care.
- Although Madden Intake gives priority consideration to individuals from Region 1 South, any individual from Region 1 Central seeking admission to Madden MHC may be referred by Madden Intake, as clinically appropriate, to the following services:
 - Madden MHC Intensive Stabilization Unit
 - Mental Health Crisis Residential
 - DASA Residential Crisis Stabilization

Note, however:

- Eligible individuals from Region 1 South remain eligible for R1S/CCS Acute Community Services regardless of where else they may have received services (e.g., such as a hospital or residential program outside of Region 1 South);
- Individuals from Region 1 Central are not eligible for R1S/CCS Acute Community Services even though they may have been served by a hospital or residential program considered part of the R1S/CCS.

X. Transportation

In managing an individual immersed in a mental health crisis or potential crisis, transportation to the most appropriate site for services or supports may be necessary. Providers are encouraged to seek and employ the least intrusive and least expensive method of safe transportation possible. For some individuals whose condition have become sufficiently stabilized this may mean the use of family or friends to drive or escort the individual on public transportation, or the payment of bus or cab fare for the individual. For other individuals and situations, however, a more safe and secure method of transportation may be required.

DHS/DMH contracts with a selected transportation provider to transport individuals who have been assessed to need residential or inpatient care as a result of a R1S/CCS Eligibility and Disposition Assessment to the site of the provider of the authorized services. The individual will have been determined to have no other means of transportation prior to a request for transport being made to the transportation provider. The same authorization for services is to be used for authorizing the use of the DHS/DMH contractual transportation provider.

A. Services and supports to be provided

The funded transportation provider is to:

1. Transport individuals authorized for entry into R1S/CCS inpatient or residential services;
2. Transport individuals via secure van, medicar, service vehicle, or other means appropriate to the needs of the individual to be transported;
3. Ensure that response to transportation request is made within 60 minutes;
4. Ensure that transportation provider staff are trained or have experience in consumer transportation, including training in the following areas:
 - An introduction to mental health and population specific characteristics;
 - Service delivery policies and protocols;

- Quality control standards and procedures;
 - Incident reporting policies and procedures;
 - Record keeping standards and procedures;
5. Maintain a toll-free telephone number staffed 24 hours per day to receive requests for transportation;
 6. Submit monthly vouchers to DHS/DMH for payment;
 7. Maintain vehicles that:
 - Meet the Secretary of State licensing requirements;
 - Have front and rear passenger door locks that can only be operated by the driver;
 - Have a safety partition installed between the driver and passenger areas;
 - Ensure the security of the partition between the rear passenger area and the trunk;
 - Have separate video camera and recording systems capable of viewing both the driver, the front of the vehicle, and the passenger and passenger area;
 - Have a supply of scrub suit tops and bottoms and slippers for the consumer to wear if needed;
 - Have a supply of bottled water if needed for the consumer during transport;
 - Have a supply of comfort items (blanket, umbrella) if needed for the consumer during transport;

1. Range of responsibility

Transportation services will serve individuals with or suspected to have severe mental illness that have been authorized for entry into R1S/CCS services and need secure transport from the provider at which presentation was made to the provider approved to supply inpatient psychiatric, mental health crisis residential services, or DASA residential services.

At its discretion, DHS/DMH will provide access to the DHS/DMH transportation contract provider for transport of persons to a residential treatment provider with approval of Madden MHC Intake Department. Such access will be for persons who otherwise would be hospitalized at Madden MHC if no residential provider were available. Transport access decisions will be dependent upon available capacity and utilization patterns for the purpose of providing the least restrictive service possible. Notification to affected hospitals and providers will occur as changes are implemented.

B. Voluntary Transportation System Request Protocol

Illinois Patient Transport (IPT), a division of Advanced Medical Transport (AMT), through contract with State of Illinois Department of Human Services, will provide transportation services to voluntary patients in Region 1 to specific facilities identified in the *Region 1 South Crisis Care System Policies and Procedures*.

1. Requesting a Transport

Once a patient is deemed eligible for transportation by the Eligibility Disposition and Assessment Evaluator, the Evaluator is to call IPT's Communication Center, complete the front and back of the *Region 1 South Voluntary Transportation System* request form and fax the transport request form, front and back, to IPT using the fax number at the top of the form.

2. Completing the Request Form (in Appendix)

1. The top of the request form provides the phone and fax number to IPT.
2. The name and a contact number to reach the Eligibility Determination and Assessment Evaluator is to be provided.

3. Identify by checking the correct box the type of facility the patient will transport to: 1) CHIPS, Community Hospital Inpatient Psychiatric Services; 2) DASA, Substance Abuse Residential Crisis Stabilization; 3) Mental Health Crisis Residential; or 4) John J Madden Mental Health Center.
4. Clearly provide the authorization number for the transport (which is the same as the services authorization number) as well as the date for the transport.
5. Complete the section on the front of the form marked "Patient Information" leaving no blanks. In rare circumstances where a social security number is not available clearly note "none available".
6. Complete the section marked "Pre-transport Risk Assessment". This tool assures each patient is transported in the safest manner possible. Please be prepared to discuss this section with the dispatcher to assure IPT is aware of the condition and demeanor of the patient.

Pre-transport Risk Assessment:

1. Do physical limitations prohibit transport by car; ambulatory, weight, or other?
If the patient cannot transport by car an ambulance may be sent.
2. Is the patient a juvenile? *IPT does not transport minors.*
3. Are there identified complicating medical conditions with potential for difficulty en route?
Medical conditions may require an ambulance transport, e.g., the potential for seizures is a concern.
4. Is there potential for drug or alcohol withdrawal en route?
Determine the likelihood the patient may experience withdrawal during the transport; patients likely to experience withdrawal may require an ambulance.
5. Is there a history of violence or assaultive behavior?
Please share any information regarding the patient's behavior just prior to admission (e.g., possible domestic violence) as well as the behavior currently exhibited.
6. Has the patient been searched for contraband?
For the patient's safety and the transport technician, patients must be searched for weapons.
7. Was there use of PRN medication for agitation with this ER/ED admission?
Medication used to calm is acceptable (Ativan, Xanax); medication used to sedate or control behavior are not appropriate for a car transport and may require an ambulance.
8. Is the patient aware of the voluntary transport and the location of treatment services?
The patient will likely be more cooperative when included in the treatment and transportation plans.
9. Has the patient been accepted at the receiving facility?
To ensure that the patient will not arrive at the destination only to find there is no treatment available for the patient.

On the back of the form, fill out the details regarding the current transferring facility as well as the destination facility. Contact names and numbers for the transferring and destination facilities are required.

Provide the form to the patient with the back of the form in view. Along with the destination, the patient will have two sentences to read and a signature line with date. The patient acknowledges the transport is directly to the facility. By signing, the patient is providing a psychological commitment more than a legal one. This is designed to reduce the chance an individual may change their mind en route or request an alternative destination.

3. Transport Technician

Upon arrival, the transport technician will obtain an update on any changes in the patient's condition and demeanor. Provide the form to the transport technician for review. Complete the box under the patient's signature marked *"To be completed by transferring facility."* The transport technician will take the request form with him.

The transport technician will escort the patient to the vehicle. The final box on the form will be completed upon arrival at the destination facility.

Should the IPT refuse to transport an individual due to insufficient stabilization of the individual, medical issues or other reasons the IPT supervisor should be contacted for resolution. All such instances will be subsequently reviewed by DHS/DMH with the IPT contractor.

XI. Medications

When necessary, the provision of psychiatric medications for a R1S/CCS eligible individual is the responsibility of the individual's current provider. The funding levels for R1S/CCS services typically included anticipated medication costs. It is presumed that generics will be prescribed whenever possible.

To facilitate and coordinate services, Emergency Departments shall provide written prescriptions for individuals transitioning from their ED into a R1S/CCS service. For planned discharges from other R1S/CCS services it is expected that written prescriptions will be faxed to the receiving service provider at least 24 hours prior to the individual's discharge and transition. Hospitals and other providers who have the capacity to dispense a 72 hour supply of medications at the time of discharge are strongly encouraged to do so in order to minimize the likelihood of an interruption in treatment.

Non-psychiatric medications for established medical issues remain the responsibility of the R1S/CCS eligible individual. It is recognized that non-availability of such medications may preclude an individual's admission into a R1S/CCS service.

XII. Processes for the Redetermination of Level of Services Needed

On occasion, after an initial Eligibility and Disposition Assessment by an Evaluator and placement in a treatment setting has occurred, it may later be determined that an alternative treatment setting or level of care is required to best serve the needs of the individual. That is, the individual may have reached a level where less intensive and restrictive services are needed or, alternatively, may have been found to require a more intensive level of services.

A. Processes

There are three different circumstances that could warrant an authorization process for the transition of an individual to a different level of services.

- A. If the individual requires a **less intense level of services** (that is from inpatient to residential or acute community services, or from residential to acute community services) no additional authorization is

required. The original authorization for services is sufficient. However, the Collaborative is to be contacted and informed of the change in the level of service and treatment setting.

To implement this transition to a less intense level of service the referring provider must contact the designated staff at the destination service provider and make appropriate arrangements for the transfer of the individual, including completion of the destination service provider’s admission protocols, including, for example, medical clearance. Any medical or other issues, including scheduled appointments, should be communicated to the destination service provider.

If the transportation services of the DHS/DMH contractor are necessary for movement of the individual to a Mental Health Crisis Residential or DASA Residential Crisis Stabilization setting, the Collaborative must be contacted for a services authorization number for the transportation.

B. If the individual is **currently receiving MH Crisis Residential or DASA Residential Crisis Stabilization**, a Licensed Practitioner of the Healing Arts (LPHA) on staff at the provider of current level of care can assess the individual and request authorization from the Collaborative for transfer to an alternative community residential (MH Crisis or DASA Crisis Stabilization) or inpatient psychiatric service. The LPHA’s assessment must include:

- a. The individual’s current mental health and/or substance abuse diagnoses, level of risk for harm, and need for mental health services;
- b. A completed Level of Care Utilization System (LOCUS) assessment based on the individual’s current psychiatric presenting condition;
- c. Document their assessment and findings, including the completion of the Uniform Screening and Referral Form (USARF).
- d. As noted above in the “Continuity of Care” section, all treatment site providers (CHIPs, MH Crisis Residential and DASA Residential Crisis Stabilization, Madden MHC) are required to call the Collaborative’s ACCESS line (CCM) at the point of discharge to verify the date of discharge and/or update the actual outpatient ACS provider site.

Once authorization is obtained from the Collaborative for the alternative treatment setting, the provider must contact the staff of the alternative treatment setting and make arrangements for the transfer of the individual to the new treatment setting, including completion of the destination service provider’s admission protocols, including, for example, medical clearance. If necessary, the authorization number for services can be used to arrange transportation by the DHS/DMH contractor following the “Voluntary Transportation System Request Protocol”. Any medical or other issues, including scheduled appointments, should be communicated to the destination service provider. (Note: should the Collaborative not authorize the requested treatment, the LPHA should follow the processes detailed in the “Services Authorization” section of this manual).

C. If the individual is receiving Acute Community Services and treatment in a more intensive level of service is needed, the individual must be reassessed by the designated Evaluator in a local Emergency Department.

The following table summarizes these authorization processes.

From ± To ∴	Acute Community Services	MH Crisis Residential	DASA Residential Crisis Stabilization	CHIPS	Madden MHC

From ± To .:	Acute Community Services	MH Crisis Residential	DASA Residential Crisis Stabilization	CHIPS	Madden MHC
Acute Community Services		(A) No authorization required but Collaborative to be informed of change in treatment setting	(A) No authorization required but Collaborative to be informed of change in treatment setting	(A) No authorization required but Collaborative to be informed of change in treatment setting	(A) No authorization required but Collaborative to be informed of change in treatment setting
MH Crisis Residential	(C) Requires Eligibility & Disposition Assessment (EDA) by Evaluator in an Emergency Department		(B) Requires authorization by the Collaborative requested by an LPHA at the provider	(A) No authorization required but Collaborative to be informed of change in treatment setting	(A) No authorization required but Collaborative to be informed of change in treatment setting
DASA Residential Crisis Stabilization	(C) Requires Eligibility & Disposition Assessment (EDA) by Evaluator in an Emergency Department	(B) Requires authorization by the Collaborative requested by an LPHA at the provider		(A) No authorization required but Collaborative to be informed of change in treatment setting	(A) No authorization required but Collaborative to be informed of change in treatment setting
CHIPS	(C) Requires Eligibility & Disposition Assessment (EDA) by Evaluator in an Emergency Department	(B) Requires authorization by the Collaborative requested by an LPHA at the provider	(B) Requires authorization by the Collaborative requested by an LPHA at the provider		(A) No authorization required but Collaborative to be informed of change in treatment setting
Madden MHC	(C) Requires Eligibility & Disposition Assessment (EDA) by Evaluator in an Emergency Department	(B) Requires authorization by the Collaborative requested by an LPHA at the provider	(B) Requires authorization by the Collaborative requested by an LPHA at the provider	(B) Requires authorization by the Collaborative requested by an LPHA at the provider	

B. Additional Requirements for Transfer to Madden

All admissions to State Operated Hospitals are at the sole discretion of the SOH physician. If an individual is receiving care within the R1S/CCS and the current provider of treatment believes a higher level of care is needed, then the SOH must be contacted by the staff (EDA for ACS and LPHA for MH Crisis Residential, DASA Residential Crisis Stabilization or CHIPS). If the SOH physician agrees to the referral for transfer, then the treating provider must call the Collaborative CCM to report the transfer. An authorization number will be provided which can be used to arrange transportation if necessary.

Individuals admitted to medical units of hospitals who are believed to be in need of SOH admission are to be referred by the physician of the treating medical unit, who is to call Madden. No involvement of the R1S/CCS is needed.

XIII. Appendix

A. Psychiatric Medical Clearance by _____

(hospital/agency)

Name _____ Date of Birth _____ Preliminary Diagnoses: _____

Confirmed as uninsured/no resources for payment for services (physician initials): _____

	Yes	No
1. Does the patient have new psychiatric condition?	9	9
2. Any history of active medical illness needing evaluation?	9	9
3. Any abnormal vital signs prior to transfer	9	9
Temperature >101F	9	9
Pulse outside of 50 to 120 beats/min	9	9
Blood pressure systolic <90 or >200; diastolic >120	9	9
Respiratory rate >24 breaths/min	9	9
4. Any abnormal physical exam (unclothed)		
a. Absence of significant part of body, e.g. limb	9	9
b. Acute and chronic trauma (including signs of victimization/abuse)	9	9
c. Breathing Sounds	9	9
d. Cardiac <i>dysrhythmia</i> , murmurs	9	9
e. Skin and vascular signs: diaphoresis, pallor, cyanosis, edema	9	9
f. Abdominal distention, bowel sounds	9	9
g. Neurological with particular focus on:	9	9
h. Ataxia _____ pupil symmetry, size _____ nystagmus _____ paralysis _____ meningeal signs _____ reflexes _____		
i. Presence of prostheses, central lines, indwelling catheters, insulin pump, etc.	9	9
5. Any abnormal mental status indicating medical illness such as: lethargic, stuporous, comatose, spontaneously fluctuating mental status?		

All patients are to have blood count (CBC), electrolytes, pregnancy test (if child-bearing age) and drug screen performed. If no to all of the above questions, no further evaluation is necessary. Go to question #9. If yes to any of the above questions go to question # 6, additional testing may be indicated.

6. Were any additional labs done?	Yes 9	No 9
7. What lab tests were performed? _____ What were the results? _____ Possibility of Pregnancy _____	Yes 9	No 9
8. Were x-rays performed? _____ What kind of x-rays were performed? _____ What were the results? _____	Yes 9	No 9
9. Was there any medical treatment needed by the patient prior to medical clearance? _____ What treatment? _____	Yes 9	No 9
10. Has the patient been medically cleared in the ED?	Yes 9	No 9
11. Any acute medical condition that was adequately treated in the emergency department that allows transfer to a R1S/CCS service or state operated psychiatric facility (SOF)? _____ What treatment? _____	Yes 9	No 9
12. Current medications and last administered? _____		
13. Diagnoses: Psychiatric _____ Medical _____ Substance abuse _____		
14. Medical follow-up or treatment required in a R1S/CCS service or at state operated facility: _____ _____		

15. I have had adequate time to evaluate the patient and the patient's medical condition is sufficiently stable that transfer to an alternative level of care does not pose a significant risk of deterioration.

Time Evaluator called: _____ MD/DO Date: _____

Physician Signature

B. Region 1 South Community Hospital Pairings with Eligibility & Disposition Evaluators

Region 1 South Area	Community Hospitals to be Served	DMH Funded Services	
		Eligibility & Disposition Assessment Agency	Acute Community Services Agency
City of Chicago South of 67 th Street	Roseland Community Hospital	Human Resource Development Institute	Human Resource Development Institute (will refer some individuals to Metropolitan Family Services)
	St. Bernard Hospital		
South Suburban Cook County	Franciscan St. James Health	Grand Prairie Services	Grand Prairie Services for individuals residing in Bremen, Thornton, Rich and Bloom townships
	Metro South Medical Center		
	Advocate South Suburban Hospital		
	Palos Community Hospital	Advocate Christ Medical Center	Metropolitan Family Services for individuals residing in Lemont, Calumet, Palo, Worth, and Orland townships
	Little Company of Mary Hospital		
	Advocate Christ Medical Center		
Ingalls Memorial Hospital	Ingalls Memorial Hospital		
Kankakee County	Riverside Medical Center	Helen Wheeler Mental Health Center	Helen Wheeler Mental Health Center
	Provena St. Mary's Hospital		
Will County	Provena St. Joseph Medical Center	Will County Behavioral Health	Will County Behavioral Health (will refer some individuals to Cornerstone Services, Inc.)
	Silver Cross Hospital		
	Adventist Bolingbrook Hospital		
Grundy County	Morris Hospital	Grundy County Health Department	Grundy County Health Department

C. CHIPS & DASA Residential Crisis Stabilization Providers for the Region 1 South Crisis Care System

CHIPS Hospital	Street	City
Advocate Christ Medical Center	4440 West 95th Street	Oak Lawn, IL 60453
Ingalls Memorial Hospital	1 Ingalls Drive	Harvey, IL 60426
MacNeal Hospital	3249 South Oak Park Avenue	Berwyn, IL 60402
Mt. Sinai Hospital	1500 South California Avenue	Chicago, IL 60608
Riverside Hospital	350 North Wall Street	Kankakee, IL 60901-2991
St. Anthony's Hospital	2875 West 19th Street	Chicago, IL 60623
St. Bernard Hospital & Health Care Center	326 West 64th Street	Chicago, IL 60621
Provena St Mary's	500 W. Court Street	Kankakee, IL
University of Illinois Hospital	1801 W Taylor St # 4E	Chicago, IL 60612

DASA Residential Crisis Stabilization	Street	City
The Haymarket Center	932 W. Washington	Chicago, IL 60607
Healthcare Alternative Systems	2755 West Armitage Avenue	Chicago IL 60647
The South Suburban Council on Alcoholism and Substance Abuse	1909 Cheker Square	East Hazel Crest, IL 60429
The Women's Treatment Center	140 North Ashland Avenue	Chicago, Illinois 60607

D. Transportation Request Form

Region 1 South
Voluntary Transportation System

Served by  **Illinois Patient Transport**
a division of Advanced Medical Transport of Central Illinois

To request transportation call 877-745-8367 or 309-999-4040
 AND
 Fax the front and back of this form completed to: **309-494-6227**

Behavioral Health Services

EDA – Eligibility Disposition and Assessment Evaluator (complete front and back)

Name _____ Phone _____

Requests a voluntary transport to (check one);

- CHIPS – Community Hospital Inpatient Psychiatric Services
- DASA – Substance Abuse Residential Crisis Stabilization
- Mental Health Crisis Residential
- John J Madden Mental Health Center

Authorization Number _____ Date of Service _____

Patient Information

Patient Name: _____ Age: _____ DOB: _____ Gender: M F
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Emergency Contact: _____
 SSN: _____ Emergency Contact Phone: () _____

Pre-transport Risk Assessment

1. Do physical limitations prohibit transport by car; ambulatory, weight, or other?	YES	NO
2. Is the patient a juvenile? <i>(IPT does not transport juveniles)</i>	YES	NO
3. Are there identified complicating medical conditions with potential for difficulty en route?	YES	NO
4. Is there a potential for drug or alcohol withdrawal en route?	YES	NO
5. Is there a history of violence or assaultive behavior?	YES	NO
6. Has the patient been searched for contraband?	YES	NO
7. Was there use of PRN medications for agitation with this ER admission?	YES	NO
8. Is the patient aware of the voluntary transport and the location of treatment services?	YES	NO
9. Has the patient been accepted at the receiving facility?	YES	NO

Transferring Facility		County of Originating Facility: _____	
Transferring Facility: _____	Room: _____	Phone: () _____	
Address: _____	City: _____	State: _____	Zip: _____
ER Supervisor/Contact Person: _____	Contact Phone: () _____		

Destination Facility		County of Destination Facility: _____	
Destination Facility: _____	Room: _____	Phone: () _____	
Address: _____	City: _____	State: _____	Zip: _____
Contact Person: _____	Contact Phone: () _____		

To be completed by the patient

I am aware of the treatment opportunity at the destination facility above. I understand and accept transportation directly to the destination facility.

Name _____ Date _____

<p><i>Transferring Facility Sign Off</i></p> <p>Patient Picked up:</p> <p>Date: _____</p> <p>Time: _____</p> <p>Signature: _____</p> <p>Title: _____</p>
--

<p><i>Destination Facility Sign Off</i></p> <p>Patient Arrived:</p> <p>Date: _____</p> <p>Time: _____</p> <p>Signature: _____</p> <p>Title: _____</p>

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DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH

E. Notice on Program Funding for Psychiatric Inpatient Services

*****IMPORTANT NOTICE*****

Regarding the State of Illinois Department of Human Services' Division of Mental Health Community Hospital Inpatient Psychiatric Services (CHIPS) Program:

A program of funding may be available for certain individuals requiring inpatient psychiatric hospital treatment. The Division of Mental Health (DMH) funds are to be utilized only after all other appropriate sources of payment to the hospital and physician have been exhausted.

- ! It shall be the patient=s responsibility (or if applicable, the spouse, or the parents) with assistance from the service providers (hospital and community mental health agency) to provide required information to determine eligibility for the CHIPS program and to determine eligibility for Medicaid or KidCare.
- ! **Patients and parents/guardians of minors must follow through with Medical Assistance Applications completely** in order to become eligible for the utilization of Program funds. Therefore, Medical Assistance Application **denials** based upon patient and/or legal guardian failure to complete or cooperate with the application process **will not** normally be eligible to utilize Program funds and subsequently the patient/parents of minors may incur **all financial liability** for all services rendered.

**You are potentially eligible to receive Program funds;
however, the use of DMH funds cannot be guaranteed in advance.**

This notice was explained and given to me on:

(Date)

Signature of Admittee
(or interested person):

Employee Signature:

(Copy to client and original left on chart)

F. Communication and Problem Solving Channels for R1S/CCS

R1SCCS Dedicated Web Page – There is a link in the news column of the main DHS web page that will direct to a special page DHS/DMH has created for posting important documents for the new crisis system. The page address is:

<http://www.dhs.state.il.us/page.aspx?item=60664>

and some R1SCCS features include:

- System of Care Overview, Policy and Procedures
- Policy and Procedure Document
- Frequently asked questions (FAQ)
- Transportation Protocol and PDF transportation referral form
- As other materials are developed, they will be posted to this site.

R1SCCS Dedicated Mail Box – The Division has established an email address: DHS.R1SCCS@illinois.gov. This was created so that our system partners can file any questions and concerns at a site where a log of all messages sent will be maintained, as well as a log of all follow-up performed by DHS, up to and including whether the item resulted in change to posted policy document, was incorporated into system training, or was added to the FAQ document.

Systems Issues Line – A telephonic way to provide feedback, questions, or to pursue any non-emergent R1SCCS issue. As with the email box, a log of calls/voice mail messages will be kept and resulting actions traced above. The phone number is: **312-814-0930**.

Access To DMH Executives – A “24/7” option for real-time R1SCCS problem resolution. The Administrator on Duty (AOD) at Madden Mental Health Center can be contacted if there are emergent issues that need DMH intervention. The AOD will take a message and contact the on-call DHS/DMH executive, who in turn will return the call from the system partner. The 24/7 AOD telephone number is: **708-426-8739**.

Ad Hoc System Conference Calls – The DHS team will monitor the functioning of the system and conduct teleconferences of some or all of its partners as needed. E-mail lists for the entire system and for subgroups of partners (e.g., CHIPS providers, Emergency Department Managers, ACS providers, etc.) have been created and will be used to send notice of schedule calls. Any system partner can ask for TA, or forward an item for inclusion on a scheduled call agenda using the R1SCCS email box or the Issues Line.