

 <p style="text-align: center;">County of Sacramento Department of Health Services Division of Behavioral Health Services Policy and Procedure</p>	Policy Issuer (Unit/Program)	Mental Health Services
	Policy Number	03-07
	Effective Date	1-24-19
	Revision Date	10-18-19
Title: Bi-Directional Referral Process: Whole Person Care	Functional Area: Clinical Services	
Approved By: <i>Signed version available upon request</i>		
Melissa Jacobs, LCSW Division Manager	Kelli Weaver, LCSW Division Manager	

Background/Context:

The City of Sacramento is the Lead Entity for the Pathways to Health + Home (Pathways), which is the Whole Person Care (WPC) pilot program in Sacramento County as a business associate of the State of California, Department of Health Care Services (DHCS). Pathways is a multi-year, statewide Medi-Cal waiver program that allows local communities to coordinate physical health, behavioral health, and social services for vulnerable individuals who are high users of multiple health care systems and continue to have poor outcomes. The City has contracted with a third party (Data Management Entity) to perform certain duties on behalf of the City as part of the WPC Pilot, including obtaining relevant information from Sacramento County Department of Health Services as needed for effective care coordination and reporting. Healthy Community Forum for the Greater Sacramento Region dba Sacramento Covered currently serves as the Data Management Entity for Pathways.

Sacramento County Department of Health Services has entered into a Data Sharing Agreement (Agreement) with the City of Sacramento Pathways in order to share information, in accordance with the Health Information Portability and Accountability Act (HIPAA) and all other applicable laws, to coordinate access and delivery of services for shared members. Therefore, the Sacramento County Division of Behavioral Health Services (DBHS) Mental Health Plan (MHP) and Pathways have developed processes regarding members linked to each party's services as needed for effective care coordination.

Definitions/Abbreviations:

CST – Community Support Team is a Sacramento County operated Prevention and Early Intervention program

DHCS – California State Department of Health Care Services

Enrollee – An individual enrolled in the Pathways Health + Home program

Guest House - El Hogar Guest House is a Sacramento County contractor with DBHS and homeless entry point provider

MCST – Sacramento County Mobile Crisis Support Team, a Sacramento County operated program

Member – Medi-Cal MHP beneficiary

Pathways – Sacramento Covered, Pathways Health + Home Program

SMHC – County Senior Mental Health Counselor, Community Support Team Program

WPC – Sacramento City, Pathways to Health + Home (“Pathways”) Whole Person Care Pilot

Purpose:

To outline the bi-directional referral and care coordination process for Sacramento County’s MHP and the City of Sacramento Pathways’ WPC.

Details:

Referral and Coordination Process from Pathways to the MHP:

- A. To determine if a Pathways enrollee is linked to the MHP, Pathways will complete and submit the Community Support Team Referral Form for Sacramento Covered – Pathways to Health + Home Enrollees (see Attachment A).
- B. The CST referral will include the request type and all information necessary to complete the request, including requests for:
 1. Confirmation of linkage to the MHP: Pathways will provide enough information (*Enrollee Name, Date of Birth, and Social Security number*) for CST to determine if the enrollee is linked or not linked to the MHP.
 2. Mental Health Assessment:
 - a. If it is determined that the enrollee is not linked to the MHP and Pathways believes the enrollee could benefit from County specialty mental health services, Pathways will either indicate on the referral that they will follow-up with Guesthouse for the assessment or request a community-based assessment from CST – completing all remaining Pathways Enrollee Information on the request form.
 - i. Pathways will coordinate with El Hogar Guest House on completing the mental health assessment for all enrollees willing and able to attend and participate in the Guest House assessment process.
 - ii. Pathways will coordinate with CST on completing a community-based assessment if the enrollee does not appear to be able to participate in an assessment at Guest House.
- C. If it is determined that the enrollee is open to an MHP provider, Pathways will complete the following steps:

1. Obtain a release of information (ROI) from the enrollee to allow coordination of care between Pathways and the authorized MHP Provider.
 2. Pathways, the enrollee, and the MHP provider will identify enrollee needs and coordinate care to ensure that services are in place by the MHP provider to support those needs.
 3. Pathways will close services once in agreement that either the client is housed and able to maintain stability, or is in a MHP level of care that can provide intensive services to support ongoing care management needs.
- D. Upon receiving the Community Support Team Referral Form for Sacramento Covered – Pathways to Health + Home Enrollees, CST will assign the referral to a SMHC to follow-up with Pathways regarding the request.
- E. The assigned CST SMHC will utilize Avatar (Sacramento County Electronic Health Record) to determine if the enrollee is currently open to an MHP provider.
- F. CST will contact the Pathways contact identified on the referral within twenty-four (24) business hours of receiving the referral and complete the following:
1. Indicate whether the enrollee is linked or not linked to the MHP.
 2. If the enrollee is linked to the MHP, provide the name of the MHP provider and authorization date.
 3. If the enrollee is not linked to the MHP and the referral includes a request for a community-based CST mental health assessment, CST will complete the following:
 - a. Coordinate with Pathways on a plan for meeting the individual in the community to complete the assessment.
 - b. Based on the plan developed in coordination with Pathways, CST will meet with the individual to complete all necessary consents, ROIs and the mental health assessment.
 - c. If it is determined as a result of the assessment that the individual meets medical necessity for specialty mental services as defined in accordance with *PP-BHS-QM-01-07 Determination for Medical Necessity and Target Population* and the member is in agreement with services through the MHP, CST will submit a Sacramento County Mental Health [Access Team Service Request](#) and include the biopsychosocial assessment used to assist in making the level of care determination. CST will ensure the Request includes information that the member is open to Pathways and includes contact information for coordination of care.
 - d. If it is determined as a result of the assessment that the individual meets criteria for mental health services through their Managed Care Plan (MCP), CST will submit the [Sacramento County Bi-Directional Medi-Cal Transition of Care Request](#) to the respective Managed Care Plan. CST will ensure the Service Request includes information indicating the member is open to Pathways and the Pathways contact information.
 - e. If the member is linked to ongoing outpatient mental health services through the MHP or MCP as a result of the Service Request, CST will

inform Pathways of the provider name and contact information before closing.

Referral Process from the MHP to Pathways:

- A. The MHP provider (Guest House, CST or MCST) will submit a Pathways Referral Form (see Attachment A) along with an ROI to Pathways Health + Home if the following criteria are met:
 1. As a result of a mental health assessment, it is determined that the individual does not meet medical necessity for specialty mental services as defined in accordance with *PP-BHS-QM-01-07 Determination for Medical Necessity and Target Population*; or
 2. The individual meets medical necessity for specialty mental services as defined in accordance with *PP-BHS-QM-01-07 Determination for Medical Necessity and Target Population*, but declines mental health services; and
 3. Meets one of the above and meets criteria for Pathways Health + Home eligibility criteria as outlined on the Pathways Referral Form (see Attachment A); and
 4. The individual is in agreement with services provided by Pathways Health + Home program services to assist enrollees in connecting to stabilizing health care services and housing supports.
- B. Upon receipt of the Pathways Referral Form, Pathways will contact the MHP provider indicated on the referral form.
- C. Pathways and the MHP provider will coordinate care planning to ensure care management needs are identified and services are in place by Pathways to support the ongoing needs.
- D. The referring MHP provider (Guest House, CST or the MCST) will close services once it is confirmed that the individual has been accepted into the Pathways program and has met with Pathways for services prior to closing.

References/Attachments:

- Attachment A – Community Support Team Referral Form for Sacramento Covered – Pathways to Health + Home Enrollees
- [Sacramento County Access Team Service Request](#)
- [Sacramento County Bi-Directional Medi-Cal Transition of Care Request](#)
- [Level of Care System \(LOCUS\) Request](#)
- Data Sharing Agreement

Related Policies:

- [PP-BHS-QM-01-07 Determination for Medical Necessity and Target Population Policy](#)
- [PP-BHS-Access-02-02 Access Team Services Policy](#)
- [PP-BHS-Access-02-04 Authorization Requests](#)
- [PP-BHS-MH-03-08 Bi-Directional Managed Care Plan Referral Process](#)

- [County of Sacramento – Health Insurance Portability and Accountability Act \(HIPAA\) – Security Rule Policies and Procedures](#)

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