	County of Sacramento Department of Health Services Division of Behavioral Health Services Policy and Procedure	Policy Issuer (Unit/Program)	Mental Health Services
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Title: **Multi-Agency Collaboration Agreement**	Functional Area: **Programs**

Approved By: *Signed version available upon request*

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Background/Context:

The County of Sacramento and its contracted providers are committed to placing clients in the least restrictive level of care to meet their needs and promoting recovery oriented treatment. Placement decisions for individuals on Lanterman-Petris-Short (LPS) Conservatorship require the participation of key individuals and/or teams involved in the client's care.

Definitions:

Acute Status: Acute Status is defined as a client who requires and is receiving inpatient psychiatric care. Clients on Acute Status are not ready for placement in a non-acute setting.

Administrative Stay Status: Administrative Stay Status is defined as a client who has been in an acute care setting receiving psychiatric stabilization services, and is now considered to be stable and at baseline. Clients on Administrative Stay Status are

ready to transfer to the next level of care and are waiting for placement in a subacute or community setting.

Client-Centered: The client is the best authority on their own experience, and is fully capable of changing and growing into all that the client can and wants to be.

Conservatee: A person who, as a result of a mental illness, has been adjudicated by the Superior court as gravely disabled and lacking the ability to make decisions regarding food, clothing, shelter and their psychiatric treatment and placement, therefore a conservator is appointed to make those decisions for them.

Conservator: An individual Public or Private appointed as conservator by the Superior court to act as surrogate decision maker for a client. The conservator ensures the client has food, clothing and shelter, including authorization of psychiatric treatment, and placement. Conservator can also be the conservator of estate, responsible for managing entitlements and other benefits as well.

Grave Disability: A condition in which a person, as a result of a mental disorder, is unable to provide for basic personal needs, including food, clothing, or shelter – see California Welfare & Institutions Section 5008(h)(1)(a)+(b).

Intensive Placement Team (IPT): The IPT is a County-operated clinical team of staff who evaluate referrals and provides service authorization and consultation for the following adult services: Subacute placements, Electroconvulsive Therapy (ECT) authorizations, and Level of Care Utilization System (LOCUS) requests.

Lanterman-Petris-Short (LPS) Conservatorship: Legislative intent of the LPS Act (Welfare and Institutions Code 5001) to provide individualized treatment, supervision, and placement services by a conservatorship program for persons who are gravely disabled (W+I code 5000). To provide services in the least restrictive setting appropriate to the needs of each person receiving services under this part 5001 (i) and under Part 1.5 of the LPS act.

LOCUS: Level of Care Utilization System. See PP-BHS-MH 03-04-Level of Care Determination.

Multi-Disciplinary Team Meeting Representatives: Planning meeting representatives decision makers who shall be present at meetings involving a client to discuss changes in level of care determination. Representation is outlined in the table below:

AGENCY	REPRESENTATIVES

DBHS	▪ IPT Senior Mental Health Counselor ▪ IPT Program Coordinator ▪ Contract Monitor (when a mental health provider is involved)
Psychiatric Hospital	▪ Team Psychiatrist and/or Team Attending *and* ▪ Clinician and/or Administrative Specialist *and* ▪ Program Coordinator
Mental Health Outpatient Provider	▪ Service Coordinator or Team Lead *and* ▪ Psychiatrist *and* ▪ Clinical and/or Program Director
Public Guardian	▪ LPS Deputy Conservator assigned ▪ Supervising Deputy Public Administrator/Public Guardian/Public Conservator (PAPGPC)

Olmstead Act: On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity. The Supreme Court explained that its holding "reflects two evident judgments."

First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life."

Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." Olmstead v. L.C. Olmstead v. L.C., 527 U.S. 581 (1999). For most recent updates on the Act, see https://www.ada.gov/olmstead/index.htm.

Outpatient Mental Health Services: Mental Health services provided to a client in a clinic or community setting on a voluntary basis.

Recovery Model: Recovery for the intent of this policy is defined by Substance Abuse Mental Health Services Administration (SAMHSA), as a process of change through which clients improve their health and wellness, live a self-directed life, and strive to reach their full potential by way of the four major dimensions that support a life in recovery:

A. Health – overcoming or managing one's symptoms and making informed, healthy choices that support physical and emotional well-being.

B. Housing – having a stable and safe place to live.

C. Purpose – engaging in meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.

D. Community – having relationships and social networks that provide support, friendship, love, interconnectedness, and hope.

Subacute Placement Referral Process: An evaluation process for subacute placement per Sacramento County DBHS PP-BHS-MH-04-03 Subacute Placement Referrals.

Subacute Services: For the purpose of this policy, Subacute Services include the following: Mental health rehabilitation services provided within a secured or semi-secured facility by a contracted provider with Sacramento County DBHS. Subacute facilities include, Mental Health Rehabilitation Center (MHRC), Transitional Residential Program (TRP), Skilled Nursing Facility (SNF)/STP and State Hospitals. The Sacramento County DBHS Intensive Placement Team (IPT) provides authorization and linkage to subacute services.

Treatment Provider: The current person or entity whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill.

Purpose:

To outline a multi-agency collaboration process to support timely level of care decisions for appropriate treatment and placement to meet the needs of the client on LPS conservatorship by providing a framework for effective communication, collaboration, transparency, and clear role identification between all participants involved in the client's care.

Details:

A. MDT Roles:

1. DBHS IPT:

    a. Determines and identifies eligibility for the Sacramento County Mental Health Plan (MHP). The MHP provides specialty mental health services to beneficiaries who meet medical necessity criteria in accordance with County Policy PP-BHS-QM-01-07 Determination for Medical Necessity and Target Population.

    b. Gathers information from the clinical team, including the current inpatient treatment team (if the client is inpatient), current outpatient provider (if the client is outpatient or admitted to an outpatient provider), the current subacute provider (when the client is admitted to a subacute provider), the LPS Conservator, and the client's support system/family when available.

    c. Performs a clinical interview with the client in order to use all available information to complete the Level of Care Utilization System (LOCUS) in accordance with County Policy PP-BHS-MH 03-04 to determine level of care that is least restrictive and meets the needs of the client.

    d. Provides subacute service authorization for eligible clients once all MDT members are in agreement on level of care.

    e. Provides oversite of contracted subacute services and management of mental health funding for the DBHS subacute pool and State hospital placement resources.

    f. Participates in clinical care conferences, utilization review, and MDT meetings when indicated.

2. Current Acute Psychiatric Hospital Treatment Team:

    a. Provides acute inpatient psychiatric treatment until determined stable and ready for discharge.

    b. Participates in clinical care conferences and MDT meetings.

    c. Once considered stable and at baseline functioning, incorporates all collateral information from available sources, such as an open outpatient provider, the LPS Conservator, DBHS, and the client's support system/family when available to formulate a level of care recommendation in collaboration with IPT.

3. Mental Health Outpatient Provider:

    a. Provides current and historical information regarding the client's treatment and functioning while the client has been in services.

b. Provides clinical insight into the client's current functioning, based on previous biopsychosocial and psychiatric assessments completed as well as other clinical sources of information while working with the client.

c. Participates in level of care assessments and decision making.

d. Participates in clinical care conferences and MDT meetings when indicated.

4. LPS Conservator:

a. Interviews and conducts a Behavioral History Summary of the client's needs.

b. Provides collateral information, including the behavioral history to the current treatment team and DBHS IPT.

c. Participates in clinical care conferences and MDT meetings to advocate for the needs of clients.

d. Provides consent for medications, mental health treatment and placement for client.

B. MDT Shared Values and Working Framework:

1. All decisions involving clients are based on the principles of the Recovery Model of care and the perspective that recovery is possible.

2. All decisions integrate the client's voice, strengths, goals, resilience, challenges, language, and culture.

3. MDT members consider the Olmstead Act when making decisions involving goal of providing the least restrictive level of care determined to be clinically appropriate to meet the needs of the client.

4. MDT members collaborate in a professional, constructive, transparent and respectful manner.

5. MDT members participate in all MDT planning meetings.

6. MDT members prepare for planning meetings with a focus on:

a. Current Factors:

i. Clinical presentations

ii. Medical presentation

iii. Risk and resiliency factors

iv. Precipitating events that led to the hospitalization

v. Client and family voice whenever possible

vi. Legal status and pending legal processes

b. Historical Factors within the last three years:

i. Relevant clinical history

ii. Relevant medical history

iii. Relevant risk and resiliency factors

iv. Legal status history

C. MDT Collaboration Process:

1. A client who is inpatient is moved to Administrative Stay Status upon the recommendation of the MDT.

2. If the level of care recommendation by the acute psychiatric inpatient MDT is consistent with the level of care prior to the inpatient admission, a discharge planning meeting will occur within 2-4 business days, involving the outpatient provider (if previously outpatient), or IPT (if previously in subacute), and the LPS Conservator.

3. If any member of the MDT requests an assessment to determine if a different level of care is appropriate to meet the needs of the client, a LOCUS Request will be submitted to IPT consistent with County policy.

    a. A LOCUS Assessment is completed by IPT within 1-2 business days of receipt of LOCUS Request and consistent with County policy.

    b. IPT collaborates with the current treatment team to complete and submit the level of care recommendation on the Level of Care Recommendation and Response form (see Attachment A) to the LPS Conservator, along with any supporting documentation.

    c. The treatment team will share any essential facts and basis of the level of care determination.

d. An LPS Conservator will complete the response section on the Level of Care Recommendation and Response form and submit to all parties involved within 1-2 business days, indicating one of the following:

    i. An LPS Conservator approves the recommended level of care and the recommended level of care is community placement.

        1. The psychiatric hospital treatment team will coordinate with the outpatient provider and LPS Conservator on discharge planning.

    ii. An LPS Conservator approves the recommended level of care and the recommended level of care is subacute placement.

        1. See Sacramento County DBHS PP-BHS-MH-04-03 Subacute Placement Referrals.

    iii. An LPS Conservator does not approve the recommended level of care based on the Office of the Public Guardian's Behavioral History Summary due to one of the following risk factors not satisfactorily addressed by the current plan:

        1. Risk to self: Indicating specific behaviors and date(s) last exhibited.

        2. Risk to others: Indicating specific behaviors and last date(s) exhibited.

e. If an LPS Conservator does not approve the recommended level of care, the acute psychiatric treatment team will request an MDT meeting.

f. The MDT meeting should occur within 2-4 business days.

g. The MDT should include supervisory level representatives from the Public Guardian's Office and IPT.

h. If as a result of the MDT meeting, the level of care and updated discharge plan is approved by an LPS Conservator, the treatment team will coordinate with all MDT members as agreed upon in the discharge plan.

i. If as a result of the MDT meeting, the level of care and updated discharge plan is not approved by an LPS Conservator, the dispute resolution process will be initiated.

D. Dispute Resolution Process:

1. The Level of Care Recommendation and Response form, supporting documentation, and brief overview of the MDT will be submitted in writing to the Management of both the Public Guardian's office and IPT.

2. If after review, the Manager from the Public Guardian's Office and IPT are unable to come to a consensus within 2 business days, a follow-up MDT is scheduled within 2-4 business days and will include participants from the initial MDT, the Program Manager of the Public Guardian's Office, the IPT Program Manager, management from the acute psychiatric hospital, management from an involved outpatient provider, and a neutral facilitator agreed upon by DBHS and the Public Guardian's Office in collaboration with County counsel.

    a. The designated MDT facilitator and County representatives will follow the MDT model as agreed upon in collaboration with County Counsel until consensus is reached.

        i. The MDT meeting should include at minimum the following:

            1. An agreed upon vision

            2. Goals to reach the vision

            3. Barriers to meeting the goals

            4. Strategies brainstormed to address the barriers

            5. An MDT Action Plan agreed upon by all MDT representatives

    b. The agreed upon MDT Action Plan will be drafted in writing by the designated facilitator, signed by MDT representatives, and copies provided to MDT participants by close of business.

3. The treatment team will engage in next steps consistent with the agreed upon plan.

4. The client will be re-assessed by IPT for level of care at minimum every thirty (30) days, or more often as requested by any member of the MDT while in acute care.

5. If the clinical level of care recommendation changes at any time, the Level of Care Recommendation and Response form will be updated and procedures followed consistent with this policy and procedure.

Reference(s)/Attachments:

Attachment A: Level of Care Recommendation and Response Form

Related Policies:

PP-BHS-MH-04-03-Subacute-Placement-Referrals

PP-BHS-MH-03-04-Level of Care Determination (LOCUS)

QM 01-07 Determination for Medical Necessity and Target Population

Distribution:

Enter X	DL Name	Enter X	DL Name
X	Behavioral Health Services	X	Publish to Intranet
X	Mental Health Treatment Center	X	Publish to Internet
X	Adult Contract Providers	X	Office of the Public Guardian

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Attachment A

LEVEL OF CARE RECOMMENDATION AND RESPONSE FORM

THIS FORM IS ONLY **TO BE USED** FOR SACRAMENTO COUNTY MENTAL HEALTH CLIENTS ON LPS CONSERVATORSHIP: SEE COUNTY P&P FOR DETAILS

CLIENT/CONSERVATEE INFORMATION		
Name:	Date of Birth:	SSN:
LPS Conservator:	Conservator Phone:	Conservator Fax:
Current Placement : (select one)	If Inpatient, Previous Level of Care: (select one)	

LEVEL OF CARE RECOMMENDATION

Recommended Level of Care: (select one) (See attached for specifics)

- Specific to the recommended level of care, please attach the most recent of the following:
  - ☐ Bio-psycho-social assessment/psychiatric assessment
  - ☐ Relevant progress notes
  - ☐ Current Medication List
  - ☐ Level of Care Utilization Request (LOCUS)

CURRENT TREATMENT PROVIDER		
Agency Name:	Program Name:	Admission Date:
Program Level of Care: (select one)	☐ See Community Entry Plan Attached (if applicable)	

PUBLIC GUARDIAN RESPONSE

☐ The recommended level of care is approved.

☐ The recommended level of care is approved with Care Plus

☐ The recommended level of care is NOT approved due to one of the following risk factors not satisfactorily addressed:

- ☐ Risk to Self:
  - o Behaviors with Dates Last Exhibited:

- ☐ Risk to Others:
  - o Behaviors with Dates Last Exhibited: