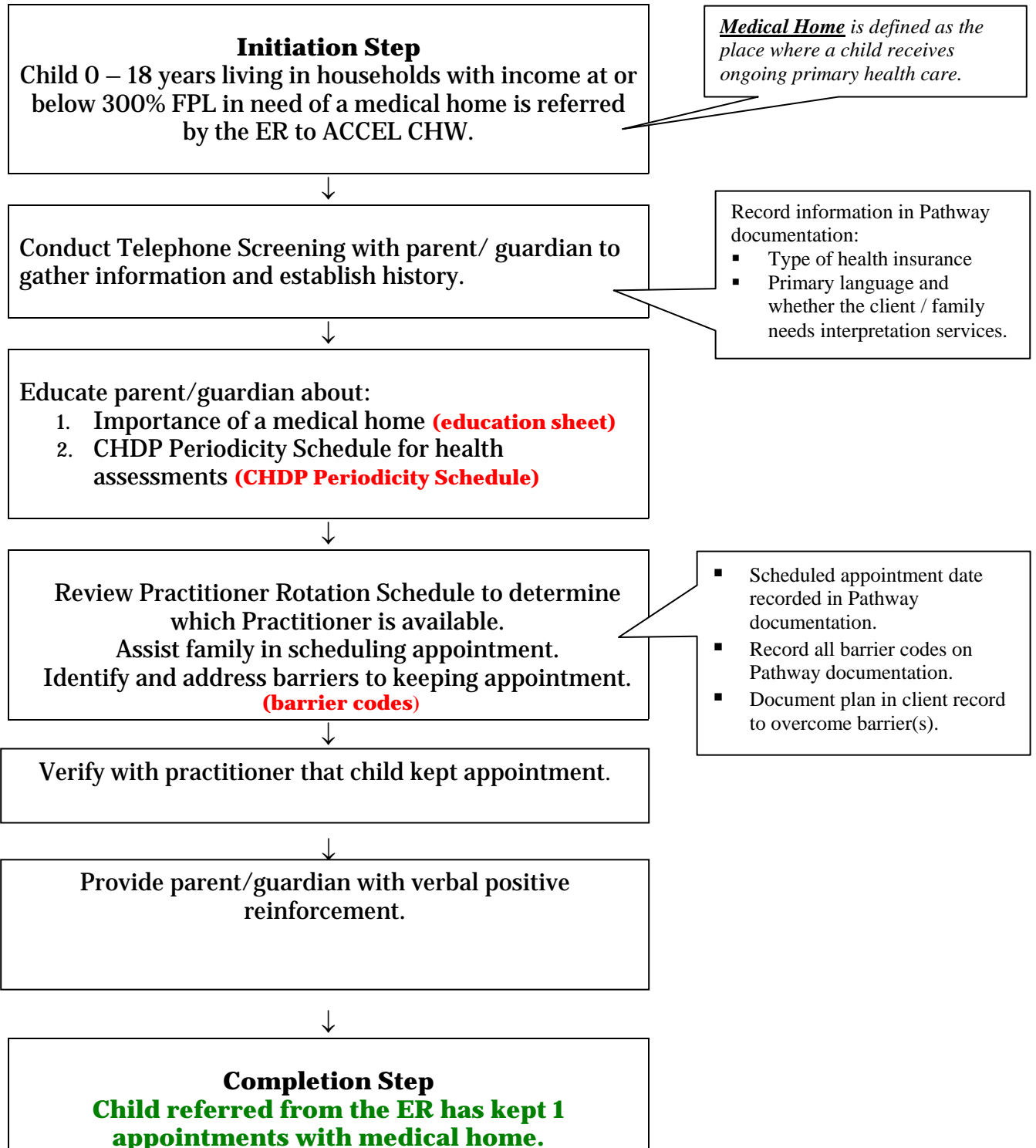


ACCEL Care Pathway
Obtaining Medical Home
 Child will be referred from ER





Obtaining a Medical Home (OMH) Process as of July 30, 2007

BACKGROUND

The OMH pathway was reviewed and refined in preparation for its transition from a manual/paper process to a protocol that will manage clients using InfoCom's iREACH electronic application. The group that reviewed and refined this pathway include:

- Sandra Dunn - Accel Program Director
- Kim Dickson - Accel Program Manager
- Kirsten Rogers - EDC PHD Supervising Health Education Coordinator
- Vicki Cowley -- Accel Supervisor
- Trever Lee - IT Project Manager
- Maria Chaves - Business Process Consultant

Important points to consider are:

- This narrative is accompanied by process maps (in PowerPoint and Visio) and milestone and instruction documents (in Excel) for programming into iREACH.
- The process maps and milestones and instructions for programming into the iREACH application were developed from the perspectives of both the Community Health Worker (CHW) and the Mental Health Dept. Worker (MHW) who have the primary responsibility for managing clients through the pathway.
- Process maps were developed based on existing processes and refinements made accordingly. The process maps do not define data entry points into iREACH.
- The milestones and instructions document describes data entry and client management interfaces still to be programmed into iREACH. No user experience analyses were performed to determine optimum navigation through the iREACH application.
- Assistance would be provided to Accel partners (at a later date) to develop and customize their Internal clinic operations for interface with the iREACH application as programmed per the milestones and instructions identified.

PATHWAY PROCESS STEPS

The purpose of the OMH pathway is to assist children referred who received non-urgent care at the Marshall Hospital Emergency Room because they did not have a medical home.

A. Identification of child needing a pediatric mental health consultation

- The primary care provider identifies a child less than 18 years of age needing a psychiatric consult and completes the first section of the Pediatric Mental Health Referral Report form (See Appendix A).
- The Pediatric Mental Health Referral Report form is given to the Referral Specialist in the PCP's office.

B. Determination of health coverage

- The Referral Specialist reviews the health coverage status of the child and takes action based on the following scenarios.

Does the child have health care coverage?	What kind of health care coverage?	Action(s) by PCP Referral Specialist
Yes	Commercial coverage	<ul style="list-style-type: none"> • The child is not eligible for the pathway. • Pursue mental health services via commercial coverage route.
Yes	Public Coverage	<ul style="list-style-type: none"> • Document the following on the PMCH

Does the child have health care coverage?	What kind of health care coverage?	Action(s) by PCP Referral Specialist
	<ul style="list-style-type: none"> • In county Medi-Cal or Healthy Families • Out of county 	referral form: <ul style="list-style-type: none"> ○ Referral date including contact information for 2-3 source ○ Date when consent obtained ○ Insurance coverage information • Fax/email PMHC form to Mental Health Worker (MHW) and the Community Health Worker (CHW)
Yes	Public Coverage: First week of Gateway/CHDP	<ul style="list-style-type: none"> • Document the following on the PMCH referral form: <ul style="list-style-type: none"> ○ Referral date including contact information for 2-3 source ○ Date when consent obtained ○ Insurance coverage information • Fax/email PMHC form to Mental Health Worker (MHW) and the Community Health Worker (CHW). • Obtain signature for Accel referral for SHCC pathway and fax/email to CHW @ EDCPHD
None	OR the child will be "Gatewayed"	

- For children who are in the first week of Gateway/CHDP, will be "Gatewayed", or who have no insurance, the CHW will open the SHCC pathway for a Medi-Cal application. QUESTION: is this for incountry or does it matter? The pathway is on hold until the CHW has completed the Medi-Cal application at which time, he/she informs the MHW that the application has been completed and provides the signal to move forward with the pathway.
- Once the MHW receives the PMHC referral and insurance coverage, he/she reviews the child's health coverage information collected by the Referral Specialist.
 - The MHW will check the MED System Screen to determine if the child has In County Medi-Cal, Healthy Families coverage, or within the first week of Gateway/CHDP.
 - If the child has Out of County Medi-Cal, the MHW first determines if EDC MHD has the capacity to take the child.
 - If there is no capacity, the MHW closes the case, documents the reason, and informs the PCP Referral Specialist and CHW.
 - If there is capacity, the MHW contacts the county the child lives in and asks for authorization to provide the mental health services (number of appointments or hours) to obtain the assessment per the PCP request.
 - If the county approves the request, the child moves forward in the pathway.
 - If the county denies the request, the MHW closes the case, documents the reason, and informs the PCP Referral Specialist and the CHW.
 - Once it is clarified that the child has the appropriate health care coverage to move forward in the PMHC pathway, the MHW enters the child's information into the MHD system.

C. Pre-screening process and assignment to a Mental Health Clinician

- The MHW contacts the parent within 48 hours of receiving the PMHC referral and performs a pre-screen to confirm the issues/chief complaint resulting in the referral.
- If the MHW cannot contact the parent, the MHW will contact the CHW to obtain other contact numbers for the parent. If the MHW still cannot contact the parent, the MHW sends a letter to the parent stating attempts to contact and if there is no response after eight days after the letter was sent, the case will be closed. In addition, the letter invites the parent to open the referral at another time. Then the MHW closes the case, documents the reason, and informs the CHW of the case closure.
- After the MHW has performed the pre-screening call, the MHW will assign a MH clinician - either one from the MHD or a contract MH clinician such as one from Summit View or New Morning.
- The MH Clinician will contact the parent to schedule the Initial MH Assessment appointment. The goal is to have the appointment for the Initial MH Assessment occur within 14 calendar days from the date of

the referral. The MH Clinician documents the appointment date on the I-Trac System and “assigns” the appointment to the MHW after scheduling.

- Assigning the appointment to the MHW informs the MHW of these appointment date(s) which the MHW can then enter into iREACH.

D. Update meetings between the MHW and CHW

- The MHW and CHW have standing Monday morning meetings for the purpose of information sharing and coordination of activities of patients in the pathway including:
 - Informing the CHW of all Initial MH appointments 1 - 3 weeks out
 - Specific data sharing: name of child, name of clinician, date/time/location of Initial MH assessment appointment, and parent contact information
 - Patient progress through the pathway including any delays
 - Joint advocacy and problem solving between the MHW and CHW on the patient’s behalf for any needs

E. Specific CHW role and tasks

- The CHW will call the PCP for any delay made in making the Initial MH Assessment appointment including if it has been more than 2 weeks since the referral, if the CHW or MHW cannot get hold of the parent, and/or if the patient is not showing at to the scheduled appointments.
- Once the CHW is made aware of the referral, he/she will call the parent
 - If the CHW is unable to contact the parent, the CHW will search and/or obtain other contact numbers through either the PCP office and/or the MHW. He/she will leave a message for the parent, if possible, containing the CHW’s name and to call back.
 - If the CHW is able to contact the parent or the parent calls back after the CHW has left a message, the CHW introduces themselves, their role in facilitating the patient through the pathway and to remind the parent of the Initial MH Assessment appointment. The CHW also helps the parent identify barriers to the appointment and works with the parent to problem solve and develop alternatives including rescheduling the appointment date.
 - If the appointment date needs to be changed:
 - the CHW provides the parent with the number of the MHW and also calls the MHW to let them know that the parent will be calling to reschedule the appointment.
 - When the parent calls the MHW to reschedule the appointment, the MHW will refer the parent to the assigned MH Clinician. The MH Clinician will reschedule the appointment with the parent.
 - The MH Clinician enters the appointment into the MHD systems and “assigns” the appointment to the MHW so that the MHW is informed of the appointment date.
 - The MHW enters the new appointment date in iREACH.
 - The MHW informs the CHW of the rescheduled appointment date either through a phone call, email, or during their standing Monday morning meetings.
- The CHW will call the parent one day prior to the Initial MH Assessment appointment as a reminder and reassess any barriers to keeping the appointment.

F. Attendance at the Initial MH Assessment Appointment(s)

- The Initial MH Assessment may require several appointments with the MH Clinician before a report and management plan is completed.
- In general, the MH Clinician or MHW for the psychiatrist will reschedule up to a maximum of three appointments for now shows before a case is closed; however, this is discretionary per the clinician.
- The roles and tasks between the MHW and the CHW during this stage of the pathway are:

MHW	CHW
<ul style="list-style-type: none"> • Ensures that all appointments required to perform and complete the Initial MH Assessment are made. • If the MH Clinician is an outsourced provider, the MHW calls the outsourced clinician to find out appointments dates and informs the CHW. 	<ul style="list-style-type: none"> • Call the patients 24 - 48 hours prior to each appointment and perform the appointment education and reminder function. • Assess barriers, problem solve with parents, and develop alternatives so that the child can make all necessary appointments.

MHW	CHW
<ul style="list-style-type: none"> • Checks if the patient attended the appointment with the MH Clinician. • If the patient did not make it to the appointment, the MHW will make sure that the next appointment is rescheduled either by the MH Clinician or by the MHW. • Informs the CHW of appointment no show and rescheduled appointment date via phone, email, or standing Monday morning meetings. • 	

- There are two scenarios to consider before completing the Initial MH Assessment.

Did the initial PMHC request ask for a psychiatric evaluation?	Next Steps	What is sent to the MHW
No	<ul style="list-style-type: none"> • The MH clinician continues to see the client until he/she can complete the assessment and able to create the patient’s management plan. • The MH clinician completes the Initial MH Assessment report in the desired timeframe of a month from the day the referral is received. 	<ul style="list-style-type: none"> • Final MH Clinician Pediatric Mental Health Referral form and assessment and management plan
No but the MH Clinician after seeing the feels that the patient should see the psychiatrist	<ul style="list-style-type: none"> • On behalf of the psychiatrist, the MH clinician will confer with the parents and the front desk for the psychiatrist’s (Dr. Price) next available appointment. • The MHW and CHW continue in their roles of appointment scheduling, appointment education and reminder as described in the table above. 	<ul style="list-style-type: none"> • Preliminary MH Clinician Pediatric Mental Health Referral form and assessment and management plan pending psychiatric evaluation
Yes	<ul style="list-style-type: none"> • The patient will see the psychiatrist for a number of appointments as needed until he/she can complete the assessment and able to create the patient’s management plan. • The desired goal is that the psychiatrist/Dr. Price completes his assessment within 10 weeks from the day the referral is received. 	<ul style="list-style-type: none"> • Final Psychiatric Pediatric Mental Health Referral form and assessment and management plan

G. Informing the PCP

- The MHW compiles all documents for the preliminary and/or final Pediatric Mental Health Referral, assessment, and management plans and faxes or emails them directly to the referring PCP.
- The PCP office staff picks up the documents and should place them in the PCP’s office.
- The PCP office staff will send confirmation of receipt of either final or preliminary report via fax/email back to the MHW.
- The PCP signs and verifies that he/she has read the preliminary or final report which is sent directly to the patient records department where it is placed in the patient’s chart.

H. Pathway closure

- The MHW faxes/emails the top page only of the final Pediatric Mental Health Referral form to the CHW. The top page shows case disposition only and that the assessment was completed.
- The CHW keeps an ongoing list of clients in the pathway:
 - final assessments completed by the MH Clinician
 - preliminary assessments in progress pending psychiatric evaluation

- final assessments completed by the psychiatrist
- On a monthly basis, the CHW faxes/emails the list of clients with final assessments/reports completed to the PCP's Referral Specialist.
- The Referral Specialist will pull the patient's charts and confirm that the PCP has read the final assessment/report as evidenced by his signature on it.
- The Referral Specialist will fax/email back the confirmed list to the CHW.
- The CHW closes those cases in which the PCP has confirmed that he/she has read the report as evidenced by his/her signature.