COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

Coordination with Primary Care Physicians and Behavioral Health Services

Coordination of care between behavioral health care providers and health care providers is necessary to optimize the overall health of a client. Behavioral Health Services (BHS) values and expects coordination of care with health care providers, linkage of clients to medical homes, acquisition of primary care provider (PCP) information and the entry of all information into the client's behavioral health record. With healthcare reform, BHS providers shall further strengthen integration efforts by improving care coordination with primary care providers. Requesting client/guardian authorization to exchange information with primary care providers is mandatory, and upon authorization, communicating with primary care providers is required. County providers shall utilize the *Coordination and/or Referral of Physical & Behavioral Health Form & Update Form*, while contracted providers may obtain legal counsel to determine the format to exchange the required information. *This requirement is effective immediately and County QI staff and/or COTR will audit to this standard beginning FY 13-14*.

For all clients:

Coordination and/or Referral of Physical & Behavioral Health Form:

- Obtain written consent from the client/guardian on the *Coordination and/or Referral of Physical & Behavioral Health Form*/ contractor identified form at intake, but no later than 30 days of episode opening.

- For clients that do not have a PCP, provider shall connect them to a medical home. Contractor will initiate the process by completing the *Coordination and/or Referral of Physical & Behavioral Health Form* /contractor form and sending it to the PCP within 30 days of episode opening. It is critical to have the specific name of the treating physician.

- Users of the form shall check the appropriate box at the top of the *Coordination and/or Referral of Physical & Behavioral Health Form* /contractor form noting if this is a referral for physical healthcare, a referral for physical healthcare and medication management, a referral for total healthcare, or coordination of care notification only. If it is a referral for physical healthcare, or physical healthcare and medication management, type in your program name in the blank, and select appropriate program type.

Coordination of Physical and Behavioral Health Update Form:

- Update and send the *Coordination of Physical and Behavioral Health Update Form* /contractor form if there are significant changes like an addition, change or discontinuation of a medication.

- Notify the PCP when the client is discharged from services by sending the *Coordination of Physical and Behavioral Health Update Form* /contractor form. The form shall be completed prior to completion of a discharge summary.

Tracking Reminders:

- Users of the form shall have a system in place to track the expiration date of the authorization to release/exchange information.

- Users of the form shall have a system in place to track and adhere to any written revocation for authorization to release/exchange information.

- Users of the form shall have a system in place to track and discontinue release/exchange of information upon termination of treatment relationship. Upon termination of treatment the provider may only communicate the conclusion of treatment, but not the reason for termination.

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Coordination and/or Referral of Physical & Behavioral Health Form

☐ Referral for *physical* healthcare – [ ] will continue to provide specialty behavioral health services
☐ Mental Health ☐ Alcohol and Drug

☐ Referral for *physical* healthcare & Medication Management – [ ] will continue to provide limited specialty behavioral health services
☐ Mental Health ☐ Alcohol and Drug

☐ Referral for *total* healthcare – [ ] is no longer providing specialty behavioral health services. Available for psychiatric consult.

☐ Coordination of care notification only.

Section A: CLIENT INFORMATION

Client Name: Last First Middle Initial	AKA	☐ Male ☐ Female
Street Address	Date of Birth	
City	Telephone #	
Zip	Alternate Telephone #	

Section B: BEHAVIORAL HEALTH PROVIDER INFORMATION

Name of Treatment Provider:	Name of Treating Psychiatrist (If applicable)
Agency/Program	
Street Address	City, State, Zip
Telephone #	Specific provider secure fax # or secure email address:
Date of Initial Assessment:	
Focus of Treatment (*Use Additional Progress Note if Needed*)	
Case Manager/ Mental Health Clinician/ Alcohol and Drug Counselor/ Program Manager:	Behavioral Health Nurse: Phone #:

Date Last Seen	Mental Health Diagnoses: Alcohol and Drug Related Diagnoses:

Current Mental and Physical Health Symptoms (*Use Additional Progress Note if Needed*)

Current Mental Health and Non-Psychiatric Medication and Doses
(*Use Additional Medication/Progress Note if Needed*)

Last Psychiatric Hospitalization
☐ Date: ☐ None

Section C: PRIMARY CARE PHYSICIAN INFORMATION

Provider's Name

Organization OR Medical Group

Street Address

City, State, Zip

Telephone #:	Specific provider secure fax # or secure email address:

Section D: FOR PRIMARY CARE PHYSICIAN COMPLETION ACCEPTED FOR TREATMENT OR REFERED BACK TO SDCBHS PROGRAM (PLEASE COMPLETE THE FOLLOWING INFORMATION AND RETURN TO BEHAVIORAL HEALTH PROVIDER WITHIN TWO WEEKS OF RECEIPT)

☐ Coordination of Care notification received.

If this is a primary care referral, please indicate appropriate response below:

1. ☐ Patient accepted for physical health treatment only
2. ☐ Patient accepted for physical healthcare and psychotropic medication treatment while additional services continue with behavioral health program
3. ☐ Patient accepted for total healthcare including psychotropic medication treatment
4. ☐ Patient not accepted for psychotropic medication treatment and referred back due to:

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax:
I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:

Client Name (*Please type or print clearly*)
Last: First: Middle:

IF SIGNED BY LEGAL REPRESENTATIVE, PRINT NAME:	RELATIONSHIP OF INDIVIDUAL:

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

☐ Information Contained on this form	☐ Discharge Reports/Summaries
☐ Current Medication & Treatment Plan	☐ Laboratory/Diagnostics Test Results
☐ Substance Dependence Assessments	☐ Medical History
☐ Assessment /Evaluation Report	☐ Other _____

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the medical records and Information/updates concerning the patient. The purpose of such a release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.

I would like a copy of this authorization ☐Yes ☐No
Clients/Guardians Initials

➔Please place a copy of this Form in your client's chart

TO REACH A PLAN REPRESENTATIVE

Care1st Health Plan	Community Health Group	Health Net	Kaiser Permanente	Molina Healthcare	Access &Crisis Line
(800) 605-2556	(800) 404-3332	(800) 675-6110	(800) 464-4000	(888) 665-4621	(888) 724-7240

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Date Release of Information Signed:

COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH UPDATE FORM

CLIENT NAME

Last	First	Middle
Date of Birth	☐ Male	☐ Female

BEHAVIORAL HEALTH UPDATE

Date:

Treating Provider Name	Phone	FAX
Treating Psychiatrist Name (If applicable)	Phone	FAX

☐ Medications prescribed on _____ Date ☐ Medications changed on _____ Date ☐ Medications discontinued on _____ Date	Name/Dosage:_____ Name/Dosage:_____ Name/Dosage:_____
☐ Medications prescribed on _____ Date ☐ Medications changed on _____ Date ☐ Medications discontinued on _____ Date	Name/Dosage:_____ Name/Dosage:_____ Name/Dosage:_____

☐ Diagnosis Update :

☐ Key Information Update:

☐ Discharge from Treatment Date:

☐ Follow-up Recommendations:

PRIMARY CARE PHYSICIAN UPDATE

Please provide any relevant Update/Change to Patient's Physical Health Status.