COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
OFFICE OF INTEGRATED CARE

HEALTHY WAY L.A. GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
Referral Response Process for Healthy Way L.A. (HWLA) Enrollees	**I.B**	**07/01/2011**	**1 of 2**

DISTRIBUTION:		
☒ Community Partners	☒ Legal Entity Providers	
☒ Directly-operated Programs	☐ Service Area Navigators	

PURPOSE: To describe the process used by Department of Mental Health (DMH) providers to facilitate referral responses of non-emergency clients to Department of Health Services (DHS) providers.

DEFINITIONS:

1. Primary Care Provider (PCP) – PCP, for the purpose of this guideline, refers to a physician, nurse practitioner or physician assistant working at a DHS directly-operated or contracted hospital, ambulatory care clinic or outpatient setting.

2. Non-emergency – A non-emergency refers to a routine psychiatric referral in which the patient does not pose an imminent risk of suicide, homicide, or is not gravely disabled due to a mental illness and, therefore, unable to care for their basic needs such as food, clothing, and shelter.

3. HWLA Member – For the purpose of this guideline, HWLA members are individuals who are enrolled in HWLA or who have submitted an application for HWLA and are pending a decision on whether they have been approved or denied for HWLA.

GUIDELINES:

1. All DMH providers that have evaluated a HWLA member are required to provide a response back to the referring PCP using the Department of Mental Health Referral Response form MH 694B (Attachment I).

PROCESS:

1. Following completion of the initial evaluation, DMH providers shall complete the Department of Mental Health Referral Response form. The original Referral Response form shall be given to the referring PCP while a copy of the form is retained in the DMH Clinical Record.

2. The Referral Response form shall be completed and returned to the referring PCP as promptly as possible following DMH initiating services with the referred individual.

2.1 In addition to providing a response to the referring PCP following the first visit, updates will be provided to the provider whenever clinically significant changes occur using the Department of Mental Health Referral Response form.

2.2 Upon discharge of the client from mental health services, a DMH Discharge Summary form, MH 517 (Attachment II), shall be sent to the referring PCP.

3. In cases where the referred individual declines DMH services, is inappropriate for specialty mental health services, or when DMH is unable to contact the enrollee, communication via a Mental Health Referral Response form, phone call, or fax containing this information shall be provided as promptly as possible following such determination.

Attachment I: Department of Mental Health Referral Response form, MH 649B

Attachment II: DMH Discharge Summary form, MH 517

MH-649B PCP
Revised 11/2/11

DEPARTMENT OF MENTAL HEALTH REFERRAL RESPONSE

For a Healthy Way L.A. Referral, provide the HWLA ID#: ☐

Client Information

MRUN: _____

Name: _____ DOB: _____

Address: _____ Phone Number: _____

Referring Physician and Care Coordinator Information

Referring Physician: _____

Name of Clinic: _____

Phone Number:_____ Fax Number:_____

DMH Disposition

Initial Appointment Date: _____ (If appointment was not able to be scheduled or was not kept, please indicate)

☐ Unable to contact individual to schedule appointment ☐ Scheduled appointment not kept

☐ **Individual accepted for services**

☐ **Individual declined DMH services**

☐ **DMH services not indicated** *(If selecting this box, please be sure to include in General Findings the reason DMH services are not indicated at this time, along with any recommended linkage information.)*

General Findings (include additional areas of identified need)**:**

Mental Health Diagnosis(es):

All medications prescribed by DMH:

Treatment Plan Overview (include planned treatment interventions; if barriers or complications are a focus of concern include below):

Responding Provider Information

Print Name & Title of Responding Provider: _____

Signature: _____ Date: _____ Time: _____

Name of DMH Clinic:_____Telephone #:_____

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

DMH REFERRAL RESPONSE FORM to HEALTHCARE PROVIDERS

Original Copy – To Agency Initiating Referral
NCR Copy – Retained by DMH Program

DEPARTMENT OF MENTAL HEALTH REFERRAL RESPONSE FORM to HEALTHCARE PROVIDERS

Purpose: This form is for the use of DMH Staff when responding to referrals of non-emergency clients by Primary Care Providers (PCP).

Completion Instructions: It is important that all information requested on the form be completed.

INSTRUCTIONS BELOW FOR DMH USE ONLY

Filing Procedures:

File as follows:

- Existing or New Client DMH Record within Provider – File chronologically in Section 2 Correspondence of the Clinical Record.
- Non-eligible Referrals – Maintain a manila folder labeled DMH Referrals/Responses that is in a locked area of the Record Room. File alphabetically by last name and staple to Response. Maintain for a period of seven (7) years from the initial referral date.

MH 517
Revised 05/16/03

DISCHARGE SUMMARY

Admission Date: _____ **Discharge Date*:** _____

Presenting Information:

Services Received and Response:

Medication(s): (Include Dosage & Response) ☐ None

Disposition and Recommendations: (If referred, include name of agency(s) or practitioner(s))

Referral Out Code _____

Diagnosis: **(check one)**

Axis I ☐ Prin / Sec _____ Code _____

☐ Prin / Sec _____ Code _____

Axis II ☐ Prin / Sec _____ Code _____

Axis III ☐ _____ Code _____

Axis V ☐ Discharge GAF _____ Prognosis _____

Signature & Discipline	Date	Reviewer's Signature & Discipline	Date

*Discharge Date: last service date or last cancelled or missed appointment.

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County - Department of Mental Health

DISCHARGE SUMMARY