



## **Complex Care Programs**

*September 2021*

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## **BHI-Behavioral Health Integration Program**

### **Target population**

- Resident of Shasta County
- Individuals between the ages of 12 and 65
- Discharging from hospital/ER visit initiated by mental health or substance use (including alcohol).

### **Program Support**

- Coordinate with hospital Substance Use Navigators (SUD) and Social Workers (SW) to provide support post discharge.
- Hospital/ER visits to identify and assess individuals with the appropriate supports post discharge. These supports may include but are not limited to:
  - Transportation
  - Medical and Mental Health appointments,
  - Housing Support
  - Assistance and referrals to outside community-based providers such as domestic violence providers, and detox/recovery centers.
- Assistance with WRAP plans to increase individual safety through self-planning as it relates to the initial needs assessment and ongoing health a survival needs as they arise.

### **Referral Process**

- **Local Hospitals** notify BHI Team through phone or by email with completed referral form at [bhig@hillcountryclinic.org](mailto:bhig@hillcountryclinic.org).
- **Mental Health Facility** notifies BHI Team through phone.
- **Hill Country Provider/Staff** notifies BHI Team that patient has been or is currently hospitalized for mental health or substance use and notifies BHI Team Team through phone or by email at [bhig@hillcountryclinic.org](mailto:bhig@hillcountryclinic.org).
- **Hill Country BHI Team** identifies a hospitalized patient through the Partnership Hospitalization Report.
- **Detox and Recovery Facilities discharging a current patient from program post completion or prior to completion** notify BHI Team through phone.

Behavioral Health Integration (BHI) form is utilized by local hospitals as the initial referral to BHI. The BHI form is sent through secured email to ensure HIPPA compliance.

## CEP- Community Engagement Program

### Target Population

- Resident of Shasta County
- Individuals must be 18 years or older.
- Current citing or arrest for a misdemeanor charge.
- Cannot have a current felony charge.
- Individuals who are homeless or at risk of being homeless.
- Individuals who have substance use and/or mental health disorder.

### Program Support

- Provide case plan development and case coordination to help clients navigate the justice system and access needed rehabilitative services in the community.
- Identify and assess individuals with unmet mental health and alcohol and other drug treatment needs and refer clients to community-based providers.
- Provide housing support services, including budgeting workshops, rent subsidies, and housing assistance to promote stable housing.

### Referral Process

- **Self-Referral:** Information about the program and services will be available in the offices of the Probation Department, local criminal justice partners and Hill Country Health and Wellness Center (HCHWC)
- **County Jail/review of arrests:** The Probation Assistant (P.A) will review bookings and releases for eligible participants.
- **Court Hearings/early identification:** The PA will review the misdemeanor court calendar and provide names of potential participants to the HCHWC.
- **Law Enforcement:** Law enforcement will be given flyers to provide to those misdemeanor arrests or public nuisance offenders who may benefit from the program.
- **Public Defender Social Worker:** The attorneys who represent eligible participants can refer them directly to HCHWC.
- **District Attorney's pre-filing Misdemeanor Division Program:** The District Attorney's office will refer appropriate cases to HCHWC directly from the Pre-Filing Diversion Program or from court.

The "Community Engagement Program" (CEP) form is to be used as the initial referral to CEP. The CEP Team will send referral to Shasta County Probation to check eligibility. All eligible referrals will then be routed back to Hill County's CEP case manager **(530) 238-0471** who will begin outreach & engagement with the referred person. *\*referral form attached end of document*

## **DD- Dual Diagnosis**

### **Target Population**

- Adult age 18-64
- Severe mental health diagnosis
- Unsheltered or at risk of being unsheltered
- And/or active substance use

### **Program Support**

- Linkage to medical and mental health services
- Linkage to substance use services
- Linkage to education and referrals to other services
- Assist with housing options
- Assist with transportation barriers
- Wellness groups as safe space, creative outlet, and support

### **Referral Process**

- Individual referred internally through EHR or by contacting case manager directly

## FSP – Full Service Partnership

### Target Population

- Youth 0-25 years old – *qualifier for Youth FSP*
- Adult age 26 or older – *qualifier for Adult FSP*
- Must reside in Eastern Shasta County
- **-ONE OF-**
- Homeless or at risk of homelessness
- Increased risk of hospitalization or incarceration
- **-WITH-**
- Qualifying mental health diagnosis
- **-NOT-**
- Must not be on parole

### Program Support

- Linkage to medical and mental health services
- Linkage to substance use services
- Linkage to education and referrals to other services
- Assist with housing options
- Assist with transportation barriers

### Referral Process

- Individual is referred by clinician via phone contact to FSP office  
Youth Referral **(530) 238-7606** - *Natalie Jacobs*  
Adult Referral **(530) 949-0756** - *Lisa Crowell*
- FSP staff provide outreach & engagement, to individual being referred, to determine eligibility

## IOPCM – Intensive Outpatient Case Management

### Target Population

- Individual must have Partnership HealthPlan Medi-Cal
- Individual must NOT have Medicare coverage
- At least 18 years of age
- PCP agrees that individual will benefit from care management
- Individual agrees to participate
- Individual NOT enrolled in duplicate program
- **-AND-**
- Two or more Designated Chronic Conditions  
*(asthma, cancer, kidney disease, liver disease, COPD, heart failure, coronary artery disease, diabetes, frailty, homelessness, major depression, substance use disorder, traumatic brain injury, seizure disorder, pregnancy)*
- **-AND-**
- One in-patient admission **-or-** Four emergency dept. visits in the last 6 months
- At least two separate claims in the past year for chronic condition

### Program Support

- Comprehensive care management and coordination of care services
- Linkage to medical and mental health services
- Regular health screenings
- Accompany individual to office visits
- Linkage to other social services including transportation, housing, food, etc. as needed
- Facilitate care plan and adherence with patient participation

### Referral Process

- Referral is made by primary care provider by flagging IOPCM staff (currently Janet Holm or Happy Shaw) in internal EHR (Centricity)
- IOPCM staff follow up to determine eligibility

## **MAT – Medication Assisted Treatment**

### **Target Population**

- Individuals with a history of opiate use

### **Program Support**

- Medication assisted outpatient treatment
- Case management to help with adherence and linkage to other services

### **Referral Process**

- Internal referrals are made by PCP or by other clinician flagging provider in EHR
- External referrals are made by partnering agency contacting clinic staff via phone call



## **MCOT – Mobile Crisis Outreach Team**

### **Target Population**

- Adults at least 18 years of age who are in a current mental health crisis

### **Program Support**

- Mobile response team (clinician & case manager) dispatch to individual in crisis to provide de-escalation and/or assistance accessing further care

### **Referral Process**

- Anyone can phone in a crisis for themselves or others by calling: **(530) 238-7133**

## **MSH – Medical Safe Haven**

### **Target Population**

- Adults 18 years of age or older who identify as being a victim of sex trafficking

### **Program Support**

- Linkage to primary care provider
- Linkage to other social services
- Assistance with housing applications and other necessary support services
- Assistance with legal documents and processes related to victim services
- Accompaniment to medical, legal, and other appointments related to victim services

### **Referral Process**

- Referral by service agency representative by calling MSH staff (currently Tiffney Ottoboni) at: **(530) 355-6558**
- Self-referral in person or by calling MSH staff at: **(530) 244-0117**
- MSH staff will schedule initial intake meeting to take place at One Safe Place

## **REACH – Re-entry Empowerment & Assistance for Community Health**

### **Target Population**

- Individual currently on probation or parole
- At least 18 years of age
- Must make Hill Country Clinic their medical home if not already established

### **Program Support**

- Linkage to medical and mental health services
- Linkage to substance use treatment services
- Assistance with accessing other services as identified by participant
- Care plan development & coordination of services

### **Referral Process**

- Internal referrals made by flagging REACH staff (currently David Durant) in EHR
- External referrals made via phone call to REACH staff at: **(530)238-0760**
- REACH staff engages in outreach & engagement to determine eligibility

## WPC – Whole Person Care

### Target Population

- Adults age 18-64
- Enrolled in Partnership HealthPlan of California Medi-Cal
- Two or more Emergency Dept. visits or hospitalizations in the last 3 months  
**-AND-**
- Homeless or at risk of homelessness

### Program Support

- Intensive case management to assist in linkage and navigation of medical and mental health care, and other social services
- Linkage to substance use services
- Linkage and assistance with accessing housing

### Referral Process

- Internal referrals are made by flagging a WPC staff (currently Josie Dieter or Preston Jacobs) in EHR
- External referrals are made through the Emergency Departments and other Shasta County facilities using the Shasta County Whole Person Care Referral Form **-and-** signed Shasta County HHSA Authorization to Use or Disclose PHI  
***\*referral packet & ROI attached***
- Eligibility is determined by Shasta County HHSA

## YAP – HC Young Adults Program

### **Target Population**

- Individual age 18 – 24
- Student enrolled at: CHYBA California Youth Build Academy -or- Shasta College
- Homeless or at risk of homelessness
- Individual being referred is aware of the referral & understands this is not a guarantee of participation in the YAP program

### **Program Support**

- Supportive case management to link transitional age youth and young adults to housing and other supportive services that will support their success in school and life

### **Referral Process**

- Contact Program Coordinator of YAP Program at: **530-238-7105** to check eligibility