Referral Profile & Eligibility Criteria

All of the following criteria must be met:

- Be at least 18-years of age.
- Allegheny County resident.
- Diagnosed with a serious and persistent mental illness (SPMI).
- Experience difficulties progressing towards recovery due to the inconsistent adherence or non-adherence to a currently prescribed psychiatric medication regime.
- In need of intensive community delivered psychiatric medication management nursing services to prevent the need for more restrictive levels of care and to improve community tenure.
- Currently receiving Service Coordination services.

And one of the following criteria must be met:

- Current inpatient admission or readmission due to non-adherence; or
- Inconsistent adherence to a prescribed medication regime; or
- Initiation or revision of a complex medication regime; or
- Medical diagnosis that requires coordination of Physical and Behavioral Health issues, including medication management; or
- Temporary or permanent absence/withdrawal of a primary support who had been assisting the person with medication management.

Note: Mobile Medication Teams consist of a Registered Nurse and Certified Peer Support; if a person is currently working with a Certified Peer Support or Certified Recovery Specialist, this would be considered a duplication in services and would need to be reviewed by Community Care to assess appropriateness. The target population for this service is persons being prescribed a psychiatric medication and not solely those for physical health needs. Additionally, the Mobile Medication Team is not indicated to support persons who only require the administration of an injectable psychiatric medication. The expected length of treatment with the Mobile Medication Team is 3 - 6 months with a goal of providing community based medication education and assistance with adhering to a medication regime in order to foster independence with medication management.

Form Instructions

1. Before submission of the referral form, the referral source needs to confirm:
   a. Housing: The person must have stable housing in the community which does not provide nursing or medication support services. Persons supported by in-home services or those living in a structured and supervised setting are not the target population of the the Mobile Medication service.
   b. Service Coordination: The person will be supported by a Blended Service Coordinator. Other types of Service Coordination may be appropriate based on the person's clinical needs, but this is determined case by case.
   c. Prescriber: The Mobile Medication team does not have a prescriber of medications therefore a person needs to be actively engaged with an outpatient provider who prescribes psychiatric medications which are generally prescribed to be taken daily.

2. The referral source should complete this form to begin the referral process; referrals cannot be accepted via phone. All sections of this document must be thoroughly completed and legible in order to make a determination of services. Items should not be left blank- please indicate N/A where appropriate. Also, a current psychiatric evaluation and a list of the most recent medications can be submitted to the selected provider with the referral.

3. The signature of the person being referred is required indicating that they understand that a referral is being made and that they will allow the Mobile Medication team to come into their place of residence to provide services. The signature must be no more than 30 days from the date of the referral. Mobile Medication is a voluntary service, so the signature is required however, if the person is unable to sign, the referral source must state if it is due to current symptoms, physical limitations, or another reason. Also include the name and phone number of the person who discussed the referral with the individual being referred.

4. Submit the completed referral via a secure email message to only one mobile medication provider; information is listed below. Please do not send a referral to each provider. For questions regarding the referral process, please contact the selected Mobile Medication provider. If needed, Community Care can also be contacted at 1-888-252-2224.

UPMC Western Psychiatric Hospital Mobile Medication Team: SRRSMIMobileMed@upmc.edu
Wesley Family Services Mobile Medication Team: Cathy.Dellostritto@wfspa.org, Deneen.Sobota@wfspa.org, and Erica.Murrio@wfspa.org.

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After Form Submission

1. The identified Mobile Medication Provider will follow up with the referral source to review the referral and request additional information if needed.

2. Referrals will be reviewed by the identified Mobile Medication Provider for appropriateness. Mobile Medication providers will confirm eligibility and current services with Community Care. Referrals for Allegheny County residents that do not have Community Care coverage will be reviewed by a designated Allegheny County Office of Behavioral Health (OBH) liaison for approval of county funding.

3. If the identified Mobile Medication Provider does not feel that Medical Necessity Criteria is met, they will consult with Community Care/ OBH for recommendations. An alternative and appropriate level of support and treatment necessary to address the needs of the person being referred would be recommended at that time.

4. If the individual being referred meets Medical Necessity Criteria, the identified Mobile Medication Provider will contact Community Care/ OBH for an authorization and confirm the date that the team plans to make initial contact with the individual. The identified Mobile Medication Provider will follow up with the referral source to notify of acceptance and to confirm a start date for the service.

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Member Information

Name: (First) ______________________ (Last) ______________________

MA ID #: DOB: *(mm/dd/yyyy)* [ ]

Home Address: ______________________

Home or Mobile Phone #'s: *(no dashes)* (main) [ ] (other) [ ]

Guardian Name: ______________________ Guardian Phone #: *no dashes)* [ ]

Guardian Address: ______________________

I certify that this specialized service has been explained to me and I am willing to accept these services at this time.

Signature of Person Referred ______________________ Date: *(mm/dd/yyyy)* [ ]

If no signature obtained, reason why: [ ]

Name of person who completed referral/ explained specialized services to person being referred: ______________________ Phone Number: *no dashes)* [ ]

Include information regarding the clinical rationale for requesting Mobile Medication:

[ ]

Does the person need any assistive devices, supports, or accommodations in order to communicate with others? If so, please list them here:

[ ]

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Diagnosis

Please include a primary behavioral health diagnosis. Other diagnoses may be included.

Must have a primary diagnosis of a serious mental illness (Major Depressive Disorder, Bipolar Disorder, Psychosis NOS, Schizophrenia, or Schizoaffective Disorder)

Behavioral Health ______________________________

Behavioral Health ______________________________

Behavioral Health ______________________________

Medical Conditions/
Physical Health Issues ______________________________

Medical Conditions/
Physical Health Issues ______________________________

Medical Conditions/
Physical Health Issues ______________________________

List all current medications, including those prescribed for physical and behavioral health conditions. A MAR could also be included with the referral. If the person is on an injectable medication for a behavioral health condition, please be sure to include the last date of administration and next due date.

Medication Name	Dose	Frequency	Route	Presciber	Number of Refills	Additional Info

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Services

List Hospitalizations for physical and behavioral health needs, Incarcerations, and Emergency Encounters in last 12 months (list most recent first):

	Type/Facility	Date *(mm/dd/yyyy)*
1.		
2.		
3.		
4.		

Treatment Services in past 5 years (IOP, Partial, CTT, etc). Please provide reason service was discontinued:

1. ______
2. ______
3. ______

Current Services:

Current	**Provider/ Agency**	**Contact Name**	**Contact Phone No.** *(no dashes)*	**Date of Initial Contact** *(mm/dd/yyyy)*	**Next Appointment** *(mm/dd/yyyy)*	**Has the member has signed a Release of Information for Mobile Medication provider?**
Outpatient Psychiatrist (required)						
Service Coordinator (required)						
Outpatient Therapist						
Primary Care Physician						
Certified Peer Support/ Certified Recovery Specialist						
Pharmacy Information						

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List Substance Use/Dependence

	Type Used	Frequency	Date of last use *(mm/dd/yyyy)*
1.			
2.			
3.			
4.			

History of Life Threatening Suicide Attempts/Life Threatening Self Harm

	List Specific Behaviors/Method	Outcome *(admitted to, etc.)*	Date *(mm/dd/yyyy)*
1.			
2.			
3.			
4.			

Legal History

List current or history of legal charges. List if on probation or parole. Provide history of impulsive acting out, physical assault or uncontrolled anger that resulted in physical harm or real potential harm to others (ex. assault, rape, arson).

	List Impulsive/Acting Out Behavior	Outcome *(admitted to, etc.)*	Date *(mm/dd/yyyy)*
1.			
2.			
3.			

Assessment of Strengths

1. ______________________________

2. ______________________________

Support System

List current natural support system (family, friends, or social programs) and the frequency of contact. If there were natural supports who are no longer involved, provide a brief reason why no longer involved.

	List Supports/Relationships	Frequency of Contact/Last Contact	Reason No Contact
1.			
2.			
3.			

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Psychotic or Mood Related Symptoms

Identify psychotic or mood related symptoms person experiences when symptomatic that interfere with daily functioning.

1. ______
2. ______
3. ______

Current Housing Placements and History

List most recent first.

1. ______
2. ______
3. ______

Tobacco Cessation

Tobacco screen completed on: *(mm/dd/yyyy)* [ ]

Tobacco user? ◯ Yes ◯ No

Has cessation been discussed? ◯ Yes ◯ No

Is member interested in a referral for tobacco cessation?

◯ Yes ◯ No

☐ Referred to Tobacco Cessation Therapist/Program

☐ Referred to Quit Line

To be completed by Mobile Medication Provider

Accepted/Approved for Assignment ( ):

Community Care Reviewer ______ Date of Review *(mm/dd/yyyy)* ______

Allegheny County OBH Reviewer, if needed ______

Date of Review, if needed *(mm/dd/yyyy)* ______

Authorization Number and Mobile Medication Service Start Date ______

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