# Sample Policy
# Pathways Hub for Referral & Screening

**CCC Incoming Referrals**

Referrals to the XX Pathways-Community HUB for complex care coordination will be sourced from referral partners HOSPITAL Y and Hub Network Partner. Following successful evaluation of the CCC pilot, including care coordination performance metrics, the CCC referral network may be expanded to other referral partners.

The Community HUB is responsible for receiving community member referrals from HOSPITAL and Hub Network Partner staff, including the CCC. All referrals are directed to the HUB are then assigned to the Hub Network Partner CCC using an identified roster list in the Community Care Solutions (CCS) platform.

The initial referral network will include:

1. HOSPITAL case managers; behavioral health providers, primary care providers will refer when they find at-risk community members who may benefit from intensive services with a community-based care coordination team.

2. Hub Network Partner CCC team who identify clients from within the community or through Hub Network Partner staff, will refer for community-based services through the HUB.

Self-referral for the CCC may occur if a client seeking Pathways services self-refers to the HUB and is identified to meet the CCC eligibility criteria.

Methods to place a referral to the Community HUB include use of a HIPAA secure phone line and voicemail system for all referral partners. The Community HUB will process referrals and connect CCC eligible clients within *1-business* after the referral is received.

In addition, the Hub Network Partner CCC team Program Manager is provided a unique username and password direct access to the referral form and eligibility screening tool loaded onto the Care Coordination Systems. This provides an alternative route for the Hub Network Partner CCC to refer and capture eligible clients for the CCC.

The HUB team will receive referral information form referral partners that must include:

- Client First and Last Name
- Client DOB
- Client's current phone number
- Client's current address
- Date of recent visit
- Health plan or insurance coverage

- If inpatient: diagnosis and reason for inpatient stay
- Client reported history of substance use
- Additional Information: frequent hospital stays; client reports history of IVDU

**Community HUB Screening and Referrals to CCC**

It is the policy of XX Pathways Community HUB to ensure that services are equitable to underserved, socially disadvantaged, and ethnically diverse groups which include services that are culturally and linguistically appropriate.

Clients referred to the Community HUB for the CCC program will be screened to assess if they meet eligibility requirements for the program. If the client does not meet eligibility requirements, the Community HUB will screen the client for other care coordination programs including Pathways and Health Homes that the client may be eligible for. If the client is eligible for another XX care coordination program the Community HUB will comply with those programmatic policies and procedures.

The following screening is completed by the Community HUB team within the Care Coordination Systems (CCS) platform. If the client meets CCC eligibility, the Community HUB team will assign the client to the Hub Network Partner CCC. The CCC then conducts outreach and engagement with the client (refer to the Hub Network Partner policies and procedures).

**Eligibility**

- Resident of YY County
- Adult patients being served by Hub Network Partner and HOSPITAL, or patients being exclusively served by HOSPITAL
- Individuals covered by Medicaid
- Individuals identified as frequent utilizers of services as defined by having 4 or more E.R. or Inpatient visits within the last six months
- Individuals with admission complaints related to
    - Infections or infectious disease
    - Respiratory diagnoses or complications
    - Cardiovascular diagnoses or complications
- Individuals engaging in active Intravenous Drug Use; this information will be gathered by self-report or by observations by clinical staff

If there is missing referral information that inhibits proper screening, the Community HUB team may refer the client to the CCC program manager to initiate contact with the client to further assess eligibility.