Mental Health Transition Tool Training (adult & youth)

Santa Cruz County Behavioral Health

February 2023 / April 2023

Purpose of Transition Tool

- ❖ Provide a guide for timely mental health referrals to the appropriate Medi-Cal mental health delivery system
- ❖ Support timely, coordinated care for clients who require transition between delivery systems or additional services from a different delivery system

The Transition Tool is the SAME tool for both youth and adults

Which providers must use the transition tool?

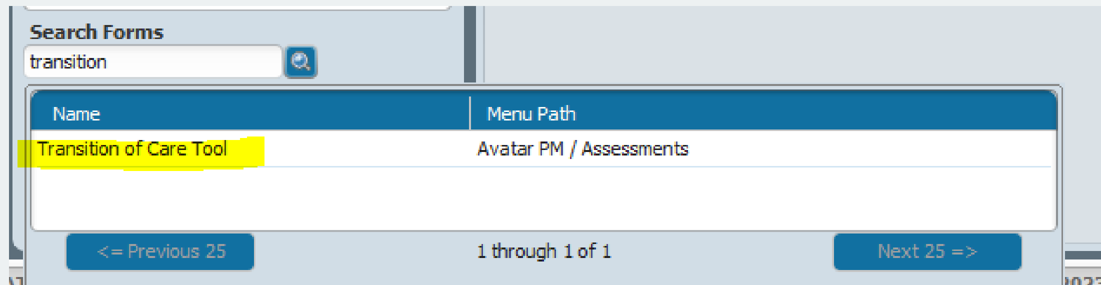
- ❑ Providers who support Medi-Cal beneficiaries in transitioning between delivery systems, in other words, between the Mental Health Plan (MHP) and the Managed Care Plan (MCP)

For which clients / beneficiaries will the transition tool be used?

- ❑ Existing clients transferring to the Managed Care Plan (MCP)
- ❑ Existing clients transferring to the Mental Health Plan (MHP)
- ❑ Existing clients who are being referred for additional services in a different delivery system

Where can I find the Transition Tool?

- Paper Version: DHCS website: HERE
- Avatar Form:
  Transition of Care Tool



What is the start date for use of the Transition Tool?

- DHCS guidance = January 1, 2023
- County BH providers in Santa Cruz = March 1, 2023
- Contract Partner providers in Santa Cruz = May 1, 2023

When do I complete the Transition Tool?

- After appropriate staff have determined a transition in care is clinically indicated
- After appropriate staff have determined additional services in a different delivery system are clinically indicated

NOTE: The Transition of Care Tool is not considered an assessment

Transition Tool Details

- The Transition of Care Tool is designed to use existing clinical information to document a client's mental health needs and facilitate a transition of care referral, to the Managed Care Plan (MCP) or Mental Health Plan (MHP)
- The Transition of Care Tool documents the client's information and referring provider's information
- The tool is to be used to facilitate transitions of care for clients of all ages by both County and Contractor programs
- The tool may be used to refer a client for additional services in a different delivery system

Planning for Transitions

- ❖ The determination to transition services to a lower or higher level of care must be made by a **<u>Licensed Practitioner of the Healing Arts (LPHA)</u>**:
  - ❖ Physician
  - ❖ Nurse Practitioner
  - ❖ Psychologist
  - ❖ LCSW, LMFT, LPCC (& all registered / waivered in these categories)
  - ❖ Registered Nurse (RN)
  - ❖ Certified Nurse Specialist (CNS)
- ❖ Additional staff may make the determination to transition care under the direction of an LPHA:
  - ❖ Mental Health Rehabilitation Specialist (MHRS)
  - ❖ Occupational Therapist
- ❖ **Clients should be included / engaged in the process**
- ❖ Appropriate verbal consent and/or Release of Information (ROI) should be obtained in accordance with accepted standards of clinical practice

Completing the Tool

Once a clinician has made the determination to transition care or refer for services, the Transition of Care Tool may be filled out by a LPHA or a non-licensed clinician under direction of a LPHA. The Transition of Care Tool may be completed:

❖ In-Person

❖ Telephone

❖ Telehealth / Video

The Transition of Care Tool, including the specific wording, the order of the questions and order of all fields and questions shall remain intact / may NOT be altered in any way.

Next Steps:

After the Transition of Care Tool is completed, the clinical team will refer the client directly to the Managed Care Plan provider.

- MHPs shall coordinate the client's services
- MHPs shall facilitate the referral, including:
  - Informing the client of the referral and gaining their consent
  - Ensuring that:
    - the referral process has been completed
    - the client is connected with a provider in the new system
    - the new provider accepts the care of the client
    - medically necessary services have been made available to the client

A release of information is not required for a referral in the context of facilitating client care

Required Information for the Transition Tool

- Referring Plan Contact Information
- Referring Plan Care Team Information

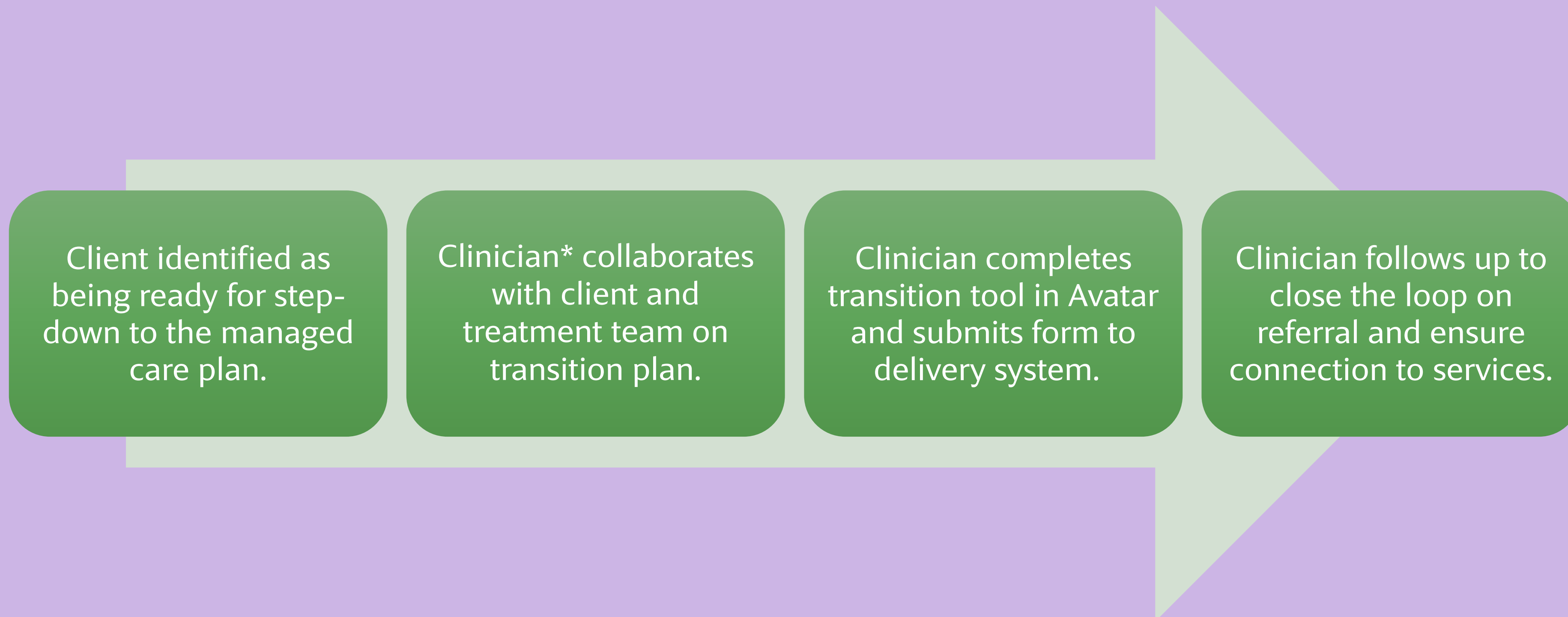
Client / Beneficiary:

- Demographics & Contact Information
- Cultural / Linguistic requests/ needs
- Presenting behaviors / symptoms / diagnosis
- Environmental Factors
- Behavioral Health History
- Medical History / Medications

- Services Requested
- Receiving Plan Information

- Additional Documentation may be provided as clinically indicated

General Workflow for Transition Tool



Transition of Care Tool for Medi-Cal Mental Health Services

*"Clinician" indicates licensed clinician OR non-licensed clinician working under direction of licensed clinician (LPHA).

Adult Behavioral Health Transition Tool Example

- ❖ 45-year-old client came through Access following psychiatric hospitalization.
- ❖ Client met criteria for Bipolar I Disorder, and had multiple functional impairments related to this diagnoses (legal involvement, lack of support network, lack of housing, substance use, and inability to work).
- ❖ Client opened to County MOST team & worked with case manager, psychiatry, peer support worker, probation, and behavioral health court. Participated in residential treatment (Telos, EDC, and Casa Pacific) before finding housing at an SLE.
- ❖ Client successfully completed probation and graduated from behavioral health court.
- ❖ Client found employment and is now active in community (MHCAN and NA) and has reconnected with friends and family.
- ❖ Client has been stable on meds for several years and reports to his case manager that he needs minimal support. Client says he is ready to "move on" from county services.
- ❖ Case manager brings up client in team meeting to discuss transition; psychiatrist and supervisor agree to transition plan.
- ❖ Client and supervisor collaboratively complete Transition Tool, which was submitted to Beacon. Supervisor followed up with client and Beacon to ensure transition of services.

Children's Behavioral Health Transition Tool Example

- 18-year-old referred to CBH through Juvenile Probation Dept after several psych hospitalizations, incarcerations, and refusal of services.
- Client met criteria for PTSD and Major Depressive Disorder plus had multiple functional impairments (interpersonal issues, family, self-care, legal, SUD)
- Client participated in BH services (therapy, psychiatry), SUD services, and completed probation.
- Client found employment, stabilized on meds and then worked with psychiatry to safely discontinue them, repaired relationships with family and friends, and build natural supports in community.
- Client, clinician, and supervisor agreed client was progressing well and could transition to Beacon for less intensive/less frequent services.
- Clinician completed Transition Tool, submitted to Beacon, and followed up with client and Beacon to ensure services were transitioned successfully.

Alignment with Recovery Oriented Values

- ❖Promotes the movement of clients to the most clinically appropriate level of care
- ❖Provides a way of ensuring continuity of care
- ❖Collaborative nature honors client self-determination
- ❖Can help reduce instances of clients being lost to follow-up

Resources

- BHIN 22-065 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services: HERE
- DHCS Screening & Transition of Care Tools webpage: HERE
- DHCS Screening & Transition of Care Tools Technical Assistance Slide Deck: HERE

Thank you

For Questions:

Talk to Supervisor / Manager