Screening & Transition of Care Tools - Overview

Implementation January 1, 2023

01

Please put questions in the chat; Q&A will be held briefly at the end of each section and more at the end of the presentation

02

Please ensure you are on mute, unless asking a question

03

At the end of the training a link to the training Attestation will be posted. Please make sure you complete the Attestation

HouseKeeping

Agenda

- Introductions & Background
- Overview of the Universal Screening Tool
- Overview of the Transition of Care Tool
- Q&A

Introductions – CCMHP / CCHP

- CCMHP / CCHP Introductions
- Today's group is a wide audience –
  - CCMHP Network Providers (contracted CCMHP providers serving both specialty and non-specialty mental health services)
  - CCHP Telehealth Providers - Serene, 3Prong, & Telemed2U
  - CCHP Community Provider Network (CPN) – Behaviorists and contracted Medi-Cal providers

Background

- The new screening and transition of care tools are being introduced as part of the State's CalAIM initiative.
  - Use of the tools are mandatory for all individuals with Medi-Cal starting January 1, 2023
  - The State has not yet released the final versions of the tools
  - The State anticipates fluid implementation of the tools in the 1st quarter 2023
- Contra Costa Health Plan (CCHP) and Contra Costa Mental Health Plan (CCMHP) have been working together over the past several months to develop the implementation plan.

Definitions

- CCHP/Kaiser/Blue Cross = Managed Care Plan (MCP)
- CCHP/MCP deliver non-specialty mental health services, aka mild/mod
- CCMHP = Mental Health Plan (MHP)
- CCMHP/MHP deliver specialty mental health services, aka mod/severe
- Individuals receiving services through MCP = Member
- Individuals receiving services through MHP = Beneficiary

Screening and Transition of Care Tools - *Together, the tools ensure individuals have access to the right care, in the right place, at the right time.*

- The **Screening Tools** determine the appropriate delivery system for individuals who are ***not currently receiving mental health services*** when they contact the Managed Care Plan (MCP) or Mental Health Plan (MHP) seeking mental health services.
- The **Transition of Care Tool** supports timely and coordinated care when completing a transition of services to the other delivery system (MCP or MHP) or adding a service from the other delivery system.

Universal Screening Tool

New Standardized Screening Tools

- Starting January 1, 2023, new standardized screening tools will be implemented for all counties in California.
  - Behavioral Health Information Notice- 22-011 No Wrong Door
  - Draft BHIN 22-xxx Adult Screening and Transition of Care Tools for Medi-Cal MH Services
- There are 3 tools:
  - 1 – Adult Screening Tool (ages 21+)
  - 2 – Youth Screening Tool (under 21)
  - 3 – Youth Screening Tool (adult calling on behalf of an individual under 21)
- The Access Line will primarily use the screening tools.
- The Screening Tools are not required for use with individuals who contact mental health providers directly to seek mental health services. In these cases, the provider may provide the assessment immediately and a screening is not needed.

Development of Screening Tools

- Adult Tool (21+):
  - Beta tested in Fall 2021; piloted for 3 months in Spring 2022; field tested for 4 weeks in Fall 2022
  - 91% of administrators agreed that the score referred beneficiaries to the right delivery system for assessment
  - Average administration time was around 12 minutes
- Youth Tool (under 21):
  - Beta tested for 4 weeks in Spring 2022; Pilot tested for 3 months in Summer 2022 (including CCCo Access Line)
  - 93% of administrators agreed that the score referred beneficiaries to the right delivery system for assessment
  - Average administration time was around 15 minutes

What is a Screening?

A screening is:

- The first step in getting an individual connected with the appropriate care
- Used to quickly determine the individual's needs and get them connected to the provider that best matches their needs
- Intended to be completed in one encounter
- Briefer than a full assessment and does not replace the need for an assessment
- Completed by any trained staff member, including both clinicians and non-clinicians. It does not require the staff to have prior knowledge of the person's presentation.

NOTE: An individual's response to certain questions may necessitate a clinical response to ensure the individual's well-being, in these instances, a non-clinician conducting the screening would transfer the individual to a clinician to intervene as appropriate.

Screening Occurs at the Point of Access

The Access Line will continue to provide the initial screening for all individuals seeking care

However, individuals may access care in several different ways (e.g., self-referral, referral from another program or treating provider)

If a provider receives a call from an individual who has not been screened by the Access Line:

The provider may still refer the individual to the Access Line in order to verify eligibility and to complete the screening, OR	The provider may agree to treat the individual without referring to the Access Line first and complete the assessment

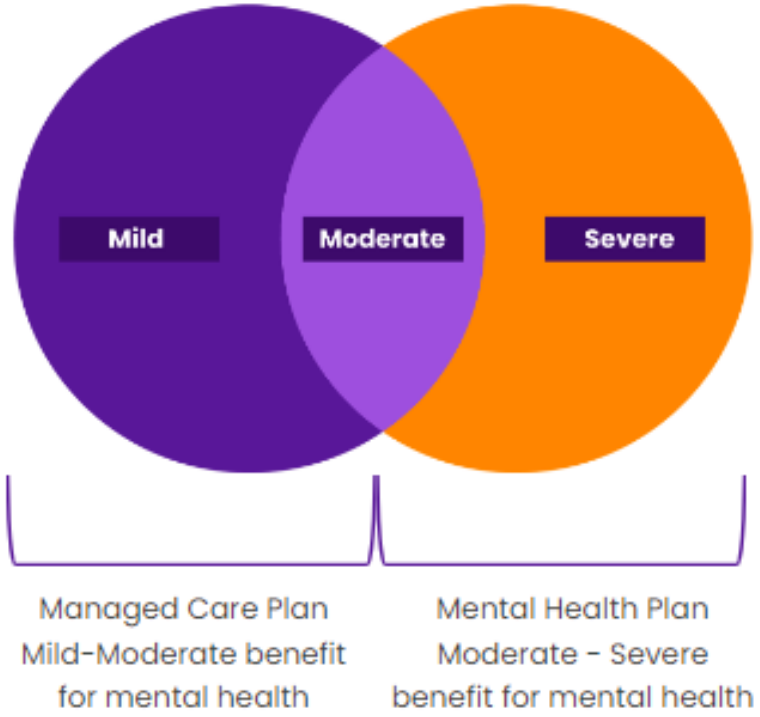
Levels of Distress/ Impairment

- Based on the screening the appropriate delivery system will be identified.

Delivery Systems:

- Non-Specialty Mental Health - Mild/moderate:
  CCHP/Kaiser/Blue Cross = Managed Care Plan (MCP)

- Specialty Mental Health - Moderate/severe:
  CCMHP = Mental Health Plan (MHP)



Universal Transition of Care Tool

Standardized Transition of Care Tool

- From the screening, an individual is referred to either specialty or non-specialty mental health services.

- The transition of care tool is used when an individual's needs require a new service, or an added service **AND** the new/ additional service is through another delivery system (MCP or MHP).

- Providers will determine whether a client's change in symptoms indicates services should be obtained through the other delivery system.

  - **If there is a change in symptoms BUT a new or additional service is not needed, then a Transition of Care tool is not indicated.**

Step up Example

- A CCHP telehealth provider is providing individual therapy to a client(**non-specialty** mental health services). During treatment, the client's symptoms increase in severity. As a result, the CCHP telehealth provider assesses the client is no longer appropriate for non-specialty services and now needs **specialty** mental health services.

- In this scenario, the CCHP telehealth provider will need to complete the transition of care tool in order to initiate services through specialty mental health.

Step Down Example

- The Mental Health Clinic is providing individual therapy and psychiatric services to a client(**specialty** mental health services). Over the course of treatment, the client's symptoms improve, but mild/moderate impairments continue to exist. As a result, the Mental Health Clinic assesses the client is no longer appropriate for specialty mental health services and now needs **non-specialty** mental health services.

- In this scenario, the MH Clinic will need to complete the transition of care tool in order to initiate services through non-specialty mental health.

Transition of Care Tool: Contents

- The transition of care tool is designed to leverage existing clinical information to document a client's mental health needs and facilitate a transition of care or service referral.

- The transition of care tool has specific fields to document:
  - Referring plan and care team
  - Client demographics and contact information
  - Client presenting behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications
  - Services requested and destination plan information

- Referring entities may provide additional documentation, such as care plans and medication lists, as attachments.

Care Coordination

Providers must coordinate with one another to facilitate care transitions and guide referrals.

Providers should continue to provide necessary behavioral health services during the transition period and coordinate the transition of care or service referral with the receiving provider

Care decisions should be made via a person-centered, shared decision-making process with the person in care

DHCS requires providers must ensure that the referral loop is closed

Process

- The transition of care tool will only be needed when:
  - The client's symptoms have changed

    AND
  - Discharging a client to another provider (from MCP to MHP or vice versa) or are requesting an additional service (from MCP to MHP or vice versa)

- To ensure this is an appropriate transition of care referral, especially if the need is not clear, consult with your supporting team.
  - Network Providers – CMU
  - CCHP Telehealth Providers/CPN – Access Line
  - Clinics/CBOs – Access Line

- If after consultation, it is determined a transition of care tool is appropriate:
  - Complete & submit the form
  - If discharging:
    - Continue to see the client until new provider confirms acceptance
    - Once new services have been rendered, complete the "Referral Questionnaire" (more information to follow)
    - Submit the Discharge form

Transition of Care Tool for Medi-Cal Mental Health Services
DRAFT – This document is a draft and is not intended to be filled out.

REFERRING PLAN INFORMATION		
☐ **County Mental Health Plan** ☐ **Managed Care Plan Network Plan**		
Submitting Plan:		
Plan Contact Name:	**Title:**	
Phone:	**Email:**	**Address:**
City:	**State:**	**Zip:**

BENEFICIARY INFORMATION		
Beneficiary's Name:	**Beneficiary's Preferred Name:**	**Date of Birth:**
☐ **Beneficiary or Legal Representative in Agreement with Referral or Transition of Care**	**Gender Identity:** ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Non-binary ☐ _____ **Pronouns:** ☐ He/Him ☐ She/Her ☐ They/Them ☐ _____	
Address:	**City:**	**Zip:**
Phone:	**Email:**	
Caregiver/Guardian:		**Phone:**
Medi-Cal# (CIN)/SSN:	**Race:**	**Ethnicity:**

Behavioral Health Diagnosis or Diagnoses, if known:

Supporting Clinical Documents Included:

Cultural and Linguistic Requests:

Current Presenting Symptoms/Behaviors (including substance use if appropriate):

☐ Additional Pages Attached

Current Environmental Factors (including changes in caregiver relationships, living environment, and educational considerations):

☐ Additional Pages Attached

Brief Behavioral Health History (including psychosocial stressors or traumatic experiences):

☐ Additional Pages Attached

Brief Medical History:

☐ Additional Pages Attached

Current Medications/Dosage:

☐ Medication List Attached

Primary Care Provider/Current Care Team: **Phone:**

SERVICES REQUESTED: ☐ **Transition Care to:** _____
☐ **Adding Service(s) from:** _____

What service(s) is the beneficiary being referred for?

TRANSITION OF CARE OR SERVICE REFERRAL DESTINATION

☐ **Managed Care Plan:** _____

Managed Care Plan Contact Information
Fax: **Phone:** **Toll Free:** **TTY:**

☐ **County Mental Health Plan:** _____

County Mental Health Plan Contact Information
Fax: **Phone:** **Toll Free:** **TTY:**

How to Submit the Transition of Care Tool

We are working on a system to allow providers to submit the transition of care tool electronically through Provider Portal/Epic. Until this is operational, please continue to submit documents in the same way you submit all other documents currently. Once the system is in place, we will send an update with a Tip Sheet.

- Network Providers – submit the form to CMU through the Provider Portal
  - Use subtopic “BHS Other” when submitting the Transition of Care Tool
- CCHP Telehealth Providers – submit the form to the Access Line through secure email
- CPN – submit the form to the Access Line through secure email or fax

Next Steps /Resources

- For questions
  - Network Providers – cmuprovider.services@cchealth.org
  - CPN / CCHP Telehealth Providers - MentalHealth.Access@cchealth.org
- Upcoming DHCS webinars - BH CalAIM Webpage
- CalMHSA LMS Webinars - CalMHSA-LMS-Instructions-5.24.22.pdf
- Resources
  - Behavioral Health Information Notice 22-011 - BHIN 22-011 No Wrong Door for Mental Health Services Policy (ca.gov)
  - All Plan Letter 22-005 - APL 22-005 (ca.gov)

Training Attestation

Please click on the link below to complete the brief training attestation.

https://forms.office.com/Pages/ResponsePage.aspx?id=3tkgKC3cY0OGJvKwA0OMRW1Yu1pIAWlNlmlOCKMVwANUM04xUTE0SUtXVVE5UjJERUU0UDBKQlpYQS4u