alameda county behavioral health MENTAL HEALTH & SUBSTANCE USE SERVICES	By: Dr. Karyn L. Tribble, PsyD, LCSW Behavioral Health Director
POLICY TITLE **Adult and Older Adult Specialty Mental Health Consumer Care Transitions**	**Policy No: 100-2-6** **Date of Original Approval**: 12/16/19 **Date(s) of Revision(s):**

PURPOSE

This policy addresses the need to ensure service providers coordinating consumer care transitions between providers and levels of care have a shared understanding of the process and expectations of all parties involved in the transition.

AUTHORITY

- MHP Contract, Ex. A, Att. 10
- 42 C.F.R. § 438.62(b)(1)-(2)

SCOPE

All ACBH county-operated programs in addition to entities, individuals and programs providing mental health services under a contract or subcontract with ACBH.

POLICY

This policy establishes expectations and procedures for the successful transition of behavioral health services between providers for adult and older adult beneficiaries within ACBH.

PROCEDURE

I. This procedure is intended to be a guide for staff involved in client care transitions within ACBH's Adult and Older Adult System of Care and from ACBH's TAY System of Care to the Adult System of Care.

II. While each consumer and their process is unique, it is important to have a shared understanding of what is involved in the transition process for consumers who are moving from one service provider to another. Transitions between providers are critical times for individuals and when done without careful attention and clear communication, they can lead to an increased risk of disengagement and negative outcomes for the people we serve.

III. It is essential to consider and plan for transitions at the beginning of the treatment relationship. Transition planning continues throughout the treatment process and is most effective when done using trauma informed and culturally responsive principles and practices.

IV. The document, *ACBH Guidelines for Consumer Care Transitions Between Providers in the Adult/Older Adult System of Care,* includes detailed procedures on initiating, completing, and ending the transition process (Attachment A). The Guidelines document clarifies the roles and responsibilities of the referring provider and new provider throughout the transition process in an ideal situation. It is understood that there will be barriers to some of these steps for some clients. Providers may incorporate the steps identified in a manner and order that is consistent with best practices in behavioral health care and the client's preferences, needs, and strengths.

V. The *Checklist for Consumer Care Transitions Between Providers in the Adult/Older Adult System of Care* (Attachment B), is an accompanying document to the Guidelines and is intended to be used in conjunction with the Guidelines. The Checklist is an abbreviated version of the Guidelines and both documents are numbered in the same order to ease the use of these documents.

VI. The document, *Guidelines for Consumer Care Transitions from TAY to Adult Service Providers,* includes specific procedures related to supporting TAY consumers move from the Children/TAY System of Care to the Adult/Older Adult System of Care (Attachment C). TAY providers are welcome to use any of the information found in other documents as well.

NON-COMPLIANCE

I. Failure to comply with this policy may result in formal actions including and up to formal sanctions as outlined in ACBH Policy# 1302-1-1 "Contract Compliance and Sanctions for BHCS Contracted Providers."

II. Procedures to be completed in the event of a policy non-compliance:

a. When a provider is not abiding by the procedural requirements of the policy, the appropriate ACBH office will be notified of the situation.

b. Reports of non-compliance can be made in writing or verbally to supervisors, and staff shall not face retribution for reporting non-compliance.

c. Reports of non-compliance shall be communicated to supervisors and to the appropriate ACBH office within 72 hours to ensure timely response and corrective action.

d. Any communication that contains protected health information or otherwise confidential information should be sent through secure methods such as email with secure encryption.

CONTACT

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DISTRIBUTION

This policy will be distributed to the following:

- ACBH Staff
- ACBH County and Contract Providers
- Public

ISSUANCE AND REVISION HISTORY

Original Authors: Kate Jones
Original Date of Approval: 12/16/19
Date of Revision:

Revise Author	Reason for Revise	Date of Approval by (Name)

DEFINITIONS

Term	Definition
TAY	Transition Aged Youth

ATTACHMENT A

Guidelines for Consumer Care Transitions Between Providers in the Adult/Older Adult System of Care

The information below is intended to be a guide for staff involved in client care transitions within ACBH's Adult and Older Adult System of Care. While each consumer and their process is unique, it is important to have a shared understanding of what is involved in the transition process for consumers who are moving from one service provider to another. Transitions between providers are critical times for our clients and when done without careful attention and clear communication, they can lead to an increased risk of disengagement from needed services and negative outcomes for the people we serve.

The intention of this guide is to increase successful transitions for clients and support staff involved in this process. The following document describes the transfer of specific services in an ideal situation. It is understood that there will be barriers to some of these steps for some clients such as when a client is disengaged and not able to be located or the client is ambivalent about treatment and/or the transition itself. Providers may incorporate the following steps in a manner and order that is consistent with their clinical judgment and the client's preferences, needs and strengths. For an abbreviated version of this document please see the "Consumer Care Transitions Checklist".

1. **Initiating the Transition Process:**
    a. The referring provider team including the psychiatric prescriber (if applicable) works with the consumer and their support system regarding the need for a referral to a new provider. The referring provider supports the client in understanding the transition process including the reason for the change in providers and what to expect during and after the transition.
    b. The referring provider completes required referral forms when indicated and gathers important information including but not limited to assessments **including a recent risk assessment**, safety plan if applicable, treatment plan, progress notes and other critical documents and creates a packet which will be sent to ACCESS.
    c. The supervisor or manager of the program contacts ACCESS to request a change in provider (move to higher level of care, lower level of care, or lateral transfer) and rational for that request. The packet of clinical information is sent to ACCESS.
    d. Within one week of ACCESS opening the consumer to the new provider's Program RU (aka P Code) and the new provider receiving the referral from ACCESS, the referring provider and new provider discuss the transition and start development of a plan.
        i. It is recommended to use the accompanying checklist titled, "Consumer Care Transitions Checklist"

2. **Completing the Transition Process:**
    a. Referring provider, new provider and client meet face to face at least one time. It is important to use your clinical judgement to determine if one meeting is enough or if more are needed.
        i. During this meeting each provider identifies the role they will have during the transition process and collaboratively develop a plan with estimated timeline for the transition of all services. See page 5 for detailed information regarding QA issues related to client transitions between providers.
    b. Referring provider and client travel together at least one time using the mode of transportation the client plans to use in the future to get to the new provider's location. This is intended to support the client in managing any transit/travel issues that may arise.
    c. Mental health services are transferred (therapy, rehab, collateral, case management, etc.)
        i. Client has at least one face to face contact with new clinician/PSC/intake staff member.
    d. Providers share information about payee services and transfer responsibility of subpayee if applicable.
        i. If client is in the Subpayee program, the referring provider completes the Subpayee Change of Case Manager form and providers work together on transferring this responsibility. Ensure checks are being sent to the correct locations and the client is informed prior to the change occurring.
    e. Providers share information about the client's housing situation. If the client is in an HSP Board and Care, MHSA funded Permanent Supported Housing unit, or other housing through the ACBH Housing Services Program, ensure the Housing Service Program staff member is aware of the transfer.
        i. Ensure any support staff onsite of the client's home is aware of the change in providers (board and care staff, support staff within permanent housing sites, etc.)
    f. Psychiatric medication services are transferred
        i. **Client has at least one face to face contact with new psychiatric prescriber and new program ensures meds will be available to client prior to client running out of meds. This needs to occur before the referring provider closes the client to their program's Team RU (aka T code).**
        ii. Ensure new provider has current psychiatric medication information including:
            1. Full medication list including psychiatric and medical meds and all prescribers.
            2. Current amount of psychiatric medications on hand, refills left, when refills will be needed.
            3. If client on a Long Acting Injectable, date and location of last injection, date of next due is shared.

4. If the client is prescribed Clozaril, a plan for the new provider taking responsibility for needed labs is in place.
5. Pharmacy informed of provider change and ensure that new provider will be able to get meds filled without the client experiencing a lapse in medications. This may mean that the referring provider ensures adequate refills will be available.
6. If the client is receiving psychiatric medications through ACBH's Pharmacy Services' indigent medications program, the new provider ensures the client can continue to access medications through this program.
7. It is recommended to have the two psychiatric prescribers directly communicate with each other to ensure accurate information is shared in a timely manner.

g. Share information about medical services and physical health needs
    i. Include medical diagnoses, physical health providers, risks, AOD use, community safety issues.
    ii. Ensure new provider has contact information of client's primary and specialty medical providers and current physical health medications list. This should include any new or outstanding referrals to medical providers and needed labs.
    iii. Ensure new provider has relevant information regarding client's physical health needs and future appointments and level of support needed to follow through with physical health needs.
    iv. Referring provider informs client's physical health providers of transition to the new team.
h. If the client's mail is being delivered to the referring provider's address, the referring provider needs to support the client in changing their mailing address with the Post Office.
i. Referring provider informs necessary collateral contacts of transition plan when appropriate
    i. Family members involved in treatment, IHSS worker, conservator, probation officer, etc.
j. Share information about client's other needs and supports in the community, such as:
    i. Transportation needs, paratransit account, etc.
    ii. Relationship with criminal justice system if applicable: For example, is client on probation? Does s/he need to register monthly or annually?
    iii. Conservator status- information on who the conservator is and contact information and when will the conservatorship expire and plan to renew or not
    iv. All pending and active referrals and linkages and contact information for each.
        1. For example, that client is on the list of the Coordinated Entry System or that client was just referred to Supported Employment program or is working with HAC/BALA on SSI appeal.

k. If the referring provider has been holding important documents for the client (such as original copies of ID, birth certificate, durable power of attorney, advanced directives, trusts, or other legal documents) discuss with the client what they would like to have happen with these documents. If the client's symptoms prevent them from being able to participate in this type of conversation, the referring provider may give the new provider these documents for safe keeping. It is recommended that the referring provider and new provider document this in the client's medical record.
    i. Sometimes the referring provider may need to go through previous volumes of the client's medical records in order to locate these documents.

3. **Ending the Transition Process:**
    a. Referring and new provider communicate with each other prior to the closing of any Reporting Units.
    b. There is agreement that the client is securely linked to the new provider.
    c. After this, the referring provider closes the client to their Team RU (aka T code). Then the referring provider faxes ACCESS the Request to Close Client to Program RU form.
    d. ACCESS will then close the client to the referring provider's Program RU (aka P code).

Tips for Documentation Needs During Client Care Transitions

When a client is transitioning services between two providers it is important to be mindful of Medi-Cal Specialty Mental Health documentation standards in order to prevent a duplication of services. When appropriate, two providers can have a client open to their programs concurrently as long as there is a clinical rational to do so and this is documented in the client's medical records. It is recommended for the two providers to communicate their unique roles early on in the transition process.

For example, the referring staff will often be focusing on providing case management to link the client to the new provider, potentially therapy to process the ending of the relationship and perhaps individual rehabilitation to support the client in building skills to successfully engage with the new team. At the same time the new provider is likely to focus on assessment and plan development. It is important to prevent any duplication of services and due to the fact that each client and their transition process is unique, clear communication between providers regarding each party's role and tasks is essential.

During the transition period, both providers can bill for services on the same day following the guidelines below. Per ACBH QA:

a. Assessment and Case Management services can be claimed on the same day, however, only one assessment claim can be billed per day.
b. Assessment and therapy may NOT be claimed on the same day.
c. Two different therapy services (e.g. individual and family therapy) may be claimed on the same day.
d. Rehab and another code may be claimed on the same day.

If questions arise during the transition process related to the documentation of services please reach out to your agency's QA contact for support.

ATTACHMENT B

Checklist for Consumer Care Transitions Between Providers in the Adult/Older Adult System of Care

This checklist is an abbreviated version of the "Guidelines for Consumer Care Transitions Between Providers" document. It is intended to be a tool to support staff involved in client care transitions. For more detailed information about each step below please refer to the "Guidelines for Consumer Care Transitions Between Providers".

Initiating the Transition Process:

- € 1a) Explain rationale to the consumer for referral to a new provider.
- € 1b) Complete required referral forms when indicated and accompanying packet of medical records (i.e. assessments, progress notes, risk assessment, safety plan, etc)
- € 1c) Supervisor/ manager coordinates change in providers, sending required documentation to ACCESS.
- € 1d) Within 1 week of new provider receiving referral, referring provider and new provider discuss the transition and arrange for a plan development meeting with the consumer.

Completing the Transition Process:

- € 2a) Have face to face meeting with client, referring provider and new provider.
- € 2b) Support client with transportation to new provider when indicated.
- € 2c) Transfer mental health services to ensure continuity of care (case management, therapy, etc.).
- € 2d) Transfer payee services.
- € 2e) Share information regarding client's housing situation and inform housing providers and HSP staff if applicable.
- € 2f) Transfer psychiatry services to ensure continuity of care (medications/ sufficient refills, update pharmacy, scheduling long acting injectables, labs etc.).
- € 2g) Address physical health needs to ensure continuity of care (including medical diagnoses, primary care and specialty referrals).
- € 2h) Support consumer with changing their mailing address when indicated.
- € 2i) Inform consumer's collateral contacts and provide these contacts to the new provider in order to obtain new releases of information.

- € 2j) Share information about client's other needs and supports in the community such as transportation needs, criminal justice needs, pending referrals/linkages (i.e. vocational rehabilitation, coordinated entry, SSI appeal, etc.)
- € 2k) Make a plan to have legal documentation that the old provider has been keeping for client (i.e. advance directives, trusts, birth certificates, etc.) transferred to client or to new provider and document this.

Ending the Transition Process:

- € 3a & 3b) Before closing client to the referring provider's Team RU- consult with the new provider to ensure consumer is securely linked to the provider.
- € 3c) Referring provider close client to their Team RU (T Code). After closing to team, fax ACCESS the request to close client to Program RU (P code).

ATTACHMENT C

Guidelines for Consumer Care Transitions from TAY to Adult Service Providers

1) TAY provider to contact ACCESS to initiate referral to an Adult Service Team or FSP two to three months before client turns 25 years of age, depending on client presentation and level of need.
2) Adult FSPs can provide therapy if clinically indicated. Adult Service Teams do not generally provide therapy. If the consumer wants to receive therapy and is assigned to a Service Team, TAY provider to assist consumer in making an additional Level 3 therapy referral through ACCESS at the same time.
3) During the transition period, both providers can bill for services on the same day following the guidelines below. Per ACBH QA:
    a. Assessment and Case Management services can be claimed on the same day, however, only one assessment claim can be billed per day.
    b. Assessment and therapy may NOT be claimed on the same day.
    c. Two different therapy services (e.g. individual and family therapy) may be claimed on the same day.
    d. Rehab and another code may be claimed on the same day.
4) Before closing to TAY team, there should be a minimum of: one face to face appointment with the Adult team staff (preferably with the clinician) and, if needed, one face to face appointment with the new psychiatric prescriber. Please consult QA for how to bill for the joint meeting with the prescriber.
5) TAY provider to travel together with the consumer at least one time to the Adult clinic to manage any transit/travel issues that may arise.
6) TAY provider to share information about payee services and transfer subpayee responsibility to new Adult provider, if applicable.
7) TAY provider to share information about client's housing situation and ensure the ACBH Housing Services Program is aware of the transfer to new Adult provider, if applicable.
8) When there is a shared understanding that the client is securely connected to the Adult team the TAY provider may request to have the client's Program Reporting Unit (P code) closed.
9) If the consumer is not following through with the referral process and is disengaged from the TAY team during the transition process, TAY provider, through ACCESS, will make an Adult IHOT referral with the goal of linking to the Adult Service Team or FSP once they reengage. The consumer will be closed to the TAY provider if there is no successful engagement after three months of assertive outreach and engagement efforts.
10) If client is engaged with the TAY provider but is having difficulties connecting to the Adult team, efforts will be made to explore another Adult clinician, provider, or level of service to ensure a successful transition.