Behavioral Health Department Alameda County Health	By: Signed by: BA107CA0C0D444A... **Karyn L. Tribble, PsyD, LCSW, Director**
POLICY TITLE **Adult and Older Adult Specialty Mental Health Member Care Transitions Within the Mental Health Plan**	**Policy No: 100-2-6** **Date of Original Approval**: 12/16/2019 **Date(s) of Revision(s):** 11/25/2025

PURPOSE

This policy addresses the need to ensure service providers coordinating member 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 ACBHD County-Operated programs, in addition to entities, individuals and programs providing specialty mental health services (SMHS) under a contract or subcontract with ACBHD are required to adhere to this policy.

POLICY

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

PROCEDURE

I. This procedure is intended to be a guide for staff involved in member care transitions within ACBHD's Adult and Older Adult System of Care (AOASOC) and from ACBHD's Transition Age Youth (TAY) Division/Child and Young Adult System of Care (CYASOC) to the AOASOC.

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

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, *Guidelines for Care Transitions Between Providers in the Adult and Older Adult System of Care* (Attachment A), includes detailed procedures on initiating, completing, and ending the transition process . 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 members. Providers may incorporate the steps identified in a manner and order that is consistent with best practices in behavioral health care and the member's preferences, needs, and strengths.

V. The *Checklist for Care Transitions Between Providers in the Adult and Older Adult System of Care* (Attachment B), is an accompanying document 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 Care Transitions from TAY to Adult Service Providers* (Attachment C), includes specific procedures related to supporting TAY members' move from the TAY Division/CYASOC to the Adult and Older Adult System of Care . 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 ACBHD 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 ACBHD 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 ACBHD 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

ACBHD Office	Current As Of	Email
Adult and Older Adult System of Care	4/25/2025	Katherine.Jones@acgov.org
Transition Age Youth Division/Child and Young Adult System of Care	4/25/2025	SunHyung.Lee@acgov.org

DISTRIBUTION

This policy will be distributed to the following:

- ACBHD Staff
- ACBHD Contract Providers
- Public

ISSUANCE AND REVISION HISTORY

Original Author: Kate Jones
Original Date of Approval: 12/16/2019 by Dr. Karyn L. Tribble, Behavioral Health Director

Revision Author	Reason for Revision	Date of Approval by (Name, Title)
Kate Jones, Director, Adult and Older Adult System of Care Sun Hyung Lee, Division Director, Transition Age Youth Services	Alignment with current ACBHD policies and procedures and updating of outdated language and logos.	11/25/2025 by Dr. Karyn L. Tribble, Behavioral Health Director

DEFINITIONS

Term	Definition

APPENDICES

- Attachment A: Guidelines for Care Transitions Between Providers in the Adult and Older Adult System of Care
- Attachment B: Checklist for Care Transitions Between Providers in the Adult and Older Adult System of Care
- Attachment C: Guidelines for Care Transitions from TAY to Adult Service Providers

ATTACHMENT A

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

The information below is intended to be a guide for staff involved in member care transitions within ACBHD's Adult and Older Adult System of Care (AOASOC). While each member and their process is unique, it is important to have a shared understanding of what is involved in the transition process for members who are moving from one service provider to another. Transitions between providers are critical times for our members 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 being served.

The intention of this guide is to increase successful transitions for members 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 members such as when a member is disengaged and not able to be located or the member 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 member's preferences, needs and strengths. For an abbreviated version of this document please see the "Checklist for Care Transitions Between Providers in the Adult and Older Adult System of Care".

1. **Initiating the Transition Process:**
    a. The referring provider team including the psychiatric prescriber (if applicable) works with the member and their support system regarding the need for a referral to a new provider. The referring provider supports the member 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), care plan, problem list, progress notes and other critical documents and creates a packet which will be sent to ACBHD's Acute Crisis Care and Evaluation for Systemwide Services (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 rationale for that request. The packet of clinical information is sent to ACCESS.
    d. Within one week of ACCESS opening the member to the new provider's Program code (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, "Checklist for Care Transitions Between Providers in the Adult and Older Adult System of Care"

2. **Completing the Transition Process:**

a. Referring provider, new provider and member meet face to face at least one time. It is important that clinical judgement be used 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.
b. Referring provider and member travel together at least one time using the mode of transportation the member plans to use in the future to get to the new provider's location. This is intended to support the member in managing any transit/travel issues that may arise.
c. Mental health services are transferred (therapy, rehab, collateral, case management, etc.)
    i. Member has at least one face to face contact with new clinician/team member.
d. Providers share information about payee services and transfer responsibility of Subpayee if applicable.
    i. If member is in the Subpayee program, the referring provider completes the Subpayee Change of Case Manager form and providers work together on transferring this responsibility. Attention should also be paid to ensure that checks are being sent to the correct locations and that the member is informed prior to the change occurring.
e. Providers share information about the member's housing situation. If the member is in a Housing Support Program (HSP) Board and Care, Mental Health Services Act (MHSA) funded Permanent Supported Housing unit, or other housing through the ACBHD Housing Services Program, attention should be paid to ensure the Housing Service Program staff member is aware of the transfer.
    i. It is important to ensure any support staff onsite of the member'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. **Member has at least one face to face contact with new psychiatric prescriber and new program ensures medications will be available to member prior to them running out of medications. This needs to occur before the referring provider closes the member to their program's Team code (aka T code).**
    ii. It is important to ensure new provider has current psychiatric medication information including:
        1. Full medication list including psychiatric and medical medications and all prescribers.
        2. Current amount of psychiatric medications on hand, refills left, when refills will be needed.
        3. If member is on a Long Acting Injectable, date and location of last injection, date of next due is shared.
        4. If the member is prescribed Clozaril, a plan for the new provider taking responsibility for needed labs is in place.

5. Pharmacy is informed of provider change and ensures that new provider will be able to get medications filled without the member experiencing a lapse in medications. This may mean that the referring provider ensures adequate refills will be available.
6. If the member is receiving psychiatric medications through ACBHD's Pharmacy Services' indigent medications program, the new provider ensures the member 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. It is important to share information about medical services and physical health needs
    i. Include medical diagnoses, physical health providers, risks, alcohol and other drug use, community safety issues.
    ii. Ensure new provider has contact information for member'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 member's physical health needs and future appointments and level of support needed to follow through with physical health needs.
    iv. Referring provider informs member's physical health providers of transition to the new team.
h. If the member's mail is being delivered to the referring provider's address, the referring provider needs to support the member 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. It is important to share information about member'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 member on probation? Does the member need to register monthly or annually?
    iii. Conservator status: For example, information on who the conservator is and contact information and when the conservatorship will expire and the plan to renew or not.
    iv. All pending and active referrals and linkages and contact information for each.
        1. For example, that member is on the list of the Coordinated Entry System or that they were just referred to Supported Employment program or is working with the Homeless Action Center or Bay Area Legal Aid on Supplemental Security Income (SSI) appeal.

k. If the referring provider has been holding important documents for the member (such as original copies of identification, birth certificate, durable power of attorney, advanced directives, trusts, or other legal documents) discuss with the member what they would like to have happen with these documents. If the member'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 safekeeping. It is recommended that the referring provider and new provider document this in the member's medical record.
    i. Sometimes the referring provider may need to go through previous volumes of the member's medical records in order to locate these documents.

3. <u>Ending the Transition Process:</u>

a. Referring and new provider communicate with each other prior to the closing of any Program code.
b. There is agreement that the member is securely linked to the new provider.
c. After this, the referring provider closes the member to their T code.
d. Referring provider communicates with their ACBHD Operational Lead regarding the plan to close the member to P code. After consultation and agreement, the referring provider closes member to their P code.

Tips for Documentation Needs During Care Transitions

When a member 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 member open to their programs concurrently as long as there is a clinical rationale to do so, and this is documented in the member'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 member to the new provider, potentially therapy to process the ending of the relationship and perhaps individual rehabilitation to support the member 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 member and their transition process is unique, clear communication between providers regarding each party's role and tasks is essential.

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

ATTACHMENT B

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

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

Initiating the Transition Process:

1a) Explain rationale to the member for referral to a new provider.

1b) Complete required referral forms when indicated and accompanying packet of medical records (i.e. assessments, progress notes, problem list, 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 member.

Completing the Transition Process:

2a) Have face to face meeting with member, referring provider and new provider.

2b) Support member 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 member'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 member with changing their mailing address when indicated.

2i) Inform member's collateral contacts and provide these contacts to the new provider in order to obtain new releases of information.

2j) Share information about member's other needs and supports in the community such as transportation needs, criminal justice needs, pending referrals/linkages (i.e. vocational rehabilitation, coordinated entry, Supplemental Security Income appeal, etc.)

2k) Make a plan to have legal documentation that the old provider has been keeping for member (i.e. advance directives, trusts, birth certificates, etc.) transferred to member or to new provider and document this.

Ending the Transition Process:

3a & 3b) Before closing member to the referring provider's T Program code, consult with the new provider to ensure member is securely linked to the provider.

3c) Referring provider closes member to their T Program code.

3d) Consult with ACBHD Operational Lead regarding closing the P code. After agreement to close the member, the referring team may close the P code.

ATTACHMENT C

Guidelines for Care Transitions from TAY to Adult Service Providers

1) TAY provider to contact ACCESS to initiate referral to an Adult Service Team or Full Service Partnership (FSP) two to three months before individual ages out of services, depending on member presentation and level of need.
2) Adult FSPs can provide therapy if clinically indicated. Adult Service Teams do not generally provide therapy. If the member wants to receive therapy and is assigned to a Service Team, TAY provider to assist member in making an additional referral through ACCESS to an ACBHD Fee for Service therapist at the same time.
3) During the transition period, both providers can bill for services on the same day following QA guidelines. Providers should contact QA for documentation related questions.
4) Before closing to the TAY team, there should be a minimum of one face to face appointment with the Adult Service 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 member 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 member's housing situation and ensure the Alameda County Health (AC Health) Office of Housing and Homeless Program is aware of the transfer to new Adult provider, if applicable.
8) When there is a shared understanding that the member is securely connected to the Adult Service team, the TAY provider may close the T code. After consultation and agreement with their ACBHD Operational Lead, the TAY team may close their P code.
9) If the member 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 In-Home Outreach Team (IHOT) referral with the goal of linking to the Adult Service Team or FSP once they reengage. The member will be closed to the TAY provider if there is no successful engagement after three months of assertive outreach and engagement efforts.
10) If the member is engaged with the TAY provider but is having difficulties connecting to the Adult Service team, efforts will be made to explore another Adult clinician, provider, or level of service to ensure a successful transition.