Transition of Care Tool

Behavioral Health Department (ACBHD)

Alameda County Health

April 2024

What will we cover today?

- What is the Transition of Care Tool?
- When will I need to complete it?
- How do I complete it?
- Who do I send it to and what goes with it?
- What should I expect after I send it?
- Connecting with Managed Care Plans
- When a Managed Care Plan sends Us a Transition of Care Tool
- Questions and Answers

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What is the Transition of Care Tool

- The Transition of Care Tool was published by the Department of Health Care Services (DHCS) in Behavioral Health Information Notice 22-065 in December 2022

- As providers within the County's Mental Health Plan, we are mandated to use the Transition of Care Tool to coordinate care transitions between Behavioral Health Department (ACBHD) and the client's Managed Care Plan (MCP)

- The Transition of Care Tool provides a standardized process for sharing information and facilitating coordination across Medi-Cal mental health delivery systems when adding a service from, or completing a transition of care to, the other Medi-Cal mental health delivery system.

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A Quick Overview of Medi-Cal Mental Health Delivery Systems

Managed Care Plans

- Deliver **Non-Specialty Mental Health Services**
- In Alameda County Alameda Alliance for Health is the primary Managed Care Plan
- Kaiser Managed Care Plan is also available in Alameda County through a contract with the State

Mental Health Plans

- Deliver **Specialty Mental Health Services**
- Behavioral Health Department (ACBHD) is the Mental Health Plan for Alameda County

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Non-Specialty Mental Health Services Provided by the Managed Care Plans (MCPs)

- Mental health evaluation and treatment, including individual, group and family psychotherapy
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition
- Outpatient services for purposes of monitoring drug therapy
- Psychiatric consultation
- Outpatient laboratory, drugs, supplies and supplements

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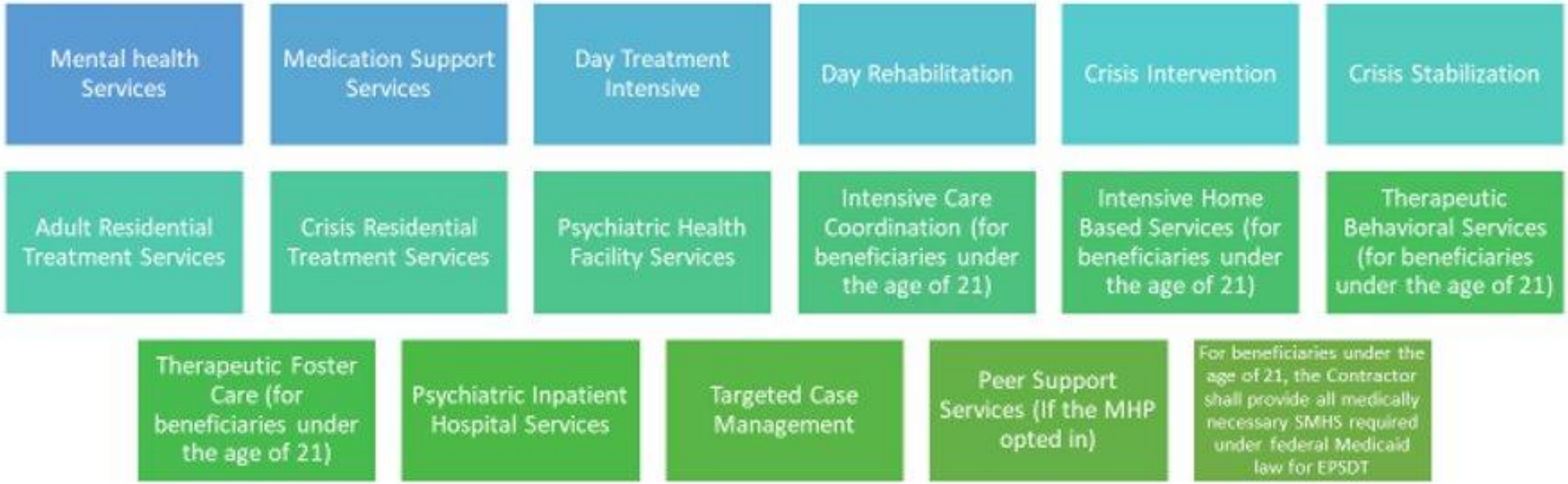
Specialty Mental Health Services Provided by the Mental Health Plan (MHP)



When Will I Need to Complete It?

There are 3 situations that will trigger your need to complete a Transition of Care Tool for a client.

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Completing the Transition of Care Tool for Full Transitions

#1. When all existing mental health services need to be transitioned to the Managed Care Plan

- When a client is ready to transition out of Specialty Mental Health Services provided by the Mental Health Plan to Non-Specialty Mental Health Services provided by the Managed Care Plan

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Completing the Transition of Care Tool for Adding a Service

#2. When services need to be added to their existing mental health treatment from the Managed Care Plan

- When you are providing Specialty Mental Health Services through the Mental Health Plan, and the client would like to concurrently receive services through the Managed Care Plan.
  - This became possible through the CalAIM No Wrong Door initiative described in BHIN 22-011.
  - Concurrent services across plans need to be coordinated and non-duplicative.

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Completing the Transition of Care Tool for Right Matched Care

#3. When you complete a comprehensive assessment for an individual and determine that they do not meet Specialty Mental Health Access criteria and need to obtain mental health services through their Managed Care Plan.

- Specialty Mental Health access criteria is found in BHIN 21-073.

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How Do I Complete It?

Page 1 of the Transition of Care Tool provides an overview and instructions.

State of California – Health and Human Services Agency Department of Health Care Services

Transition of Care Tool for Medi-Cal Mental Health Services

The Transition of Care Tool for Medi-Cal Mental Health Services (hereafter referred to as the Transition of Care Tool) leverages existing clinical information to document an individual's mental health needs and facilitate a referral to the individual's Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) as needed. The Transition of Care Tool is to be used when an individual who is receiving mental health services from one delivery system experiences a change in their service needs and 1) their existing services need to be transitioned to the other delivery system or 2) services need to be added to their existing mental health treatment from the other delivery system.

Instructions: The determination to transition services to and/or add services from the other mental health delivery system must be made by a clinician in alignment with protocols. Once a clinician has made the determination to transition care or refer for services, all of the following actions must be taken:

1. Complete the Transition of Care Tool.
2. Send the Transition of Care Tool and any relevant supporting documentation to the plan the beneficiary is being referred to.
3. Continue to provide necessary mental health services and coordinate the transition of care or service referral with the receiving plan, including follow up to ensure services have been made available to the individual.

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How Do I Complete It?
Continued

Page 2 of the Transition of Care Tool is for demographic information.

Please note, checkbox agreeing with referral/transition of care.

State of California – Health and Human Services Agency | Department of Health Care Services

Transition of Care Tool for Medi-Cal Mental Health Services

REFERRING PLAN INFORMATION		
☐ County Mental Health Plan ☐ Managed Care Plan		
Submitting Plan:		
Plan Contact Name:	Title:	
Phone:	Email:	
Address:		
City:	State:	Zip:
BENEFICIARY INFORMATION		
Beneficiary's Name:		Date of Birth:
Beneficiary's Preferred Name:		
☐ Beneficiary or Legal Representative is 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:	State:	Zip:
Phone:	Email:	
Caregiver/Guardian:	Phone:	
Medi-Cal Number (CIN)/SSN:		

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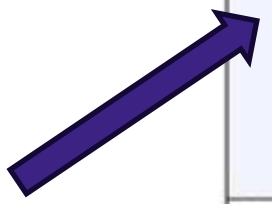
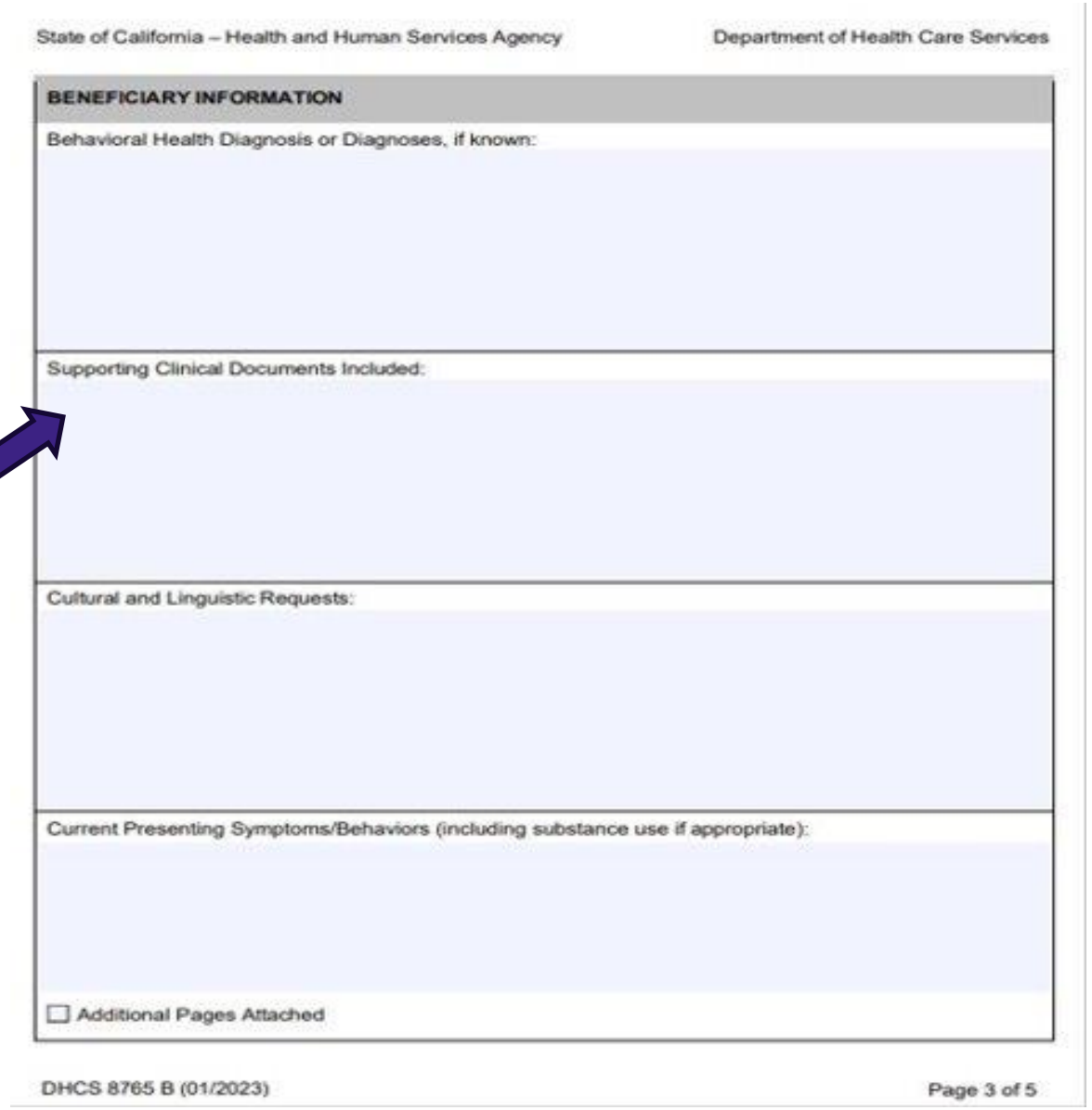
How Do I Complete It?
Continued

Page 3 of the Transition of Care Tool is for basic clinical information.

- Always include the following clinical documents and list them here:
  - Most recent assessment
  - Medication list if client is taking medications
  - Service history (client face sheet with history of services)
  - Statement regarding client's willingness to be referred to the Managed Care Plan. Page 2 of the Tool has a checkbox for this.





State of California – Health and Human Services Agency | Department of Health Care Services

BENEFICIARY INFORMATION

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

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How Do I Complete It?
Continued

Page 4 of the Transition of Care Tool is continued from page 3 and includes space for more clinical information.

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BENEFICIARY INFORMATION

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

☐ Additional Pages Attached

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

☐ Additional Pages Attached

Brief Medical History:

☐ Additional Pages Attached

Current Medications/Dosage:

☐ Additional Pages Attached

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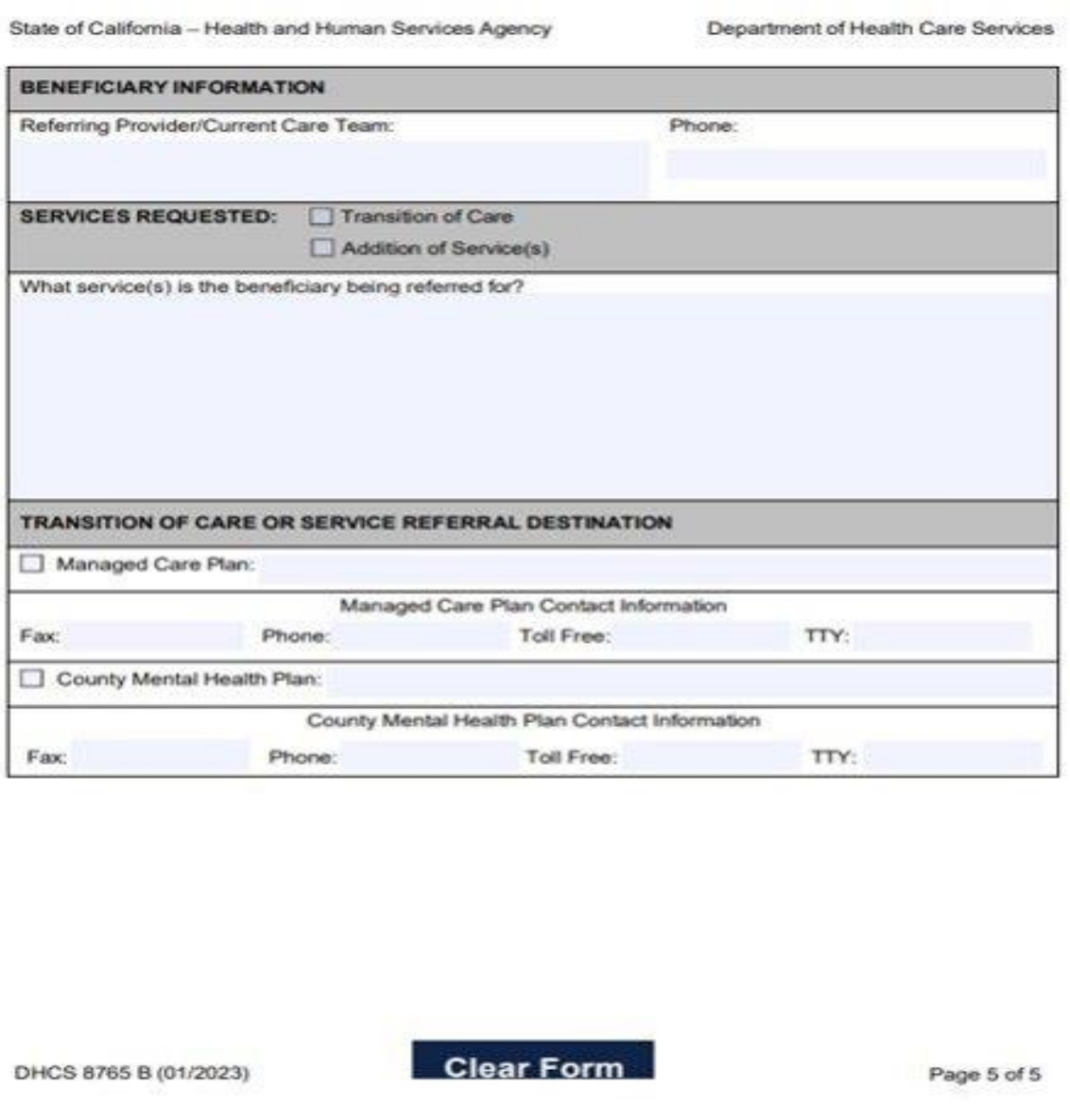
How Do I Complete It?
Continued

Page 5 of the Transition of Care Tool provides a space for the provider completing the form to put their name and phone number, to identify the specific services being requested, and to enter where the Transition of Care Tool is being sent to (either to the Managed Care Plan or the Mental Health Plan).

Link: Transition of Care Tool



State of California – Health and Human Services Agency Department of Health Care Services

BENEFICIARY INFORMATION

Referring Provider/Current Care Team: Phone:

SERVICES REQUESTED: ☐ Transition of Care ☐ Addition of Service(s)

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:

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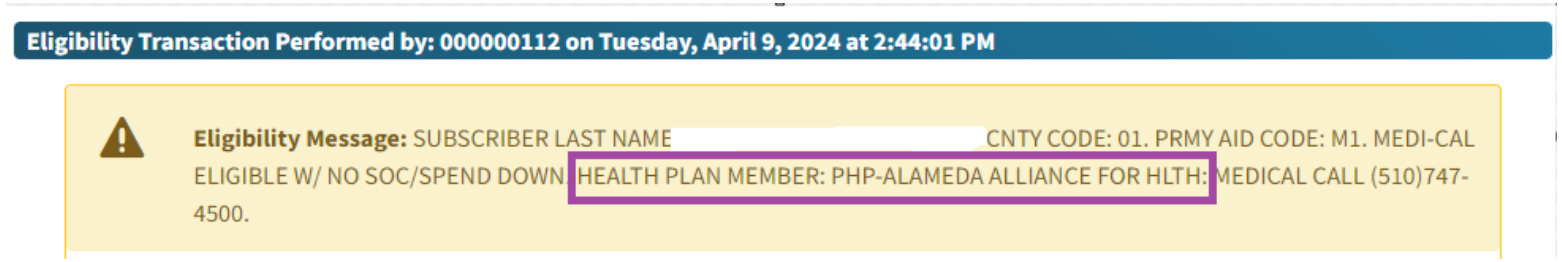
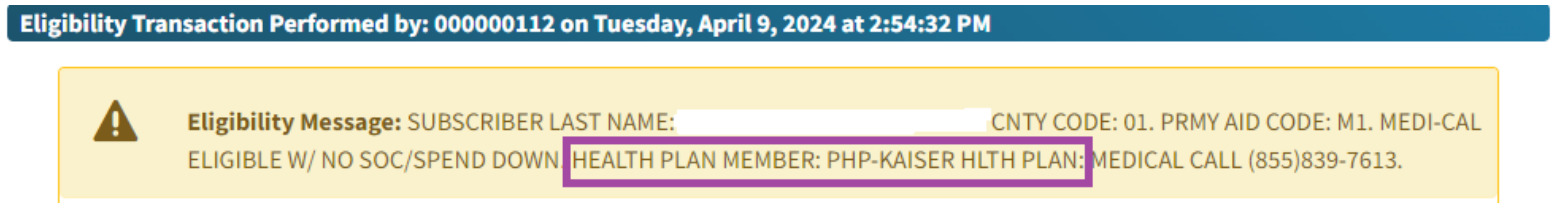
How do I Know Which Managed Care Plan My Client Has?

Eligibility response examples. Please ask admin/billing staff for a copy.

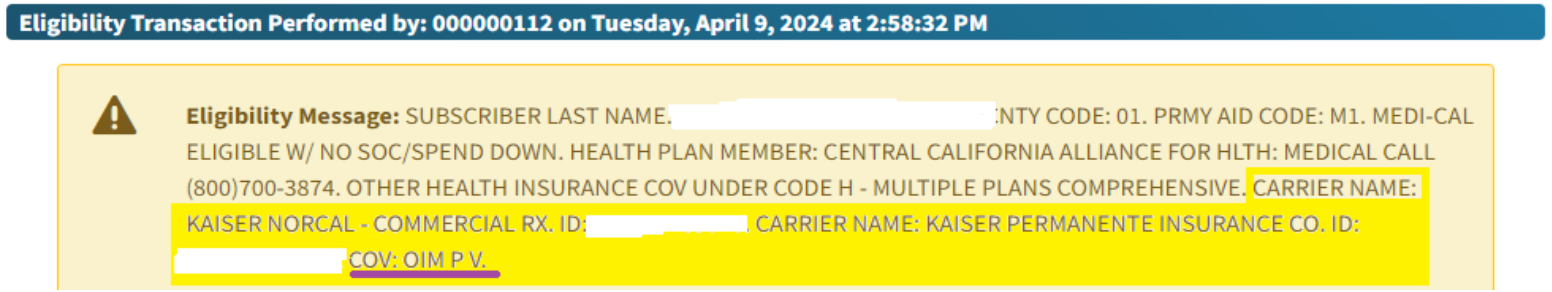
Alameda Alliance



Kaiser Managed Care



Kaiser HMO (private/commercial insurance)



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Who Do I Send It To & What Goes With It?

Current provider sends the Transition of Care Tool and supporting documentation to the client's Managed Care Plan

- For Alameda Alliance, send the Transition of Care Tool with accompanying documents via encrypted email to: deptbhmentalhealth@alamedaalliance.org
- For Kaiser MCP, send the Transition of Care Tool with accompanying documents via encrypted email to:
  - For North County: Kaiser Oakland: email to jenica.x.babbitt-pearce@kp.org
  - For all other parts of the County: Kaiser Fremont / Union City / San Leandro: email to radawn.l.alcorn@kp.org
- Accompanying documents to send with each Transition of Care Tool:
  - Most recent assessment
  - Medication list if client is taking medications
  - Service history (client face sheet)
  - Statement regarding client's willingness to be referred to the Managed Care Plan (note: checkbox on page 2).

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What Should I Expect After I Send It?

- Someone from the Managed Care Plan should reach out to the client within 10 business days of receiving the Transition of Care Tool.

- If your client does not receive a phone call within this timeframe, you may reach out to the Managed Care Plan to obtain an update on the status.
  - Alameda Alliance for Health: 1-855-856-0577
  - Kaiser Oakland: 510-752-1075
  - Kaiser San Leandro: 510-626-2800
  - Kaiser Union City: 510-675-3080
  - Kaiser Fremont: 510-248-5050

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Connecting with the Managed Care Plan

For Full Transitions to the Managed Care Plan:

- Continue to provide services to the client until you are confident that the client is securely connected to the provider from the Managed Care Plan.

For Adding a Service from the Managed Care Plan:

- Maintain ongoing communication with the provider from the Managed Care Plan to ensure services are coordinated and not duplicated.
- If you need support finding out who the specific provider is from the Managed Care, you may call the Managed Care Plan and ask.
  - Alameda Alliance for Health: 1-855-856-0577
  - Kaiser Oakland: 510-752-1075
  - Kaiser San Leandro: 510-626-2800
  - Kaiser Union City: 510-675-3080
  - Kaiser Fremont: 510-248-5050

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Warm Hand-Off During Transitions of Care

- Continue to support and serve the client until you can verify that they have successfully engaged with their new provider.
- Until methods are established for closed loop referrals, assist client with reaching out to the Managed Care Plan for follow-up as needed.
- "Adult and Older Adult SMH Consumer Care Transitions" policy:
  - https://bhcsproviders.acgov.org/providers/PP/100-2-6%20Adult%20Transition%20of%20Care.pdf

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What Happens When the Managed Care Plans Send a Transition of Care Tool to ACBHD?

- ACBHD ACCESS receives all Transitions of Care Tools from the Managed Care Plans.
- ACBHD ACCESS reviews the Transitions of Care Tools and makes a referral to an ACBHD provider when appropriate.
- You may receive a Transition of Care Tool along with the ACCESS referral. If this occurs, follow up as you normally would with the newly referred client.

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