Quality Assurance Bulletin

Quality Assurance Unit

County of Los Angeles – Department of Mental Health

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SCREENING AND TRANSITION OF CARE

This Bulletin provides guidance to all Los Angeles County Department of Mental Health (LACDMH) Providers regarding new screening and transition requirements based on Department of Health Care Services (DHCS) Behavioral Health Information Notice (BHIN) 22-065, which goes into effect January 1, 2023. As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, DHCS aims to ensure all Medi-Cal beneficiaries receive timely, coordinated services across Medi-Cal mental health delivery systems, including Managed Care Plan (MCP) Non Specialty Mental Health Services (Non-SMHS) and Mental Health Plan (MHP) Specialty Mental Health Services (SMHS). The goal is to ensure beneficiary access to the right care, in the right place at the right time.

Screening

(Refer to Appendix A for the Screening Workflow)

Purpose:
Beneficiaries shall be screened upon initial request for services to identify the mental health delivery system most appropriate for their level of need. The standardized screening process shall be used across all MCPs and MHPs to ensure an efficient and effective referral process based on initial indicators of a beneficiary's mental health needs. The process and tools are designed to guide the referral process to the Medi-Cal MCP for Non-SMHS or LACDMH for SMHS as well as assisting in managing the resources available in each delivery system.

Completion of screening is not considered an assessment. Upon completion of screening and referral to the appropriate mental health delivery system, the beneficiary shall receive an assessment from a provider to determine medically necessary mental health services.

For additional information on criteria to access SMHS and Non-SMHS refer to QA Bulletins 21-08 and 22-06.

When to Administer:
Screening shall be administered at first contact when a beneficiary or caregiver on behalf of a youth initially requests outpatient mental health services and is not currently receiving services anywhere within LACDMH. All requests by the beneficiary or caregiver originating at a call center (e.g., the DMH Help Line/ACCESS Center) are required to be screened. If the beneficiary/caregiver requests services directly from a provider (e.g. clinic), the provider is not required to administer the screening. However, pending further DHCS guidance, it is considered best practice for providers to administer the screening tool when clinically appropriate in order to get the beneficiary to the most appropriate level of care (Non-SMHS or SMHS) from the outset.

At all times, it is important to remember that all beneficiaries have a right to receive an assessment for SMHS and any medically necessary services during the assessment period. If the beneficiary/caregiver does not wish to complete the screening or it is determined to not be clinically appropriate to conduct the screening (e.g., beneficiary is very agitated), they shall be referred for a mental health assessment for SMHS and/or other clinically needed services. If upon completion of an assessment, the beneficiary does not meet criteria to access SMHS, they shall be issued an NOABD and transitioned to their MCP for Non-SMHS (refer to Transition of Care below).

Please note that screening does not replace current procedures for handling urgent or crisis/emergency care needs.

What to Administer:
The DHCS standardized screening tools, used by both the MCPs and the MHPs, shall be used for the screening in addition to documenting within the Service Request Log (SRL) or Service Request Tracking System (SRTS)

in accord with DMH Policy 302.14. The standardized screening tools include screening questions and an associated scoring methodology. The screening questions must be read verbatim to the beneficiary/caregiver and the order of the questions shall not be altered in any way. Until translated versions of the tool are made available, bi-lingual staff may translate the screening questions themselves which may require deviation from the specific wording of the tool.

The Adult Screener shall be used for beneficiaries twenty-one (21) years of age and older and includes screening questions to elicit information about safety, clinical experiences, life circumstances and risk. The Youth Screener shall be used for beneficiaries under the age of 21 and is available in a Youth version and a Caregiver version. When a youth is requesting services for themselves, the Youth version shall be used. When a caregiver is requesting services on behalf of a youth, the Caregiver version shall be used. Both youth versions include questions to elicit information about safety, system involvement, life circumstances, and risk. The Youth Screener includes initial questions that automatically qualify an individual for SMHS (e.g., foster care involvement) which prevents the need to complete additional screening questions. While the additional screening questions are not required, best practice is to continue with the entire screener when clinically appropriate to provide valuable clinical information to the assessing provider.

If a third party (other than a caregiver) is requesting services for a beneficiary, the screening tools are not required. If clinically appropriate, the screening tools shall then be administered upon contacting the beneficiary/caregiver prior to entering a disposition in the SRL/SRTS.

Who can Administer:
The Screeners can be administered by any staff including clinicians or non-clinicians. They may be administered in a variety of ways, including in person, by telephone, or by video conference.

Actions After Administering:
Based on their screening score, the beneficiary shall be referred to the appropriate mental health delivery system (either Non-SMHS through their MCP or SMHS through LACDMH) for a clinical assessment following the workflow in Appendix A. If a beneficiary is referred to an LACDMH provider, providers must offer and provide a timely clinical assessment. Providers may not conduct additional screening. If a beneficiary is referred to the MCP, the workflow in Appendix A shall be followed including sending the completed screener to the MCP via fax or email.

Please note that while DHCS requires beneficiaries to be referred based on their screening score, beneficiary safety shall continue to be priority and staff shall continue to ensure beneficiaries are referred for the appropriate services to meet their clinical needs.

If the beneficiary/caregiver responds affirmatively to the substance use screening questions, the Department of Public Health Substance Abuse Service Helpline (SASH) number shall be offered. If a beneficiary under the age of 21 or their caregiver indicates there is a gap in connection to primary care, referral to their MCP shall be offered.

Transition of Care

(Refer to Appendix B for the Transition Workflow)

Purpose:

When the beneficiary's condition changes, transition of care is needed to smoothly transition the beneficiary to the most appropriate mental health delivery system (Non-SMHS through MCP or SMHS through LACDMH) to meet their needs. In order to facilitate a smooth transition, providers shall provide clinical information to the new system and continue seeing the beneficiary until they are connected.

When to Complete:
Beneficiaries shall be transitioned to Non-SMHS through their MCP when the beneficiary no longer meets criteria to access SMHS and is in need of a lower level of care. Refer to QA Bulletin 21-08 for criteria to access

SMHS. For additional assistance in identifying when a beneficiary may be ready for transition, the questions and scoring from the screening tools may be utilized.

Please note there may be situations in which it is clinically appropriate to transition only a subset of the beneficiaries services to the MCP or vice versa. Refer to QA Bulletin 22-06 for additional information on concurrent Non-SMHS and SMHS.

What to Complete:
The DHCS Transition of Care form, used by both the MHPs and the MCPs, shall be used to initiate a transition to the MCP and provide clinical information to the receiving provider. The Transition of Care form includes specific fields to document the:

- Referring plan contact information and care team;
- Beneficiary demographics and contact information;
- Beneficiary behavioral health diagnosis, cultural and linguistic requests, presenting behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications; and
- Services requested and receiving plan contact information.

Referring providers may provide additional documentation, such as medical history reviews, care plans, and medication lists, as attachments to the Transition of Care form.

Who can Administer:
The Transition of Care form may be completed by any staff; however, the determination to transition the beneficiary must be made by any Medi-Cal practitioner through a patient-centered shared decision-making process.

Actions After Administering:
After the Transition of Care form is completed, the workflow in Appendix B shall be followed including sending the completed Transition of Care form to the MCP via fax or email. Providers shall ensure that the referral process has been completed and the beneficiary has been connected with a MCP provider. Providers shall continue providing medically necessary services until the new MCP provider has accepted the care of the beneficiary and services have been made available.

All providers shall demonstrate a good-faith effort to implement the new screening and transition processes beginning in January 2023. DMH will continue to meet with the MCPs on a regular basis in an effort to continue working to streamline the screening and transition process and address any concerns that arise.

DMH policy 302.14 will be updated to account for the new screening requirements outlined in this Bulletin. The SRL (in IBHIS) and SRTS will be updated to incorporate the new screening tools in the coming months and the Transition of Care form will be added to IBHIS. In addition, short training videos on the screening and transition process outlined in this Bulletin will be available on the QA Unit's website under Training.

If directly-operated or contracted providers have any questions related to this Bulletin, please contact the QA Unit at AccesstoCare@dmh.lacounty.gov.

cc: DMH Executive Management
DMH Administration Managers
DMH QA Liaisons
Legal Entity Executive Management
DMH Clinical Operations Managers
DMH Quality, Outcomes & Training Division
DMH CIOB Managers
Legal Entity QA contacts

County of Los Angeles – Department of Mental Health
Quality, Outcomes and Training Division – Quality Assurance Unit
Screening Protocol

For Requests Originating with DMH:

DMH Staff workflow:

1. Receive a request for outpatient mental health services made by the beneficiary or a caregiver acting on behalf of a youth (under age 21)
2. Run Medi-Cal Eligibility Check on the Medi-Cal website to identify their Managed Care Plan (MCP)
    a. If DMH staff do not have access to the Medi-Cal website, or a client does not have an MCP or cannot provide enough information to run the check, then do not complete the screener. Proceed to normal mental health referral/scheduling process within DMH.
3. Introduce the screener (suggested language below) and complete the appropriate Screener based on the age of the beneficiary. The Screener is embedded within the SRTS and SRL (IBHIS).

    "The Medi-Cal mental health system has two different levels of care which are served by different providers. In order to get you (or your child) to the appropriate level of care for your mental health treatment, may I ask you some screening questions?"

4. If the beneficiary screens for Specialty Mental Health Services (SMHS) through LACDMH (higher level of care) (**Screener total score = 6 or more**), say:

    "Based on your responses, it looks like you (or your child) would be best served with us, the Department of Mental Health for specialty mental health services. Let me refer/schedule you for an assessment with a mental health clinician."

    a. Proceed with your normal referral/scheduling process for an appointment with a DMH provider
5. If the beneficiary screens for Non Specialty Mental Health Services (NSMHS) through the Managed Care Plan (lower level of care) (**Screener total score = 0 – 5**), say:

    "Based on your responses, it looks like you (or your child) would be better served by your Managed Care Plan [insert MCP name] for non specialty mental health services. I can either transfer you over to them to schedule a clinical assessment or you can hang up and I will send the referral to [MCP name] and they will contact you directly."

    a. If the beneficiary/caregiver prefers to hang up, then proceed to #5d
    b. If the beneficiary/caregiver prefers that you transfer the call to the MCP (e.g., warm transfer), then:
        i. Call the respective MCP (refer to Contact List)
        ii. Let the MCP agent know that a member is on the line by saying:

        "This is [name] from DMH. I have one of your members on the line. I've completed the Screener and they meet your level of care for mental health services and need an assessment appointment. May I put them through?"

    c. DMH staff may hang up once the MCP staff takes the call
    d. Export screener to a PDF report. Save the completed PDF Screener as file name: *[Youth or Adult] Screener [insert client's initials]*

Screening Protocol

   e. Fax or Email the completed screener to the MCP
      i. Subject Line*: [Youth or Adult] Screener [insert client's initials]*

MCP Staff Workflow:

1. The MCP will provide the beneficiary/caregiver with information for MCP providers accepting appointments for the beneficiary/caregiver to contact for an assessment appointment.
   a. If appointment assistance is needed,

For Requests Originating with the MCP:

Managed Care Plan Staff Workflow:

1. Receive a request for outpatient mental health services made by their member or a caregiver acting on behalf of a youth (under age 21)
2. Introduce and Complete the PDF Screener
3. If the member screens for Specialty Mental Health Services (SMHS) through LACDMH (higher level of care) (**Screener total score = 6 or more**) refer to LACDMH by emailing the completed screener to DMH-Referrals@dmh.lacounty.gov

DMH Staff Workflow:

1. DMH Help Line (ACCESS) appointment line agents will identify a DMH LE or DO provider accepting clients and submit an SRTS referral and attach the completed screener to the corresponding SRTS referral
2. Appointment line agents will send a confirmation email, which includes the DMH provider name and phone number to the requester
3. LE or DO provider will follow up with the client to schedule an appointment as soon as possible and in no case more than three (3) business days from the date of request

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Transition of Care Protocol

For Transitions Originating with DMH LE or DO Providers

DMH LE or DO Staff Workflow:

1. When it is determined through a client-centered shared decision-making process, that an existing client is ready to transition to a lower level of care, let the client know to expect a call from their Managed Care Plan (MCP).
2. Complete the Transition of Care Form & email/fax it, along with any relevant clinical documentation, to the client's MCP (refer to Contact List)

Once the Transition Form is received, MCP staff will:

1. Contact the client and provide referrals or appointment assistance (if client requested)
2. Notify the DMH LE or DO staff submitting the Transition Form of the scheduled appointment within 10 business days after the date of referral

Once the appointment has been scheduled, DMH LE or DO staff will:

1. Call the client to confirm they have been connected with an MCP provider and services have been offered.
2. 'Discharge' the client upon confirming the above.

If an appointment was not scheduled**:**

1. If DMH LE or DO staff did not receive notification from the MCP of client's scheduled appointment, DMH LE or DO staff will follow up with client to learn if the MCP has contacted the client
2. If client has not had contact with the MCP and/or has any issues getting an appointment, DMH LE or DO staff may either:
    i. Direct the client to call the MCP directly to obtain referrals or appointment assistance
    ii. Call the MCP with the client to obtain referrals or appointment assistance
3. If DMH LE or DO staff are unable to obtain or confirm appointment from MCP after several attempts, email AccesstoCare@dmh.lacounty.gov to request assistance and provide the following information in the email:
    a. Completed Transition Form
    b. Date it was emailed to the MCP
    c. Name & phone number of the MCP staff that DMH staff spoke with/left voicemail
    d. Date contact was attempted or made
    e. Outcome of the outreach to MCP

Transition of Care Protocol

For Transitions Originating with MCP:

MCP Staff Workflow:

1. When it is determined that the client is ready to transition to a higher level of care, complete the Transition of Care Form. Let the client know to expect a call from a DMH provider
2. Email the completed Transition of Care Form, and any relevant clinical documentation to DMH-Referrals@dmh.lacounty.gov
   a. Subject Line: *Youth or Adult Transition w/client's initials*

DMH Staff Workflow:

1. DMH Help Line (ACCESS) appointment line agents will identify a DMH LE or DO provider accepting clients and submit a referral using SRTS and attach the completed transition of care form to the corresponding SRTS referral
2. The DMH LE or DO provider receiving the SRTS referral will notify the MCP provider who submitted the Transition of Care Form of the client's scheduled appointment (ideally, the same day that they confirmed the appointment with the client but no more than 5 business days)

MCP Staff Workflow:

1. MCP provider to call the client to confirm they have been connected with a DMH provider and services have been offered
2. MCP provider may 'discharge' the client once confirmed that the client has been connected to a DMH provider and services have been offered