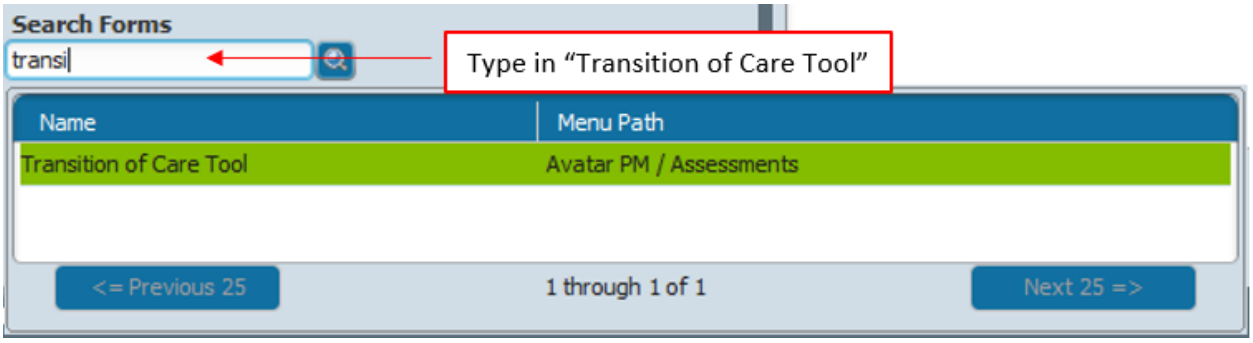
Transition of Care Tool

The purpose of this desk reference is to provide guidance in how to complete the Transition of Care Tool.

Menu Path

Avatar PM > Assessments or you can enter "Transition of Care Tool" under Search Forms



Details

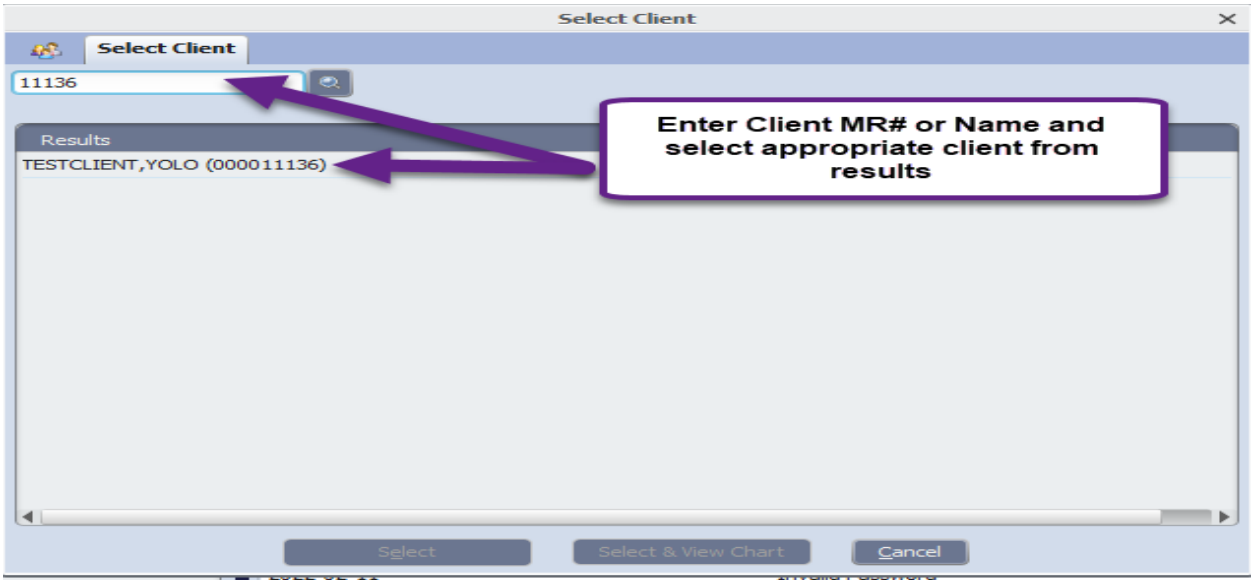
- The Transition of Care Tool is a Netsmart and Yolo County Health and Human Services Agency (YCHHSA) version of the DHCS form created as part of CalAIM. It is intended to ensure that beneficiaries who are receiving mental health services from one delivery system receive timely and coordinated care when either: 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 consistent with the No Wrong Door policies regarding concurrent treatment. The Transition of Care Tool documents beneficiary needs for a transition of care referral or a service referral to Partnership Health Plan or YCHHSA.

- This form is driven by the "Transition of Care Date." A new entry should be completed when a referral for a transition of care to, or addition of services from, Partnership Health Plan or YCHHSA is imminent.
- All fields highlighted "Red" are required; the form cannot be submitted until completed.

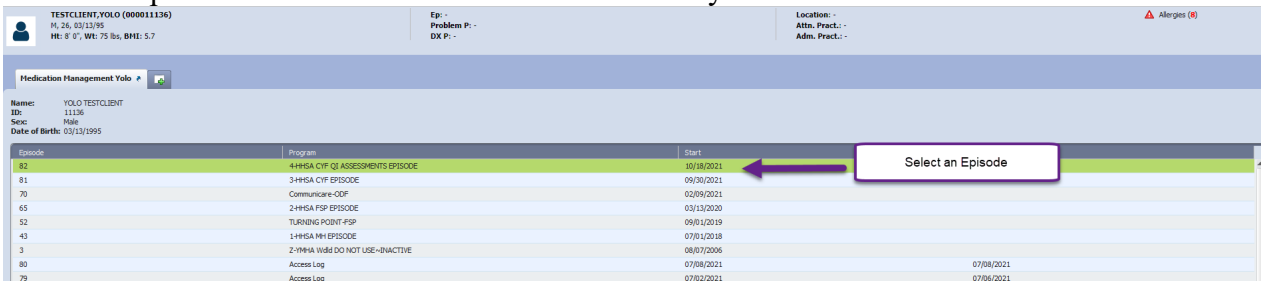
Steps

➢ Open the Transition of Care Tool form

➢ Select the client

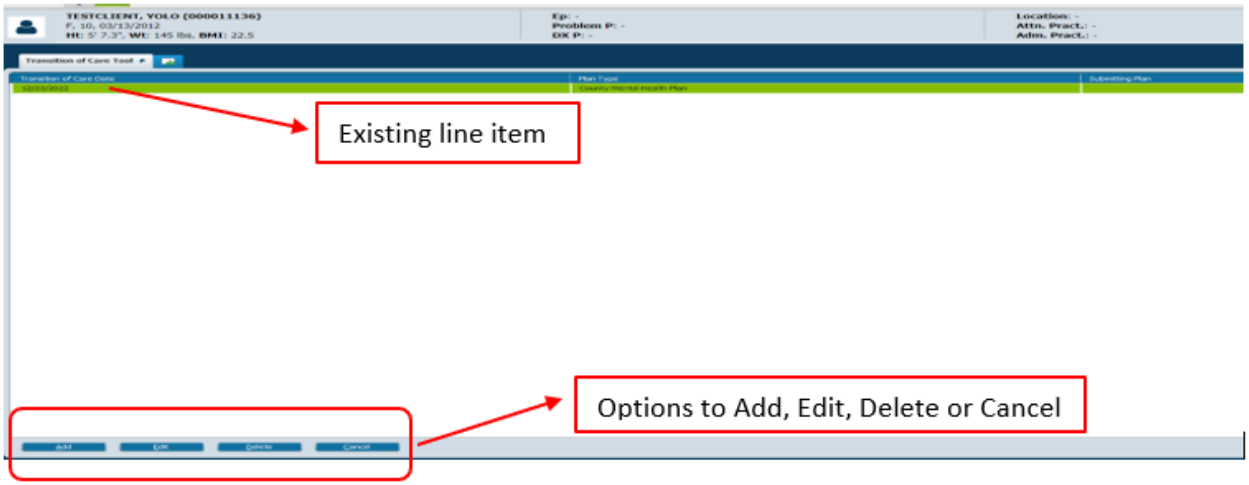


➢ Select the episode and double click or select the OK key

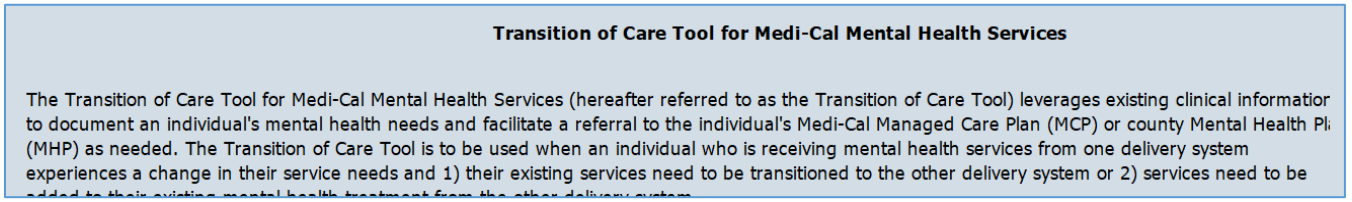


➢ If the client has never had a Transition of Care form recorded, the form will open automatically. If the client has had previous Transition of Care Tool forms completed, various actions options are available at the bottom left of the screen (Add, Edit, Delete, or

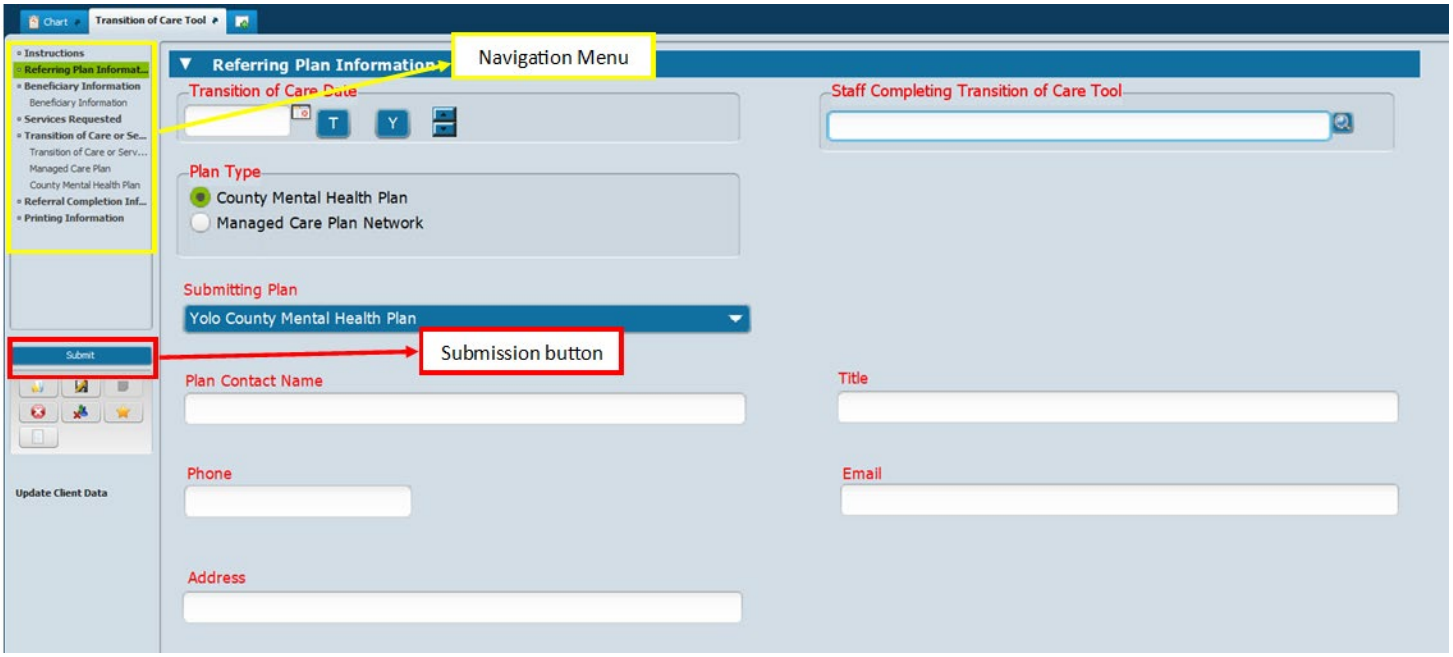
Cancel). <u>You should never delete a completed tool.</u> Use Add to add a new tool, Edit to correct an error on completed tool, or Cancel to return to the previous screen.



- The initial screen lists the instructions for the tool (see example screenshot, below). Each user is required to **<u>read the full instructions carefully</u>** prior to using the tool, to assure fidelity of usage.



There are five Tabs in the Navigation Menu that will be completed: Referring Plan Information, Beneficiary Information, Services Requested, Transition of Care or Service Referral Destination, and Referral Completion Information.

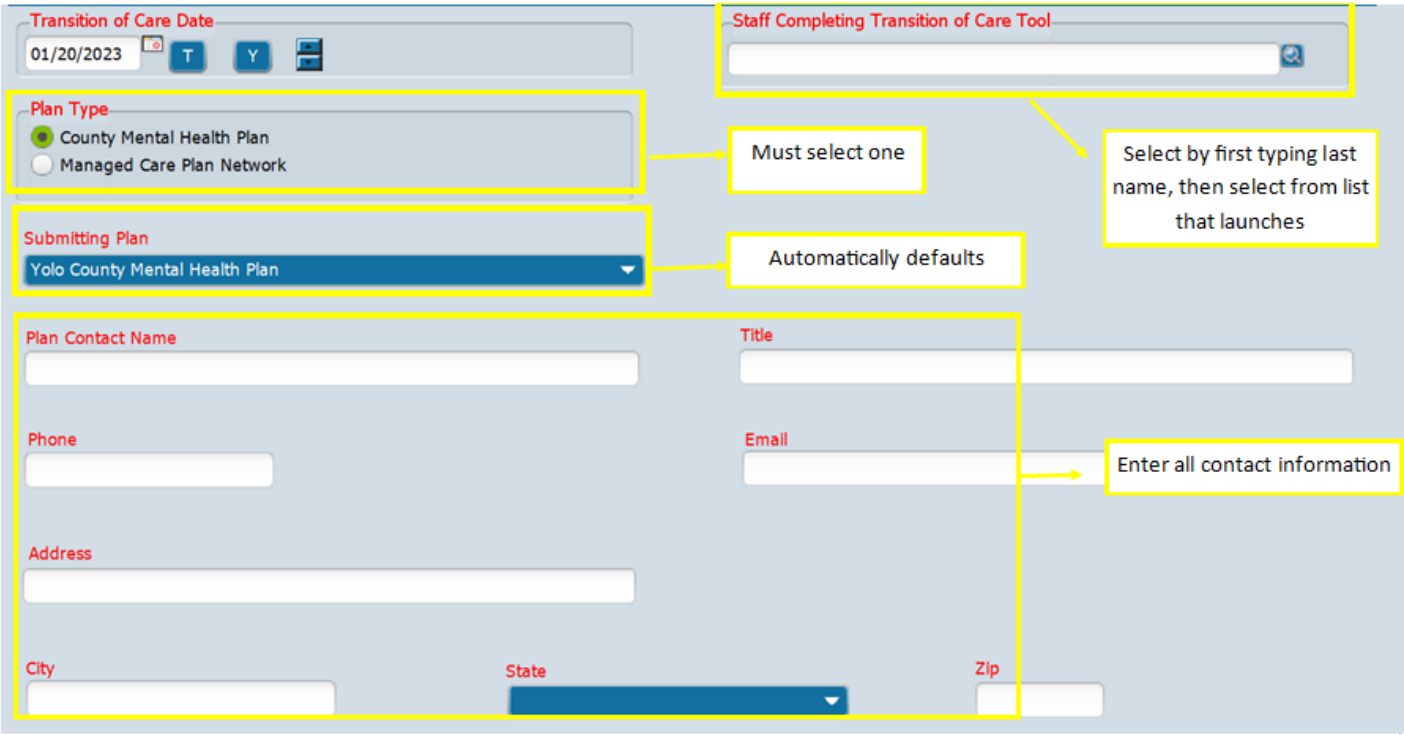


- **Referring Plan Information Tab**: "Referring Plan" is the plan completing the tool. For YCHHSA staff and contracted providers, the "Plan Type" will be "County Mental Health Plan." All fields are mandatory. Enter the date, and leave the Plan Type as "County Mental Health Plan."

  Populate the "Staff Completing Transition of Care Tool" field by typing the last name of the provider and selecting the appropriate option. Please note: This field will not show on the printed report as it is for internal tracking purposes only.

  Leave the default option in the "Submitting Plan" dropdown field (which is "Yolo County Mental Health Plan").

  In the "Plan Contact Name" and "Title" fields, type the staff name and title, and enter staff contact information in the fields provided.

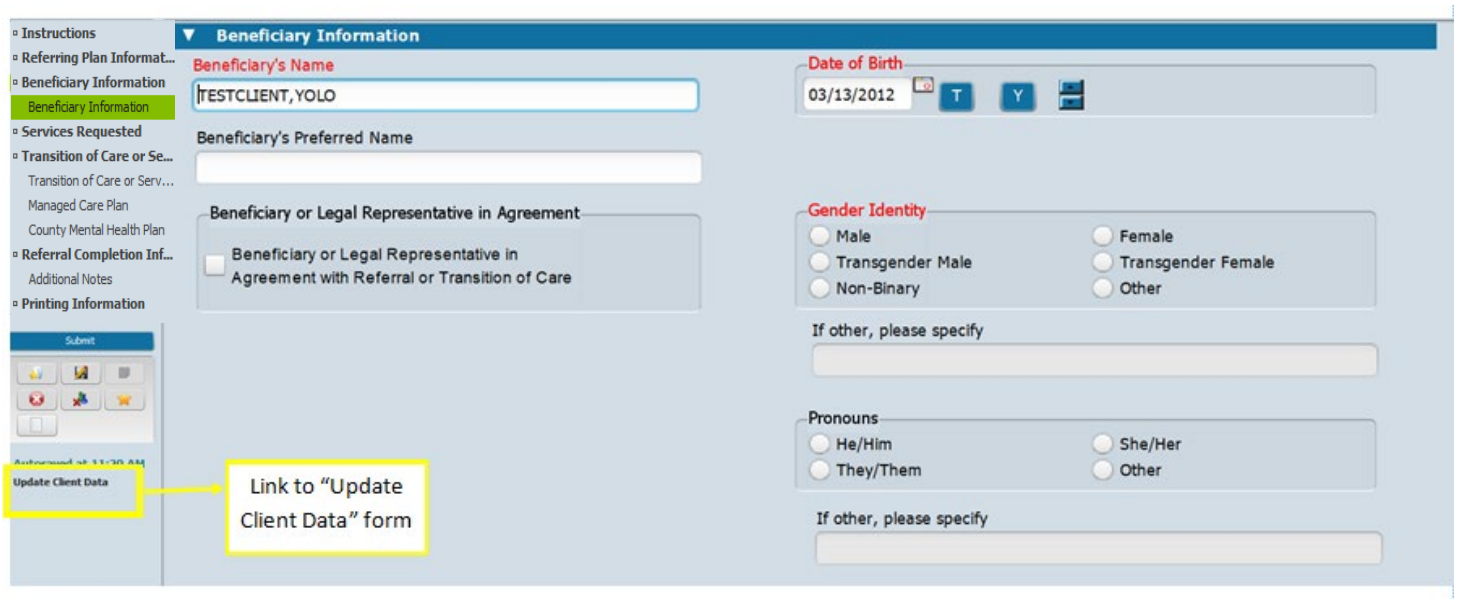


- **Beneficiary Information Tab**: Various demographic information fields autofill by pulling from the client's "Update Client Data" form. If the auto filled information is incorrect, the form allows the user to delete the field's content and enter something else.

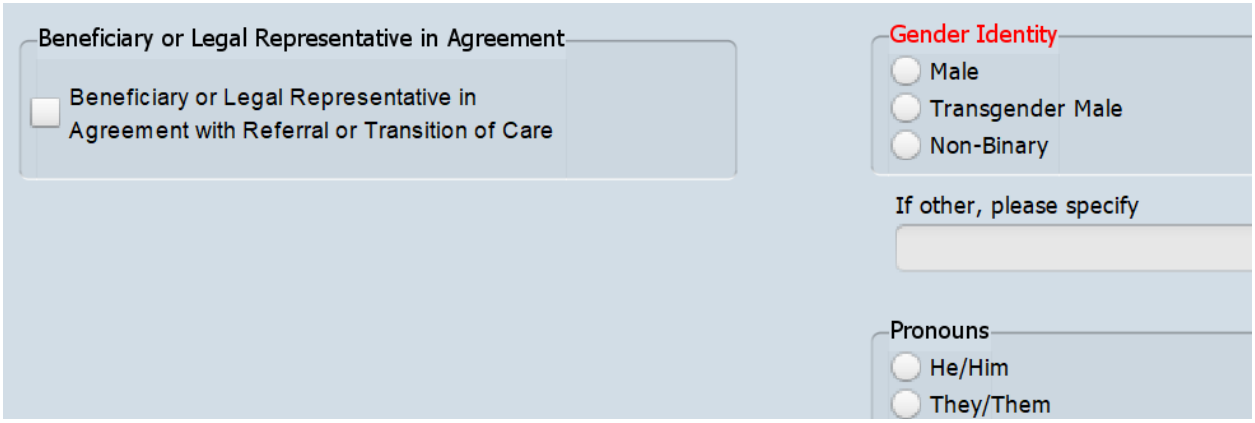
  Please note that there is a link to the Update Client Data form within the Transition Tool if the user would like to update any information needed at that moment. If Update Client Data is clicked, that form will open in a separate window. If the user makes changes to the Update Client Data form and submits it, the Transition of Care Tool form will not show the changes made in auto filled fields unless the user closes the Transition of Care Tool form without submitting then opens a new one. Once a Transition of Care Tool is

submitted, any changes to the Update Client Data form will not reflect in that previously submitted Transition of Care Tool form.

Fields that autofill are: Beneficiary's Name, Date of Birth, Address, Phone (pulls from 'Client's Message Phone' field of Update Client Data form) and Email.



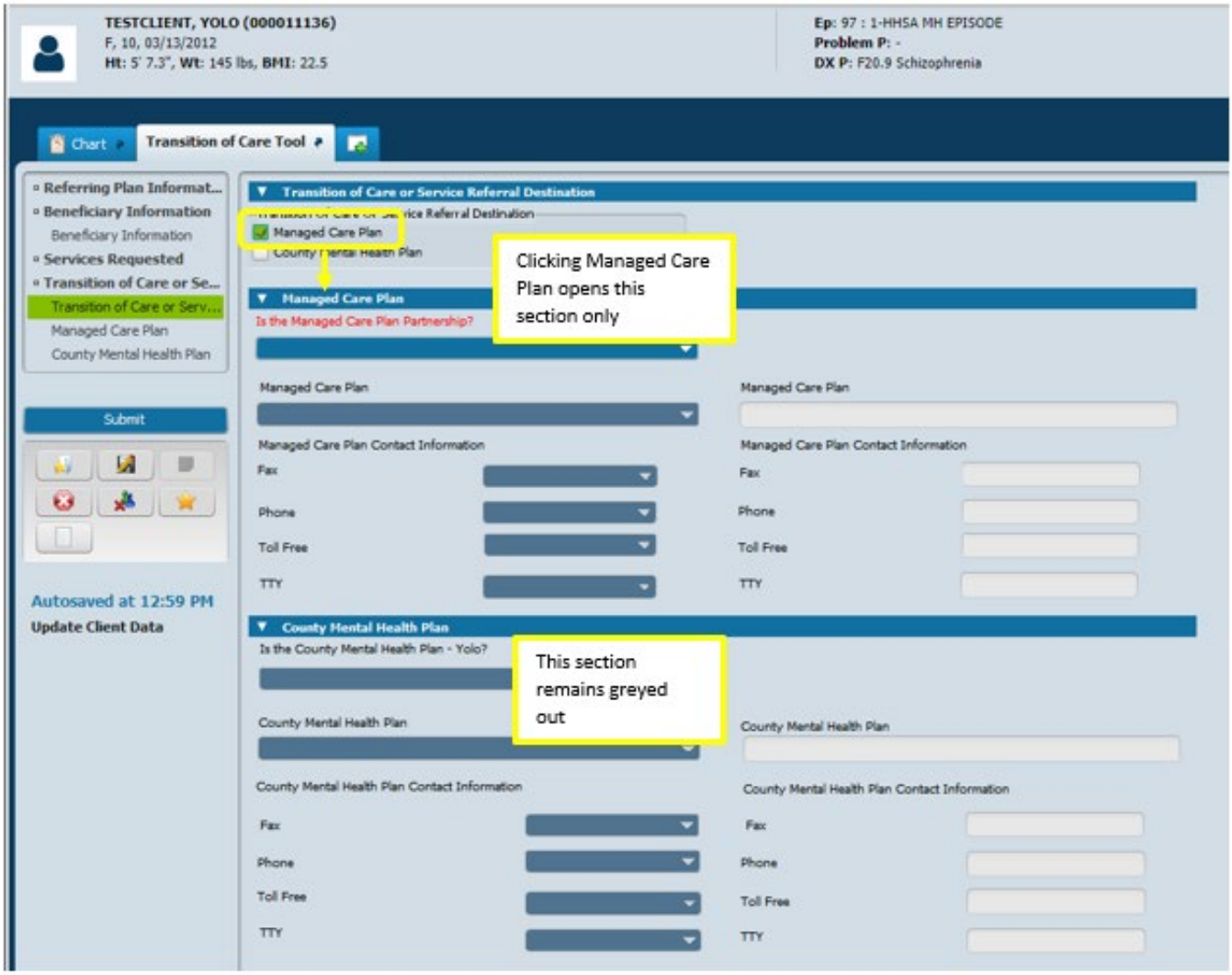
Beneficiary or Legal Representative in Agreement field. Select the checkbox if the beneficiary or legal representative are in agreement with the transition. Consult with supervisor if, for some reason, the beneficiary or legal representative are not in agreement.

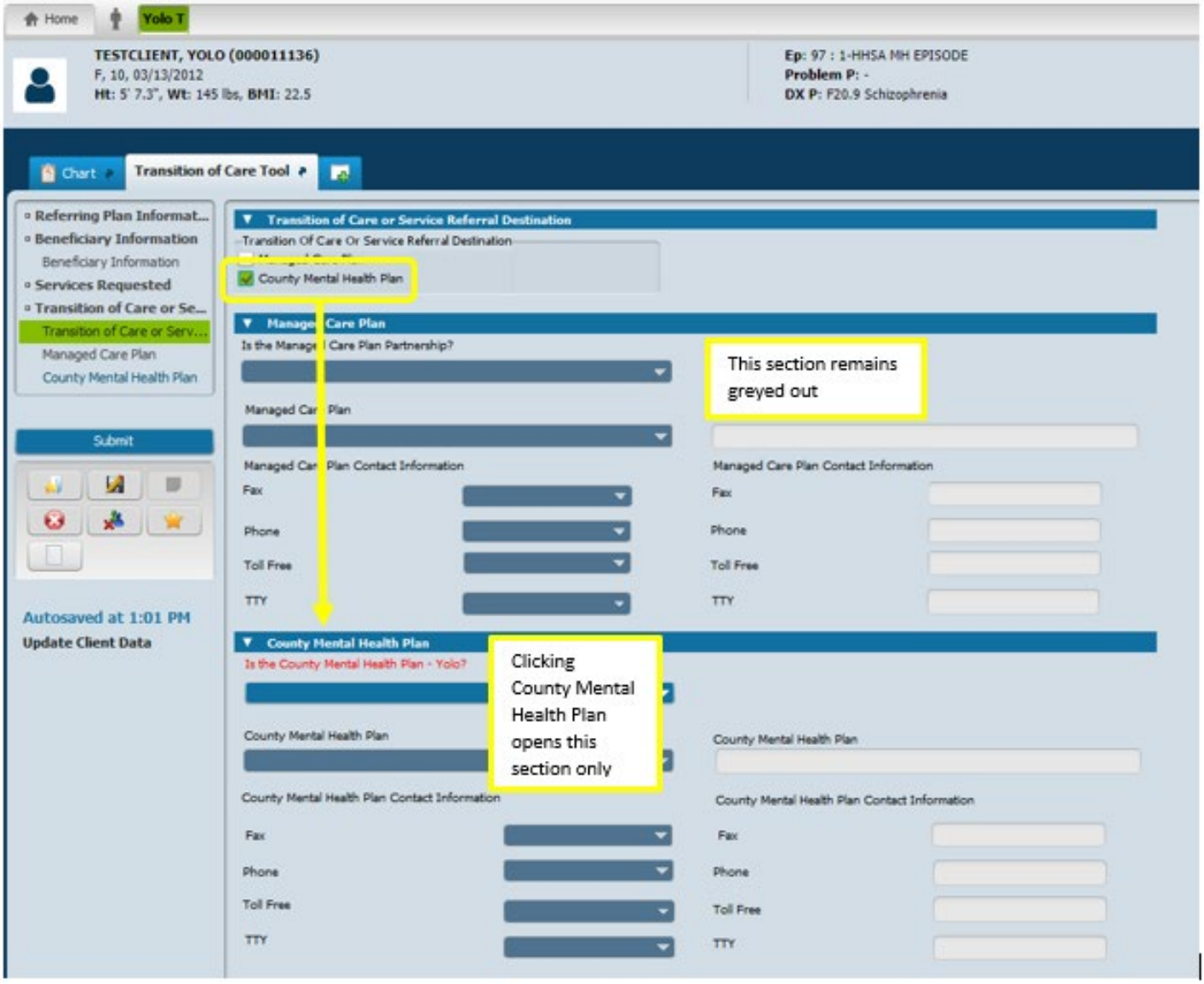


The Medi-Cal# (CIN)/SSN field (not pictured here, but found immediately after the client's address and caregiver/guardian information) is required and does not autofill. Enter either the social security or Medi-Cal number in this field. The client's social security number is generally found in the Update Client Data form, the client's Medi-Cal# (CIN) is generally found the Financial Eligibility form.

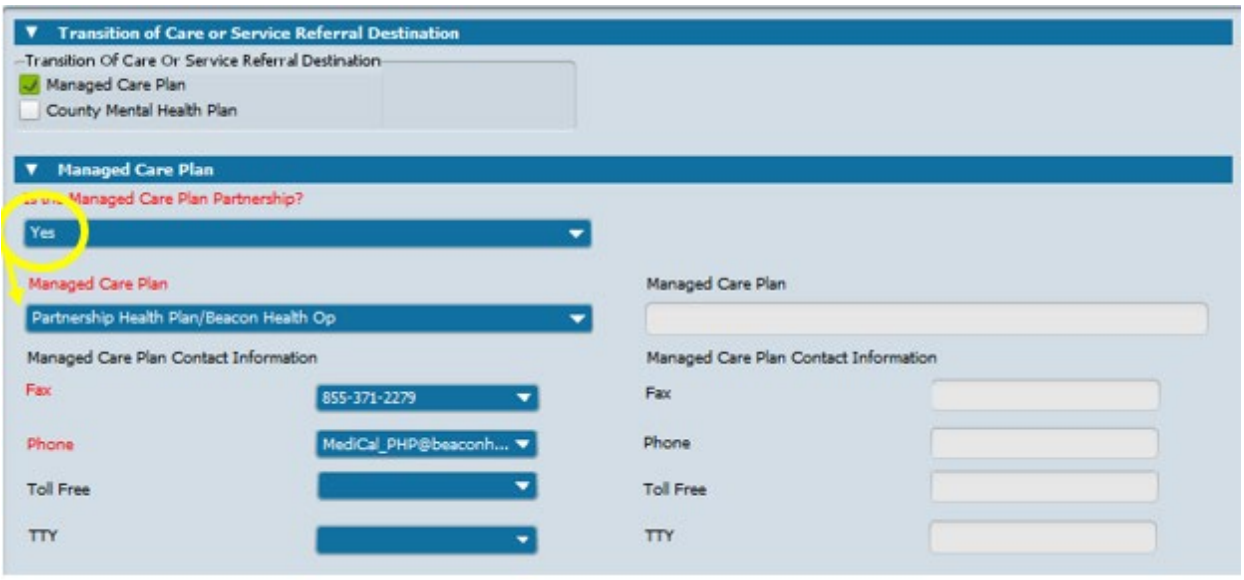
- **Services Requested Tab**: Select "Transition of Care" or "Addition of Service(s)" check box. Proceed to mandatory field "What service(s) is the beneficiary being referred for?" and enter description.

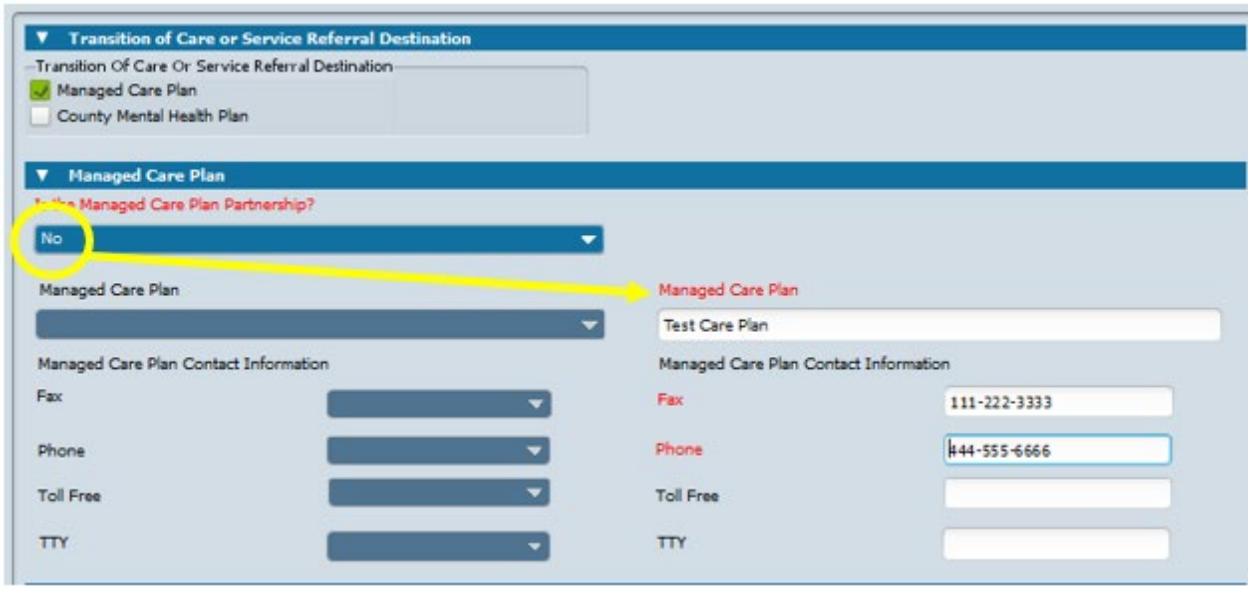
- **Transition of Care or Service Referral Destination Tab**: Select one of the check boxes, Managed Care Plan or County Mental Health Plan. Depending on which is chosen, one of the sections below will open.





- If Managed Care Plan check box is chosen, user will need to answer the "Is the Managed Care Plan Partnership?" drop down with a Yes or a No. A Yes answer opens the section below it where user can drop down the prepopulated Managed Care Plan Name, Fax and Phone. A No answer opens the below right section where user can type in Managed Care Plan name, Fax and Phone numbers.



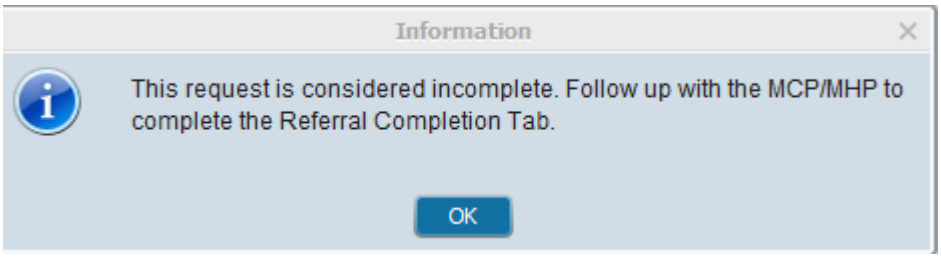


- If County Mental Health Plan – Yolo check box is chosen, user will need to answer the "Is the County Mental Health Plan – Yolo?" drop down with a Yes or a No. A Yes answer opens the section below it where user can drop down the prepopulated County Mental

Health Plan name, Fax and Phone fields. A No answer opens the below right section where user can type in the County Mental Health Plan name, Fax and Phone numbers.

- Regardless of whether the referral destination is an MCP or County MHP, user will need to answer, "Has the referral been received by the new agency/provider?" by selecting yes or no.

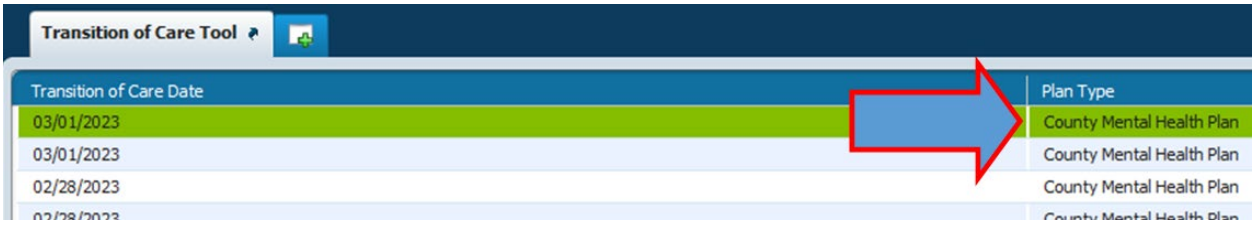
- A No answer will result in a pop-up reminder that the request is considered incomplete and follow up with the MCP/MHP is required. Select "OK" then "Submit" to close the form. A copy of the tool will open in PDF. Close this window.



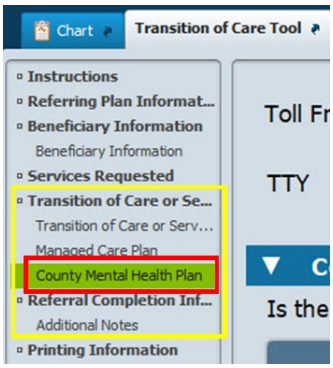
- A Yes answer will result in a pop-up message to complete the Referral Completion Tab. Please see the **Referral Completion Information Tab** section below for next steps.

- Once the referral process is completed, the user will need to return to the Transition of Care Tool form. If this is done as described at the beginning of this desk reference, a list of Episodes will display. Be sure to select the correct Episode and double click on that Episode to launch the Transition of Care tools that are associated with the Episode.

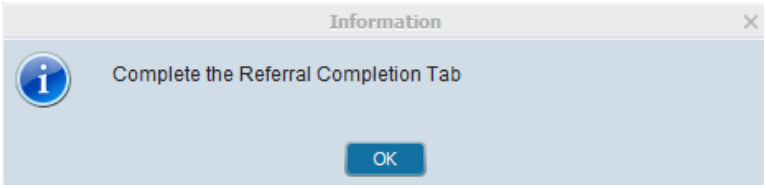
- A list of completed (or nearly completed) Transition of Care tools launches. Make sure to select the one you'd previously been working on and double click it to launch the tool.



- On the left side of the tool, select “County Mental Health Plan” under the Transition of Care or Services heading.

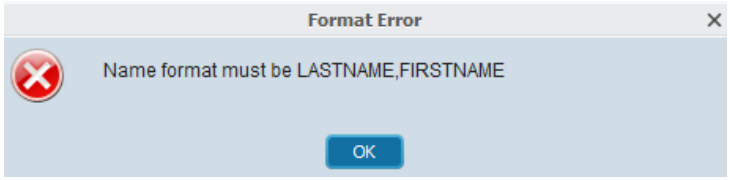


- Change the response in the “Has the referral process been completed with the new provider?” field from No to Yes. A pop-up message to complete the Referral Completion Tab launches. Select OK.

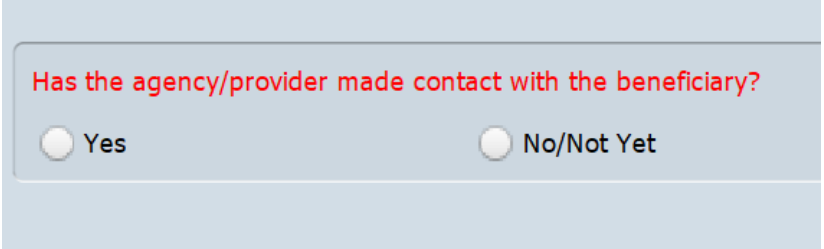


- **Referral Completion Information Tab**: Users will complete this tab once a referral has been completed for the beneficiary. This tab will not show up on the transition of care tool report but is used to track regulatory requirements to ensure that the referral process has been completed, the beneficiary has been connected with a provider in the new system, the new provider accepts the care of the beneficiary and medically necessary services have been made available to the new beneficiary.

  Enter the date of contact with the MCP/MHP, as well as the MHP/MCP contact name, and the staff making the referral. Note: Contact Name and Name of Staff Completing Referral Verification must be entered in “Last Name, First Name” format to avoid receiving an error message. Should the error message be received, simply select “OK” and return to the field to enter the names in the appropriate format.

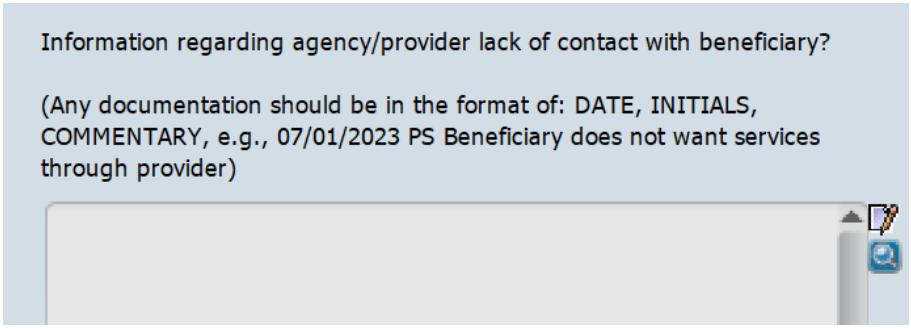


After following up with the referred agency/provider to close the loop on the referral, the user must answer the following question by selecting Yes or No/Not Yet:

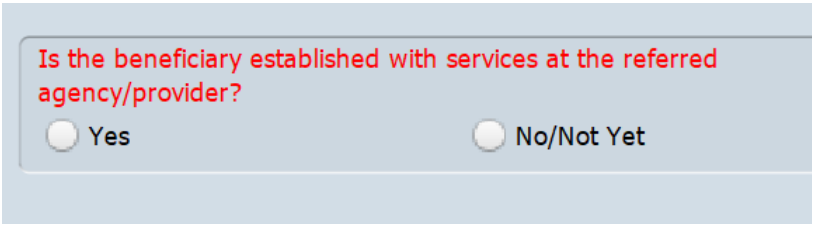


If **No/Not Yet** is selected, the "Information regarding agency/provider lack of contact with beneficiary" becomes enabled. Continue to follow-up until the referred agency/provider has made contact and document each follow-up according to the instructions provided.

Once the referred agency/provider has made contact with the beneficiary, change the response to the previous question to **Yes.** Any content previously entered in the field below should not be deleted**.**



If **Yes** is selected, move to the next question:

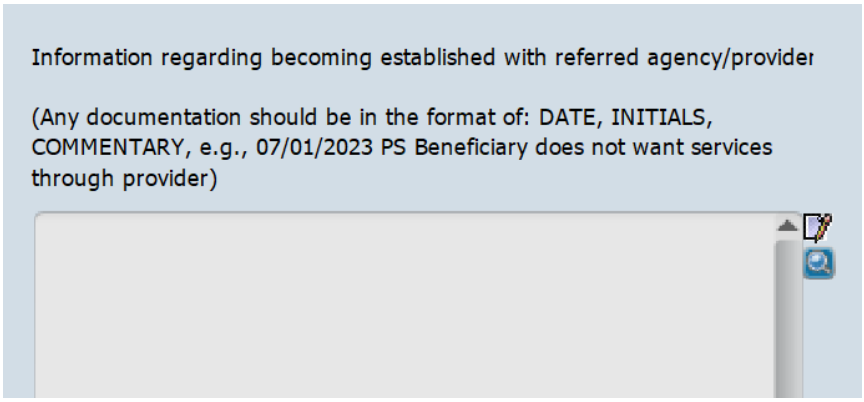


"Established with services" is defined by the referred agency provider (i.e., they may provide a date of intake appointment or simply acknowledge that the beneficiary is established with them).

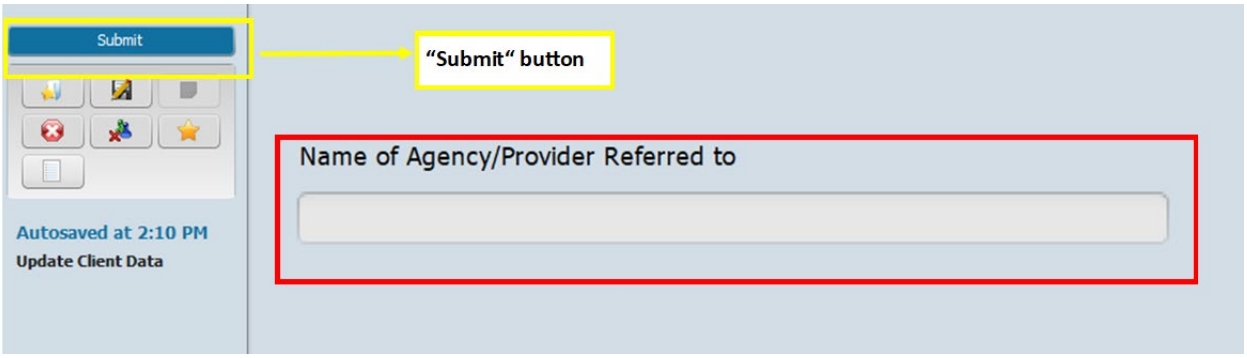
If **No/Not Yet** is selected, the "Information regarding becoming established with referred agency/provider" field becomes enabled. Continue to follow-up until the

referred agency/provider has established services with the beneficiary and document each follow-up according to the instructions provided.

Once services have been established at the referred agency/provider, change the response to the previous question to **Yes.** Any content previously entered in the field below should not be deleted.



If **Yes** is selected, enter the name of the Agency/Provider beneficiary was referred to. Once entered, click "Submit" – this will launch a PDF version of the tool that can be printed and faxed as needed.



- Should you need to reprint the tool at a future date, you can return to it by finding the tool in the Episode in which it was placed, and selecting the "Printing Information" tab in the Navigation Menu. From here, select the "Reprint Transition of Care Tool" button.