COUNTY OF SANTA CLARA
Behavioral Health Services

Transition of Care Tools Training Webinar (2/27/2023) – Questions & Answers

Q: Should the transition of care tool be used when transferring within the County of Santa Clara system (BHSD Network of Providers)?

A: No. It is only used to refer clients to the Managed Care Plan for Mental Health Services (i.e., Anthem & SCC Family Health Plan).

Q: Could a client request to stay with their managed care therapist and just add on SMHS at the SMHS provider for additional support (e.g., case management, medication management, etc.) based on their increased needs?

A: Yes. Clients can receive services from both plans as long as the services are not duplicated. Clients and providers will work together to decide the best method.

Q: Does the transition of care tool also apply to youth systems of care?

A: Yes. It applies to both systems of care.

Q: In the County of Santa Clara, we use the "Intra-Agency Form", does this form not apply anymore?

A: The transition of care tool does not affect the intra-agency form. The Intra-Agency form will still be used.

Q: What will be the turnaround time for the call center to provide the feedback of MCP status to the transitioning SMHS provider?

A: Currently, there is no set timeframe. The Call Center will let providers know of the status once MCP provides update to the Call Center. This will be addressed in the upcoming policy once it's published.

Q: For outpatient clinics (Ambulatory Care PCBH Clinics), do they follow this new procedure to refer their clients to specialty behavioral health services?

A: Yes if the client is referred to the MCP. No if the client is referred within the MHP/County of Santa Clara health system.

Q: When the call center is referring to the MCPs, which providers are providing mild to moderate services?

A: The call center will refer the client to their respective MCP, either Santa Clara Family Health Plan or Anthem.

Q: Does the MCPs include Kaiser, Fremont Hospital, and San Jose Behavioral Health?

A: The call center will refer the client to their respective MCP, either Santa Clara Family Health Plan or Anthem.

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Q: For locked facilities, the case managers/probation officer refer clients to services in the community. Do the clinic therapist or case managers/probation officers complete the transition of care tool?

A: The transition of care tool is only used when the client is referred for SMHS from MHP to MCP or MCP to MHP. The transition of care tool is not required when referring clients within the County of Santa Clara system (BHSD Network of Providers) or to other community services. The tool can be completed by a clinician or non-clinician.

Q: Can you provide additional examples the transition of care tool would be used to refer from MHP to MCP?

A: The transition of care tool is only used when the client is referred for SMHS from MHP to MCP or MCP to MHP. The transition of care tool is not required when referring clients within the County of Santa Clara system (BHSD Network of Providers) or to other community services.

Q: Are there guidelines for determining switching systems of care vs. adding service?

A: Guidelines on the transition of care tool were covered in the training webinar. The presentation also references BHINs and policies for more information. The provider will have to make sound clinical judgement, in partnership with the client, to assess and determine referral, as appropriate.

Q: What if the client's level of case management support is higher than what the MCP has the ability to provide?

A: It is the MCPs responsibility to ensure their members have appropriate access to services. If the client needs to be referred to the MCP, follow the appropriate workflow through the call center.

Q: Is there a policy where we can provide feedback on?

A: The policy is currently being developed and will be available soon.

Q: Is completing the transition of care tool billable?

A: Documentation time will no longer be billable beginning July 1, 2023.

Q: If the call center refers a mild/moderate client to specialty mental health, can the assessing clinician use the transition of care tool to ensure the client receives the appropriate level of care?

A: The transition of care tool must be completed to transition the client to the other mental health delivery system. It is the call center's responsibility to connect with the appropriate provider and provide them with the completed transition of care tool. Please refer to the appropriate workflow through the call center.

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Q: Would the transition of care tool be used to refer a client to the MCP for only therapy services?

A: It is the MCPs responsibility to ensure their members have appropriate access to services. If the client needs to be referred to the MCP, follow the appropriate workflow through the call center.

Q: We've had challenges when working with the PCPs, will completing this tool change that?

A: The transition of care tool is used to capture appropriate information when referring clients to the other mental health system. The workflow with the call center is a new process for both the County of Santa Clara and the MCPs. The county has been working very closely with the MCPs and we anticipate improvements moving forward. Any concerns with MCP providers should be addressed with them directly.

Q: Do the MCPs provide medication support if we refer clients to the MCPs?

A: It is the MCPs responsibility to ensure their members have appropriate access to services. If the client needs to be referred to the MCP, follow the appropriate workflow through the call center.