

## Screening & Transition Tools Frequently Asked Questions

MCBH remains committed to the implementation of CalAIM initiatives. Below is a list of internally frequently asked questions (FAQs). DHCS regularly releases FAQs we believe County and Contractors may find helpful. If you'd like to review DHCS's full FAQ release visit: <https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-FAQ.aspx#Intersection%20with%20Other%20Policies>

### **Screening Tool**

1. Question 12 of the Adult Screening tool uses the term "Recently" while other screening questions use timeframes such as "In the last 6 months...". Is there a universal definition of the term "recent" to get clarification on what we are asking of the beneficiary?

DHCS has not defined a timeframe for question 12 in the Adult Screening Tool. If the individual seeking mental health services considers themselves to have recently engaged in any self-harming behavior, the response must be documented in the "Yes" column. If there is an instance where the person administering the screening is asked to clarify a question for the individual to be able to respond (i.e. beneficiary asks for clarification of "recent"), the clarification must be aligned with the intent of the question(s) and existing internal policies.

2. In the screening tool, there are questions about suicidality which includes 3 scenarios in the one sentence, and we are asked to read the question as it is. Are there any differences between the scenarios?

Any affirmative response to any of those questions should be taken seriously and would be considered a "YES" response.

3. For returning beneficiaries under 365 days, is the Screening Tool to be completed again?

The screening tool would not need to be used. The screening tool is only to be used for new beneficiaries (new to behavioral health or closed for more than 365 days).

4. If a beneficiary scores 6+ on the screening tool and they need an assessment scheduled, what is considered "timely?"

Timeliness standards have not changed, and remain the same as outlined below (Policy 148).

New beneficiary requesting Outpatient Mental Health Services

- Non-Urgent: Offer appointment within 10 business days from request
- Urgent: Offer appointment within 48 hours of request, 96 hours for

service requests that require prior authorization

New beneficiary Requesting Outpatient Psychiatry services

- Non-Urgent: Offer appointment within 10 business days from request
- Urgent: Offer appointment within 48 hours of request

5. If someone scores a 6+ on the screening tool, does it place them in the level of care they should receive within MCBH (i.e. FSP, etc.)?

No. The Screening Tool identifies initial indicators of beneficiary needs to make a determination for referral to either Carelon (formerly known as Beacon) or MCBH for a clinical assessment

6. Do youth who are not systems involved (Juvenile Detention, CWS, etc.) still need to be screened?

If they meet the definition of new beneficiary and/or closed longer than 365 days, yes.

7. Who can complete the screening?

Clinicians and non-clinicians.

8. Is the Screening Tool usually completed by SWIII?

The Screening Tool may be administered by clinicians or non-clinicians. Consult with your Program Manager and Supervisor regarding your Programs specific workflow to determine who may be completing this tool.

9. An individual may identify a “crisis” differently than we do and may respond “Yes” when asked if they are in crisis. If their definition is different than what MCBH would define a crisis, how should we answer that question?

Ask the beneficiary, “what is the emergency” and then based on your clinical impression you may proceed with the crisis protocol or proceed with the screening. Per Policy 148, an “urgent request” refers to cases in which a beneficiary or provider indicates, or MCBH determines, that the standard timeframe could seriously jeopardize the beneficiary’s life or health or ability to attain, maintain, or regain maximum function.

10. When an individual answers yes to questions 6, 7, or 9 on the Youth Screening Tool, why do the instructions require the screener to stop the screening? Can the screener still ask the remaining screening questions?

If a child/youth, or the person responding on their behalf, responds “Yes” to question 6, 7, or 9, in the Youth Screening Tool, they meet criteria to access specialty mental health services per BHIN 21-073. In these cases, the appropriate delivery system for clinical assessment (i.e., MCBH) has already been determined and, therefore, the remainder of the screening is optional, and the screener must offer and coordinate a referral for a clinical assessment with MCBH.

11. Can we re-screen individuals if we feel they were not scored appropriately?

No. Once an individual is referred to a MCBH or Carelon after using the Screening Tools, the receiving program (MCBH or Carelon) may not re-screen individuals. If an individual is referred to MCBH or Carelon based on the score generated by administration of the Screening Tool, then that program must ensure the individual receives timely access to care, including a timely clinical assessment, in alignment with existing standards and medically necessary mental health services.

12. What will happen if the beneficiary's Medi-Cal information is not entered into Avatar when the screening tool is finalized?

The screening tool will not be sent to Carelon. Medi-Cal financial eligibility must be entered, ideally prior to finalizing the screening tool, otherwise staff may get the following message: "Screening will not be sent to Carelon and will stay with MCBH as: Client does not have active Medi-Cal". If you are getting this message you may reference "Appendix A" for instructions on how to complete the financial eligibility.

### **Transition of Care Tool**

13. The transition tool looks like what used to be the bidirectional form. Will this form still be used?

No, the bidirectional form will no longer be required.

14. Do clinicians re-utilize the screening tool when it's time to transition beneficiaries down to a lower level of care?

No. The determination to transition services and/or add services must be made by a clinician via a patient-centered shared decision-making process. The transition of care tool shall be used for these purposes.

15. If a beneficiary scores 6+ on the screening tool, is subsequently assessed by Access, and then context becomes clear and it shows that they are Carelon appropriate, would clinician just then do Transition of Care tool or NOABD? Complete both the Transition of Care Tool that will be sent to Carelon and NOABD which must be sent to the beneficiary.

### **Youth Screening**

16. When using the youth tool: if both parent and youth come in or call together, is there a preference for who should be asked the questions?

This will depend on clinical judgment; either the Youth Responding or Adult Responding on Behalf of Youth tab should be completed.

### **Substance Use Disorder**

17. What constitutes a referral to SUD services: Giving numbers? Integrated ASAM assessment?

For the purpose of this screening tool, if the beneficiary scored below a 6 and is being referred to SUD services, giving phone numbers and offering linkage support (if beneficiary accepts such referrals) is sufficient. Additionally, if the tool determines they remain with MCBH (a score of 6 or above), a CalAIM Assessment with integrated ASAM components should be completed. To note, MCBH should be offering the beneficiary the option to complete an integrated assessment and then be referred to the indicated LOC (if beneficiary accepts such a referral) based on the outcome of the assessment.

## **Workflow Processes**

18. Is the NOABD still completed when the person is referred to Carelon or does the disposition tab cover that?

When the staff completes the *screening tool*, and they are being referred to Carelon a NOABD is NOT required.

If a clinician has determined that the beneficiary will be *transitioned* to Carelon, MCBH staff shall complete the Transition of Care Tool, complete the NOABD, mail the NOABD to beneficiary, and ensure the beneficiary is connected with a provider. The beneficiary shall be engaged in the process and appropriate consents obtained as needed (Note: NOABDs are not required if services are being added to Carelon).

19. Is a NOABD needed for ASOC and ACCESS when we are stepping a beneficiary down for services?

Yes, a NOABD should be completed any time we are stepping beneficiary down for services and will no longer be receiving services through MCBH. MCBH staff shall complete the Transition of Care Tool, complete the NOABD, mail the NOABD to beneficiary, and ensure the beneficiary is connected with a provider. (Note: NOABDs are not required if services are being added to Carelon).

20. When using the tools, are there any flexibilities for follow up questions?

No. Questions/fields may not be added to or removed from the Screening Tools or the Transition of Care Tool. Questions in the Screening Tools must be asked in full using the specific wording provided in the tool and in the specific order the questions appear in the tools, to the extent that the individual is able to respond. There may be instances where the person administering the screening is asked to clarify a question for the individual to be able to respond.

21. Can we refer the beneficiary to Carelon for therapy and keep them open to MCBH for other non-duplicative services, for example with MCBH psychiatry

for medication?

Yes. With the No Wrong Door Policy (BHIN 22-11), we have the ability to take into account continuity of care. Different systems can provide services so long as it is not duplicative.

22. Can I use the Department of Health Care Services (DHCS) PDF and then input it into Avatar later if I'm in a location without Wi-Fi?

Yes.

23. When we refer to Carelon, how long do we keep them open? Is it on us to manage the beneficiary until they are connected to a therapist? And how does this fit with our timeliness standards?

It may take a couple of weeks before the beneficiary is connected to Carelon and it is important to continue to provide medically necessary services in the meantime. If the beneficiary is being referred to Carelon based on the outcome of the Screening Tool, it is the responsibility of Carelon to meet the timeliness standards.

24. When keeping beneficiaries open until connected to Carelon, can a SW help with monitoring and connecting?

Yes, a SW or BHA can support that.

25. For those charts that are kept open after a screening only until linked to Carelon, do compliance measures need to be completed (i.e., CANS, Problem List, etc.)?

No

26. Neither of these tools look at relational issues between caregiver and child for 0- 5, can additional items be added or tweaks be made?

No. Questions/fields may not be added to or removed from the Screening Tools or the Transition of Care Tool. Questions in the Screening Tools must be asked in full using the specific wording provided in the tool and in the specific order the questions appear in the tools, to the extent that the individual is able to respond.

## **Insurance Coverage**

27. Not all folks that come in through the Access Doors are Medi-Cal beneficiaries. This tool is asking that everyone regardless of insurance coverage receive the Screening Tool. What will we do if the beneficiary has private insurance, no insurance, and/or Medi-Medi?

The Screening and Transition of Care Tools guide referrals to the Medi-Cal mental health delivery system (i.e., Carelon or MCBH) that is expected to best support each beneficiary. It is not required to use the tools with individuals who are not Medi-Cal beneficiaries.

28. County is safety net, so we see Medi-Cal beneficiaries and people without Medi-Cal if moderate-severe. What if they are mild-moderate but no Medi-Cal and Carelon does not take that?

MCBH would still be responsible to provide services to beneficiaries who are mild-moderate with no Medi-Cal.

## Appendix A Medi-Cal Eligibility in Avatar

Below are the steps to completed if staff are receiving the following message:

**Screening will not be sent to Carelon and will stay with MCBH as: Client does not have active Medi-Cal**

Completed by PSR (usually)

1. Open client form: Financial Eligibility
2. Choose the appropriate episode number
3. Go to section: Benefits and Eligibility
4. Verify that the information under Medi-Cal Eligibility is correct with what was verified under MEDSLite

The screenshot shows the Avatar Financial Eligibility form. The left sidebar contains a navigation menu with the following items: Financial Eligibility, Guarantor, Guarantor Selection, Guarantor Information, Subscriber Information, Employer Information, Benefits and Eligibility (highlighted with a red box), and Customize Plan. The main form area is titled 'Financial Eligibility' and includes several sections. The 'Benefits and Eligibility' section is highlighted with a red box and contains the following fields: 'Date Benefits Terminated' and 'Date Benefits Denied' (both with MM/TT/YY pickers), 'Denial Code' (a dropdown menu), 'Subscriber's Covered Days' (text input with '9999'), 'Lifetime Reserve Days' (text input), 'Number Of Days For Interim Billing' (text input), and 'Maximum Covered Dollars' (text input with '9999999.99'). The 'Medi-Cal Eligibility' section, also highlighted with a red box, contains: 'Effective Date Of Medi-Cal Eligibility' (MM/TT/YY picker with '06/01/2023'), 'Eligibility Code' (dropdown menu with '(381) OTHER CONDITIONS'), and 'Aid Code' (text input with '(35) CalWORKS - Two Parent').

The following will trigger the message stated above:

1. Effective date of Medi-Cal Eligibility is after the date of screening OR
2. Eligibility Code = (999) Ineligible OR
3. Aid Code field is blank

Having a CIN or Aid Code on file for the client does not automatically make them eligible for Medi-Cal. It is based off the Eligibility Code in addition to having the other fields completed.