Client Flow Focus Group

1. Entry/intake into the system. Is client access centralized or standardized across multiple portals? What is the role of the 24/7 Access Line?

- Providers think we should use the no wrong door approach
- AB109 provider can only see AB109 clients

Providers feel that centralized intake will delay client's access to treatment. Also there is a potential not to get paid if a client is assessed and sent to a provider just to go somewhere else.

Fresno County has the responsibility for coordination of care and movement through the levels of care. Providers must operate under the ASAM principles as well as evidence based practices.

Transitions from treatment providers experience near real time monitoring of intake/transitions/discharge. DHCS mandates that we only need prior approval for residential treatment. Other modalities are not required at this time.

Only San Mateo uses centralized intake at this time. Los Angeles utilizes intake substations. Centralized intake will equal more monitoring on the part of the county. They will have to hire case managers.

2. What are the approaches to service integration with Mental Health and Primary care? What should the approaches be for shared care planning and care coordination across systems?

Primary care is going to be a big challenge with integration. It is easier to get someone into SUD than primary care. Some of the providers refer clients to Clinica Sierra Vista for medical.

Integration should not mean co-location and if it does maybe we can build in transportation rates for integration. Dental should be offered for meth SUD.

Some issues that need to be addressed to make integration work are:

- There are not enough providers to assist integration.

- CFR 42 needs to be more sharing friendly.
- At this time treatment providers have two files on one individual when dealing with co-occurring. One for MH and one for SUD.
- Doctors do not like to take a Methadone or Suboxone client.

3. How do we handle client transitions across levels of care? ASAM continuing stay assessment. Role of case managers in making the transition? Warm hand off processes. What happens if the client does not show or drops out after a few sessions?

There will need to be multiple single modality providers that will have to work together if we want to have re-assessments every 30 days. Having re-assessments every week is unrealistic. The providers stated that there are no complaints if they have to re-assess every 30 days. They have to review the plan every 30 days anyway so this will be a natural progression.

Providers are united in that they think that all clients should have one consistent case manager. Even if the case managers are different people as long as they are receiving consistent care. The statement was made that if we want to have each client to have a consistent case manager maybe making case management the County's responsibility is a better idea. Or maybe with the implementation of the Waiver there will be better pay offered by providers and create longevity for employees.

V. Kogler asked the group: What does a client ready to move on look like?

- Depends on their attitude toward recovery
- Stable, able to make groups on time
- Complete 70% of their treatment plan

4. Do/how assessments/treatment plans, notes follow clients between programs?

The level of care will be based on the ASAM criteria. Once the client shows up at the treatment provider, they complete the ASI. They will have to assess clients every time a new client arrives. This causes problems because clients want to know why they are being assessed so often.