Patient Flow Narrative

The Department of Public Health, Substance Abuse Prevention and Control (DPH-SAPC) operates two systems of care for Substance Use Disorder (SUD) treatment services: one for adults (18 years of age and older) and one for youth (under 18 years of age). Services are delivered through contracts with community-based, State-certified and/or licensed SUD treatment programs, and the County-operated Antelope Valley Rehabilitation Centers (AVRC), an outpatient and residential treatment provider for adults. Referrals are accepted from all sources, including County Medi-Cal managed care health plans, other County departments, criminal justice and juvenile justice agencies, the child dependency system, community-based human service agencies, employers, schools, families, and from individuals themselves. Services available include the entire range of services contained in the youth and adult benefit packages. Patients move through the system of care via the Beneficiary Access Line (BAL) and the SUD provider network.

Entry Point

The point of entry into the SUD system of care occurs one of two ways: 1) the adult patient, youth patient/parent, or referral source contacts the BAL, or 2) the adult patient, youth patient/parent contacts the SUD provider directly.

Initial Placement Determination

The process for initial placement determination will be similar for both entry points. Expectations for assessments/screening, referring, and tracking are the same for the BAL and the SUD provider network and are described below:

Beneficiary Access Line:

- If an adult patient contacts the BAL, the BAL will determine Medi-Cal or My Health LA program eligibility and conduct a brief tele-triage assessment (BTA) to determine the provisional level of care (LOC). If a youth or parent/other adult contacts the BAL, the BAL will determine Medi-Cal or My Health LA program eligibility and screen the caller using the appropriate screener (youth or parent).
- If the BTA determines that the adult caller does not meet the criteria for LOC, then he/she will be referred to other appropriate primary care, mental health, or social services. If the adult caller does meet criteria for LOC, the BAL will set an appointment for an initial assessment/intake with a selected provider while the patient is on the call, except under limited circumstances but no longer than 3-business days from the date of the brief triage assessment.
- For youth callers, if the screening clinician determines a youth does not need a full assessment, they will be referred to resource materials on SAPC website. If the screener determines that a full assessment is needed, BAL staff will refer the youth to a qualified youth outpatient provider for further assessment and SUD treatment services.
- All Medi-Cal-eligible youth and adult patients will be referred to, and/or served by, a Drug Medi-Cal (DMC) certified agency for DMC reimbursable services. Unless the patient has specific provider or other preferences (e.g., cultural/linguistic-specific services) that would require a longer waiting period, the assessment/intake appointment with a qualified SUD

network provider that is geographically accessible will be conducted within 15-business days from the date of the brief triage assessment[1].

- If the receiving provider determines that it does not offer the appropriate LOC based on the full assessment, they may refer the patient back to the BAL for a subsequent referral to a provider that offers the appropriate LOC. When available, BAL staff will utilize an electronic appointment system that will include the real-time availability of appointments, as well as withdrawal management and residential bed vacancies.
- If residential treatment is needed, a provider will submit a pre-authorization request to the DPH-SAPC Office of the Medical Director and Science Officer (OMDSO) and a response will be provided within 24 hours of the pre-authorization request. Authorization by the County is not required for admission into other ASAM LOCs, though it will be required for Medication Assisted Treatment for youth.
- If a youth outpatient provider determines that it does not offer the appropriate LOC, the youth patient will receive a referral to a provider of the appropriate level of care. If the full assessment determines that the youth patient does not meet medical criteria for SUD treatment, they will be referred to early intervention services. Early intervention services will be provided by a prevention provider or a SUD agency that offers SUD education.
  - If residential treatment is needed, a youth agency will refer the patient to a residential provider, which will submit a pre-authorization request to the DPH-SAPC OMDSO. A response will be provided within 24 hours of the pre-authorization request.

- BAL staff will track the referrals and submit monthly data reports to DPH-SAPC. BAL staff will also follow-up with patients to better ensure that they keep their assessment/intake appointments. With patients' permission, BAL staff will make attempts to contact callers on a minimum of three different days and at various times throughout the day, to remind them of their upcoming appointments. Within one day after the scheduled appointment, BAL staff will also contact a network provider to determine if the caller appeared for his/her intake/assessment. If the patient did not show for his/her appointment, the BAL will make also make a final attempt to contact the patient to reschedule the appointment.
- Once the intake process and authorizations (if needed) are complete, the patient will be admitted into SUD treatment services and will begin receiving treatment services within 3 business days of the full assessment/intake appointment date, or as soon as possible for residential treatment. For cases in which the preliminary level of care recommendation is residential treatment but residential beds are not available, the patient will be referred to the next most appropriate level of care and then admitted into residential treatment as soon as possible. The BAL will notify both the patient and the case manager of the interim outpatient care provider agency when a slot opens for admission into residential treatment. The BAL will provide the interim outpatient provider with the contact information for the receiving residential treatment provider.

SUD Provider:

[1] *In July 2017, the assessment/intake appointment target will be 5-business days for outpatient cases and 10-business days for residential cases. In July 2018, the assessment/intake appointment target will shift to 5-business days for all levels of care.*

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- If a patient presents at a SUD provider site first, the above processes and timeliness expectations placed on the BAL, are the same for the SUD provider. If a provider conducts a BTA or a full assessment and does not provide the appropriate LOC, the provider may contact the BAL to schedule an appointment with a provider that does offer the appropriate LOC. In any case, alternate referrals (to the BAL or another provider) should be offered and documented if these expectations cannot be achieved.
- If an agency accepts responsibility for conducting the BTA/screening and making transitions in care outside of the BAL, the treatment provider will be responsible for ensuring that clients are successfully linked to SUD treatment services when appropriate and performing the activities that would otherwise take place at the BAL. Such providers will track their referrals to the appropriate LOCs and report referral outcomes to DPH-SAPC. The treatment provider will also follow the same procedure as the BAL for following up with patients to remind them of their appointment times and locations to better ensure that patients complete an assessment/intake, and admission into treatment if appropriate.

Treatment Services

- Once the patient is admitted into SUD treatment services, they 1) receive the appropriate case management and care coordination services needed to successfully engage in the initial treatment episode; 2) receive other necessary services, including concurrent Medication Assisted Treatment (if clinically appropriate), and 3) transition through levels of care as clinically appropriate.
    - Transitions in care will be dictated by the regular re-evaluation of medical necessity and appropriate placement according to ASAM Criteria and SAPC's QI/UM plan.
- A Certified SUD Counselor or higher develops, and a Licensed Practitioner of the Healing Arts (LPHA) reviews and signs an individualized treatment plan and begins the process of discharge planning to prepare the individual for return or reentry into the community, and to provide linkages to essential supportive services, such as education, employment training, employment, housing, benefit enrollment, and other human services.
- The treatment plan for will be reviewed, updated, and adjusted accordingly at least every 30-days in all treatment settings.
    - During this review, a provider will conduct a re-evaluation of medical necessity & ASAM Criteria and determine one of three options:
        - 1) Continuation of care – the patient will remain at the current LOC;
        - 2) Transfer to a different LOC – the patient requires more intensive or less intensive care and will be stepped up or down accordingly; or
        - 3) Discharge – the patient no longer meets medical necessity criteria for SUD treatment.
    - If the patient no longer meets medical necessity criteria for SUD treatment or prematurely exits the SUD system of care, they will be discharged and begin receiving Recovery Support Services from the last treatment provider.

Case Management

- As previously noted, patients receive case-management and care coordination services to successfully engage in the initial treatment episode, receive necessary services, and transition through levels of care as clinically appropriate.

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- The network provider will provide a variety of case management and care coordination activities, including assistance with admission into SUD services, transitioning from one LOC to another, and navigating the mental health, physical health and social service systems.
- Providers will also monitor and track patient progress, coordinate SUD services with physical and mental health services, and provide linkages with community support services, as well as coordinate referrals to other LOCs.
    - Providers are responsible for communicating with other network providers to support successful transition(s) as patients move between LOCs and into post-discharge recovery support services.
        - Providers will be responsible for documenting all transitions (whether referring or admitting) in addition to documenting monthly and continual assessment results.

Recovery Support Services

- Recovery support services (RSS) begin once the patient has been discharged from treatment. They refer to non-clinical services and periodic outreach to evaluate patients' stability in recovery and to foster health and resilience in individuals and families by helping them to navigate systems of care, and reduce barriers to employment, housing, education, and other life goals. They incorporate a broad range of support and social services that facilitate recovery, wellness, and linkage to and coordination among service providers. Similar to how patients see their primary care provider for periodic health checkups even when healthy, RSS can be viewed as aftercare or continuity of care in SUD treatment. The frequency of RSS is dependent on patient need, preference, and stage of recovery.