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| **Department of Public Health, Substance Abuse Prevention and Control****Required Language for Discharge Policy in Alignment with R95 Access to Care Expectations (DRAFT 12/20/23)** |
| * Required Language – Noted in **BLUE**
* Recommended Language – Noted in **BLACK** text and can be modified or omitted
* Comments – Noted in ***ORANGE ITALICS*** text are clarification and are not inclusion in the policy
* Use agency specific headers / formats in accordance with your policy and procedure standards
* This is not an exhaustive discharge policy and any other County or State requirements need to be included in an agency’s final version, including additional guidance that aligns with the intent of the R95 initiative.
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**PURPOSE:**

This policy outlines agency expectations on how to support patients enrolled in substance use disorder (SUD) treatment services to receive services at the appropriate level of care, and support care transitions to higher or lower levels of care based on the patient’s clinical needs, including when patients lapse but remain committed to participate in ongoing services in pursuit of personalized recovery goals.

**POLICY:**

This policy outlines the process and requirements for discharging patients from SUD treatment, including offering patient referrals and linkage to additional treatment and related services clinically appropriate for the patient. This policy further outlines the management of situations when clients lapse or relapse while in treatment. A lapse or relapse alone is not an automatic reason to discharge a patient. Patient substance use should be considered within the broader context of the patient’s response, behaviors, and commitment to participate in continued care.

**SCOPE:**

This policy applies to all supervisors, Licensed Practitioners of the Healing Arts (LPHA), registered/certified counselors, Medi-Cal Peer Support Services Specialists, and other staff who provide direct services and/or have a role in patient discharges. Furthermore, it applies to all levels of care and services: outpatient, residential, outpatient/residential/inpatient withdrawal management, Opioid Treatment Programs, Recovery Services, Recovery Bridge Housing, and Recovery Housing. [remove levels of care not offered at the agency]

**DEFINITIONS:**

**Lapse:** A brief return to substance use following a sustained period of abstinence, despite the patient remaining committed to recover and demonstrating a willingness to re-engage with the recovery journey.

**Relapse:** A prolonged episode of substance use during which the patient is not interested or open to a therapeutic intervention.

**Stages of Change**: A model developed by Prochaska and DiClemente that posits that individual move through the following five stages when changing a behavior: precontemplation, contemplation, preparation, action, and maintenance.

**Toxicology Testing**: An optional tool that can be offered alongside other clinical interventions when requested by a patient to support their individualized goals. Toxicology (also known as “drug” or “urinalysis”) testing is not a requirement for all patients or at a determined frequency and is not a prerequisite to patients achieving their treatment goals and/or to demonstrate treatment progress. For example, every patient may not need to submit to toxicology testing as a part of treatment participation, while others may request or be required (if authorized via consent to release information) as part of an agreement with Probation or DCFS. [SAPC is seeking to transition to the term “toxicology” rather than “UA” or “drug” testing. As part of the P&P agencies may continue to use “drug” testing provided at minimum “also known as “toxicology testing” is referenced to begin to familiarize the workforce]

**Warm Handoff**: A transfer of a patient from one SUD facility to another that occurs with agreement or at the request of the individual and where the involved agency makes every effort to facilitate a successful connection, preferably by ensuring that the individual arrives at the new facility (e.g., transportation provided).

**PROCEDURES:**

1. Toxicology Testing: A positive test result is not in and of itself a reason for discharge or transition to another level of care. See agency policy [insert title/number] for more information. [Attach a copy of the agency’s toxicology testing policy that aligns with the above definition as part of the discharge policy submission]
2. Confirmed Substance Use: A patient is not automatically discharged if a toxicology test (also known as drug or urinalysis test) indicates a positive result or if the patient states that they used substances (regardless of toxicology testing results).
	1. This supports the fact that SUD is a chronic and relapsing health condition that benefits from continued connections to services to facilitate achievement of personalized recovery goals; and
	2. Patients are not prevented from receiving services for exhibiting symptoms (use of substances) for the very condition they are in the program to treat.
3. Discharge Determination and Transitions: Staff engage with patients throughout the treatment process to encourage connections to SUD services when transitioning / discharging from their current level of care.
	1. Before discharge or transition to a higher or lower level of care is determined, steps must be taken with the patient and leadership to confirm that the patient cannot best be served through continuation of services and adjustment of treatment and recovery goals, including when a patient changes their abstinence goals.
4. Patient is offered crisis intervention and individual counseling to support their physical and emotional wellbeing, including exploring their current treatment and recovery goals.
5. Residential patients who lapse are not automatically transferred or discharged to a withdrawal management or hospital setting, including those who indicate use of alcohol or opioids. The decision to transfer a patient is based on what is clinically appropriate for the patient as determined through consultation with designated Licensed Practitioner of the Healing Arts (LPHA).
	* + 1. Patients who lapse and remain in the program are provided a dedicated resting/sleeping area temporarily to facilitate improved staff monitoring when this supports the safety and comfort of the patient and other residents.
	1. When it is clinically appropriate for a patient to transition to another level of care, the following steps are taken:
		1. Patients are connected via Warm Handoff to a different level of care if a different intensity or structure for services is needed to better manage and support a patient’s treatment goals. This is either at [insert your agency name] or another treatment provider if the needed level of care is not available or preferred.
		2. Patients are connected via Warm Handoff to Recovery Services offered by [insert your agency name] when these services are clinically appropriate and desired by the patient.
		3. Staff ensure that patients who receive services in their preferred language via staff fluent in speaking the patient’s preferred language (or through an interpreter) are connected with ongoing services that are linguistically responsive to the patient’s needs.
6. Same Day Admissions: Every effort will be made to offer individuals same-day intake and admission appointments (e.g., establishing flex in counselor and clinician schedules to accommodate same-day appointments, utilizing empty slots and no-shows to schedule appointments, etc.) to better ensure that those who reach out for care successfully connect with services.
7. Medi-Cal Enrollment Status: [insert agency name] is required to check that patients maintain Medi-Cal enrollment on a monthly basis (at minimum). [Insert agency specific information on how agency manages Medi-Cal eligibility monthly monitoring or refer to agency existing policy. NOTE: This is reimbursable through the care coordination benefit.].
	1. A lapse in Medi-Cal enrollment for patients who remain eligible for Medi-Cal is not an allowable reason for discharge. Care coordination services must be provided to support a patient with continued enrollment. This is not a responsibility of the patient, their family, or other service providers.
	2. A termination of Medi-Cal enrollment due to the patient no longer meeting income and other requirements requires the program to transition the patient in one of these ways:
		1. Continue serving the patient under non-Drug Medi-Cal (DMC) funding sources or agency scholarship to avoid disruption in care.
8. Discharge Process: Ensure that the process of transitioning a patient to another level of care (including Recovery Services) within the agency or to another agency or discharging a patient from all SUD treatment services when requested by the patient, is collaborative and meets the patient needs and preferences. This is to better ensure that the patient will want to reengage with the program if future services are needed.
	1. [Insert agency specific discharge process, documents etc. in alignment with the SAPC Provider Manual]
9. Informational Materials: Ensure that all clients exiting services are provided with information, overdose prevention resources, linkage to community based services, and emphasize how patients can reconnect with treatment services as needed. This includes, but is not limited to:
	1. Link to [www.RecoverLA.org](http://www.RecoverLA.org) ensure individuals have access to SUD educational information and how to find a new provider if needed in the future.
	2. Provide the patient naloxone and educational materials and discuss reasons for providing this information (e.g., resources are provided because SUDs are relapsing conditions and while lapse or relapse is not expected, everyone should know about available resources if there is a return to use). [SAPC overdose bag materials are available here: http://ph.lacounty.gov/sapc/providers/overdose-materials.htm]
	3. Provide information about nearby harm reduction services in the community and the reasons for providing this information (e.g., resources are provided because SUDs are relapsing conditions and while lapse or relapse is not expected, everyone should know about available resources if there is a return to use). [Information on harm reduction services and service locations is available here: http://ph.lacounty.gov/sapc/public/harm-reduction]
10. Staff Training and Development: All administrative and direct service staff (e.g., counselors, LPHAs) working at treatment sites must participate in the following activities:
	1. Upon hire, and minimally overview updates annually thereafter, on the discharge policy and demonstrate understanding of its requirements by attending a SAPC training or approved alternate presentation, including:
		1. Understand importance and reasons for preventing avoidable discharge from care.
		2. Key information and resources to provide upon transfer or discharge.
		3. Crisis intervention and supporting patients remain in treatment upon lapse and continued treatment interest and appropriateness.
		4. Basic training on the Reaching the 95% (R95) Initiative including demographics and various SUD and other health service needs.
	2. Conduct regular staff meetings and dialogue on at least an annual basis with a focus on ensuring that all staff can contribute to the discussion, design and implementation of strategies that effectively lower the bar for SUD treatment discharges and better serve the R95 population, which may be incorporated within the annual training or other forums.
11. [Add other topic areas as needed, in appropriate order]

Attachments