

Required Language for Discharge Policy in Alignment with R95 Access to Care Expectations

- 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, unless requested to insert information.
- 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.

Note: Provider agencies may use “client” or “patient” depending on your standard language

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 interested in participating 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 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 provided by agency (e.g., outpatient, intensive outpatient, residential, withdrawal management, Opioid Treatment Programs, Recovery Services, Recovery Bridge Housing, and Recovery Housing). **[Include all levels of care and services offered by your agency]**

DEFINITIONS:

Lapse: A brief return to substance use following a sustained period of abstinence, despite the patient remaining interested in SUD treatment and demonstrating a willingness to re-engage with treatment services.

Relapse: A prolonged episode of substance use during which the patient is not interested or open to receiving SUD treatment services.

Reaching the 95% (R95): This is an initiative specifically designed to reach the 95% of people who according to national data meet criteria for SUD treatment but either do not want it or chose not to access it by reducing barriers to care, including but not limited to, updating admission and discharge policies to include admission and delivery of services to those who are not abstinent but are interested in receiving services, do not state a readiness for complete abstinence; developing and implementing a service design that accommodates those who are not ready for complete abstinence; and identifying new collaborative opportunities and/or alternate service locations to better reach this population.

R95 Population: Individuals who most likely did not come to the program with a clear desire to commit to treatment and achieve long-term abstinence but do recognize that their substance use has been problematic and/or are willing to take steps to address those issues through participation in services.

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: A [An optional] tool that can be offered alongside other clinical interventions to support patients' individualized goals and used by the treatment team to better inform care. The frequency of toxicology (also known as "drug" or "urinalysis") testing is informed by clinical need. When a person has a clinically unexpected result or declines to test, this should prompt therapeutic discussions with the patient and consideration of the patient's plan of care and it does not result in an automatic refusal in admission or discharge from treatment. Provider agency staff prioritize engaging a person in treatment, which may include referrals to additional appropriate services.

[SAPC is seeking to transition to the term "toxicology" rather than "UA" or "drug" testing. As part of the policy and procedure, agencies may continue to use terms such as "drug" testing that may be better understood by agency staff and recommend including "also known as 'toxicology testing'" to begin to familiarize the workforce with this terminology]

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., intake scheduled and transportation arranged).

PROCEDURES:

- I. Toxicology Testing: A positive test result does not automatically trigger discharge or transition to another level of care without full consideration of the patient's individualized clinical circumstances and determination of an appropriate plan 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]

- II. 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).
 - A. 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

 - B. Patients are not prevented from receiving services for exhibiting symptoms (use of substances) for the very condition they are in the program to treat.

- III. 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.
 - A. Before discharge or transition to a higher or lower level of care is determined, steps must be taken with the patient and the treatment team 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.
 1. Patients are offered crisis intervention and individual counseling when appropriate to support their physical and emotional wellbeing, including exploring their current treatment and recovery goals.

 2. Individuals who lapse are still eligible to continue to receive care within the program, provided that there are no acute medical or behavioral symptoms requiring resolution at a different level of care.

- a. Patients who lapse are not automatically transferred or discharged to emergency services, withdrawal management, or hospital settings unless the patient has medical symptoms that these levels of care are necessary to resolve.
 - b. It is not a standard practice to refer patients for medical clearance solely because of identified substance use and the decision to transfer a patient is based on what is clinically appropriate for the patient as determined through consultation with qualified professions.
 - c. 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.
- B. 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.
- IV. 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.].

- A. 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 Medi-Cal eligible patient resolve an interruption in Medi-Cal enrollment concurrently with ongoing services. This is not a responsibility of the patient, their family, or other service providers.
 - B. A termination of Medi-Cal enrollment due to the patient no longer meeting income and other Medi-Cal 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 any available agency scholarship to avoid disruption in care.
- V. 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.
- A. [Insert agency specific discharge process, documents etc. in alignment with the SAPC Provider Manual]
- VI. Informational Materials: Ensure that all patients 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:
- A. Link to www.RecoverLA.org ensure individuals have access to SUD educational information and how to find a new provider if needed in the future.
 - B. 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>]
 - C. 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>]

VII. Staff Training and Development: All administrative and direct service staff (e.g., counselors, LPHAs) working at treatment sites must participate in the following activities:

A. Training upon hire, and minimally overview updates annually thereafter, on the discharge policy and demonstrate understanding of its requirements by attending an approved agency or SAPC training, including:

1. Best practices to prevent 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.

B. 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 on the lower barrier SUD treatment aims of the R95 Initiative, 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.

VIII. [Add other topic areas as needed, in appropriate order]

ATTACHMENTS

- [Insert title of agency toxicology policy referenced in Procedures Section and attached copy below]
- [Insert the title of any additional documents referenced above and attach copies below]