**Provider Feedback Table for R95 Discharge Policy Template:**

Thank you for your feedback! The last column “SAPC Response to Provider Feedback” outlines changes and explanations. Updated 2/15/24.

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| **DRAFT DISCHARGE POLICY - FEEDBACK** | | | | |
| **Page #** | **TEMPLATE SECTION**  *Purpose, Policy, Scope, Definitions, & Procedures* | **ORIGINAL TEXT** | **PROVIDER COMMENTS, OR PROPOSED EDITS / REVISIONS ON REFERENCED TEXT** | **SAPC RESPONSE TO PROVIDER FEEDBACK** |
| *1* | *Procedures, I*  *Toxicology Testing* | *Toxicology Testing: A positive test result is not in and of itself a reason for discharge or transition to another level of care.* | *Are we required to use “toxicology” instead of “drug” or “urinalysis” term?* | *No. SAPC is moving to the “toxicology” terminology because it is more precise than “drug” or “urinalysis” terminology, but SAPC is not requiring the use of any specific terminology.* |
| 1 | *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] | 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, residential, ~~outpatient/residential/inpatient~~ withdrawal management, and Opioid Treatment Programs, etc. ~~Recovery Services, Recovery Bridge Housing, and Recovery Housing~~~~etc.)~~ [remove levels of care not offered at the agency] | REVISED TO: *Furthermore, it applies to all levels of care and services provided by agency (e.g., outpatient and intensive outpatient, residential, withdrawal management, and Opioid Treatment Programs, Recovery Services, Recovery Bridge Housing, and Recovery Housing**etc.).* |
| 2 | *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. | **Lapse:** A brief return to substance use following a sustained period of abstinence, despite the patient remaining committed to ~~recover~~ **SUD treatment** and demonstrating a willingness to re-engage with ~~the recovery journey~~ **treatment services**. | Edited as recommended, with a few additional stylistic edits from SAPC.  Providers will need to update the Admission Policy in the same manner for consistency. SAPC will update its online template as well. |
| 2 | *Definitions* | **Relapse:** A prolonged episode of substance use during which the patient is not interested or open to a therapeutic intervention. | **Relapse:** A prolonged episode of substance use during which the patient is not interested or open to ~~a therapeutic intervention~~ **receiving SUD treatment services.** | Edited as recommended.  Providers will need to update the Admission Policy in the same manner for consistency. SAPC will update its online template as well. |
| 2 | *Definitions* | **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. | **Toxicology Testing**: A **treatment** tool that can be offered alongside other clinical interventions when requested by a patient to support their individualized goals **and/or used by treatment provider to better inform patient care**. Toxicology (also known as “drug” or “urinalysis”) testing is not a requirement for all **settings** or ~~at~~ **should be implemented 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.~~ | Revised per Discussion: *A 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.* NOTE: Agencies may insert “optional” based on preference.  This maintains that toxicology testing is a clinical tool and based on patient need, and the frequency should reflect that. Because the Medi-Cal contingency program does involved a fixed frequency of urine toxicology testing, eligible patients are able to opt into this program with its fixed testing frequency, but patients should not be categorically required to participate in toxicology testing to receive other treatment services.  Added definition of “toxicology testing” to the Admission Policy prior to submission as well as reference to test results and use under Admission Criteria A and B. The Admission Policy template will be reposted with the above change as a requirement. |
| Toxicology Testing should not be “an optional tool” not only when “requested by the patient.” Currently and in most programs testing is required for all patients both on a regular basis and when there is cause for suspicion of recent use. This is an important part of programmatic efforts to maintain a safe environment and should not be reduced or eliminated. | A cornerstone of DMC-ODS, and now CalAIM, is to provide services that are patient-centered and not program-centered, in other words services cannot be “cookie-cutter” and apply to each person coming to the program.  The purpose of this addition was to explicitly work with providers to rethink how testing is used in programs. If patients can engage in treatment without a commitment to abstinence, then a positive toxicology/drug test should not result in discharge or adverse impact on their ability to remain in care. Fundamentally, toxicology/drug testing is based on patient choice because there is no mechanism to force testing involuntarily. When patients decline to participate in testing, that is clinical information that provider agency’s treatment staff can use to determine clinically appropriate next steps in the patient’s plan of care.  For these reasons, SAPC is supportive of its agencies using toxicology tests as clinical tools to inform the patient’s individualized plan of care, but not as barriers to initiation of care or itself an automatic trigger of discharge without consideration of patients’ full clinical circumstances. SAPC is moving our system of care to a lower barrier model of SUD care and those practices are inconsistent with low barrier care. Many patients will want to commit to or progress towards abstinence-based goals at some point during the treatment episode, which is encouraged but there also needs to be a focused effort to support patients who are not ready to commit to abstinence or lapse during care.  The definition was revised as outlined above. |
| Some agencies require toxicology testing for enrollment to program or for purposes of treatment and services. (e.g. OTP programs) | A “positive” test for alcohol or drugs cannot be a requirement or prerequisite to program admission, however, it can be used as one of many tools, which includes clinical assessment and judgement to determine if this is the appropriate level of care. Specifically, a patient cannot be turned away solely because they did not test “positive” before admission to OTP, withdrawal management, and residential as is currently the case at some service locations.  SAPC made the following above edit (see “toxicology testing”) to the Admission Policy to address this issue there as well. Please ensure this update is included in your Admission Policy submission. |
| Provider Manual 8.0 states that drug testing is required in OTPs at least once per month. | California regulations require a minimum of monthly test per year, and when a patient fails to provide a body specimen, the OTP shall proceed as though the patient's sample from his or her body specimen disclosed the presence of an intoxicant. |
| Some patients may be requested or required to submit to toxicology testing as part of treatment admission (e.g. NTP/OTP level of care), on-going care, or due to an agreement with Probation or DCFS. Toxicology testing and result disclosure to external entities would still need to be authorized via a consent to release information. | If Probation requires testing, it is still that patient’s choice whether or not to submit to testing, even when there a very real consequences for declining. |
| The current text suggests patients can opt out of toxicology testing, which would be problematic for agency in determining if patient is at risk for withdrawal. | Addressed above. |
| It’s important for agency to know if patient is using fentanyl because the overdose probability is very high | The likelihood of overdose is high regardless of toxicology test findings and all SUD clients should be treated as if they are high-risk for overdose. SAPC agrees that agencies should inquire about drug and fentanyl use. SAPC is not prohibiting toxicology tests and is supportive of its agencies using toxicology tests as clinically helpful and appropriate but does not support mandating toxicology tests and either not admitting people or discharging people based on the results of that toxicology test. SAPC is moving its system of care to a lower barrier model of SUD care. |
| Medical Directors may need this information to refer patients to MAT services. | SAPC is not prohibiting offering patients toxicology testing and is supportive of our agencies using toxicology testing as clinically helpful and appropriate but does not support restricting admission or requiring discharge based solely on the toxicology testing results without a full consideration of the patient’s clinical circumstances. SAPC is moving its system of care to a lower barrier model of SUD care. |
| Flexible language would allow for agencies that operate in multiple counties to follow different protocols set by various counties | SAPC sets policies for Los Angeles County’s specialty SUD system and while SAPC supports some level of flexibility, it will not support practices that deviate from a low barrier system, as this is best practice to better engage more people with SUDs. |
| Toxic, positive and negative terms send wrong message in SUD tx as substances detected is neither deemed positive or negative – just means they are not abstinent of substance use | The terms toxicology, positive, and negative with respect to testing are medically neutral terms, and provider agencies are able to use other terms that best align with staff and patient participation in clinically appropriate testing as a component of (not requirement for) treatment. |
| 2 | *Definitions* | **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). | **Warm Handoff**: A transfer of a patient from one SUD facility to another that occurs with agreement or at the request of the ~~individual~~ **patient** and where the involved ~~agency make~~ **agencies make** every effort **to leverage resources** to facilitate a successful ~~connection, preferably by ensuring that the individual arrives at the new facility~~ **transfer** (e.g. ~~transportation provided~~, **coordinating patient needed transportation**). | These edits were not accepted. This definition had been previously reviewed under the admission policy. Furthermore, the edits remove elements of a “warm handoff” (e.g., connection) and focus on current practice of referrals. Modified definition in admission and discharge to also say “(e.g., intake scheduled and transportation arranged)”. |
| 3 | *Procedures. III. Discharge Determination and Transitions. A* | 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 | Before discharge or transition to a higher or lower level of care is determined, steps must be taken with the patient and ~~leadership~~ **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 | Edit made. |
| Comment: Unless I’m misunderstanding the breadth of the new AWOL policy included in Provider Manual 8.0, because of its specific timeline and implications for clients with challenges maintaining consistent engagement with their services, it might be critical to incorporate it into this section on Discharge Determination and Transitions. | Agencies are able to add this to their discharge policy if desired. SAPC clarified that the CalOMS AWOL policy is related to the last missed appointment. Clinicians/counselors are able to offer additional appointments as appropriate. |
| Staff engage with patients throughout the treatment process to encourage connections to SUD services when transitioning / discharging from their current level of care.  Our policies include language about providing clients with a NOABD. This should be included in this policy. | The NOABD actions should occur at the time an adverse determination regarding admission has been made and patients who reach out to initiate treatment or who have already been admitted to treatment should be provided a warm handoff to another level of care if it is determine that the current level of care is inappropriate. |
| In this context, lower level of care reference is not warranted | These edits were not accepted. This policy was meant to include those that are discharging because they completed the level of care and/or otherwise would benefit from a lower level of care as well as those that need to be stepped up for need. |
| 3 | *Procedures. III. Discharge Determination and Transitions. A.1.* | Patient is offered crisis intervention and individual counseling to support their physical and emotional wellbeing, including exploring their current treatment and recovery goals. | **When appropriate,** patient is offered crisis intervention and individual counseling to support their physical and emotional wellbeing, including exploring their current treatment and recovery goals.  • This assumes that transition/discharge is associated with a “problem” versus patient now needing a lower level of care, e.g. going from residential to outpatient.  • Some patients may be successful in their current level of care, so crisis intervention is not always appropriate. This decision can be made between the patient and treatment team. | Revised: Added *“when appropriate”* for clarity. |
| 3 | *Procedures. III. Discharge Determination and Transitions. A.2.* | 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). | 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) **or consultation with a Medical Director.**  This broadens level of care. If patient requires medical care, they may also require attention from a Medical Director. For example, agency may discharge a patient and transfer them to a hospital setting because they're no longer appropriate for agency’s level of care until they get stabilized and can be brought back if appropriate. | This statement is to clarify that all patients who lapse, including those that use opioids or alcohol, do not need to receive off-site medical clearance at a hospital, other urgent or emergency services, or referred to withdrawal management. Further, it should not be standard policy to obtain medical clearance or require withdrawal management services when the patient’s presenting symptoms do not warrant that level of care. The decision to seek medical services must be determined on a case-by-case-basis, and based upon an individualized determination that the patient has symptoms which require medical services based on consultation with a qualified practitioner (including, but not limited to, the medical director).  There are other facility types that manage patients onsite when substances are used and this can be an effective model for some patients and reduce the risk that patients do not return to the program after the off-site services.  While a “Medical Director” is an LPHA – this was added to clarify consulting positions. SAPC also added “or physician” to include physicians that are not the DMC designated “Medical Director”. |
| How does this conflict with DHCS standards? | SAPC is aware of DHCS [Title 9 Section California Code of Regulations for Residential Licensing](https://govt.westlaw.com/calregs/Document/I630BEBA34C6B11EC93A8000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)%20) [Section 10572e](https://govt.westlaw.com/calregs/Document/I630BEBA34C6B11EC93A8000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)%20) that states *“(e) No person, who, within the previous 24 hours, has consumed, used, or is still otherwise under the influence of alcohol or drugs as specified in section 10501(a), shall be permitted on the premises except for individuals admitted for detoxification or withdrawal. The licensee shall have specific written rules and policies and procedures to enforce this provision”*, however, this is not current best practice and the State is currently working to update regulations. In the meantime, providers should obtain Incidental Medical Services (IMS) certification if there are concerns about this transition and notify SAPC if the State issues an associated citation so support can be provided. If there are concerns about how to operationalize this, please contact SAPC. |
| 3 | *Procedures. III. Discharge Determination and Transitions. A.2.a* | 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. | **(REMOVE LINE)** ~~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.~~ | A dedicated sleeping area is optional, as noted with “black” text. See below for further information. |
| * Providing a “dedicated resting/sleeping area” may not be practical for most residential programs to provide as most do not have private rooms available to accomplish this. The alternative is to house the relapsed patient with others. Exposing others to individuals who are clearly under the influence is extremely triggering to them and should be avoided. * Some agencies can accommodate while others may be required to move someone out of their bed to move this patient over, which may unfairly penalize other patients in program. * Agencies require autonomy to choose how to support the patient, monitor the patient, and conduct the day-to-day operations of treatment and to do all they can to avoid discharge for patients who lapse in their recovery | The lack of a dedicated sleeping area is not a reason to discharge a person or transfer them to a medical or withdrawal management facility so that they are not with other patients. Providers have autonomy to determine how to best serve patients who have recently used an intoxicant but it is necessary that whenever a patient can be accommodated within the program it should be done so that there is not an opportunity for them to not return to the program when they are already vulnerable to continued use. Options to create separate space without requiring construction or other capital investments include things such as partitions (similar to what was used during the pandemic), other barriers/furniture, sound machines to reduce noise disruption, etc. |
| 3 | *Procedures. III. Discharge Determination and Transitions. A.* | Not included | Dischargeable offenses – violence – physical and verbal threats | These edits were not accepted – Providers are required to include other agency-specific instructions and requirements to their discharge policy and procedure which may include this information, provided it is not in conflict with the R95 text. |
| Psychotic and bipolar instability – when to hospitalize for stabilization and due to disruption of services for other clients |
| 4 | *IIV. Same Day Admissions* | 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. | **(REMOVE LINE)** ~~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.~~  Unsure how this is related to Discharge policy? | Deleted |
| 4 | *V. Medi-Cal Enrollment Status. 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 patient with continued enrollment. This is not a responsibility of the patient, their family, or other service providers. | A lapse in Medi-Cal enrollment for patients who remain eligible for Medi-Cal is not an allowable reason for discharge. **SAPC must ensure provider payments in such cases.** Care coordination services must be provided to support a patient with continued enrollment. This is not **solely** a responsibility of the patient, their family, or other service providers. | These edits were not accepted. The discharge policy refers to enrolled patients. Therefore, it is a clear responsibility of the contractor to ensure that they are checking Medi-Cal enrollment on at minimum a monthly basis to ensure that claims can be processed and reimbursed by the State. The care coordination benefit is to be used to support this effort. Additionally, the fee-for-service nature of reimbursement now enables providers to redirect funds to support the cost of services for patients who lose Medi-Cal mid-treatment episode and where support is not provided to assist in the renewal process. |
| Providers need support from patient work on Medi-Cal Enrollment.  Providers cannot contact Medi-Cal online or by phone without the patient being present and being involved in that process. | For technical assistance, please contact Nancy Crosby at [ncrosby@ph.lacounty.gov](mailto:ncrosby@ph.lacounty.gov).  To address this concern, providers can and should implement processes to ensure patients are aware that they should notify their treatment team when they receive Medi-Cal renewal and/or eligibility verification requests, and that the treatment team will assist them with this process to ensure patients maintain health benefits and the provider is able to continue billing for services. When this does not work, and the patient loses Medi-Cal benefits but remains eligible, providers can and should also implement a notification system between those that check at minimum monthly Medi-Cal enrollment and the treatment team / primary contact to ensure the care coordination benefit is used when the patient next arrives at the facility and prioritize reenrollment in conjunction with other needed services (e.g., group, individual). |
| The intention is to support patients and recognize that some patients are going to need agency support to fill out forms | Agreed, see above regarding implementation of agency policies that can help address this and how to enhance use of care coordination to support completion. |
| There needs to be clear language around disruption in Medi-Cal, because it's sometimes necessary to work with families, especially when patient is a youth and doesn't know what's happening with their Medi-Cal | Agreed, see above regarding implementation of agency policies that can help address this and how to enhance use of care coordination to support completion. |
| If patient suddenly has private insurance, then agency would need some time to transition patient out to those other funding sources. | SAPC is unable to reimburse services for ineligible patients, including those enrolled in treatment under Medi-Cal but transition to private insurance. Providers can and should offer sliding scale services in these instances, and/or become a provider for private insurance. |
| 4 | *V. Medi-Cal Enrollment Status. A.* | 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. | For this to not unfairly impact providers, SAPC must:   1. Allow for a “grace period” under the “applying for Medi-Cal” (beyond the current 30 day limit) to allow providers ample time to reactivate a patient’s Medi-Cal. 2. SAPC must provide the referenced “non-Medi-Cal funding sources to fund treatment for individuals whose Medi-Cal issue cannot be rectified.   It is unfair and unjust for SAPC to expect providers to provide “agency scholarships” to accomplish this | Similar to above, SAPC is unable to reimburse services for ineligible patients. The transition to fee-for-service Medi-Cal reimbursement model enables providers to examine how to use service revenue which could be to support patients who do not meet County requirements. |
| 4 | *VII. 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. | 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. | Edit made. |
| 5 | *VIII. Staff Training and Development. A.* | 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 | Upon hire, and minimally overview updates annually thereafter, on the discharge policy and demonstrate understanding of its requirements by attending ~~a~~ **an agency or** SAPC training or ~~approved alternate~~ other comparable presentation, including | Edit made.  The Admission Policy template will be reposted with this for consistency. |
| 5 | *VIII. Staff Training and Development. 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, 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. | 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~~ **meet recommended standards** for SUD treatment discharges**/transfers** and better serve the R95 population; which may be incorporated within the annual training or other forums. | These edits were not accepted. The standards SAPC is setting here are not recommended and instead are required for those participating in the R95 Initiative, and SAPC thinks it is important to be clear on the goal here – to lower the bar for SUD treatment discharges. |
| N/A | - | - | **Additional comment**: Since there's an effort to keep patients as long as possible, has there been any change in agency requirement for IOP or residential for a patient to maintain treatment? For example, if the current policy is to move forward and retain patients at a longer period, then those should those hours change on residential? | When patients meet Medical Necessity, there are no fixed duration of time a patient can be served in a residential or high intensity outpatient level of care. Medical necessity for ongoing care is based upon the patient’s individual clinical needs. For IOP, service hours can be in excess of 19 hours per week when medically necessary and a separate partial hospital level of care designation is not needed. For residential, providers should submit a reauthorization request whenever a continued stay is determined to be medically necessary including those that are necessary to prevent discharge to homelessness, within the timeframes specified in the current version of the SAPC Checklist of Required Documentation for Utilization Management posted via <http://publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm?tm#clinical>. |