PROVIDER ALERT

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Beacon Health Options Expectations for Safe Discharge from Residential Care Settings

At Beacon Health Options, we strive to ensure that our members are receiving the highest quality of care, in line with evidence-based standards. One area of concern in recent years has been the safety of patients being discharged from residential care settings. Discharge from a facility is not an end of treatment, but rather, **one of many transitions to another phase of treatment in the on-going recovery process** (Waring, et al., 2014). The discharging facility has a responsibility to ensure that every effort is made to arrange for adequate shelter, safe transportation and an appropriate level of aftercare for individuals leaving their program. This applies to all discharges, including those that are against medical advice (AMA).

There is little research published about discharge from residential care settings but quite a bit on hospital discharges. This document draws upon that literature and substance use disorder research to outline what facilities can and should be doing to prevent tragic outcomes after patients leave a facility.

Discharge Planning

- As in hospitals, discharge planning is an on-going process that begins with admission and continues throughout the course of treatment (PA code 28 § 105.22).
- Also, as with hospitals, facilities should have written policies regarding discharge planning, which include appropriate referral and transfer plans, methods to facilitate the provision of follow-up care, information to be given to the patient or his family or other persons involved in care and procedures for assisting the patient and his family in gaining information regarding financial assistance in paying bills incurred as a result of treatment (PA code 28 § 105.22).
- The Pennsylvania Caregiver Advise, Record and Enable Act (CARE Act) became effective on April 20, 2017. This law requires that hospitals request each patient name a lay caregiver, who will provide assistance to the patient at home after discharge. This assistance can be help with basic activities of daily living, medication administration or any other tasks that the discharging physician deems appropriate (Timko, 2017). While this law does not apply to non-hospital residential treatment, facilities are encouraged to follow this guidance as a best practice.
- Tentative and alternate dispositions should be identified upon admission.

- Emergency contacts should be identified at the time of admission. Unanticipated discharge should be specified as an emergency event and patients informed that emergency contacts will be notified should that happen.
- There should be regular contact between the facility and responsible parties at the identified discharge location throughout residential treatment.
- Discharge plans should be confirmed and responsible parties contacted at least 48 hours prior to anticipated discharge.
- Discharges should occur during the week, as discharges between Saturday and Monday are associated with a higher risk of death (Waring, et al., 2014).
- Individuals with psychiatric symptoms or cognitive impairment must be assessed by a qualified clinician prior to discharge. In the case of AMA discharges, this should include an assessment of whether involuntary commitment is appropriate.
- Individuals with functional impairment (mobility, self-care) must be assessed before being discharged to living independently (Alper, et al., 2021).
- Discharge locations must be appropriate for the medical needs of the individual (Alper, et al., 2021).
- Individuals who leave AMA should not be subject to punitive conditions as a disincentive to leaving treatment.

Transportation and Shelter

- All patients leaving a facility should be offered a safe means of transportation to appropriate shelter or aftercare location (Alper, et al., 2021).
- Instructing individuals to walk, hitchhike or find their own transportation is an unsafe practice. If a friend or family member will provide transportation, the facility should document contacting that individual.
- Leaving an individual at a facility (shelter, bus station, etc.) that is closed is an unsafe practice.
- Giving an individual a list of shelters is insufficient. Efforts must be made to ensure that the facility is open, has vacancies and will accept the individual.

High Risk Windows

- Individuals who have started or completed withdrawal/detoxification from substances are at very high risk of relapse, overdose and death in the first 30 days of treatment and for the 30 days after treatment (Sordo, et al., 2017).
- Those completing inpatient detox are more likely to die of overdose within a year (Strang, et al., 2003).
- Individuals who have stopped long-acting naltrexone (Vivitrol) are at very high risk of overdose and death between one and two months after stopping (Binswanger & Glanz, 2014).

After-Care

- All discharged individuals should be offered multiple options for follow-up care, including the level of care recommended by clinical staff (such as another residential setting) but also including crisis intervention and emergency services.
- After-care should be arranged for all appropriate services, including medical, behavioral health and substance use-related treatment. Encouraging the patient to set up their own appointments after discharge is insufficient.
- All individuals who use or may use opioids should leave with naloxone (Narcan) or be given clear instructions regarding how to obtain it.
- Prescriptions for medications should be transmitted to the appropriate pharmacy at least 24 hours in advance of discharge.

If you have questions or concerns about these expectations, please contact your Provider Field Coordinator.

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