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Substance Use Residential Provider Guidance: Discharge Planning and Arrangement of Step-Down Services Following Residential Substance Use Disorder Treatment

Residential substance use disorder (SUD) treatment is one component of a continuum of care, rather than a stand-alone episode that ends when a client leaves a facility. Effective discharge planning helps preserve treatment gains, maintain medication continuity, reduce recurrence of substance use, and prevent avoidable emergency department visits, readmissions, overdose, and death.

The period immediately following residential treatment or withdrawal management is particularly vulnerable. National quality standards therefore assess whether clients receive SUD follow-up within 7 and 30 days after discharge from residential treatment, inpatient treatment, or withdrawal management.

LDH expects residential providers to treat discharge planning as an active clinical and care-coordination function. Providing a client with a provider directory, telephone number, or general recommendation to obtain outpatient treatment does not, in itself, constitute adequate arrangement of step-down care.

The Louisiana Medicaid Behavioral Health Services Provider Manual indicates that:

1. **Discharge planning begins at admission.** For residential treatment levels, referral arrangements must be made prior to discharge.

2. **The discharge plan includes an appointment date and/or time period of follow-up with the transitioning behavioral health provider and client's primary care provider when clinically indicated.** The provider must document any barriers if unable to schedule an appointment when member is discharged or transitioned to a different level of care.

3. **The provider must ensure collaborative transition of care occurred with the receiving clinician/program as evidenced by documented communication.** The provider must document any barriers if unable to communicate with the receiving clinician/program when member is discharged or transitioned to a different level of care.

4. **The provider must provide the medication profile, if applicable, to the client and outpatient provider.** The provider must document any barriers while reviewing the transition of care with the member or while providing the medication profile to the receiving provider.

Expectations for Effective Discharge Planning

1. **Begin early and assign responsibility.** At admission, identify the staff member responsible for discharge planning and incorporate the anticipated next level of care, barriers, responsible parties, and action dates into the treatment plan. Before discharge, reassess the client's current ASAM and biopsychosocial needs. The disposition must reflect the client's current clinical risk, functioning, recovery environment, preferences, and ability to participate safely – not a predetermined length of stay, program completion, or administrative convenience.

2. **Complete a closed-loop transition**. For a planned discharge, the provider is expected to send a complete referral; confirm receipt, acceptance, authorization, and a specific appointment; communicate necessary clinical information consistent with consent and confidentiality requirements; and give the client the date, time, location or telehealth instructions, and contact information in an understandable form. The plan for follow-up care must match the client's current needs and may include a lower or higher level of SUD care. Address practical barriers such as transportation, housing, pharmacy, family or work obligations, accommodations, legal requirements, and crisis planning.

3. **Ensure medication continuity and reduce overdose risk**. Before discharge, reconcile medications and ensure an adequate supply or bridge prescription through the next prescriber visit.

3. **Escalate barriers and manage unplanned discharges**. When the recommended service is unavailable, promptly engage the client's managed care organization (MCO) to locate, authorize, and arrange an appropriate service. Notify the MCO as early as possible before an anticipated discharge and on the same day of an unexpected discharge and identify the safest interim plan. Document provider contacts, responses, barriers, escalations, services offered, client preferences or refusals, and final disposition.

For a client-directed or unplanned discharge, make reasonable efforts to assess immediate risks when the client is available; explain the risks of abrupt transition; offer medication continuity, crisis information, and follow-up; notify the MCO, receiving providers, and authorized supports as appropriate; conduct outreach within one business day when consent and circumstances permit; and document the client's response and unresolved risks.

4. **Conduct post-discharge follow-up.** The discharging provider contacts the client within 48 hours after discharge to determine whether the client:
    - **a.** Obtained prescribed medications if applicable;
    - **b.** Attended or remains able to attend the scheduled appointment;
    - **c.** Has experienced a recurrence of use, withdrawal symptoms, or another crisis; and
    - **d.** Needs assistance with transportation, rescheduling, or connection to another provider.

    If the initial appointment is missed or cannot occur, the provider makes reasonable efforts to re-engage the client and coordinate an alternative with the MCO and receiving provider during the first seven days after discharge.