| Health Care Agency<br>Behavioral Health Services<br>Policies and Procedures | Section Name:<br>Sub Section:<br>Section Number:<br>Policy Status: | Care and Treatment<br>Referral<br>01.01.04<br>☒New ☐Revised |
|---|---|---|

| | SIGNATURE | DATE APPROVED |
|---|---|---|
| Director of Operations<br>Behavioral Health Services | Signature on File | 11/14/17 |

| **SUBJECT:** | Continuity of Care and Referrals in SUD Programs |
|---|---|

**PURPOSE:**

Establish a guideline and procedures for transition of care for clients throughout the County of Orange Behavioral Health Services (BHS), Drug Medi-Cal Organized Delivery System (DMC-ODS) Continuum of Care and to ensure beneficiaries receive a level of care that would most appropriately address their needs.

**POLICY:**

County of Orange BHS provides a continuum of care for DMC-ODS beneficiaries. Providers are to continually assess a beneficiary's treatment needs in order to offer and/or link beneficiaries to the most appropriate level of care for each person. Providers will:

1. Continually assess for the appropriate level of care needs for each beneficiary;

2. Provide case management services to link beneficiaries to the next appropriate modality and/or provider; and

3. When appropriate, collaborate with next the provider site to ensure a smooth transition for the beneficiary.

**SCOPE:**

These procedures apply to beneficiaries entering into the County of Orange BHS, Substance Use Disorder (SUD) Programs, both DMC-ODS and non DMC-ODS services.

**REFERENCES:**

Alcohol and/or Other Drug Programs Certification Standards

Drug Medical Special Terms and Conditions

American Society of Addiction Medicine (ASAM)

County of Orange ASAM Level of Care (LOC) Assessment

**DEFINITIONS:**

Provider - Any treatment provider who is either a County of Orange SUD treatment provider or an SUD treatment provider who is contracted to provide services for the County of Orange.

ASAM Levels of Care (LOC) – Treatment described as a continuum marked by four broad levels of service and an early intervention level as defined by the American Society of Addiction Medicine (ASAM).

Warm Handoff – refers to the referral practice wherein the provider introduces a beneficiary to another provider in real-time, either in person or by phone. Warm handoffs are done in front of the client (and family if they are present) to facilitate transitions and continuity of care. The warm handoff engages the beneficiary as a team member and partner in his or her care.

**PROCEDURE:**

I. Assessment

A. Each provider will use the ASAM LOC Assessment at intake to ensure that the beneficiary meets medical necessity and to determine which level of care would most appropriately address their needs.

B. Once the assessment is complete and the level of care which would be most appropriate to address the beneficiary's needs has been determined, the Care Coordinator shall discuss results with the beneficiary and the beneficiary can accept to enter that level of care.

1. A beneficiary may decline to attend the level of care that was determined most appropriate, but then can only attend the level of care below that determined level.

2. Beneficiaries may not receive treatment from a level of care that is higher than the level of care that was determined most appropriate from the ASAM LOC Assessment.

C. Beneficiaries in all treatment modalities are reassessed whenever necessary and not later than every 90 days. Reassessments determine whether treatment is supporting the beneficiary in reaching established goals and whether transition to a lower or higher level of care is more appropriate.

II. Transition in Level Of Care

A. If it is determined during the ASAM LOC Assessment or re-assessment using the ASAM criteria that a different level or type of treatment is more appropriate to meet a beneficiary's needs, a warm handoff (if possible) or referral will be made to an appropriate provider by the program in which the assessment was done.

1. When linking a beneficiary to a level of care, provider shall:

a) Contact the program and consult with appropriate personnel regarding the admission criteria and requirements for linkage to the receiving program.

b) Acquire and complete all available and appropriate forms applicable to the receiving program.

c) Provide clear instructions regarding admission criteria to the beneficiary for access to the receiving program.

d) Provide directions to the receiving program for the beneficiary and assist with transportation, if appropriate. (i.e. bus passes or printing directions, etc.).

e) Assist the beneficiary in completing an Authorization to Disclose (ATD) health information and any other documents that will ensure two way consultation/communication between the referring and receiving providers (if appropriate).

f) Document the linkage in an Encounter Document as a case management progress note.

g) Follow up with the beneficiary and/or program to ensure that the beneficiary has successfully linked to the program. Document the results in the beneficiary Electronic Health Record or chart.

h) If linkage was not successful, the referring provider is to follow up with the beneficiary and address any barriers to linkage.

III. Referral

A. If during the course of treatment services, the beneficiary is assessed and determined to be in need of additional services, the treating program shall provide the beneficiary with referrals to the appropriate services, as available.

B. The treating program shall maintain and make available to beneficiaries a current list of resources within the community that offer services that are not provided within the program.

1. At minimum, the list of resources shall include:

a) Medical

b) Dental

c) Mental Health

d) Public Health

e) Social Services

f) Where to apply for the determination of eligibility for State, Federal County entitlement program.

IV. Conditions under which referrals are made shall include, but are not limited to:

A. Unstable Housing/homelessness.

B. Identified or possible untreated medical condition.

C. Identified or possible untreated mental health condition.

D. Identified or possible untreated dental health condition.

E. Financial instability that may result in eligibility for Social Services programs, such as, general relief, CalFresh, etc.

F. Vocational/Educational needs.

V. When it is determined that a referral is appropriate, the treating provider shall:

A. Contact the identified resource program and consult with appropriate personnel regarding the admission criteria and requirements for such program.

B. Acquire and complete all available and appropriate forms applicable to such program.

C. Provide clear instructions regarding admission criteria to the beneficiary for access to the program.

D. Provide directions to the program or resource for the beneficiary and assist with transportation, if appropriate and available. (i.e. bus passes or printing directions).

E. Assist the beneficiary in completing an ATD and any other documents that will ensure two way consultation/communication between the treating provider and identified resource program (if appropriate).

F. Document the referral in the Encounter Document as a case management progress note.

G. Follow up with the beneficiary in 7-14 days to ensure that the beneficiary has successfully accessed the referral/resource. Document the results in the beneficiary Electronic Health Record or chart.

H. If linkage was not successful, the treating provider may follow up with the beneficiary and address any barriers to linkage, as appropriate.