

**POLICY: MAT MANAGEMENT OF SUBSTANCE ABUSE TREATMENT FOR CONSUMERS WITH
CO-OCCURRING DISORDERS**

DEFINITION AND INTRODUCTION

- The coexistence of both mental health and substance use (abuse or dependence) disorders is referred to as co-occurring disorders (COD). Co-occurring disorders were previously referred to as dual diagnoses. A diagnosis of co-occurring disorders (COD) occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder. Such persons are more likely to have a severe addiction combined with mild- to moderate-severity mental disorders than a severe mental disorder; an example would be a person with alcohol dependence combined with a depressive disorder or an anxiety disorder.
- People with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder. Co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. In many cases, people receive treatment for one disorder while the other disorder remains untreated. This may occur because both mental and substance use disorders can have biological, psychological, and social components. Other reasons may be inadequate provider training or screening, an overlap of symptoms, or that other health issues need to be addressed first. In any case, the consequences of undiagnosed, untreated, or undertreated co-occurring disorders can lead to a higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, or even early death.
- Consumers with co-occurring disorders are best served through integrated treatment. With integrated treatment, practitioners can address mental and substance use disorders at the same time, often lowering costs and creating better outcomes. Increasing awareness and building capacity in service systems are important in helping identify and treat co-occurring disorders. Early detection and treatment can improve treatment outcomes and the quality of life for those who need these services.
- Co-occurring disorders are common among people experiencing homelessness and QBH deals with a high volume of homeless consumers. This population often has a variety of issues that require services beyond behavioral health treatment, such as life skills development, employment assistance, and housing. Treating people experiencing homelessness who are suffering from co-occurring disorders through integrated care is important to recovery. Failure to address their co-occurring disorders can lead to chronic homelessness and further deterioration in physical and behavioral health, as well as social and economic functioning.

PROCEDURES:

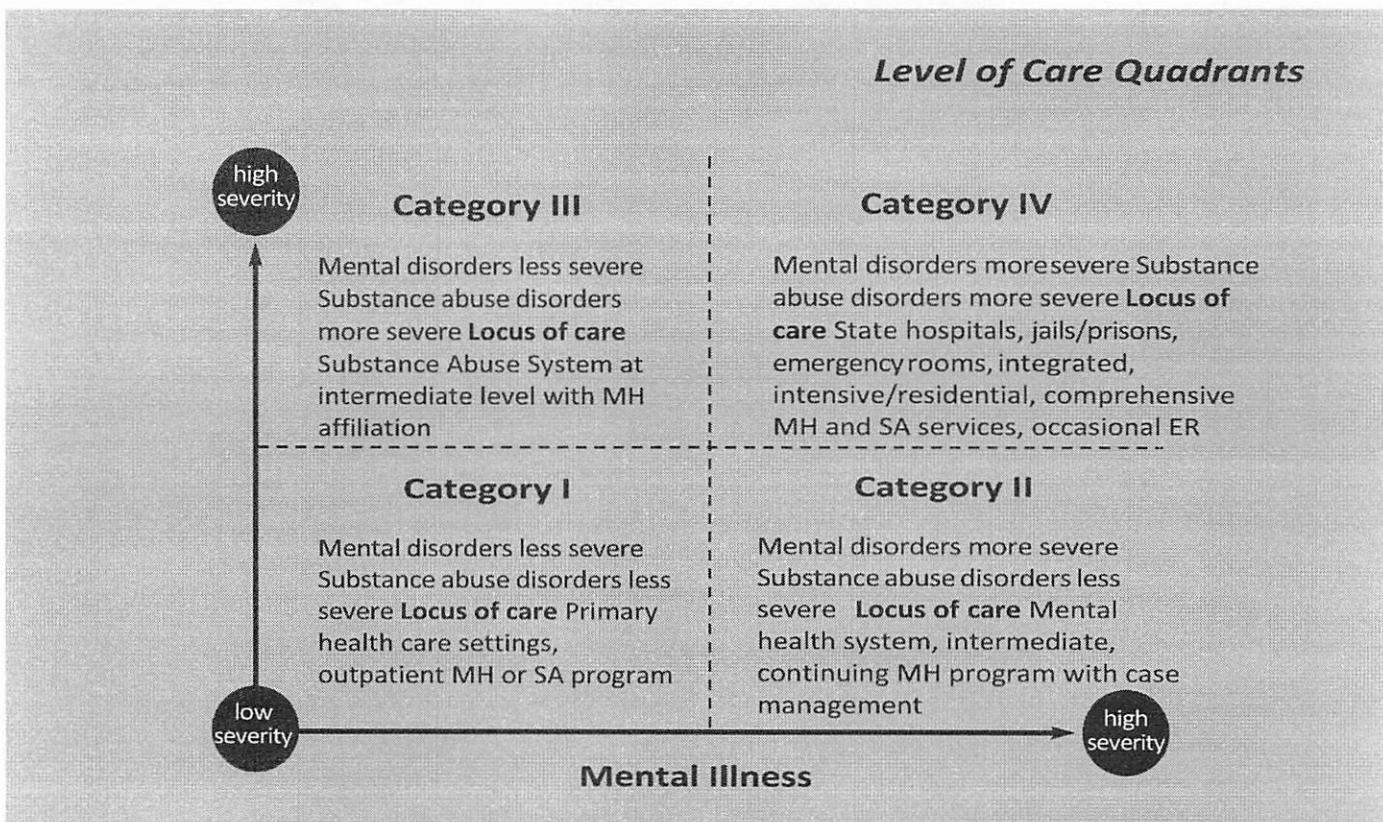
INTEGRATED TREATMENT

PRINCIPLES FOR SUCCESSFUL COD TREATMENT

Initiated: 2/2022

Reviewed/Revised: 2/2023, 1/2024, 1/2025

- Integrated treatment emphasizes a correlation between treatment models to treat mental illness and addiction that stresses a recovery focus, concomitant treatment of the mental illness and substance abuse, application of treatment stages, and the use of treatment strategies from both mental health and substance abuse treatment fields. QBH programs coordinate substance abuse and mental health interventions to treat the whole person more effectively.
- QBH's treatment programs are designed to incorporate the best practices as set forth by SAMHSA and the Center for Substance Abuse Treatment (CSAT), as well as state and federal health services guidelines as regards the management of consumers with COD. QBH programs attempt to integrate substance abuse treatment and mental health services for consumers with COD in an attempt to treat the whole person most effectively. The recovery focus of QBH programs acknowledges that recovery is a long-term process of internal change in which progress occurs in stages. Thus the consumer will likely receive treatment in various levels of care over time and much of recovery occurs outside of, or following treatment, through participation in mutual self-help groups and establishment or strengthening of reliable support systems
- Literature often references four categories or quadrants of COD. The four categories of COD are:
 - Quadrant I: Less severe mental disorder/less severe substance disorder
 - Quadrant II: More severe mental disorder/less severe substance disorder
 - Quadrant III: Less severe mental disorder/more severe substance disorder
 - Quadrant IV: More severe mental disorder/more severe substance disorder



QBH consumers fall within all Quadrants, depending upon the level of care needed.

QBH has intermediate level of capacity in that the focus is primarily on substance abuse without substantial modification of that treatment model, but with the capability to explicitly address some specific needs of the mental health disorder. Clinical staffs have dual diagnosis capability in all programs and are able to address the interaction between mental and substance related disorders and their effect on the consumer's readiness for change, as well as relapse and recovery environment issues, through individual and group program content.

- The guiding principles of treatment of consumers with COD are:
 - Employ a recovery perspective – the treatment plan provides for continuity of care over time and within various levels of care, especially emphasizing aftercare planning, with precise, realistic steps, and markers of progress defined in a way that is meaningful to the consumer at each stage of treatment
 - Adopt a multi-problem viewpoint – treatment planning addresses intermediate and long-term comprehensive services to meet the multi-dimensional problems (mental health, substance abuse, family and social problems that require substantial rehabilitation as well as initial learning and acquisition of skills)
 - Develop a phased approach to treatment – phases include engagement, stabilization, treatment, aftercare/continuing care that parallel stages in the recovery perspective; the clinician uses these phases to develop effective, stage-appropriate treatment planning
 - Address specific real-life problems early in treatment – COD arises in the context of personal and social problems resulting in the need for case management or intensive case management to help the consumer address special, specific areas of need such as housing, legal or family concerns, money management, and other psychosocial rehabilitation needs/skills acquisition; solving these is often an important first step in achieving consumer engagement which is a critical part of COD treatment since treatment for an adequate length of time is essential to behavioral change
 - Plan for the consumer's cognitive and functional impairments – consumers with COD often display cognitive and other functional impairments that affect their ability to comprehend information or complete tasks; interventions must be presented in a fashion compatible with the consumer's needs and functioning, calling for relatively short, highly structured sessions focused on practical life problems, gradual pacing, visual aids, and repetition
 - Use support systems to maintain and extend treatment effectiveness – mutual self-help groups, the family, the faith community and other resources within the consumer's community are invaluable for recovery, especially for the COD consumer who has rarely enjoyed a consistent supportive environment, and often faces being ostracized due to the stigmas of his/her diagnoses; making the consumer aware of available support systems and motivating him/her to use them effectively is a critical clinical role. Two critical support systems for COD consumers

are mutual self-help engagement and reintegration with family and community through such resources as religious, recreational and social organizations.

PRACTITIONER COMPETENCE FOR TREATING CO-OCCURRING DISORDERS

- QBH depends upon trained staff to deliver quality services that meet the goals and mission of its programs. It is recognized that creating a supportive environment for staff that encourages continued professional development, including skill acquisition, values clarification and competency attainment are necessary to achieve this end. Staff development and high-quality, supportive supervision are an ongoing commitment. These and sound personnel policies, benefits, and rewards/incentives for quality work ethics create the infrastructure for quality services.
- While substance abuse counselors may not be prepared to make mental health disorder diagnoses, initial orientation and ongoing training is focused on increasing their familiarity with mental disorder terminology and diagnostic criteria and to aid them in how to proceed with consumers who demonstrate symptoms of mental health disorder. Likewise, mental health counselors may not be prepared to make substance disorder diagnoses, so their initial orientation and ongoing training is focused on increasing their familiarity with substance abuse/dependence terminology and diagnostic criteria and to aid them in how to proceed with consumers who demonstrate symptoms of substance abuse/dependence. Both types of counselors are encouraged to collaborate in treatment planning and team building to draw out the expertise of both. Each type of counselor is expected to demonstrate competency in both areas, including:
 - Ability to establish an integrated diagnosis of substance abuse and mental disorder with knowledge of differential diagnosis terminology, pharmacological knowledge for both disorders, knowledge of effects of cultural factors, of trauma on symptoms, and of withdrawal symptoms
 - Ability to conduct an integrated assessment of treatment needs to include severity assessment, lethality/risk, assessment of motivation/readiness for treatment, appropriateness/treatment selection appropriate to severity of each disorder (see quadrants discussion above)
 - Ability to do integrated treatment planning involving goal-setting/problem –solving, treatment planning, documentation, confidentiality, legal/reporting issues, documenting issues for managed care providers for both disorders
 - Engagement and education through staff self-awareness of abilities in engaging, motivating and educating consumers with COD
 - Ability to identify and develop early integrated treatment for emergency/crisis intervention, knowledge and access to treatment services, when and how to refer or communicate
 - Understanding and ability to implement longer term integrated treatment using group treatment, relapse prevention, case management, pharmacology, alternative/risk education, ethics, confidentiality, mental health, reporting requirements, family interventions
- Orientation and ongoing training for clinical staff includes providing them with a better understanding of the signs and symptoms of mental disorders and access to medical support; a key focus of training is to help the clinician provide the prescribing physician with an accurate description of the consumer's symptoms and behavior to help facilitate proper medication selection.

Another training focus is to address the clinician's responsibility to assist the consumer in medication regimen adherence. They may also draw upon the peer community to help support consumer medication compliance.

ESTABLISHING CONTACT AND WORKING RELATIONSHIPS WITH COD CONSUMERS

- Providing access to services is a critical component and essential element of service delivery. QBH attempts to locate and provide service hours that allow the maximum possible opportunity for the COD consumer to make initial contact with our programs whether or not in crisis, receive a timely initial evaluation, and be welcomed into treatment that is appropriate to the consumer's needs. We also do outreach to educate the other community resources about our services through involvement in health fairs, offering education in various ways to diverse populations within the community, and through staff's involvement in various community organizations and committees which expands the visibility of our programs and increases referral potential. Access is also available through contracts with criminal justice and welfare systems and employers.
- Of particular focus is for the clinician to be aware of how the consumer's culture views disease/disorders, including COD, so that a model that is disease familiar and culturally relevant to the consumer can help communication and facilitate treatment. Trauma sensitivity is also important; all questioning should avoid "re-traumatizing" the consumer.
- Clinical staff is to communicate to the consumer from the first contact that they and the consumer will work together and that the staff will be help the consumer to help themselves. Attempt should be made to help the consumer solve some external problem directly and immediately can help convey this therapeutic alliance. Expect some avoidance behaviors in early stages of the alliance relationship.
- Clinical staff is expected, early on in their contact with a consumer, to be welcoming and to express empathy and hope, maintaining a recovery perspective, and to stay connected with the consumer as part of the treatment team. Rapport building begins with the first contact and is built upon through reliable, honest, caring behaviors that convey a sense of safety and a nonjudgmental environment to the consumer. Interactions are preferably in the consumer's primary language, if possible.

SCREENING AND ASSESSMENT

- Screening and assessment are the beginning of the treatment planning process. Screening is intended to identify those consumers seeking substance abuse treatment that show signs of mental health problems that also warrant attention.
- Assessment follows screening to establish evidence of COD and mental and substance abuse diagnoses; identification of problem areas, disabilities and strengths; determine readiness of the consumer to change, and data gathering to assist in level of care decisions. Intake staff makes every effort to contact all involved parties, including family members, persons who have treated the

consumer previously, other mental health and substance abuse providers, friends, significant others, probation officers as quickly as possible in the assessment process.

- Standardized assessment tools are used, as appropriate to the consumer's presenting issues, such as the Beck Depression Inventory or Addiction Severity Index, but no one tool stands alone as the best tool to complete a comprehensive clinical assessment.
- Intake assessments gather information to include (see MAT Assessment, Update and Clinical Summary policy for additional assessment content) :
 - *Background* information about the consumer's family, cultural, linguistic, gender and sexual orientation issues, trauma history, marital status, legal and financial issues, education, housing and employment status, and any strengths and resources of the consumer.
 - *Substance use* is determined, including primary drugs used and use patterns to establish diagnosis for abuse or dependence, past treatment, periods of abstinence of 30 days or longer to isolate mental health symptoms/disability and treatment during abstinent periods.
 - *Psychiatric issues* are explored by determining consumer and family history, including diagnosis and treatment history, current symptoms/diagnoses, medication use and adherence, past periods of mental health stability and treatment successes for any mental issues as well as the nature of substance use during stable periods, and identification of current treatment providers for information sharing and cooperation.
 - *Integrated assessment* to establish interrelationships among symptoms of mental health issues and substance, use as well as interrelationships of symptoms of substance use and mental health symptoms, and how these interrelationships relate to treatment experiences, stages of change, periods of stability and periods of crisis.
 - *Diagnosis* is an end result of the screening and assessment process, applying appropriate DSM criteria for each diagnosis.
 - *Initial matching* of the consumer to services and assessment the consumer's motivation to change with regard to one or both diagnoses.
 - *Appraisal* of existing social and community support systems.
 - *Continuous evaluation /re-evaluation* over time as needs and symptoms change or more information becomes available.
 - *Maintenance of a "no wrong door" policy* which means that a consumer needing treatment is identified and assessed and will receive treatment, either directly or through appropriate referral, no matter where he/she enters the realm of QBH services. This means that treatment access is available at any point of entry, even via creative outreach strategies, to access consumers with COD who are unlikely to knock on the door of a treatment facility.
- Medication is an essential program element to help consumers stabilize and control their symptoms, enhancing their receptivity to treatment. QBH medical staff attempts to employ psychiatric medications that are effective but with minimal side effects. An effective medication regimen allows the consumer to be stable enough to participate in medication assisted treatment and make progress that leads to more satisfying and productive lifestyles.

TREATMENT PLANNING AND /INTERVENTIONS FOR DUAL RECOVERY

- Treatment planning should fall into phases, beginning with engagement, then moving to stabilization, followed by primary treatment and ultimately continuing care, called aftercare. Which phase(s) is addressed depends upon the program the consumer is in and their specific needs/risks.
- QBH attempts to provide a combination of professional mental health and addiction counselor specialists as well as on-site and consultative psychiatrist participation in treatment planning and implementation with COD consumers.
- Treatment planning for the COD consumer, as with all consumers, must factor in the consumer's culture/ethnicity, socioeconomic and geographic considerations, gender and sexual orientation, age, religion/spirituality, and any physical/cognitive barriers.
- *Psychopharmacology*, in addition to MAT, is often a component of treatment, at least to the point of aftercare, for most consumers and is overseen and directed by the psychiatrist.
- *Individual counseling* is employed, as appropriate to the individual consumer's needs, in all programs. Likewise, *family interventions*, if appropriate and family engagement is possible, are part of all programs.
- *Case management* is provided either through the program or in coordination with another provider.
- An important aspect of treatment for the COD consumer is *psychoeducational classes* on topics to include education on mental disorders as well as substance abuse, and relapse prevention, to elevate the consumer's awareness of the disorders and their symptoms.
- *Groups* that provide for discussion of the interrelated problems of mental and substance use disorders, identification of triggers for relapse, and other COD issues are a part of the treatment plan.
- QBH clinical staff is also continually urged to adapt strategies from the substance abuse field to help the COD consumer be successful as they are revealed by the industry as being successful. Some that currently show promise which are being employed include:
 - *Motivational interviewing* during which the clinician helps the consumer, through directive methods, to increase their intrinsic motivation to change by exploring and resolving ambivalence, helping the consumer to clarify their goals and commit to change.
 - *Contingency management* whereby planned and organized system of positive and negative consequences is employed with the consumer to alter the type or frequency of a behavior may be used with some COD consumers. Particular focus is on rewarding or praising particular behaviors or accomplishment and/or progressive attainment of a level of privilege that is

- contingent on meeting certain behavioral criteria. Evidential data as to success with COD consumers is variable, but it is successful with some COD consumers.
- *Cognitive-behavioral therapy (CBT)* which seeks to modify negative or self-defeating thoughts or behaviors and is aimed at change in both is helpful to COD consumers to help build up their coping skills.
 - *Relapse prevention* is used to help the consumer develop their ability to recognize cues and to intervene in the relapse process, so that lapses occur less frequently and with less severity. This intervention helps the consumer to anticipate likely problems and then to apply various tactics for avoiding lapses.
 - *Assertive community treatment (ACT)* is employed with COD consumers, when available, in all of QBH's outpatient programs. ACT employs extensive outreach activities, active and continuing engagement with consumers, and a high intensity of services, emphasizing multidisciplinary teams and shared decision making, with the goal of engaging the consumer in helping relationships, assisting with basic needs such as housing, stabilizing the consumer in the community, and overseeing that they get direct and integrated substance abuse treatment and mental health services
 - *Conflict resolution group* (a modification of the traditional encounter group) which is highly structured, guided, of low emotional intensity, and geared toward achieving self-understanding and behavior change. The adaption from the traditional encounter group is that it allows for increased flexibility, more individualized treatment, and reduced intensity, creating a culture in which the consumer learns through mutual self-help and affiliation with the peer community to foster change in themselves and others.
 - *Specific disorder groups (e.g. Bipolar disorder) and groups with unique requirements (e.g. women, homeless)* are also employed to focus on the special issues of the group and how they can be managed.
- Participation of the COD consumer in community-based *dual recovery mutual self-help groups*, with a 12 step structure, that offer an understanding, supportive environment and safe forum for discussing medication, mental health and substance abuse issues is part of treatment planning when available.

DISCHARGE AND AFTERCARE PLANNING

- The COD consumer is particularly challenged by a return to life in the community, especially those from residential treatment, with relapse an ever-present danger. Discharge planning is focused on maintaining gains achieved through treatment. A number of aftercare options may be employed with these consumers, as available in their community:
 - *Mutual self-help group* – preferably a dual recovery group, built upon the 12 step model with a planned regimen for change
 - *Identification of a sponsor* - if engaged in a self-help group; ideally one who also has COD and is in the last stage of recovery
 - *Relapse prevention group*
 - *Continued individual counseling*

- *Psychiatric services* – especially if on medication
- *Intensive case management* – to continue monitoring and support
- Discharge planning always involves the consumer and, if possible, at least one support system resource. The plan must identify community resources based upon the consumer's specific needs and engagement with support systems identified during treatment to support sustaining progress already achieved during treatment.

COORDINATION OF CARE/COLLaborATION WITH OTHER SOCIAL SERVICE SYSTEMS

- Continuity of care as the consumer moves across different service systems is essential, especially for COD consumers who have two disorders (mental health and substance addiction) that are long-term, chronic disorders, to:
 - Provide consistency among primary treatment activities and ancillary services
 - Provide a seamless transition across levels of care
 - To coordinate present and past treatment episodesQBH places high priority on this process and includes orientation and training to clinical staffs in this area.
- QBH is involved in consumer and advocacy activities to expand services available in communities where QBH serves consumers, and in education to the community to reduce the stigma associated with the populations QBH treats.

EVALUATION:

- This policy shall be reviewed annually by the Clinical Director and submitted to Clinical Committee for approval, including any revisions, as needed.

POLICY: HAND-OFF COMMUNICATION (TRANSFER OF CARE BETWEEN PROVIDERS AND ASSOCIATED VERBAL/WRITTEN COMMUNICATION MANAGEMENT)

Hand-off communication will occur to facilitate an interactive exchange of pertinent information to establish a standardized model of communication and to facilitate consumer's safety every time care is transferred whether from staff member to staff member or staff member to family or consumer within the MAT program, or between QBH and another agency.

Hand-off of care means the communication exchange between providers any time a consumer is transitioned from one provider to another whether the transfer is internal to the MAT program or from the MAT program to another external provider. The hand-off is always done in a manner that allows both parties to exchange information. This includes asking and answering questions with clarifications if needed. Whenever possible, the hand-off will occur face-to-face. If face-to-face is not feasible, then the exchange will be by phone and/or confidential facsimile, complying with HIPAA regulations. When confidential facsimile is used, the name and phone number on each end of the transfer shall be included. By whatever means the hand-off is accomplished, the medical record shall contain documentation of that hand-off.

Occasionally, the transfer occurs because a staff member is no longer engaged by QBH and there was not time to communicate with the new staff in advance. In this circumstance, another team member providing services to the consumer may, by necessity, become the appointed, available source for answering or asking questions of clarification. The Clinical Director or designee shall appoint the alternate team member.

DEFINITIONS: EXAMPLES OF TRANSFERS OF CARE (not necessarily inclusive)**Hand-Off Requiring Completion of a Change of Practitioner Form:**

- Change in Therapist
- Change in Case Manager
- Change in Physician or another Licensed Independent Practitioner

Hand-Off Requiring Exchange by Verbal, Written or Taped Report:

- Nurse to Nurse
- Therapist to Therapist
- Nurse to Physician/Physician to Nurse
- Licensed Independent Practitioner to Licensed Independent Practitioner

- Clinical, Nursing or Medical Staff to Parent/Guardian/ Court/Collateral Source and vice versa.

Hand-Off Requiring Completion of a Discharge or Transfer Summary or Equivalent:

- Transfer of information from a MAT program Therapist or Physician to next or alternative care provider for reasons such as the need for a different level of care, request of consumer or guardian to change to a provider other than QBH, consumer discharge because care is completed or other reason for discharge or transfer.

Transfer Summary: a brief summary that is used when a consumer is being temporarily transferred to a different provider, but the consumer is not discharged from QBH during this period of service from a different provider. The consumer will return to QBH for treatment afterward. A primary example is the temporary need for a higher level of care. This summary is made available to the interim provider within one business day when the consumer is intended to return to QBH and is not discharged.

Discharge Summary: a thorough summary that meets regulatory and accreditation requirements that is employed when a consumer is leaving the MAT program to enter another QBH program or is leaving a QBH MAT program without intent to return to QBH for services. In either situation the consumer is discharged from the QBH MAT program in which they were receiving services. Examples might include: a consumer has completed treatment and no longer needs MAT services at the current level of care, a consumer leaves service without medical authorization, a consumer dies. This summary is made available to the next provider of care, if known, and to the last known Primary Care Physician within 14 days.

PROCEDURES:

- The hand-off always is done in a manner that allows both parties to exchange information, including asking and answering questions for clarification. Limit the possibility of interruptions during the process to minimize possible miscommunication.
 - Any clarifying questions/answers should be documented.
 - ✓ If the hand-off is permanent between internal providers, document in the designated area on the Change of Practitioner Form and/or in a progress note which goes in the consumer's medical record.
 - ✓ If the hand-off is shift to shift or transition from one service/discipline to another, no medical record documentation is needed, but following of Company or department protocol is done. If the hand-off involves turning responsibility of the consumer over to a transporter, or guardian, the staff releasing the consumer must document the transition and any instructions given in a progress note.
 - ✓ If the hand-off is with an external provider or collateral source, document in a progress note in the consumer's medical record.
- During a hand-off the transferring provider communicates to the receiving provider in an interactive manner, as applicable, providing **SRP** (an acronym that assists staff in the complete exchange of hand-off information) whether the transfer is orally or in writing:

- **Status:** Relevant information relating to the consumer's status or condition at the time of the hand-off. This will include up-to-date information on the consumer's progress or lack thereof relative to treatment goals at time of hand-off, and any recent or anticipated changes. Current diagnosis (es) and any high-risk behaviors, along with pertinent history, are included. Any PHI restrictions, if applicable, must also be communicated.
- **Recommendations:** Any recommendations made by the clinician to facilitate continuity, increase consumer/family participation, and/or improvement of care efforts.
- **Plan:** Current care, to include treatment methods, medication, assistance with any disability or other special care needs, and other services received. Also include information as to when and where the consumer was usually seen, any restrictions regarding when the consumer is usually available, who participated in family therapy sessions, and the guardianship status of the consumer. Identify current diagnosis (es) at time of transfer of care.

PERMANENT HAND-OFFS BETWEEN COMPANY PRACTITIONERS (THERAPISTS, NURSES, OR PHYSICIANS)

- Whenever possible, the hand-off will occur face-to-face.
- If face-to-face is not feasible, then the exchange will be by tape, written report, phone and/or confidential facsimile. *If sent facsimile, the cover sheet must contain the name and phone number for contact of both the sending and receiving practitioners.* HIPAA privacy policies must be followed whatever means is used.
- Whether face-to-face or not, the Change of Practitioner Form or a progress note must document that the hand-off occurred, and SRP information was exchanged, including contact information of both parties involved. Both parties shall sign the Change of Practitioner Form or progress note. This form or note is placed in the consumer's record.
- When a hand-off between Therapists occurs, the Therapist handing off the case should review the Integrated Summary and, if not current, should update the Integrated Summary, share it with the receiving Therapist, and it should be included in the consumer record.
- The person who is transferring care will be responsible for required documentation in the consumer's record, if applicable. They will also document in a progress note the name of the person with whom they spoke. The entry is to include the time, date, a summary of the information transferred, and the transferring person's signature and title.
 - If the hand-off is between medical practitioners, the Medical Director or designee will oversee completion/signatures by the medical practitioners.

HAND-OFFS BETWEEN COMPANY PRACTITIONERS (THERAPIST OR PHYSICIAN) AND AN EXTERNAL PROVIDER OR COURT ORDERED SOURCE

Another Provider

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- QBH strives to develop and maintain a referral and consultative relationship with a network of agencies and providers capable of providing primary and specialty services for the range of psychiatric comorbid conditions, medical complications, and communicable diseases that may be part of a consumer's problem list. Information exchange across this network must both facilitate treatment and protect consumer privacy.
- In a case of transfer to a sister provider or an external provider, the Therapist or Physician will, upon receipt of a completed Release of Information Form, provide the next provider of care with SRP information, which is followed by a copy of the completed Transfer Summary (which also contains SRP) within one business day of transfer or a completed Discharge Summary within seven (7) business days, if the consumer is being discharged.
- If feasible, the hand-off will occur face-to-face.
- If face-to-face is not feasible, then the exchange will be by phone and/or confidential facsimile.
- Whether face-to-face or not, a progress note, or equivalent, must document that the hand-off occurred, that information was exchanged, and the contact information of both parties involved. The Company Practitioner of the MAT program the consumer is leaving shall document the time, date and length of the exchange; the name and title of the person to who they spoke; a brief summary of the information shared (follow SRP) and any pertinent questions/answers during the exchange; and shall sign the entry, including their title. This documentation is placed in the consumer record.
- Once a Release of Information Form has been completed by the consumer or guardian, in instances where required, a copy of the completed Transfer Summary or Discharge Summary, as appropriate to the situation (see Definitions Section of this policy), will be provided to the receiving external provider. Provision of the appropriate Summary to the receiving external provider shall be documented by the sending provider in a progress note or equivalent in the consumer record.
- When a temporary licensed independent practitioner (LIP) staff covers for a permanent LIP staff, a documented review of any orders issued by the temporary LIP is conducted by the permanent LIP staff within three business days of his/her return.
- *If mental health services are being provided by a source outside of QBH's MAT program, that provider and the program provider shall jointly review any prescribed medications.*
- *If a consumer is provided medical care (e.g., treatment for Hepatitis C) by an outside source, that medical provider and the MAT program provider mutually communicate regarding the consumer's adherence to the medication regimen and any adverse events.*
- *The MAT program therapist assigned to the consumer periodically queries the prescription drug monitoring program (PDMP) throughout the course of each consumer's treatment and, in particular, before ordering take-home doses as well as at other important clinical decision points.*

Court Ordered Source

Initiated: 2/2022

Reviewed/Revised: 2/2023, 1/2024, 1/2025

- Court ordered information exchanges, whether for the continuing treatment of an incarcerated consumer, or a consumer on parole or probation, shall comply with HIPAA requirements.
- Communication shall be of the sort, format and frequency as directed by the court.
 - If communication is verbal, the content of the communication, time and date, and the name of the court official with whom information was exchanged shall be noted in a progress note, signed, and dated by the MAT practitioner, and included in the consumer record.
 - If the communication is written, a copy of the communication document is included in the consumer record. The MAT practitioner who provided or received the information shall note the date, time, and sign the document in a visible location that does not obscure document content.

MANAGEMENT OF VERBAL COMMUNICATIONS FROM OUTSIDE SOURCES

- Though not considered hand-off communication by the JC, there are circumstances when consumer information is received verbally from external sources that must be transferred promptly from one Company staff to another. *Such verbal information should also be requested in writing, if feasible.* Content of the verbal communication should be verified by the receiving staff for accuracy. For example, the Nurse provides Physician with verbal reports or alerts from outside sources, family members or the consumer that are pertinent to the consumer's current care such as lab results, medication errors and/or reactions, etc.
- When such information is received verbally, the receiving staff verifies information received, by writing it down on a progress note and then reading it back to the outside source that provided the information to confirm accuracy. The staff member should ask questions for clarification of information if needed to provide for full understanding of the communication. Read back and any questions/answers will be documented on the progress note along with the name of the person to whom staff spoke, the time and date, and the signature if the staff who received the information and placed in the consumer record.
- The staff who received the verbal communication should, as soon as feasible, communicate the information to the consumer's Therapist and/or Physician, as appropriate to the information received. This communication is also documented in the progress note. The date and time when the information was communicated is documented. The Therapist and/or Physician to whom the information is relayed shall repeat the information back to verify an accurate hearing of the information provided to them.
- Staff that may accept this information is trained on the procedure.

MANAGEMENT OF WRITTEN COMMUNICATIONS FROM OUTSIDE SOURCES

- Written communication received by the MAT program related to a consumer served shall be received by the Receptionist or designee and shall be promptly stamped with the date of receipt.
 - Examples of written communications from outside sources that must be communicated to other practitioners includes, but not exclusively: reports from prior providers such as a previous

psychological evaluation, a physical examination report, records from prior treatment or hospitalization, court records, lab reports, etc.

- The Clinical Director or designee is responsible to provide the report as soon as feasible to the Therapist and/or Physician, as appropriate, for their review.
 - If the report is provided to another practitioner, they should promptly give it to the Clinical Director, or designee, so that the receipt date can be stamped on the document and proper circulation initiated.
- The Therapist and/or Physician shall review the report and, on a clear space at the bottom of the first page shall provide a signature, title, and date of their review of the document. If there is anything in the document that requires a change in treatment, there shall also be a notation that says, "See note." A progress note addressing the treatment issue found in the report should then be initiated by either the Therapist and/or Physician as appropriate to the type of report. The Therapist shall modify the Treatment Plan, if appropriate, when a "See note" entry indicates a need.
- After the Therapist and/or Physician has reviewed the report and documented as stated above, the report and progress note, if applicable, shall be returned to the consumer's assigned therapist, as appropriate, who shall include it in the official consumer record as per policy.

EDUCATION AND TRAINING

- Applicable staff will be trained on any revisions to this policy within thirty (30) days after review and approval by the Clinical Committee.
- Training will occur during general orientation on Hand-Off Communication Policy and annually thereafter. Training will also occur for staff by supervisors as needed.

EVALUATION:

- The Clinical Committee will review this policy annually and make modifications as needed based upon changes in regulations, changes necessary due to nature of services, etc.

RELATED POLICIES/FORMS:

Change of Practitioner Form
Clinical Integrated Summary Form
Transfer Summary Form
Discharge Summary Form
Care Coordination Policy
Record of Clinical Progress Policy
Medical Records Management Policy
All HIPAA Policies

POLICY: MANAGING ACUTE AND CHRONIC HEALTH CONDITIONS AND HEALTH CONDITIONS IN REMISSION DURING MAT SERVICES

PROCEDURES:

IDENTIFICATION OF HEALTH ISSUES

DURING TREATMENT IN THE MAT PROGRAM

- If a consumer presents for a treatment session and appears to be or reports that they are not feeling well, they will be instructed to reschedule their appointment, if indicated, and instead go to their primary care physician for evaluation and treatment.
- If the consumer presents for treatment or, during a treatment session, becomes acutely ill, 911 will be called and arrangements will be made for their prompt transfer to the local hospital emergency facilities for evaluation and treatment.

DOCUMENTATION

- History and Physical Exams shall document the existence of any acute or chronic health conditions and those conditions in remission as reported by informants.
- Physician orders shall reflect any interventions to be taken as precaution and/or management of such conditions during their course of treatment in the MAT program.
- Medical conditions will have referrals for further evaluation and treatment completed within three months after admission.
- Nursing, medical and/or clinical notes, of whatever form is appropriate, shall document the implementation of any orders provided for monitoring, evaluation and/or management interventions deemed appropriate by the treatment team and/or ordered by the physician.
- Discharge and aftercare planning documents shall describe any referrals for continuing treatment during and/or post-discharge by external providers.
- Incident reports shall reflect any untoward events that might occur despite all precautions taken by the treatment team.

STAFF TRAINING

- Medical, nursing, and clinical staff shall be trained in this policy and procedures during initial orientation, annually and as needed.

- They shall also be trained to stay alert for signs that a consumer is experiencing symptoms of acute, chronic and/or relapse of medical conditions and the appropriate responses.
- At least one or more staff shall always be present in treatment areas will and proficiency in the following:
 - Cardiopulmonary resuscitation (CPR) from an evidence-based training program
 - Management of opiate overdose
 - Management of medical emergencies
 - Other relevant emergency techniques as relevant to the program and consumer population treated

GENERAL GUIDELINES FOR DOCUMENTATION OF PROGRESS

- Entries must be legible, written in ink, concise, authentic, and professional. Documentation will contain explicit observations, omitting non-essential or subjective information, unfamiliar technical terms, and slang expressions (except when directly quoting a consumer).
- Only abbreviations included in the approved abbreviation list may be used. Abbreviations from the *Do Not Use Abbreviation List* are never used.
- Documentation is completed by the practitioner who made the observation, delivered a specific intervention/service, or who was involved in communication about the consumer.
- Regardless of format, a note should include, minimally, the following content:
 - The contact source – consumer, collateral party, family/guardian, etc.
 - An identified need(s) and the goal(s) and objective(s) addressed.
 - Issues discussed and/or observations made.
 - Describe progress toward any goal(s)/objective(s) that were the focus of the session.
 - The consumer should be informed of his/her status and progress or lack thereof.
 - Progress or lack should be evaluated to determine if treatment needs to be redirected.
 - Any significant changes or events that have transpired in the consumer's life since the last contact, when applicable, should be described.
 - The modality and specific methods/interventions/services provided and the outcome.
 - The time/duration of the contact.
 - Describe any changes in frequency, method or level of care indicated, when applicable.
 - The date and legible signature and credential/position of the writer.
- When appropriate, logs, graphs or other appropriate formats may be used in lieu of or in addition to narrative progress notes to denote progress and/or consumer response.
- When an aspect of the record has been dictated, a progress note briefly summarizing the dictated information and a comment that the complete information is being dictated shall be entered in the progress note section of the clinical record/case file.
- Any activity with the consumer that occurs after discharge shall be recorded in a progress note and included in the clinical record.

TYPES OF PROGRESS NOTES

- *Progress notes* may take various formats (narrative notes and/or summaries, spreadsheets, logs, etc.) but are to be written before the end of shift after all consumer contacts. A list (not all inclusive) of types of progress notes includes:
 - An admission note is completed on a *Progress Note* by the Counselor **within 24 hours of admission to the program**.
 - The Counselor must see and write a *Progress Note* for each assigned consumer at a **minimum of weekly**.
 - A *Group or Didactic Note*, for each participant, is written by the Group Facilitator/Didactic Leader **after any group or didactic session**.
 - The physician writes a *Progress Note* after **each contact** with a consumer, which includes minimally when the intake *Medical History and Physical Exam* is done and for any medical issues that arise during treatment. [If medical attention is needed, the consumer is referred to their Primary Care

- Practitioner (PCP.) The physician reviews each consumer's MAT progress as established in the treatment plan. A *CGI* is completed at each medication review along with the progress note.
- Nursing staff writes nursing notes as needed in the program, addressing nursing care given, any complications, all medication passes, and any hospital visits by consumers. Intake and discharge nursing notes are also written.
 - A *Medical Order Form* is used by medical and nursing staff to write orders within the scope of their practices; an MD order is not required for a nurse to order a transfer when medical or psychiatric crisis, in the nurse's judgment, requires a consumer transfer.
 - Case Managers write a *Case Management Progress Note* after each consumer contact. Any significant case management activity must be documented in the progress notes, including phone calls to and from individuals or organizations regarding the consumer.
 - The Counselor shall write a *Progress Note* after any consumer or family contact/session.
 - Treatment reviews will be documented on the *Status Report* and placed with progress notes in the medical record.
 - Should a transfer be necessary, the Counselor or Nurse writes a *Progress Note* that includes where and how the consumer was transferred, why they were transferred, the time and date of transfer and the consumer's condition at time the of transfer.
 - A *Progress Note* is written when the Counselor does follow-up with discharged consumers at various intervals during the first year after discharge.
 - A *Progress Note* is written at discharge by the Counselor when a consumer is discharged; this is followed within 7 days by a final note called the *Discharge Summary*.

PHYSICIAN ORDER REQUIREMENTS

- *Physician Orders* shall include the date and time they are written, be legible and signed by the physician, including degree held.
- Any consultations, laboratory or other diagnostic testing shall require a written order by a physician. All orders for referral shall designate the reason for the referral.
- Telephone and verbal orders cannot be accepted unless received by a licensed nurse in an emergency.

CONSULTATION, LABORATORY AND OTHER DIAGNOSTIC REPORTS

- All consultation, laboratory and other diagnostic reports shall be initiated and dated by the physician before placement in the medical record.
- Significant deviation from normal results must be noted in the progress notes and an explanation of the course of action and/or non-action, as appropriate, noted.

FORMS:

- Various Progress Note Formats
- Discharge Summary
- Transition/Aftercare Plan
- Status Report Form
- Medication Administration Record (MAR)
- Medical Order Form
- CGI Form
- Medical History and Physical Exam Form
- Psychiatric Evaluation Form

POLICY: MAT ASSESSMENTS, UPDATES AND CLINICAL SUMMARIES POLICY

The purpose of an assessment is to determine treatment eligibility, develop a treatment plan, and establish a measure for the response to treatment. For all applicants initially deemed eligible for medication-assisted treatment, designated, qualified program staff members complete a comprehensive physical examination, laboratory workup as indicated, psychosocial assessment, preliminary treatment plan, and consumer orientation during the initial treatment stage. Other assessments may also be ordered based upon screen results that trigger then need or based upon professional judgment or medical order. As a consumer progresses through treatment, their status and indicated changes in treatment approach will be reviewed and assessments updated, as indicated, on a regular basis. The clinical summary shall summarize the consumer's status from a holistic perspective at least at admission, at review points and at discharge from treatment.

GENERAL GUIDELINES APPLICABLE TO ALL ASSESSMENTS

- The battery of assessments is comprehensive and covers, minimally, based upon the consumer's needs and condition: medical, psychosocial, vocational, educational, behavioral, family, financial, legal, health and self-care needs.
 - Rehab, education, and other counseling services are not required for consumers receiving interim maintenance treatment only.
- Assessments shall be completed with each consumer at admission intake or within timeframes as set forth in this policy. All required assessments must have been completed within 30 days of admission or less, if feasible.
 - Integrated Assessment: Part I is completed by the consumer during intake, with assistance of the Counselor.
 - Integrated Assessment: Part II is completed by the Nurse (Nursing Assessment)
 - Integrated Assessment: Part III is completed by the Counselor as part of the initial intake appointment. This assessment must include, minimally for MAT consumers, psychosocial, vocational, educational, current/historical behavioral/emotional functioning, family, financial, transportation status, legal, health and self-care needs, and screens for pain, nutritional issues, safety, and suicidal/homicidal issues.
 - Physical Examination is completed and signed by the physician within 24 hours of intake. Telemedicine may not be used for this exam but may be used to support the decision making of a physician when a provider qualified to conduct the physical exam and make diagnoses is physically located with the consumer.
 - Psychiatric Evaluation is completed by the physician/psychiatrist when the physician doing their physical evaluation determines it is needed or their personal psychiatrist requests it, or by Counselor request. It is completed within 72 hours of an order for the evaluation.
 - Initial Lab Analysis and Diagnostic Evaluation is part of the admission process and may include any of the following that are relevant to the consumer's medical status:
 - Vital signs, including blood pressure, pulse, respiration, and temperature
 - Assess for symptoms of and risk factors for torsade's de pointes and any follow-up tests
 - Drug screening for opiates, methadone, amphetamines, cocaine, marijuana, benzodiazepines, and other substances if indicated by individual consumer circumstances and local drug use patterns
 - Screen for syphilis
 - CBC and lipid panel

- Liver function tests and viral hepatitis marker tests
- HIV testing and counseling
- Tests appropriate for screening or confirmation of illnesses or conditions based on concerns specific to the consumer regarding renal function, electrolyte imbalances, metabolic syndromes, pain, etc.
- Pregnancy test
- Neurological or psychological testing and assessment
- Tb test and chest x-ray if skin test is positive
- EKG
- Pap smear
- Screening for sickle cell disease
- Additional tests based on results of baseline screens, especially when the results potentially impact treatment decisions
- PHQ 9 shall be completed at admission by the consumer, and then repeated every 90 days by the consumer during the full course of treatment.
- Other Assessments, if indicated, will be completed and/or referred to the appropriate contractor or external resource for completion. Transport for these assessments will be provided by QBH if needed.
 - ✓ A nutritional screen that reveals a weight gain or loss of 10 pounds or more over the past three months, a noticeable change in appetite, dental problems, noncompliance with a special diet, or food allergies shall trigger a full nutritional assessment.
 - ✓ A pain screen that reveals constant pain more than a 5 on a 0-10 pain scale, has not been evaluated or treated, is interfering with ADL capabilities or job/school performance shall trigger a full assessment by referral.
 - ✓ A risk screen that reveals moderate or high risk for suicide/homicide shall trigger a full risk assessment.
 - ✓ When indicated, the following evaluations may also be conducted by qualified staff or by referral: psychological, intellectual/cognitive functioning
- All assessments shall remain in the medical record.
- All assessments shall be conducted by qualified staff that has demonstrated that they are knowledgeable to assess the specific needs of consumers served, has been trained in use of the forms/tools involved, and has demonstrated skill in communicating with the consumer population served.
- Diagnosis(es) derived from assessments may only be made by the assigned counselor or the physician. If there is a discrepancy in diagnosis(es) arrived at by either of these staff, they shall discuss the differences and come to consensus. If consensus is not achieved, the physician's diagnosis(es) shall stand.
- The problems identified from all assessments shall be listed on the *Master Needs List* and prioritized for treatment.
- All assessments shall be conducted in the primary language of the consumer. When a consumer is to complete a form, it shall be translated into his/her primary language. All assessments entered into the medical record shall be accompanied by an English translation if originally completed in

another language. If a translator or technological assistance is needed, arrangement will be made to provide for this need.

ASSESSMENT INFORMATION SOURCES

- The consumer being admitted to treatment is the primary source for provision of assessment information. If the consumer has a legal guardian, this person will also contribute to the assessment.
- Family or significant others contribution to the assessment is encouraged but is done only with written informed consent for information release and at the request of the consumer.
- When relevant to the consumer's care or services, the Counselor will gather behavioral and physical health information from both inpatient and outpatient providers who have treated the consumer.
 - If information is needed from other collateral sources such as the PCP, another provider, the outpatient case manager or social worker, the consumer's employer, or a parole or probation officer, the Counselor will contact those sources only after receiving written informed consent for release of information from the consumer or their legal guardian, when applicable, unless such contact is legally mandated with or without consumer consent.
 - When it is not possible to obtain this information, the Counselor documents the reason why it could not be obtained.

ASSESSMENT PROCESS AND UPDATES

- The purpose of the assessments is to learn the consumer's specific needs so that treatment can be personalized.
- Assessments shall be completed as soon as possible, but always within at least 30 days of intake.
- Assessments are signed and dated by the team member completing each.
- Assessments shall identify the consumer's personal short- and long-term goals and expectations of treatment as captured in their own words.
- Assessment tools and treatment processes are designed to be sensitive in identifying significant life or status changes of the consumer and to be responsive to the changing needs of the consumer. Reassessment for changing needs and adjustment of treatment to meet changing needs is an ongoing process with each consumer encounter during treatment.
 - Assessments are formally updated and documented quarterly during the patient's first year of continuous treatment and semiannually during subsequent years.
 - Drug testing of consumers in the MAT program is conducted on an ongoing basis in compliance with MI state laws and following Company protocol.
 - Consumers in interim maintenance treatment experience urine screening upon admission and at least two more additional times if the consumer remains for the maximum 120 days permitted for interim treatment.
 - The consumer's counselor determines the ongoing drug-testing regime of a given consumer by analyzing individual circumstances, the consumer's stage of treatment, and community drug use patterns.

- The counselor discusses results of toxicology testing promptly with the consumer and documents both the results of the toxicology tests and the follow-up therapeutic interventions discussed with the consumer in the consumer's clinical record.
- The clinical team intervenes when a consumer disclosed illicit drug use, has a positive drug test, or is suspected of diversion of opioid medication as evidenced by a lack of opioids or related metabolites in their drug toxicology tests.
- Assessment results are communicated to the consumer and/or legal guardian at the end of the intake process and during treatment planning activities.
- As indicated for treatment implementation and coordination, other staff making up the treatment team may be informed of assessment results.
- If information needs to be shared with family or collateral sources such as the PCP, another provider, the outpatient case manager or social worker, the consumer's employer, or a parole or probation officer, the Counselor will contact those sources only after receiving written informed consent for release of information from the consumer or their legal guardian, when applicable, unless such contact is legally mandated with or without consumer consent.
- If a consumer has been in MAT services in the past year, the Bureau does not require that assessments be repeated at re-admission; however, QBH repeats the assessments if the interim since prior treatment has been at least six months, even though there are no reimbursements. Even when regulation or policy does not require a new assessment, the latest assessments are nonetheless reviewed for any needed updates at every admission if the 6 month or 1-year timeframe has not triggered a new assessment series.

ASSESSMENT CONTENT

- The staff conducting the various assessments gathers and documents adequate information during assessments to provide a complete picture of the consumer so that a comprehensive, consumer-centered plan can be developed. Minimally, assessments collectively capture information regarding:
- The consumer's presenting issues and treatment goals in their own words, and those of the family when indicated and available.
- Identification of urgent needs associated with suicidal risk, personal safety and/or risk to others.
 - If suicidal risk is high, the consumer may be transported to a crisis intervention program; otherwise, a *Safety Plan* is developed with the consumer and risk is monitored till no longer present.
 - If personal safety risk is high, a *Safety Plan* is developed with the consumer and, if indicated, appropriate reporting to agencies associated with abuse or neglect will be notified.
 - If a risk to others is highly suspected or imminent, the staff identifying this risk shall immediately notify the CEO or designee AND the staff to notify both the at-risk party directly and notify a Safety Officer of the Police Department.
- Personal strengths, individual limitations or needs, and personal abilities, leisure/recreation interests and preferences.
- Previous diagnosis and treatment history, including what the consumer felt was and was not helpful in past treatment experiences; also, including any complementary/alternative health approaches instead of, or in addition to, conventional medical treatment.
- Current mental status.

- Medication history and current use profile, including the efficacy of current or previously used medication and any known medication allergies or adverse reactions.
- Physical health information, including current and past health needs, any co-occurring disabilities/disorders/medical conditions, current pregnancy status (if applicable, including notation of any prenatal care), and current level of psychological/social adjustment to these, and current level of health function in activities of daily living and self-care capabilities; the physical exam includes, in addition to routine elements, a determination of the presence of clinical signs of addiction such as old or fresh needle marks, constricted or dilated pupils, and/or an eroded or perforated nasal septum, and dermatologic sequelae of addiction such as abscesses or presence and condition of tattoos and body piercings, as well as observable and reported presence of withdrawal symptoms, such as, yawning, rhinorrhea, lacrimation, chills, restlessness, irritability, perspiration, piloerection, nausea and diarrhea. Additionally, the consumer's medical and family history to determine chronic or acute medical conditions such as, but not exclusively, diabetes; renal and/or pulmonary disease; chronic cardiopulmonary disease or cardiac abnormalities; and a series of infectious diseases such as hepatitis A, B, C and D; HIV exposure; Tb; STDs and other infectious diseases prevalent in the area or with the drug culture; sickle-cell trait or anemia; surgical problems; pregnancy (history and current, including prenatal care involvement); for evidence of physical pain; and psychiatric conditions meriting a psychiatric evaluation.
 - Consumers identified with physical pain will be referred for a physical pain assessment and for treatment of the physical pain at a pain management clinic. Coordination with the pain management clinic and MAT program will occur to manage the treatment of both the chronic pain disorder and addiction; the consumer will receive their regular opioid medication at adequate doses to treat the addiction.
 - Consumers testing positive for viral hepatitis receive a referral for further evaluation and treatment.
 - Consumers are immunized, or referred for immunization, against hepatitis A and B if not already immune and against other viral hepatitis strains as vaccines become available
- The health screen or physical exam shall screen for nutritional issues and, the following information, at a minimum shall trigger a full nutritional assessment, either by a qualified staff within the Company or by referral:
 - Food allergies that are not being managed
 - Weight loss or gain of ten pounds or more in the last 3 months
 - Decrease in food intake and/or appetite
 - Unmanaged dental problems
 - Eating habits or behaviors that may be indicators of an eating disorder, such as binging or inducing vomiting
- As relevant to consumer care and treatment, current and historical life situation information, including age, gender and sexual orientation/gender expression; cultural and spiritual identity and preferences, childhood and family history and current family circumstances, legal involvement, education and employment/vocational history, military history, language preference, current living situation, and availability of relationships/need for support systems within their family, friends, community or other interested parties, current resources tapped as needed;
- Educational status assessment shall include educational background, academic performance and preferred areas of study, attitude toward academic achievement, possibilities for future education.

- The consumer's legal status assessment includes the following: legal history; preliminary discussion to determine how much the individual's legal situation will influence their progress in care, treatment, or services, and the urgency of the legal situation; relationship between the presenting conditions and legal involvement.
 - If a vocational assessment is indicated, based on the consumer's needs, preferences, interests, and goals, they will be referred for such assessment.
 - Trauma history, past or present, whether experienced or witnessed, including abuse, neglect, violence, or sexual assault, or exploitation; If there is past or present history, this is listed on the MPL and is reassessed at each treatment review and documented.
 - The company maintains a list of private and public community agencies that provide or arrange for assessment and care of consumers who report having experienced abuse, neglect, or exploitation.
 - All cases of alleged or suspected abuse, neglect or exploitation are reported to appropriate authorities in conformance to Company policy and applicable law or regulation.
 - The Company CEO is immediately made aware of reports made to external authorities regarding ed or suspected cases of abuse, neglect or exploitation that involves staff.
 - Risk taking behaviors, current and past.
 - Alcohol, tobacco and/or another drug use, or other addictive behaviors as a primary or co-occurring condition(s) by the consumer and/or family members.
 - The addictions history for alcohol use, drug use, nicotine use, and other addictive behavior shall include at least: age of onset, method of acquisition of substance(s), duration of use, patterns of use (e.g., continuous, episodic, binge), frequency/amounts/route of use of the substance taken, any mental/emotional/behavioral/legal, social consequences of the addiction (e.g., legal problems, divorce, loss of family/friends, job-related incidences, financial difficulties, blackouts, memory impairment), physical problems associated with the addiction, family addiction history, readiness to change, any spiritual perceptions/beliefs they perceive can aid their recovery/life. Also assessed is previous care/treatment, relapse history, and acute intoxication and/or withdrawal potential.
 - Literacy level and any need for assistive technology as these impact services to be provided.
 - The presence of medical and/or psychiatric advance directives and/or interest in education on these matters
- From assessment data, the Counselor and/or Physician should arrive at and document current diagnostic impressions.

Special Assessment Needs of Pregnant and Postpartum Consumers

- These consumers are given priority for admission into MAT; the intake log shall document clearly the reasons for any admission denial of this consumer category.
- Pregnant consumers receiving MAT treatment are informed that their infant that is prenatally exposed to opioids may experience neonatal abstinence syndrome, characterized by hyperactivity of the central and autonomic nervous systems reflected in changes in the GI tract and respiratory system; that symptoms may begin any time from birth to two weeks later, but usually within 72 hours; and that infants with this syndrome may engage in frantic sucking behaviors and difficulty feeding. They are encouraged to seek comprehensive evaluation and treatment for the infant

because other serious conditions can also mimic neonatal abstinence syndrome that require prompt treatment.

- For those pregnant consumers without prenatal care, the consumer is referred to an appropriate provider with whom the Company has an agreement for services and a Business Associate agreement in compliance with HIPAA requirements. An ongoing exchange of information between the prenatal care provider and the program physician is imperative to the consumer's safety.
 - If the consumer refuses or cannot afford prenatal care, basic prenatal instruction is at least provided by the MAT program staff.
 - If the consumer refuses prenatal care, they shall sign a document that confirms they were offered a referral for the care and that they refused; the signed document is retained in the consumer's record.
 - If a pregnant consumer is discharged, the program staff identifies the physician to whom the person served is being discharged. The program staff records the name, address, and telephone number of the physician who will be caring for the consumer after discharge.
- Pregnant consumers in MAT treatment with concurrent HIV infection are managed in the same fashion as any other HIV infected consumer receiving MAT treatment.
 - These consumers are informed that HIV medication treatment is currently recommended to reduce perinatal transmission and provided with appropriate referral and case management to obtain that treatment.
- The MAT program supports the decision to breast-feed during methadone treatment, unless medically contraindicated, for example, by the presence of HIV or HTLV I or II infection in the mother.
 - The MAT program staff shall document appropriate counseling and informed decision-making between provider and consumer to see that issues mentioned in the latest consumer information sheets and product inserts for methadone are covered and understood.
- The staff obtains informed consent to provide appropriate follow-up and primary care for the new mother and well-baby care for the infant. Informed consent refers to the patient's agreement to receive treatment as well as agreement to release information to and obtain information from pertinent health care providers.

CLINICAL INTEGRATED SUMMARY

- Upon completion of all the intake related assessments, the assigned Counselor is responsible to review all the assessment data and to generate a *Clinical Integrated Summary of Findings* that integrates all the facts gathered during assessment(s) into a picture of the dynamics at play in the consumer's reason for seeking treatment, i.e., substance abuse.
 - Completion is by the assigned Counselor by the second appointment.
- The summary contains at least four basic elements to be complete. These are:
 - A brief description of the consumer's demographics that includes their age, gender, ethnic/cultural propensities that impact treatment approach, and whether this is their first or repeated treatment experience for substance abuse.

- The “picture” – a description of the pre-existing and/or influencing factors (social, emotional/psychological, and physical) that are interacting either causally or as a reaction/result of substance abuse. Co-occurring disabilities, co-morbidities and/or disorders are identified.
- A description of the assets or strengths the consumer brings to treatment that may be used or drawn from to establish treatment objectives.
- A description of the effects of this dynamic interplay. That is, the barriers or treatment needs that will need re-focus or where the consumer will need assistance to resolve or reduce their substance abuse and move toward recovery.
- The *Clinical Integrated Summary of Findings* is utilized in formulating the personalized treatment plan.
- Each treatment review is an opportunity to discuss how these dynamics have changed as a result of treatment to date and/or as a result of new information assessed.
- The *Discharge Summary* contains the last and final opportunity to discuss how these dynamics have changed as a result of treatment. (Often referred to in the *Discharge Summary* as “consumer’s condition or status at discharge.”)
- Each of these summaries should mirror the *Master Needs List* at that time and visa- versa...what is mentioned in one should be reflected in the other, thus creating a check and balance system.

FORMS:

Assessment: Part I Form
Integrated Assessment: Part I Form
Integrated Assessment: Part III Form
Psychiatric Evaluation Form
Medical History and Physical Exam
Master Needs List
Safety Plan
Integrated Summary of Findings
Discharge Summary

QUALITY BEHAVIORAL HEALTH, INC.

SUBJECT – BEHAVIOR MANAGEMENT

SECTION 2A – PROGRAM/SERVICE STRUCTURE

MILIEU MANAGEMENT

SUB ACUTE DETOX AND RESIDENTIAL PROGRAMS

- QBH believes in managing milieu through the building of positive relationships with consumers and staff modeling of healthy relationships and behaviors.
- Consumers are encouraged to participate in community meetings where concerns, suggestions and issues can be addressed in a structured, polite manner as a means for alleviating stress, encouraging open communication, and empowering consumers to be actively involved in their treatment and in the community of the treatment setting.
- Staff treats consumers with dignity and respect, honor privacy, monitor their body language and voice tones in interactions to help foster positive rapport.
- Every effort is made by staff to keep the environment peaceful, safe, and stress -free for consumers as they detox and begin their recovery process.
 - The emotional and physical environment is continually monitored to identify prospective behavioral issues early and intervene before they escalate into problematic behaviors.
 - Staff models with consumers how to manage behavior appropriate to the situation and setting; didactic groups or individual counseling may address this issue if need is evident for consumers as a group or for individual consumers.
 - Staff intervenes as early as possible to manage rising emotional or behavioral conflicts through application of de-escalation techniques.
 - Many of the unit rules exist to help maintain a milieu that fosters healthy interactions, positive rapport, appropriate confrontation of problems through conflict resolution measures, and to preserve personal rights.
 - The physical environment is structured to allow plenty of space, is uncluttered, homelike and comfortable.
 - Designated quiet areas are available to consumers.
 - A designated area is available for meeting with family or other visitors; visitors are allowed after completion of Sub-Acute Detox and completion of two weeks of Residential treatment. Visitors are restricted to 1-2 visits/week so that treatment and milieu is not overly disrupted.
 - A TV room, weight/exercise room, activity room and dining room and common area are available to consumers.
 - Gazebos and covered outdoor areas are available for exercise and, for smokers a designated smoking area is available outside as well during specific times of day.
 - Each consumer has personal space for privacy in their assigned sleeping room.
 - Sleeping rooms are assigned by gender with consideration for age in assignment of roommates, and of personal needs of each consumer.
 - There are not more than three consumers per sleeping room on the female unit and 3 to 4 per sleeping room on the male unit; there are separate units for males and for females.

BEHAVIOR MANAGEMENT/SPECIAL PROCEDURES

- Each consumer has their own assigned locker space for their personal belongings; if additional space is needed or for items not allowed during treatment, there is locked storage available.
- Consumers are allowed space in their sleeping room for placement of personal possessions and decoration displays.
- Bathrooms are available in multiple locations; personal laundry is done by staff in the laundry facilities provided.
- Keeping consumers adequately nourished helps to sustain emotional and physical status, thereby helping to reduce behavioral flare-ups.
 - Nutritious meals are served three times a day in the dining room; snacks are available for between meals and in the evening.
 - Cultural/religious preferences and/or restrictions are provided for in meal planning.
 - If a consumer is not physically able to go to the dining area, meals will be served to them in their sleeping room.
- At least one staff that is certified in CPR and First Aid is available on the units at all times.

BEHAVIOR MANAGEMENT – ALL PROGRAMS

- No treatment interventions shall be utilized which are intended to elicit fear, pain, humiliation or which involve the use of corporal punishment. Nutrition may not be denied as part of behavior management planning; nor shall food be used as a positive reinforcer. No behavioral management techniques related to sleeping or toileting shall be used.
- Behavioral management shall be directed towards increasing positive and pro-social peer and authority figure interactions rather than behavioral control alone.
 - Behavioral redirection and usual de-escalation techniques will be used if the consumer(s) cannot re-gain self-control.
 - The consumer(s) is encouraged to identify an appropriate action for handling the situation and to initiate that action; the goal is to help the consumer feel empowered to personally gain control of behavior rather than requiring outside intervention.
 - Staff will assist the consumer in processing an appropriate action if needed.
- If a consumer is unable to control behavior without consequences despite staff assistance, any of the following interventions might be utilized depending upon the situation:
 - Voluntary Time Out Intervention
 - Time out does not require a physician order and may be used as an intervention if contained within the PTP. An assessment of the appropriateness and outcome of using time out will be reflected in the *Progress Notes*.
 - Procedure for implementing time out shall be:
 - The staff will make a verbal request, in a calm and non-threatening manner, to the consumer to cooperate with staff, to take self-control and to walk, on their own accord, to the designated time out area (area must be free of potentially dangerous objects, not their bedroom, and non-lockable).
 - If the consumer agrees, two staff shall walk on either side of the consumer to the time out area. The time out area shall be away from other activity and persons but within view of a designated staff member.
 - The consumer, once in the time out area, will be informed that they are being given fifteen minutes to gain control and that a staff member will then return to process the previous events with them.

BEHAVIOR MANAGEMENT/SPECIAL PROCEDURES

- If, when the staff member returns to process, the consumer is still not enough in control to process, an additional fifteen minutes shall be granted before processing.
- After the fifteen or thirty minutes, the staff shall process with the consumer. The consumer is allowed to leave the time out area when they are able to identify what behavior was inappropriate and what they should do differently if the situation occurs again.
- **911 Call**
 - If a consumer's behavior escalates to a level of potential or actual violence (i.e., physically assaultive to self, others or staff), persons in the immediate area should be removed immediately.
 - A staff should position themselves where they can see the consumer but not be near them or in a location where the consumer blocks their exit from the area.
 - Simultaneously, someone should be directed to call 911 for immediate intervention and removal from the facility.
 - When law enforcement officials arrive, they shall take charge of the patient; they shall not bring firearms into the Agency.
 - The CEO and Clinical Director should be notified as soon as possible after the 911 call.
 - A *Progress Note* is written describing the incident, who was involved, what efforts to help the consumer gain control were used and the consumer's response, when the 911 call was placed and what transpired until law enforcement arrived and once they arrived.
 - An *Incident Report* should be written and submitted to the Quality and Utilization Manager within 24 hours of the incident.
- **Seclusion and restraint are not utilized in any of QBH's programs.**

STAFF TRAINING

- All staff with direct care roles shall be trained in de-escalation techniques. Re-training shall occur at least **annually**.

INTERNAL CARE COORDINATION

- The counselor assigned to a consumer is primarily responsible for coordination of care delivered within QBH to consumers assigned to the counselor. Such activities may also be assisted by a case manager, as appropriate.
- Key areas of care coordination internal to QBH include, but not exclusively:
 - Overseeing full implementation of the consumer's treatment plan.
 - Orientation of the consumer to the services s/he will be receiving.
 - Promoting the consumer's participation in discussion of his/her plan, goals and status on an ongoing basis.
 - Identifying and addressing any gaps in service provision.
 - Sharing information on how to access other community resources relevant to the consumer's needs.
 - Advocating for the consumer, when needed.
 - Communicating information regarding the consumer's progress to appropriate persons.
 - Involving the family or legal guardian, when permitted.

LINKING CONSUMERS TO SERVICES/RESOURCES

- When services or resources are needed to assist the consumer to meet their personalized treatment plan objectives that are not available within QBH's MAT program, consumers are guided in identification and contact with outside services or resources.
 - The consumer's assigned Counselor and/or case manager, if applicable, will coordinate, or assist the consumer to personally contact the service agency or other resource(s) needed to achieve their PTP objectives, when needed.
 - Counselors/case managers are knowledgeable of and/or can locate community services and resources available in the Mason/Manistee County areas, as appropriate to the location where they provide services.
 - Counselors/case managers place particular emphasis on identifying with the consumer whether they have sufficient support systems to sustain and move them forward in their recovery during and post-treatment and help the consumer to identify and select helpful resources to build that support, if lacking, prior to the consumer's discharge.
- Case management/service coordination is a joint effort of the counselor and/or case manager and the consumer; outside care may be arranged by the counselor/case manager after consumer input and agreement or arrangement may be made by the consumer with guidance from the counselor/case manager if the consumer is able and willing.
- The intensity of case management/service coordination is dependent upon the consumer's needs as reflected in the PTP.
- Referrals and follow-up for other health care related needs of the consumer in MAT are completed within 3 months of program admission.

TYPES OF CASE MANAGEMENT/SERVICE COORDINATION

- The type(s) of services or resources are directed by the specific needs of the consumer. They may include, but not exclusively:
 - Outreach to encourage the consumer's participation.
 - Coordination or assistance with crisis intervention and stabilization services.
 - Consumers with identified mental health needs are referred to appropriate treatment, concurrent with MAT treatment.
 - Optimization of resources and opportunities through community linkages and enhanced social support networks.
 - Michigan Rehabilitation Services is used to assist consumers with education, employment, personal needs or activities of daily living.
 - DHS is used to assist with income, disability and food stamp and other financial needs
 - NA and/or AA 12 Step Recovery meetings and mutual help groups to assist with recovery progress
 - Local Medical Centers/Hospitals to assist with medical and other health care needs
 - Access to transportation.
 - Facilitating the transition process, including arrangements for follow-up services.
 - Coordinating any services provided outside of QBH.
 - Securing safe housing that fits the needs and abilities of the consumer.
 - Engagement in other meaningful activities to build community ties, support structures, and/or sustain recovery and well-being, etc.
 - Linkages for skill development such as budgeting, meal planning, personal care, housekeeping and home maintenance or other identified needs if not covered by QBH program didactics or if development beyond what is provided is needed.
 - Other community services, as needed by consumers.
- Feedback is informally exchanged with outside organizations/agencies providing services to consumers only with the consumer's permission.
- All case management and service coordination activities are addressed in the *Master Needs List*, the *PTP* and in progress notes.

CARE COORDINATION NEEDS OF MOMS/PARENTS

- Consumers who are pregnant or parenting have special needs that must be addressed as a part of their MAT process. Services either provided internally or by referral include:
 - Education about neonatal abstinence syndrome, its symptoms, its potential effect on their infants, and the need for treatment.
 - Assistance to obtain evaluation and treatment if their infant may be susceptible to neonatal abstinence syndrome.
 - Referral to parenting support groups or other children's services, including referrals for services the child may need due to special mental and cognitive needs, especially if abuse or neglect has occurred.
 - Referrals for childcare services.
 - Referral for parenting skills education, unless provided in the program.
 - Referral for prenatal care; reciprocity in the exchange of pertinent clinical information about compliance with the recommended medical care will be established as required by federal law.

QUALITY BEHAVIORAL HEALTH, INC.

MAT CASE MANAGEMENT/ SERVICE COORDINATION POLICY

- If the pregnant consumer refuses direct or referred prenatal care, the program physician or designee has the consumer formally acknowledge in writing that the program offered or referred for those services, but the consumer refused them.
- If the pregnant consumer refuses direct or referred prenatal care, the program offers basic prenatal instruction on maternal, physical, and dietary care. The education is documented in the consumer record.
- Information and counsel to the pregnant consumer about the latest consumer information sheets and product inserts for methadone shall be documented in the consumer's record.

CASE MANAGEMENT LOCATIONS

- Case management services are provided at QBH facilities where MAT programs are provided in Troy, these areas highly populated by the types of citizens likely to need QBH's MAT services.

FORMS:

Personalized Treatment Plan

Master Needs List

Progress Note Forms

QUALITY BEHAVIORAL HEALTH, INC. MAT CONSUMER AND FAMILY INVOLVEMENT

QBH BELIEFS AND RESPONSIBILITIES

- Involve consumers and their significant others in the assessment, treatment, and service evaluation process to the extent feasible and appropriate.
- It is QBH's belief that consumers get sick and recover in the context of a social unit that either lends support to wellness or deters a wellness state; therefore, the most effective approach to service delivery is to provide it in the context of the whole consumer, including their social environment whenever possible.

CONSUMER AND FAMILY PARTICIPATION IN SERVICE

- The consumer and his/her significant others shall participate in all aspects of the service delivery process to the extent they are willing and that it is advisable to the consumer's condition.
- The consumer shall not receive service unless and until s/he has been informed about the expectations and consequences of treatment and signs a written *Consent to Treatment* form. In the case of assigned guardianship, the guardian or legal representative shall sign this form.
- The consumer and significant others, if appropriate, shall be informants during the assessment process. Assessment shall include documentation in the medical record, of the consumer's and significant others' expectations for treatment.
- The consumer and significant others, if appropriate, shall participate in the development of the treatment plan and sign the plan as evidence of being informed and of their participation.
 - If they have any disagreement with the treatment plan, the consumer's medical record shall so indicate and the assigned therapist shall mediate a solution to the conflict.
 - The consumer and significant others, if appropriate, shall also participate in each treatment plan review.
- When appropriate, the consumer's significant others shall be included in his/her treatment process through educational, marital, family, and/or support group therapy.
- Family involvement is documented in the consumer's medical record.

CONSUMER AND FAMILY NON-PARTISIPATION

- If a consumer's significant others are unable or unwilling to participate in the consumer's service delivery process as described above, or such participation is clinically inappropriate, such circumstances shall be documented in the consumer's medical record. The assigned therapist will work with the consumer, as part of treatment, to develop a functional support system if that normally availed by significant others is unavailable and/or nonfunctional.

FORMS:

Consent to Treatment
Personalized Treatment Plan
Consent to Contact

QUALITY BEHAVIORAL HEALTH, INC. MAT CONSUMER AND FAMILY INVOLVEMENT

POLICY: CONSUMER CONTRABAND**PROCEDURES:**

- The following is a list of items which are considered contraband, and which are not permitted on the grounds of QBH or a QBH sponsored activity:
 - Weapons of any kind, or objects which are adaptable to be used as weapons.
 - Illegal drugs or alcohol. Legally prescribed medications must be in the original packaging and in the possession of a responsible adult.
 - Sexually explicit materials in written, electronic, or other form.
 - Inhalable substances, such as aerosol spray cans and toxic glues or paints.
 - Drug paraphernalia, including but not limited to pipes, rolling papers, syringes (unless verified as medically appropriate and in the possession of a responsible adult), and clothing or other objects with explicit drug images or messages.
 - Tattooing devices.
 - Spray paint and/ or permanent markers, except as approved by a QBH MAT program staff member.
- Other objects or substances not listed above may be deemed contraband if determined by QBH MAT program staff to pose a significant risk of harm to consumers, visitors, or staff.
- Contraband is subject to being confiscated by QBH MAT program staff if brought onto QBH's property or a QBH sponsored event. Any illegal substances or illegal objects such as weapons shall be destroyed or turned over to legal authorities. Contraband that does not fall into the category of illegal may be returned to the consumer or the consumer's legal guardian when the consumer leaves the QBH MAT program premises, at the discretion of a program staff member.
- QBH MAT program staff shall not retain any item of contraband, including tobacco products, for their own use. All contraband must be destroyed, returned to the consumer/guardian, or turned over to law enforcement.
- Any contraband to be destroyed must be destroyed in the presence of at least two staff persons and according to Federal guidelines and documented in the consumer's medical record as such. Substances or chemicals (such as prescription medications, marijuana, etc.) will be dissolved, if possible, and then mixed with an undesirable substance, such as used coffee grounds or kitty litter, placed in a sealed bag, and then placed in the garbage, or using other state-of-the-art methods approved by the CEO.

- Discovery of contraband shall warrant the writing of an Incident Report by the QBH MAT program staff member. The Incident Report shall be routed internally and/or externally, dependent upon the nature of the contraband and the mandates of the licensing authority and contractual agreements with other agencies and government entities.

EVALUATION/REVIEW:

- The Clinical Director will review this policy annually, and the Clinical Committee will review and approve.

RELATED FORMS/POLICIES:

Incident Report Form
Consumer Handbook

POLICY: CONSUMER ORIENTATION AND EDUCATION

It is the policy of QBH to provide consumer, and family, if appropriate, adequate orientation and education to provide the best possible care for consumers. The educational process with MAT consumers begins at intake, continues through orientation, and is consummated in formalized educational sessions.

PROCEDURES:

- Consumer and family orientation and education are provided to meet the needs of consumers and their families.

IDENTIFYING CHALLENGES AND NEEDS**Educational Challenges**

- Specific individual consumer and family educational challenges will be identified during intake assessments by staff. Some common areas of challenge, but not exclusively, include:
 - Chronic pain ineffectively managed that impairs focus and attention
 - Social skills deficiencies
 - Learning style needs - visual, auditory or aesthetic learning style
 - Emotional barriers to treatment/recovery
 - Desire and motivation to learn
 - Physical and cognitive limitations
 - Language barriers
 - Level of understanding/learning capacity
 - Cultural and religious practices
 - Diagnosis
 - Other factors specific to the individual consumer's/family's needs and circumstances
- Teaching methods should be adapted to recognize and adjust to the educational challenges identified.

Educational Needs

- Initial and ongoing assessment of educational needs will include assessment of/for common orientation and/or educational needs, in addition to those identified in various other policies and in Attachment A of the Needs, Treatment Planning and Review policy, but not exclusively:

- Program guidelines, rules, and procedures, including, but not exclusively, the requirement to sign a formal agreement of consent, rights and responsibilities, grievance and appeal procedures, consumer input, behavioral and conduct expectations and consequences, fees and billing procedures*
- HIPAA regulations, confidentiality, and releases of information needed to exchange appropriate information within the network of providers and referral sources*
- Purpose and process of assessments and toxicology testing*
- Access to after hour services or crisis services*
- Health and safety policies related to tobacco products, illegal and legal substances, prescription medication, weapons, fire/emergency exits in the treatment facility, abuse reporting requirements*
- Understanding of the personalized plan of care, treatment, or services*
- Modalities and motivational incentives for treatment*
- Identification of staff responsible for service coordination*
- Nature of addictive disorders, the disease's natural progression, statistics about success after methadone withdrawal, and the goal of MAT to stabilize functioning*
- Benefits and risks of medication assisted treatment*
- Nature of the recovery process and phases of treatment, including transition or discharge*
- Availability of any 12 step or other mutual help group that accepts persons in MAT and the benefits of peer support
- Basic health and ADL/personal care skills, including hand washing and basic sanitary and infection control practices*
- Dispensing of, potential drug interactions, and safe, effective use of medication
- Risks of using benzodiazepines, even by prescription, overdose prevention education and naloxone (use of the professional paper available at <http://ireta.org/managing-benzodiazepine-use-in-medication-assisted-treatment/>).
- Understanding diagnoses
- Noncompliance and discharge procedures, including administrative withdrawal from medication*
- Nutrition interventions, modified diets, and oral health, as needed

- Habilitation or rehabilitation techniques to help the consumer reach the maximum level of independence possible
 - Parenting skills
 - Reproductive health education and resources for contraceptive services
 - HIV/AIDS education, including testing procedures, confidentiality, reporting, follow-up care, counseling, safer sex, social responsibilities, universal precautions, and sharing of intravenous injection equipment
 - Prevention of HIV infection, sexually transmitted diseases, and other prevalent infectious diseases, particularly those prominent in the local population
 - Viral hepatitis and its effects on physical and mental health, including prevention, treatment, and effects of treatment on dosage levels of opioid medications
 - Community resources available, given individual consumer needs
 - The emergency contact system the consumer may use to obtain dosage levels and other pertinent consumer information on a 24-hour, 7-day-a-week basis, as appropriate under confidentiality regulations. Company offices and waiting areas shall display the names and telephone number of individuals (e.g., physicians, hospitals, emergency medical technicians) who should be contacted in case of emergency, or the use of 911 or similar local emergency resources.
- Asterisked items are typically at least initially breached in the consumer's initial orientation but may be reinforced with more formal education and during sessions with the counselor.

TIMING OF AND PROVIDER FOR ORIENTATION

- Consumer orientation is initiated as part of the intake process when a consumer arrives at QBH's MAT program and is completed during the **initial intake** (about one hour is devoted to orientation).
 - The counselor will conduct the orientation in collaboration with the intake process.
- All consumers also receive a *Consumer Handbook* which provides written reinforcement of orientation information and other information pertinent to their treatment. The handbook is reviewed as part of orientation.

CONSUMER COMPREHENSION

- If a consumer's presenting physical or emotional condition makes completion of intake and orientation impossible, the consumer will be referred and, if need be, transported by QBH to a hospital or emergency crisis center, as appropriate to their condition.

- If the consumer returns to QBH MAT within 24 hours, intake and orientation will resume at that time.
- If the consumer does not return within 24 hours, orientation will be conducted after they have been reprocessed by the Michigan Institute for Population Health/Bureau of Substance Abuse Prevention, Treatment and Recovery (the Bureau) or a non-QBH Crisis Intervention program, referred and scheduled again for intake and admission.
- Orientation and education are provided in language the consumer can understand, including use of a translator or technological assistance if needed, and inquiry as to need for clarification is sought throughout the orientation process. If the consumer has an assigned guardian, the guardian is included in the orientation or education and, for orientation, will sign their name and guardianship status at the bottom of the *Consumer Orientation Checklist*.
 - The consumer signs the *Consumer Orientation Checklist* for the MAT program, which includes content areas covered, at the completion of the orientation. Their signature conveys both understanding of and receipt of the orientation. This signed Checklist becomes part of the consumer's case file along with consent forms. [See *MAT Outpatient Consumer Orientation Checklist*.]
- The consumer's counselor will re-enforce orientation and education content as needed.

CONSUMER EDUCATION

- Initially, identified educational needs may be listed on the Biopsychosocial Assessment. Training needs are identified on the Master Problem List and/or Master Treatment Plan and training provided should be reflected in the progress notes. Teaching is to be documented in the progress notes. Reassessment of needs is done at periodic intervals depending on the individual consumer.
- Education shall be provided to the consumer/family by any staff as appropriate to the Master Treatment Plan. Medication education is primarily the responsibility of the medical and nursing staff with assistance in monitoring effectiveness and education reinforcement by clinical and direct care staffs.
- Education shall be provided using methods appropriate to an individual consumer's learning style and at a level that fosters understanding; the consumer's comprehension shall be assessed after education is provided.
- Education may be provided in an individual or group format as appropriate to the issue and the consumer's needs.
- If consumer/family educational needs cannot be provided by the Company, a referral to an appropriate source will be documented in the consumer record and, if still present at discharge, on the Discharge Instructions and Aftercare Plan.

EVALUATION:

Initiated: 2/2022

Reviewed/Revised: 2/2023, 1/2024, 1/2025

- The Clinical Director will review this policy annually and make modifications as needed based upon changes in regulations, changes necessary due to nature of services, any revisions will be submitted to the Clinical Committee as scheduled.

RELATED POLICIES/FORMS:

Consumer Rights and Responsibilities List
Screening and Assessments Policy
Attachment A of Needs, Treatment Planning and Review Policy
Clinical Services Plan
Progress Note Form
Master Treatment Plan
Discharge Instructions and Aftercare Plan
Biopsychosocial Assessment
Consumer Handbook
MAT Consumer Orientation Checklist
Educational Materials, Brochures, and Information Sheets

POLICY: DISCHARGE AMA/ACA

PROCEDURES:

**S ACTION TO BE TAKEN WHEN A CONSUMER THREATENS DISCHARGE AGAINST MEDICAL
ADVICE (AMA) / DISCHARGE AGAINST CLINICAL ADVICE (ACA)**

- Consumers are informed as part of the *MAT Program* orientation at intake and agree to the following with regard to AMA/ACA plans: "I understand that, should I decide that I want to leave the program before treatment is complete, that I will inform staff in advance and that I will sign an agreement to defer departure from the program for 7 days after I give notice so that I may be given time to process the consequences and reconsider."
- When a staff member learns from a consumer or through his/her peers that s/he is planning to leave before the completion of treatment, they are to notify the Clinical Director and/or assigned counselor immediately.
- The Counselor shall promptly initiate the following steps:
 - Initiate the *Departure Deferral Agreement* with the consumer.
 - Spend increased one-on-one time with the consumer. Talk with the consumer regarding the implications and risks of discharge and disruption of their medication assisted therapy and try to find out what is causing the consumer to request the discharge. Discuss the pros and cons of early departure with emphasis on the benefits of remaining.
 - The staff is to instruct the consumer that such requests cannot be honored until the consumer has talked to his/her program doctor. A specific time and date are to be given as to when that doctor shall be available.
 - If the consumer insists on leaving before seeing the doctor, the counselor is to assess the condition of the consumer, including whether s/he presents a danger to self or others. At all times, the consumer's doctor is available to the therapist to discuss the case and make that decision should s/he feel the need for their input or ultimate decision.
 - "Danger to self or others" is a medical decision in which a counselor or nurse feels that the consumer could not be safely released without seeing a doctor; in this case if the consumer insists on leaving, the counselor or nurse will call 911 for the consumer to be transferred to a Psychiatric Hospital
 - Proper assessment and documentation must be made on the medical record/case file concerning times, exact communication from the consumer, and rationale for leaving.
- If the consumer persists in his/her desire to leave AMA/ACA, the consumer shall release the facility and physician from responsibility by signing the appropriate section of the *Departure Deferral Agreement*. If the consumer refuses to sign this form, then in the space provided for the consumer's signature, write words "consumer refuses to sign".
 - Beneath this line, the person attempting to obtain the release shall sign his/her name and enter time and date with a brief notation concerning the circumstances of refusal.
 - Staff that was present when the release was offered and their signature was refused, must sign as witnesses to the refusal. Each must write his/her complete name and title.
- If the consumer is under guardianship, his/her legal guardian is to be consulted about the consumer's plan to leave AMA. Notify the attending physician. The above procedures are followed with the guardian signing forms.
- Should the counselor feel that the consumer is not a danger to self or others and that s/he may be discharged AMA, s/he is to call the doctor or the doctor on call to discuss the case and arrive at a decision if the consumer may go against medical advice and an order shall be obtained from the consumer's doctor or the doctor on call to that effect.
- The consumer will be offered either a referral or information about other treatment options.
- Discuss the follow-up care with the doctor and talk to the consumer about this care.

- If the consumer determines to leave treatment before the 7 days and/or after the 7 days, contact the consumer's legal guardian or family if they were involved in treatment. Notify the appropriate legal party if the consumer was mandated to treatment.
- Follow the discharge procedure. The consumer who is not committed cannot be forced to stay in treatment unless court ordered. The implications of discharge can be discussed, but no threats should be made.
- Indicate in progress notes all actions taken and persons notified and whether the consumer signed a *Departure Deferral Agreement* and/or *AMA Form*. Place the completed forms in the consumer's record.
 - The counselor involved shall note on the Departure Deferral Agreement whether the consumer remained in treatment or departed AMA. A copy of this form is made and forwarded to the Utilization and Quality Manager for monitoring purposes.
- The counselor shall file an Incident Report according to Company procedure.
- The Counselor shall document in the consumer's clinical record the reason(s) the consumer gave for leaving the program early and all interventions utilized to try to discourage the consumer from leaving treatment early.
- If the consumer leaves the program abruptly, the MAT program shall allow the consumer to be readmitted without repeating the initial assessment procedures if the readmission is within 30 days.
- If the consumer leaving AMA is pregnant, the Counselor informs the physician or agency providing prenatal care that the consumer is undergoing medically supervised withdrawal in conformance with HIPAA policy.

FOLLOW UP AFTER AMA/ACA

- The consumer's primary Counselor shall attempt follow-up contact with the consumer who left AMA/ACA within 24 hours after their departure. Clarification of why the consumer left treatment should be sought and whether further services are needed ascertained. If indicated needed and if possible, the Counselor should try to convince the consumer of the advantages of returning to treatment either at QBH or at another treatment facility. If the consumer is willing to return to treatment but at another facility, the Counselor may assist them in identifying appropriate alternative treatment facilities.
- Any successful contact with the consumer shall be documented in a progress note in their medical record to include the contact time and date, the general demeanor of the consumer during the conversation, any clarification of why the departure occurred and whether further services is needed, a summary of the discussion, the consumer's response/decision following the discussion.
- The consumer's primary Counselor shall provide all notifications indicated such as to the original referral source, the primary care physician, a probation officer, or the court, etc. These notifications shall be documented in a progress note including the date and time of the notification and the person to whom the notification was provided.

FORMS:

- Deferral Departure Agreement Form
- Deferral Departure Agreement Staff Action Plan Form
- Consent to MAT Services Form

POLICY: AN OVERVIEW - MANAGEMENT OF SUBSTANCE ABUSE AND PSYCHIATRIC TREATMENT FOR MAT PROGRAM CONSUMERS**PROCEDURES:****DEFINITION AND INTRODUCTION**

- For consumers needing substance abuse treatment and/or management of psychiatric conditions, outpatient programming provides an essential level of care for achievement of long-term recovery. This program is for consumers who have succeeded with withdrawal and are making wellness and recovery progress, but now need to address emotional/psychiatric issues to help them sustain recovery movement and to build up resilience, including identifying, developing, and utilizing natural supports.
- Outpatient services provide many similarities with residential treatment programs, but in a differently structured environment that gives the consumer more freedom of movement, allowing them to maintain a regular commitment to family, work and/or educational responsibilities. In outpatient programming, the consumer can go home after day or evening program times, they have a greater level of privacy and autonomy.
- In outpatient services, the consumer is not provided with the safe, secure environment that isolates them from negatively influencing factors, requiring them to voluntarily abstain from drug or alcohol use and/or to manage stressors that impact their psychiatric illness, requiring a greater amount of diligence on their part. However, the outpatient program does provide a support network for the consumer in the form of official support groups, individual and group counseling, and family counseling so that consumers are never alone in their recovery and coping efforts.
- Outpatient consumers are provided with a strong support network of non-using peers and sponsors. This level of treatment requires a component of group therapy and support groups like AA and NA, which provide a new, positive element of social change in the consumer's life and facilitates long-term recovery. The MAT program focuses on family support and involvement, and an immediate positive element is that the consumer can automatically apply the lessons learned from the outpatient program to their daily experiences.
- Outpatient services hours are Monday through Saturday, offering programming from 5 am to 1 pm. Transport services are provided to assist consumers to and from treatment sessions as needed, including referral and transport, if needed, for crisis intervention.

INTEGRATED TREATMENT**PRINCIPLES FOR SUCCESSFUL SUBSTANCE ABUSE AND/OR PSYCHIATRIC TREATMENT**

- Integrated treatment emphasizes a correlation between treatment models to treat mental illness and addiction that stresses a recovery focus and the use of treatment strategies from both mental health and substance abuse treatment fields. QBH's MAT program coordinates substance abuse and mental health interventions to treat the whole person more effectively.

- QBH's MAT program is designed to incorporate the best practices as set forth by SAMHSA and the Center for Substance Abuse Treatment (CSAT), as well as state and federal health services guidelines as regards the management of consumers' needs. The sustained recovery focus of QBH's MAT program acknowledges that recovery is a long-term process of internal change in which progress occurs in stages.
- The guiding principles of treatment of consumers in outpatient services are:
 - Employ a recovery perspective – the treatment plan provides for continuity of care over time.
 - Adopt a multi-problem viewpoint – treatment planning addresses intermediate and long-term comprehensive services to meet the multi-dimensional problems (mental health, substance abuse, family and social problems that require substantial rehabilitation as well as initial learning and acquisition of skills)
 - Address specific real-life problems early in treatment – the consumer's illness(es) arises in the context of personal and social problems resulting in the need for case management or intensive case management to help the consumer address special, specific areas of need such as housing, legal or family concerns, money management, and other psychosocial rehabilitation needs/skills acquisition; solving these is often an important first step in achieving consumer engagement which is a critical part of treatment since treatment for an adequate length of time is essential to behavioral change
 - Plan for the consumer's cognitive and functional impairments – consumers often display cognitive and other functional impairments that affect their ability to comprehend information or complete tasks; interventions must be presented in a fashion compatible with the consumer's needs and functioning, calling for relatively short, highly structured sessions focused on practical life problems, gradual pacing, visual aids, and repetition
 - Use support systems to maintain and extend treatment effectiveness – mutual self-help groups, the family, the faith community, and other resources within the consumer's community are invaluable for recovery; making the consumer aware of available support systems and motivating him/her to use them effectively is a critical clinical role. Two critical support systems for MAT consumers are mutual self-help engagement and reintegration with family and community through such resources as religious, recreational and social organizations.

PRACTITIONER COMPETENCE FOR TREATING SUBSTANCE ABUSE/PSYCHIATRIC DISORDERS

- QBH depends upon trained staff to deliver quality services that meet the goals and mission of its program. It is recognized that creating a supportive environment for staff that encourages continued professional development, including skill acquisition, values clarification and competency attainment are necessary to achieve this end. Staff development and high-quality, supportive supervision are an ongoing commitment. These and sound personnel policies, benefits, and rewards/incentives for quality work ethics create the infrastructure for quality services.
- While substance abuse counselors may not be prepared to make mental health disorder diagnoses, initial orientation and ongoing training is focused on increasing their familiarity with mental disorder terminology and diagnostic criteria and to aid them in how to proceed with consumers who demonstrate symptoms of mental health disorder. Likewise, mental health counselors may not be

prepared to make substance disorder diagnoses, so their initial orientation and ongoing training is focused on increasing their familiarity with substance abuse/dependence terminology and diagnostic criteria and to aid them in how to proceed with consumers who demonstrate symptoms of substance abuse/dependence. Both types of counselors are encouraged to collaborate in treatment planning and team building to draw out the expertise of both. Each type of counselor is expected to demonstrate competency in both areas, including:

- Ability, if needed by the consumer, to establish an integrated diagnosis of substance abuse and mental disorder with knowledge of differential diagnosis terminology, pharmacological knowledge for both disorders, knowledge of effects of cultural factors, of trauma on symptoms, and of withdrawal symptoms
 - Ability to conduct, as needed, an integrated assessment of treatment needs to include severity assessment, lethality/risk, assessment of motivation/readiness for treatment, appropriateness/treatment selection appropriate to severity of each disorder
 - Ability to do, as needed, integrated treatment planning involving goal setting/problem –solving, treatment planning, documentation, confidentiality, legal/reporting issues, documenting issues for managed care providers for both disorders
 - Engagement and education through staff self-awareness of abilities in engaging, motivating and educating consumers with substance abuse and/or psychiatric disorder.
 - Ability to identify and develop early integrated treatment for emergency/crisis intervention, knowledge and access to treatment services, when and how to refer or communicate
 - Understanding and ability to implement longer term integrated treatment using individual, group, psychoeducational, and family counseling, relapse prevention, case management, pharmacology, alternative/risk education, ethics, confidentiality, mental health, referral and coordination with the community/support/health agencies needed, reporting requirements, family interventions
- Orientation and ongoing training for clinical staff includes providing them with a better understanding of the types of disorders they will treat and access to medical support; a key focus of training is to help the clinician provide the prescribing physician with an accurate description of the consumer's symptoms and behavior to help facilitate proper medication selection. Another training focus is to address the clinician's responsibility to assist the consumer in medication regimen adherence. They may also draw upon the peer community to help support consumer medication compliance.

ESTABLISHING CONTACT AND WORKING RELATIONSHIPS

- Providing access to services is a critical component and essential element of service delivery. QBH attempts to locate and provide service hours that allow the maximum possible opportunity for the consumer to make initial contact with our MAT program, receive a timely initial evaluation, and be welcomed into a MAT program structure that is appropriate to the consumer's needs. We also do outreach to educate the other community resources about our services through involvement in health fairs, offering education in various ways to diverse populations within the community, and through staff's involvement in various community organizations and committees which expands the visibility of our programs and increases referral potential. Access is also available through contracts with criminal justice and welfare systems and employers.

- Of particular focus is for the clinician to be aware of how the consumer's culture views disease/disorders, so that a model that is disease familiar and culturally relevant to the consumer can help communication and facilitate treatment. Trauma sensitivity is also important; all questioning should avoid "re-traumatizing" the consumer.
- Clinical staff is to communicate to the consumer from the first contact that they and the consumer will work together and that the staff will help the consumer to help themselves. Attempt should be made to help the consumer solve some external problem directly and immediately can help convey this therapeutic alliance. Staff is trained to expect some avoidance behaviors in early stages of the alliance relationship.
- Clinical staff is expected, early on in their contact with a consumer, to be welcoming and to express empathy and hope, maintaining a recovery perspective, and to stay connected with the consumer as part of the treatment team. Rapport building begins with the first contact and is built through reliable, honest, caring behaviors that convey a sense of safety and a nonjudgmental environment to the consumer. Interactions are preferably in the consumer's primary language, if possible.

SCREENING AND ASSESSMENT

- Screening and assessment are the beginning of the treatment planning process. Screening is intended to identify those consumers appropriate for MAT services, including treatment for mental health problems that warrant attention.
- Assessment follows screening to establish evidence of substance abuse and/or mental health diagnoses; identification of problem areas, disabilities, and strengths; determine readiness of the consumer to change, and data gathering to assist in level of care decisions. Intake staff makes every effort to contact all involved parties, including family members, persons who have treated the consumer previously, other mental health and substance abuse providers, friends, significant others, probation officers as quickly as possible in the assessment process.
- Standardized assessment tools are used, as appropriate to the consumer's presenting issues, such as the Beck Depression Inventory or Addiction Severity Index, but no one tool stands alone as the best tool to complete a comprehensive clinical assessment.
 - Intake assessments gather or, if transferring from another QBH level of care, update information to include (see MAT Assessment, Review and Clinical Summary Policy for more information about assessment content):
 - *Background* information about the consumer's family, cultural, linguistic, gender and sexual orientation issues, trauma history, marital status, legal and financial issues, education, housing and employment status, and any strengths and resources of the consumer.
 - *Substance use* is determined, including primary drugs used and use patterns to establish diagnosis for abuse or dependence, past treatment, periods of abstinence of 30 days or longer to isolate mental health symptoms/disability and treatment during abstinent periods.
 - *Psychiatric issues* are explored by determining consumer and family history, including diagnosis and treatment history, current symptoms/diagnoses, medication use and

adherence, past periods of mental health stability and treatment successes for any mental issues as well as the nature of substance use during stable periods, and identification of current treatment providers for information sharing and cooperation.

- *Integrated assessment* to establish interrelationships among symptoms of mental health issues and/or substance use, as well as interrelationships of symptoms of substance use and mental health symptoms, and how these interrelationships relate to treatment experiences, stages of change, periods of stability and periods of crisis, if applicable.
 - *Diagnosis* is an end result of the screening and assessment process, applying appropriate DSM criteria for each diagnosis.
 - *Initial matching* of the consumer to services and assessment of the consumer's motivation to change with regard to one or both diagnoses.
 - *Appraisal* of existing social and community support systems.
 - *Continuous evaluation /re-evaluation* over time as needs and symptoms change or more information becomes available.
 - *Maintenance of a "no wrong door" policy* which means that a consumer needing treatment is identified and assessed and will receive treatment, either directly or through appropriate referral, no matter where he/she enters the realm of QBH outpatient services. This means that treatment access is available at any point of entry, even via creative outreach strategies, to access consumers who are unlikely to knock on the door of a treatment facility.
- Medication may be an essential program element to help consumers who need assistance to maintain stabilization and control their symptoms, enhancing their receptivity to treatment. QBH medical staff attempts to employ psychiatric medications that are effective but with minimal side effects if these are needed by MAT consumers. An effective medication regimen allows the consumer to be stable enough to participate in substance abuse treatment and make progress that leads to a more satisfying and productive lifestyle.

TREATMENT PLANNING AND INTERVENTIONS FOR RECOVERY

- Treatment planning should be appropriate to continuing care, called aftercare.
- QBH attempts to provide a combination of professional mental health and addiction counselor specialists as well as on-site and consultative psychiatrist participation in treatment planning and implementation, as needed, with MAT consumers.
- Treatment planning for the MAT consumer must factor in the consumer's culture/ethnicity, socioeconomic and geographic considerations, gender and sexual orientation, age, religion/spirituality, and any physical/cognitive barriers.
- *Psychopharmacology* is sometimes a component of MAT treatment and is overseen and directed by the psychiatrist.
- *Individual and family counseling* is employed, as appropriate to the individual consumer's needs. Likewise, *family interventions*, if appropriate, and family engagement is required if possible.

- *Case management* is provided either through the program or in coordination with another provider.
- An important aspect of treatment is *psychoeducational classes* on topics to include education on mental disorders as well as substance abuse, relapse prevention, and community resources, to elevate the consumer's awareness of the disorders and their symptoms.
- *Groups* that provide for discussion of mental and substance use disorders, or the integration of these, identification of triggers for relapse, and other consumer treatment issues are a part of the treatment plan.
- QBH clinical staff is also continually urged to adapt strategies from the substance abuse and/or mental health fields to help the consumer be successful as they are revealed by the industry as being successful.
- Participation of the substance abuse, mentally compromised, or COD consumer in community-based *dual recovery mutual self-help groups*, with a 12-step structure, that offer an understanding, supportive environment, and safe forum for discussing medication, mental health and substance abuse issues is part of treatment planning when available.

DISCHARGE AND AFTERCARE PLANNING

- The MAT program consumer is challenged by life in the community, with relapse an ever-present danger. Discharge planning is focused on maintaining gains achieved through treatment. Several aftercare options may be employed with these consumers, as available in their community:
 - *Mutual self-help group* – preferably a dual recovery group if the consumer is COD, built upon the 12-step model with a planned regimen for change
 - *Identification of a sponsor* - if engaged in a self-help group; ideally one who is in the last stage of recovery
 - *Relapse prevention group*
 - *Ongoing psychiatric and/or outpatient services* – especially if on medication or after the last dose of medication
 - *Intensive case management* – to continue monitoring and support
 - *Physical and/or mental health issues following treatment* – counseling or appropriate interventions to deal with things like sleep disorder, depression, and other issues
 - *Re-entry planning* – return to maintenance treatment if relapse occurs
- Discharge planning always involves the consumer and, if possible, at least one support system resource. The plan must identify community resources based upon the consumer's specific needs and engagement with support systems identified during treatment to support sustaining progress already achieved during treatment.

COORDINATION OF CARE/COLLaborATION WITH OTHER SOCIAL SERVICE SYSTEMS

- Continuity of care as the consumer moves across different service systems is essential to:

Initiated: 2/2022

Reviewed/Revised: 2/2023, 1/2024, 1/2025

- Provide consistency among primary treatment activities and ancillary services
- Provide a seamless transition across levels of care as needed
- To coordinate present and past treatment episodes
- QBH places high priority on this process and includes orientation and training to clinical staffs in this area.
- QBH is involved in consumer and advocacy activities to expand services available in communities where QBH serves consumers, and in education to the community to reduce the stigma associated with the populations QBH treats.

EVALUATION:

- The Clinical Director shall review this policy annually and make revisions as needed, submitting the policy to the Clinical Committee for approval.

POLICY: NEEDS, TREATMENT PLANNING AND REVIEW

The clinical assessment of all consumers should consider the natural history of opioid addiction as altered by time and treatment. Consumers normally proceed from one stage of treatment to the next or move back and forth among the naturally occurring stages. Treatment tasks are determined in relation to the consumer's stage in recovery.

PROCEDURES:**IDENTIFYING AND PRIORITIZING CONSUMER NEEDS
MASTER NEEDS LIST**

- The *Master Needs List* is to be considered a component of the *Personalized Treatment Plan*.
- All needs, whether treatable at QBH or not, including any co-morbid health related issues, are identified by the Counselor and/or other professional staff on the *Master Needs List* prior to drafting of a *Clinical Integrated Summary of Findings* and development of the *Personalized Treatment Plan (PTP)*. Needs may be emotional/psychological, social, or physical in nature. The Counselor is responsible for maintaining the list.
 - This list is not static and may be adjusted at any time to reflect the current needs of the consumer; minimally it should be reviewed and adjusted, if indicated, at each treatment review.
 - Likewise, the status of a given need may change over time. The change in status should be noted and dated on the form.
 - Status of a need is recorded as one of the following at any given time: Active and thus addressed in the treatment plan; Deferred with an explanation of why such as the Counselor's anticipation that it will be resolved as another need is addressed, a refusal of the consumer to address the need at this time; the consumer's current un-readiness socially, emotionally or physically to deal with the need, the need is chronic but currently not a problem for the consumer and/or is being addressed by another professional, etc.; Referred with a notation of where or to whom the referral was made and the date referred; or Resolved with an explanation of what was observed that leads to the conclusion that the need no longer exists.
- The purpose of the *Master Needs List* is to identify in one central location all that is going on with the consumer so that their needs can be prioritized to identify those needing current treatment, those that might be deferred either till later in treatment or after discharge at a lower level of care, ones that will be referred because the treatment of those needs is beyond the scope of services of QBH MAT programing, and ones that have been resolved at any point during treatment.
- Any needs on the *Master Needs List* initially should be reflected in the *Clinical Integrated Summary of Findings*. When treatment reviews are done, the list should be updated to reflect the consumer's current status or justification for need to continue treatment as reported in that review. A final review and revision of the list occurs when the Counselor writes the *Discharge Summary* and should be reflected in that summary.

BASIS FOR TREATMENT PLAN

- There shall be a written, personalized plan of treatment/service (*PTP*) for each consumer, based upon assessment content, initial and ongoing evaluation of treatment needs and strengths, the consumer's abilities, goals, and preferences, resources of QBH and community, and the consumer's

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response to and feedback about treatment. The assigned Counselor for a consumer is responsible for the overall construct and management of that consumer's *PTP*.

- The *PTP* shall be initially completed by the first counseling session for MAT consumers.
- The *PTP* is reviewed and updated when there are changes in the consumer's problems, needs, or response to treatment or if no changes are occurring. An update shall occur at least quarterly during the consumer's first year of continuous treatment and at least semiannually during subsequent years.
- Treatment planning follows an integrated approach. The consumer and/or guardian or legally designated representative shall participate in the development and reviews of the treatment plan. The Counselor assists the consumer and/or guardian or legally designated representative in plan development by clarifying the consumer's goals and needs and assisting them in identifying realistic objectives and helpful interventions.
 - If the consumer and/or guardian or legally designated representative is unable or unwilling to participate, or such participation is clinically inappropriate, such circumstances shall be documented in writing in the clinical record.
 - The consumer's and/or guardian's or legally designated representative's dated signature indicates their participation in, having been informed of, and agreement/consent to that plan of care.
 - The family may be involved upon request by the consumer; such request must be documented in the clinical record.
 - If a consumer and/or guardian or legally designated representative or family, if involved, does not agree with the plan of care, the Counselor or Case Manager, if appropriate, shall mediate a solution to the conflict.
 - If applicable, representatives of other community and/or health resources with which the consumer is already or desires to be engaged may, with the consumer's consent, become engaged in the treatment process as well.
 - Any party to the treatment planning process may convene a treatment review session as needed to address emergent and/or ongoing issues resistant to resolution and/or to develop contingency plans and aftercare planning decisions concerning the consumer.
 - All involved in the treatment process, upon consent of the consumer, may have access to or receive a copy of the current personalized treatment plan to facilitate information exchange.
- A primary focus of treatment planning is to assist the consumer to integrate into the community in a healthy manner; to develop healthier family integration, when appropriate; to assist them to identify and develop natural, healthy support systems; and to also assist them in gaining access to other services they may need. Need based goals and objectives strongly factor in ways to build or increase these ties to the extent the consumer is interested and willing.
- With MAT program consumers, there are additional factors to be addressed in the treatment plan that are particular to this population. These include:
 - Whether the treatment drug will be methadone, buprenorphine, or another medication, as determined by the physician, depending upon the consumer's medical condition, other medications the consumer is currently taking (licit and illicit, actual versus prescribed doses, and medically active adulterants potentially present in illicit drugs being used)
 - Need to manage concurrent abuse of other drugs
 - Strategies to prevent or limit the consumer from acquiring and abusing prescriptions for controlled substances or other psychotropics from other prescribers with which the consumer may have ongoing relationships
 - Inclusion of smoking and tobacco cessation shall be a part of treatment for consumers who use tobacco products
 - The treatment plan shall address, for consumers known to be using benzodiazepines, even by prescription, their risk and the provision to them of overdose prevention education and naloxone.
 - If other forms of treatment should be considered when the consumer has had two or more unsuccessful withdrawal episodes in a 12-month period

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- If a smoker, smoking and tobacco cessation should be an integral part of treatment for the consumer
- Treatment or referral for evaluation and treatment of any diagnosed diseases that are reportable to the Health Department
- Free or low-cost on-site provision of or referral for CDC recommended immunizations
- Management of opioid medication treatment when HIV/AIDS is a primary medical issue
- Recovery support services based on consumer needs, such as follow-up phone calls, face-to-face meetings, emails, peer-to-peer services, 12 step or faith-based programs, and community groups
- Support of a consumer's decision to breast-feed during methadone treatment, unless medically contraindicated
- Effort is made to write the plan using language the consumer understands and, wherever possible, using the consumer's own words. Once developed, the *PTP* is reviewed by the Counselor again with the consumer and any questions addressed before the consumer's and/or guardian's signature is added to the plan.
- The consumer and/or guardian or legal representative is given a copy of the *PTP* if they desire a copy. The provision of a copy is noted in the clinical record.
- Based upon the consumer's specific needs and where the consumer fits, treatment planning is developed incorporating the QBH MATT Treatment Model (see Attachment A at the end of this policy).

PERSONALIZED TREATMENT PLAN COMPONENTS

- The *PTP* shall address the major tasks of treatment planning, to include:

STRENGTHS

- During the assessment process the consumer's strengths are identified. The treatment planning process draws upon those strengths by developing objectives that use consumer strengths wherever possible.

BARRIERS

- During the assessment process the consumer's barriers or limitations are identified. Whatever barriers exist to treatment, they must be factored into the development of the treatment plan so that they are accommodated or countered by the treatment approach planned. Examples of possible barriers, but not exclusively, are: co-occurring illnesses, cognitive and/or communicative disorders, developmental disabilities, vision or hearing impairments, physical disabilities, and social or environmental factors.

NEEDS

- For each need the consumer desires to address, a description of the need, including symptoms/behaviors manifested that evidence the need's existence is defined. The need identified for description should be consistent with what was listed on the *Master Needs List*.

GOALS

- For each active need, there is identification of a goal(s), preferably in the consumer's own words.
 - When applicable, goals related to legal requirements and/or required fees shall be included on listed goals.
- Goals are stated in terms understandable to the consumer when it is necessary to use other than the consumer's own words.
- Goals established are based upon the consumer's desires and reflect the consumer's and/or their guardian or legal representative's informed choice.
- Goals should be stated so that one can know when they have been reached.

OBJECTIVES

- Objectives are intended to break down into manageable steps or actions what the consumer will need to do to achieve their identified goal(s). They are reflective of both the consumer's and treatment team's expectations.
- Each objective should be stated measurably, so that one can know for certain when the consumer has accomplished it. Each objective can be viewed as a consumer directive necessary to be completed in order to reach the goal to which the objective is associated. [Objectives had four basic components: WHO is the consumer him/herself; WHAT is the change (increase or decrease) in knowledge, attitude or behavior that is to take place; HOW KNOWN is a description of where the information (may be a practitioner/caregiver; self-report of the consumer themselves; a written document such as a test/journal/tally sheet; stated observations by staff/peer/family member/teacher/coach/other collateral source) verifying that the "what" has occurred comes from; and BY WHEN which is the target date by which the consumer believes they can accomplish the objective.]
- Each treatment objective shall have a date identifying when it was initiated and a target date for its accomplishment.
- Objectives that are achievable consider the consumer's age and development, cultural and ethnic orientation, any disabilities or disorders, the consumer's strengths and appropriateness to the treatment setting. To arrive at achievable objectives that consider these factors, the Counselor encourages the consumer to personally identify and state the steps/actions they need to take to achieve objectives that allow them to arrive at their goal(s).
- Objectives sometimes include directives for contact with referral sources and/or use of resources needed to help the consumer manage a particular disorder or disability as part of treatment. These may also be described on the *Master Needs List* rather than, or in addition to, the *PTP*.

INTERVENTIONS/MODALITIES/SERVICES

- For each objective, specific intervention(s) shall be identified, including the measures [also called methodologies, including such services as cognitive processing, role playing, modeling, practicing, etc.] to be taken, modalities [such as individual or group therapy, collateral contact, evaluation session, etc.] to be used, the discipline(s) [such as counselor, nurse, MD, monitor, etc.] primarily responsible, and frequency of each intervention and its duration.
- No treatment interventions shall be utilized which are intended to elicit fear, pain or involve the use of corporal punishment. Nutrition may not be denied as part of behavior management planning; nor shall food be used as a positive re-enforcer.
- Services provided to the consumer shall be directed toward carrying out the *PTP* and shall be verified by documentation in progress notes, attendance records or related forms.
 - Methadone treatment protocols are based upon best practices guidelines in compliance with ASAM and state/federal methadone treatment guidelines.

OTHER INFORMATION

- If a consumer is, at admission, or at any other time becomes, medically fragile, the plan will address any modifications in service delivery necessary during the period of medical fragility.
- Any needs requiring referrals for additional services beyond the scope of the QBH MAT program or transition to other community services during or after treatment at QBH may be addressed in the *PTP* interventions and/or described on the *Master Needs List*. If being addressed as part of after-care, they will be addressed in the *Transition/Aftercare Plan*.
- After-care needs, options available, and community resources that might be accessed are identified and interventions defined in a separate *Transition/Aftercare Plan*.

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- The *PTP* includes documented evidence of review with the consumer and the consumer's response, including their signature.
- Signatures of all participants who participated in the development of the *PTP* are also included.

SAFETY PLAN

- A preliminary plan is initiated during the intake process and addresses, in particular, safety issues identified during the intake process. This plan serves as an interim plan until the Master Treatment Plan is developed.
- If a consumer is identified as being in danger to themselves or to/from others, i.e. displaying or reporting dangerous behaviors, **during intake or at any time during treatment**, particularly in the MAT Outpatient program where they are less closely monitored, the *Safety Plan* is promptly initiated by the assigned Counselor with the consumer's participation and, if indicated and agreed upon by the consumer, may involve other family or significant others.
- This plan is personalized to the consumer and their specific issue(s) but may address such things as identification of triggers to the dangerous behavior and how to avoid or decrease exposure to those triggers, current coping skills in regard to the dangerous behavior and how to enhance the consumer's ability to identify and recognize warning signs, a 24 hour hot-line number they may access at any time they need help to manage their situation or response, measures they or significant others may take to help minimize a negative response if a trigger surfaces, provision of information to access a community resource such as a Crisis Intervention Center if they need immediate help to protect themselves or others from them, etc.
 - Interventions within the plan include measures that will enhance both the consumer's personal safety and the safety of others/the public.
 - Advance directives are included when available.
- All consumers are provided with the 24-hour access (hot line) number at admission and again at discharge.

TREATMENT PLAN REVIEWS

- The *PTP* shall be reviewed by the Counselor and/or treatment team with the consumer's participation and updated by the Counselor, with the consumer's input.
 - For consumers in MAT Outpatient review is **every 90 days** during the first year of continuous treatment and semi-annually during subsequent years.
 - At major key decision points in each consumer's treatment course. Key decision points, in addition to the length of stay (LOS) based reviews, include:
 - When goals or objectives are achieved
 - When additional consumer needs are prioritized as active
 - When existing interventions are not being effective
 - When there is a major change in the consumer's condition
 - At the conclusion of the initial estimated length of treatment and at the conclusion of any subsequent estimated lengths of treatment
 - When transfer or discharge seems indicated
 - The review shall be documented on the *Status Report Form* and included in the clinical record.
- The written review's purpose is to make decisions regarding continuance or modification of the *PTP* or *PTP* components and shall include:
 - Assessment of whether the plan continues to reflect current needs and remains relevant.
 - Identification of any interventions included in the treatment plan which were not employed or have been ineffective and modification as needed.
 - Assessment of progress toward achievement of *PTP* goals/objectives and modification when

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- necessary.
- Issues which impeded treatment progress and whether these were consumer-based or program-based; changes to the plan as indicated based upon this analysis.
 - Whether court orders are being maintained, if applicable.
 - Assessment/re-assessment of those with past or present history of abuse or trauma
- The written review, including identification of progress to date, is conducted with the consumer's input and reviewed with the consumer upon completion of the review, before the review is signed. Progress or lack thereof is a key factor in determining if improvements are needed in the PTP.

TEAM MEMBER EXPECTATIONS

- Team members shall all be sensitive to the specific and special needs of the consumer during the treatment planning and service delivery process.
- Team members collectively attempt to empower the consumer to actively participate with the rest of the team and to empower the consumer to actively seek recovery, progress and healthier sense of well-being.
- All team members are able to communicate in a culturally and linguistically competent manner.
- The team will meet as often as necessary to carry out decision-making.
- All team members shall sign the treatment plan and/or treatment plan review as evidence of their involvement and participation in plan development and evolution.
- The treatment plan and/or treatment plan review shall document decisions made as a result of each team meeting.

RELATED POLICIES/FORMS:

- Master Needs List
 - Personalized Treatment Plan
 - Status Report (Treatment Plan Review) Form
 - Transition/ Aftercare Plan
 - Discharge Plan
 - Safety Plan
-

ATTACHMENT A
THE QBH MODEL OF MAT PROGRAM

- Although time frames for the stages of recovery are very individualized, working through the stages of recovery occurs over a period of years. Clinical experience and knowledge suggest that stabilization tasks take around 18 months from the time that the individual actually starts in recovery. In general, a greater intensity of services is desirable at the beginning when staff is helping the consumer to identify relapse triggers and are monitoring closely for relapse. Psychosocial services are often required for an extended time-period due to the multiplicity of problems common to these consumers.
- The consumer's response to treatment determines her or his progression through the phases of treatment. Some consumers may remain in one stage for a considerable period, while in contrast, others may progress very quickly. It is not uncommon for a consumer to relapse. There is both an individual and a public health advantage to maintaining a consumer on medication, even when psychosocial treatment may not be yielding optimum results.
- Pharmacotherapy may benefit the individual consumer even when he or she does not appear to be benefiting from other program services. Additionally, pharmacotherapy may benefit the consumer who no longer needs ancillary services.
- The typical phases of MAT are listed below. It is important at all phases that psychosocial and medical treatment be of sufficient intensity and duration to be effective. General timelines are given here, but must be individualized to each consumer and their unique situation.

Phase 1: Stabilization

- Individuals in this phase of treatment often struggle with the recognition of the need to abstain from all mind-altering chemicals. Providing methadone maintenance treatment services may help an individual in this phase. Individuals prescribed methadone may struggle with continued use of opioids and other drugs. Counselling will address these issues as a normal part of this treatment phase.
- Initial treatment consists of intensive assessment and intervention, from 3 to 7 days in duration, typically.
- Early stabilization follows initial treatment, starting from the 3rd to 7th day of treatment through the next several weeks.
- Education in this phase is individually determined, but MAT team members *may* provide education on:
 - Methadone maintenance treatment – dispel myths and understand the treatment process that includes prescribed methadone (i.e., daily attendance at a pharmacy/OP office)
 - Attempts to control use
 - Denial/taking ownership of addiction

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- Breaking the addiction cycle/lifestyle
- Sleep, exercise, nutrition
- Stress management
- Needle exchange and safe needle use
- Relapse prevention
- Bloodborne pathogens – especially HIV and hepatitis testing and treatment, as well as hepatitis A & B immunization
- The stabilization phase typically consists of weekly physician appointments, group and/or individual counselling, and weekly/random drug screening. This phase consists of a minimum of six (6) weeks in duration; 8 weeks is a common length.

Phase 2: Transition

- Long-term treatment begins at the end of the Stabilization Phase and last for an indefinite period.
- Individuals in this stage of recovery need to learn to manage episodes of possible acute withdrawal from non-opioid drugs, post-acute withdrawal symptoms, as well as develop hope and motivation about treatment.
- While based upon individual consumer need, the MAT team members *may* provide education on:
 - Methadone maintenance treatment regulations
 - Dispelling myths
 - Community based support programs such as cultural supports, spiritual supports/affiliations
 - Post-acute withdrawal, assessing relapse triggers, managing cravings and euphoric recall
 - Grief and loss of former friends/networks and development of new social contacts
 - Substance affected family/friends/associates and boundary information
 - Problem solving (e.g., addictive lifestyle, relationships involving strategies/techniques such as time management, containment and journaling)
 - Cognitive skills development (e.g., planning, memory, problem solving)
 - Bloodborne pathogens
 - Relapse prevention
- The transition phase usually consists of:

- Physician appointments every two (2) weeks
- Focus on the determinants of health: the social and economic environment, the physical environment, and the person's individual characteristics and behaviors
- Group and individual counselling
 - Groups may be organized with special needs in mind such as gender, sexual minority, seniors, and language
 - These psychosocial services are available to consumers receiving "0" dose levels as well as those receiving doses
- Weekly/random drug screening
- Access to community resources/referrals
- During this phase, services are provided for a minimum of six (6) weeks.

Phase 3: Community

- Individuals in this phase of treatment develop short-term stability, understand the impact of addiction, learn non-chemical stress management and develop a recovery-centered value system. They also establish lifestyle balance, resolve social damage resulting from substance use, and learn to manage change.
- Based upon individual consumer need, MAT team members **may** provide education on:
 - The development of an individualized treatment value system
 - Financial Management
 - Boundaries in relationships
 - Vocational counselling/school/work/volunteer
 - Parenting, self-image
 - Resolving outstanding legal issues
 - Containment/stabilization strategies for people showing signs/symptoms of trauma
 - Relapse prevention
 - Renewing or establishing social contacts/outlets
 - Family communications, parenting
 - Accessing services at other agencies regarding marriage/couple issues, career changes, reaching goals, managing change, recognizing and achieving lifestyle balance
- The community phase usually consists of:

- Physician appointments every thirty (30) days
- Ongoing assessment
- Group and individual counselling
- Weekly/random drug screening
- Support
- Evaluation
- Access to community resources/referrals
- Consumers remain on Methadone Maintenance
- During this phase, services are provided for as long as the consumer remains in the Medication Assisted Treatment Program. Every effort is made to retain consumers in treatment as long as is clinically appropriate, medically necessary and acceptable to the consumer.

LONG-TERM USE OF METHADONE

- If a consumer remains long-term in the MAT Program, a program physician shall document a clinical justification for continued administration of methadone in spite of potential side effects associated with long-term use.
- Justification of long-term use might include:
 - The treatment staff feels maintenance dosage is still necessary
 - Consumer continues the use of illicit drugs
 - Consumer is not ready to detox at this time
 - Other (be specific)
 - Doses of medication had to be adjusted because the MAT Program switched from one generic formulation to another and differences in effective dose caused clinically relevant complaints

COUNSELING

- Engagement, support and counseling are important components of the MAT Program and may be provided on an individual basis or in a group format. Consumers should be provided equitable and easy access to counseling upon their request, or have it offered to them when clinically indicated.
 - Counseling is provided only by licensed program counselor, qualified by education, training, or experience to assess the psychological and sociological background of consumers, to contribute to the appropriate treatment plan for the patient and to monitor patient progress.
- There is evidence, from Best Practices studies, that providing counseling adds to the effectiveness of methadone maintenance treatment programs. In the field, the term "counseling" encompasses a wide range of activities which may include, among others:
 - Crisis intervention

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- Case management, including referrals to and liaison with other agencies
- Individual, one-on-one counseling
- Group counseling
- Couples or family counseling
- Vocational counseling
- Substance use counseling
- Pre- and post-test HIV counseling, and counseling related to other medical conditions
- Health and other education programs
- Brief, supportive contacts
- Long term intensive support
- All consumers will be provided counseling, either individually or in a group setting, on the prevention of exposure to, and transmission of, immunodeficiency virus (HIV) disease.
- Either directly, or by referral, all consumers who request or whose treatment plan indicates will be provided with assistance in accessing community resources needed, vocational rehabilitation services, and/or education or employment services
- When they are ready to do so, consumers should have access to evidence-based approaches to counseling to address issues of concern to them.

VOLUNTARY CONSUMER RELOCATION, PROGRAM TRANSFER AND GUEST DOSING

- When a consumer relocates, transfers to another treatment program, or needs temporary care at another program ("guest dosing"), MAT program staff oversee that the consumer makes a smooth transition, and the program attempts to avoid breaks in treatment that could lead to relapse. Program staff will forward relevant clinical records to the receiving treatment program, with consumer consent and a signed Release of Information.

MANAGEMENT OF CO-OCCURRING DISORDERS

- When possible and appropriate, co-occurring disorders are concurrently managed onsite. This includes management of multiple drug use problems, as well as psychiatric and medical disorders.
 - Coexisting conditions, especially in consumers from disenfranchised populations, are most effectively treated at a single site.
 - MAT program staffs are trained to have an understanding of both the substance use and co-occurring disorder. If the appropriate level of expertise is not available within the program, then staff members arrange for the consumer to receive appropriate care elsewhere.
- See the Managing Acute and Chronic Health Conditions and Health Conditions in Remission Policy

Alcohol and Other Drug Abuse

- The MAT program manages concurrent abuse of other drugs within the context of the medication-assisted treatment.
- Program staff members are knowledgeable about current effective strategies for treating alcohol, cocaine, and other drug abuse.
- Ongoing multidrug abuse is not necessarily a reason for discharge. Patients engaging in such multidrug use receive careful evaluations to determine the most therapeutic course of treatment, in light of the fact that many consumers (and communities) continue to benefit from medication-

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assisted treatment even when the consumers are not fully abstinent from all drugs of abuse.

- The treatment decision for poly-drug-abusing consumers takes into account the consumer's condition and the treatment team's best clinical judgment.
- MAT program staff coordinates care with providers outside the MAT program who prescribe medication with abuse potential.

Care of Consumers With Mental Health Needs

- Consumers with mental health needs are identified through the assessment process and referred to appropriate treatment.
- During withdrawal and/or discharge MAT program consumers are monitored for emergence of symptoms of mental illness.
 - If not treated at QBH, Inc. the Company has established linkages with other mental health providers in the community.
 - Effort is made to evaluate mental health medication jointly with the mental health provider. If possible and if indicated, the MAT program may even dispense such medications in conjunction with the daily dose of opioid medication.

POLICY: PAIN MANAGEMENT

It is this Company's policy to screen all consumers for the presence of physical pain, particularly chronic pain, to initiate a full assessment when indicated, and to either refer for or institute a planned approach to treatment for consumers with acute or chronic pain.

PROCEDURES:**COMPETENCY OF HEALTH CARE PROVIDERS**

- All QBH staff who participate in the pain management program shall receive annual instruction in the following:
 - Identifying and assessing acute and chronic pain
 - Documenting the consumer's past and current responses to pain, how it affects their lives, and its treatment
 - Consumer/family personal, cultural, spiritual and/or ethnic beliefs about pain and various aspects of pain response, pain management and education
 - Pharmacological and non-pharmacological approaches to pain management
 - Pain management in conjunction with MAT treatment
 - Identification of barriers to goal attainment associated with disorders causing pain and its treatment
 - Referral to and collaboration with outside providers.
- Psychiatrists, therapists, and registered nurses are approved to participate in pain management planning once the educational component has been successfully completed. Each clinician will participate in a written post-test in order to demonstrate understanding of the pain management program.

ASSESSMENT

- Screening for the presence of acute and chronic pain is part of the initial History and Physical Exam completed by the physician as part of the intake process and as needed during a consumer's course of treatment, and shall include at a minimum:
 - Verbalized acknowledgement of whether or not the individual experiences pain
 - Description, on a scale (appropriate to the consumer's age and reading ability) of 1 to 10, of the intensity of the pain experienced and characteristics of that pain experience
 - Description of the ways in which the pain interferes or affects activities of daily living, including school/ employment, relationships, sleep, appetite, self-care and mood

- Description of previous and current treatment, including any medications used for pain management
- Notation of any discordance between information presented by the consumer and the assessor's awareness of consumer behaviors such as facial expression, body posturing, body guarding, etc.
- Screening responses that would trigger the necessity for completion of a full pain assessment include:
 - Pain intensity that exceeds 6 on a scale of 10, with 10 being intolerable pain.
 - Pain interferes persistently with activities of daily living.
 - No current treatment for acknowledged chronic pain.
 - Obvious discordance between information provided and body language.
 - A consumer request for further evaluation.
- If a full assessment is triggered, the consumer will receive a full assessment within 3 days by qualified staff. If no qualified staff is available, the consumer will be referred outside QBH for this assessment and the referral will be documented in a progress note. If referred, the primary clinician and/or psychiatrist will collaborate with the outside source for a report of assessment results and any coordination of treatment that is indicated. All attempts at collaboration and coordination shall be documented in progress notes in the medical record.
 - Consumers in MAT are eligible to receive both MAT and adequate doses of opioid analgesics for pain.
- Re-evaluation of consumers who have been determined to have pain shall occur as follows:
 - Re-evaluation shall occur with each counselor appointment and shall include documentation of the pain site, pain characteristics, including a consumer rating of intensity, changes since the last assessment, interventions provided and response.
 - The counselor will inform the program physician if pain is not being managed or has increased in intensity or duration.

TREATMENT

- A specific pain control segment is addressed in the treatment plan, in collaboration with the consumer, and the consumer is instructed in the specific components of the plan.
- The treatment plan may include referrals to outside providers/resources for further assessment and/or interventions.

Pain Medication in Conjunction with Opioid Treatment

- In some instances, a consumer receiving opioid treatment may need pain medication in conjunction with their addiction treatment. In such cases, the following applies:
 - Opioid analgesics for pain may be prescribed by the consumer's primary care physician or the program physician.
 - When such pain medication is indicated, the consumer shall not be denied off-site dosing or detox to a drug free state.
 - Methadone does not replace the need for a pain medication.
 - Ongoing coordination between the MAT Program physician and the prescribing practitioner is mandatory.
 - Alternative pain management techniques shall be taught to the consumer either in the program, by the PCP, or by referral to a pain management specialist

Methadone And Acute Pain

- Consumers on long-term methadone therapy have a lower pain threshold and are tolerant to the analgesic effects of other opioids. There is no evidence that opioid use for acute pain increases the risk of relapse. However, some have argued that being under treatment of acute pain can cause relapse by forcing the consumer to self-medicate.
- Ideally, any opioid dispensed for pain should be dispensed on the same schedule as the methadone. In injection drug users, acetaminophen-opioid combinations are preferred because they are more difficult to inject. If possible, choose opioids with a lower abuse liability (codeine, morphine) over opioids with greater liability such as oxycodone or hydromorphone. Scheduled, rather than PRN dispensing is preferred for constant pain. The physician may start the consumer at a dose that would normally be prescribed for a non-addicted consumer with a similar condition, with upward titration if necessary.
- As an alternative to adding an opioid, a temporary increase in the methadone dose of 10-15 mg may be considered as a temporary split dose. The dose should be reduced after the acute pain has resolved.

Management of Methadone Consumers With Acute Pain

- While treatment should be individualized, the following are some critical considerations in the management of acute pain for methadone consumers:
 - Use non-opioid alternatives along with (or instead of) the opioid.
 - Consumers on stable doses of methadone often require higher or more frequent opioid doses for acute pain than other consumers. Initiate treatment at doses usually used to treat consumers with a similar condition. Titrate upwards, if necessary.
 - The opioid should be dispensed along with the methadone (i.e., daily, if the consumer has no methadone off-site dosing).
 - The prescribing physician should avoid prescribing opioid agonist-antagonists
 - Acetaminophen-opioid combinations are preferred for injection drug users
 - Where possible, the physician should avoid prescribing short-acting opioids with a

- higher dependence liability, such as oxycodone or hydromorphone
- Alternatively, a 10-15 mg increase in methadone dose may be considered as a temporary split dose. The dose should be reduced after the acute pain has resolved.
- For constant pain, scheduled use is preferred to PRN use.
- The physician should address any consumer concerns about inadequate pain control, and the risk of relapse.
- The physician should be alert for signs of relapse, such as continued use of short-acting opioids long after the pain should have resolved, excessive use, and unwillingness to share information with the prescribing physician.
- Opioids should generally not be given for more than two weeks for acute pain, and a re-evaluation of the consumer's pain should be made with the appropriate referrals.
- Avoid prescribing the opioid the consumer was originally abusing.

EDUCATION

- Consumer and family education is completed based upon Company-approved protocol(s).
 - Education provided and consumer response and mastery are recorded in the medical record. Treatment is modified as appropriate based upon consumer response.

EVALUATION:

- The Clinical Director will review this policy annually and make modifications as needed based upon changes in regulations, changes necessary due to nature of services, any revisions will be submitted to the Clinical Committee as scheduled.

RELATED POLICIES/FORMS:

- Master Treatment Plan
- Pain Flow Sheet
- Referral, Screening, and Intake Policy
- Assessment, Update and Clinical Summary Policy

REFERRALS

- Referrals might be initiated by individuals, family members, primary care practitioners, addictions counselors, other community providers, or through state Medicaid or Medicare systems.
- The party making the referral must call the Institute for Population Health/Bureau of Substance Abuse Prevention, Treatment and Recovery (the Bureau) at 1-800-467-2452 and request a referral to Quality Behavioral Health's (QBH) MAT program. Referral may also be made directly from a non-QBH Crisis Intervention program.
 - Regardless of source of referral, the consumer must contact QBH's MAT program to confirm their interest in the program at which time they will be screened for eligibility following regulatory guidelines.
 - Once the referral is received by QBH, if the consumer has not also made contact, the Intake Coordinator at QBH will contact the prospective consumer and schedule an intake appointment. Transportation will also be arranged, if needed.
 - If the referral to the MAT program is from the Institute for Population Health/Bureau of Substance Abuse Prevention, Treatment and Recovery (the Bureau), they will have already assessed whether the consumer qualifies for this level of care, using ASAM criteria. A copy of their assessment decision is entered into the consumer's clinical record.
 - If, during intake, it is determined that the Bureau assigned the wrong level of care, an objection shall be submitted to the Bureau and documented in the consumer's clinical record.
 - If the consumer is a walk-in, not a referral from the Bureau, then their assessment tool/criteria will be employed to document whether this consumer meets the MAT program level of care. This documentation is included in the consumer's clinical record.
 - If a person has previously been a consumer at QBH MAT and left the program against medical advice (AMA), they cannot re-apply for 6 to 12 months. The length of time is determined by the Bureau.
- All referrals will be prioritized based upon the following guidelines:
 - Priority is given to pregnant women who seek treatment; if not accepted, there is documentation addressing the reasons for denial of admission in the intake log.
 - A check of the central registry system confirms the consumer is not enrolled in treatment at another location of by an individual practitioner. [Verification of the central registry check will be discussed and documented in the initial treatment team meeting; it is documented on the Consumer Consent Form. This documentation will also be checked by the MR Dept. and through peer review activities]
 - Consumers needing transfer from interim maintenance treatment, particularly those nearing 120 days in interim maintenance treatment, to comprehensive maintenance treatment.
 - Those fully eligible for admission to comprehensive maintenance
- Intake must occur within **24 hours** of QBH's receipt of the referral or else the customer will be placed on interim maintenance treatment.
 - If the consumer is being referred to the Motor City MAT program, interim maintenance treatment can be provided at that location which is authorized by SAMHSA and MI to do this

type of treatment. Interim maintenance treatment shall never exceed 120 days in accordance with federal regulations and the consumer must be fully eligible for admission to comprehensive maintenance to qualify for interim maintenance.

SCREENING AND ELIGIBILITY

- All consumers receiving treatment at QBH MAT are screened for eligibility of services and, if deemed eligible, are referred for treatment at one of QBH's programs, either by the Michigan Institute for Population Health/Bureau of Substance Abuse Prevention, Treatment and Recovery (the Bureau) or a non-QBH Crisis Intervention program. Screening is not conducted by QBH, nor does QBH make the admission determination.
 - *Utilization Review Eligibility Criteria* are established for QBH's MAT program and are maintained with these screening/eligibility and referral bodies.
 - All consumers receiving treatment at a QBH MAT program are screened for eligibility of services and, if deemed eligible, are admitted to treatment.
- Clear criteria have been established for admission to MAT. All consumers are assessed by a program physician against those criteria.

Inclusionary criteria include:

- Physiological evidence of addiction. A program physician has diagnosed current opioid addiction or dependence of at least 1 year duration, and determines, based on SAMHSA and/or DSM-V criteria, that maintenance or withdrawal treatment is necessary. These include: 1) significant levels of tolerance resulting in withdrawal symptoms on abrupt discontinuation of opioid substances; 2) symptoms that support compulsive, prolonged self-administration of opioid substances that are not for legitimate medical purpose or, if medical purpose exists, usage doses greatly exceed the amount needed for pain relief; 3) regular patterns of use that result in daily activities being planned around obtaining and administering opioids; 4) purchase on the illegal market or by faking or exaggerating general medical conditions, or by receiving simultaneous scripts from several doctors; 5) engaging in drug-related crimes such as fraudulent writing of scrips for opioids or diverting opioids prescribed for other consumers or from pharmacy supplies.
- ✓ If the physician makes the diagnosis and admits a consumer after reviewing by telephone or fax the medical exam of another qualified professional, it must be reviewed and countersigned by the program physician and included in the consumer's medical record within 72 hours. Standing orders for admitting consumers are not acceptable.
- ✓ The one-year duration may be based upon arrest records, medical records, information from significant others and relatives, or other reliable information.
- ✓ Behavioral manifestations are typically: continuing use despite known adverse consequences to self/others, obtaining illicit opiates, using prescribed opiates inappropriately, previous attempts at tapering methadone or other drugs
- Consumers who are not currently physiologically dependent but are susceptible to relapse to opioid addiction to include (federal regulation waives the 1-year history of addiction):
 - ✓ Persons released from penal institutions within the past six months
 - ✓ Persons recently discharged from a chronic care facility
 - ✓ Pregnant women; A number of deleterious effects for the woman and the fetus can be avoided or reduced if a pregnant opioid dependent woman is provided MAT, thus this

should be done wherever possible. If a woman is pregnant, she will be referred to Beaumont Clinic for prenatal care and substance abuse treatment.

- ✓ Persons previously treated within the past two years
- Persons with dual diagnosis of opioid dependence and a pain disorder
- Women with concurrent HIV infection or HIV diagnosis, regardless of whether they are pregnant
- Person displays at least six diagnostic criteria in accordance with DSM V for opioid dependence or meets SAMHSA criteria
- The consumer voluntarily chooses MAT
- Past treatment failures (desired, not required)
- Previous methadone treatment does not exclude a consumer from further treatment even without supporting evidence of current physiological dependence for up to six months or more if the MAT team determines in their clinical judgment to find readmission medically justified
- Willingness to comply with treatment; signs and abides by a treatment agreement
- Willingness to participate in all aspects of the MAT Program included in the treatment plan, including admission to detox, if required, drugs screening, counselling (group or individual), and consent to release of information.
- Must be able to access all Outpatient (OP) office MAT appointments, daily dispensing (at pharmacy or OP) and all clinical interventions.
- Must be willing to attend the OP office on a weekly basis and/or when required.
- The consumer must be medically manageable as determined by the physician.
- Consumers at high risk of relapse following a previous successful course of methadone treatment should be readmitted at their request (i.e. those consumers who have successfully and voluntarily tapered off methadone, then present as a high risk for relapse)

Exclusionary criteria include:

- A person seeking treatment for pain management only
- Less than 18 years of age
- A person already receiving treatment elsewhere
- Has already received two withdrawal treatment episodes in the past year
- Has evidence of psychological impairment

Admission Risk Assessment Scale

- All admissions will be prioritized using a risk assessment scale developed for that purpose. It is recognized that certain medical and/psychosocial conditions enhance the risk associated with substance use. The scale developed is not meant to be all-inclusive, but rather seeks to point out the relative risk of the most common presenting issues.
- This scale prioritizes admission based on high risk using a Laskey Scale with 10 being the highest risk and 1 being the lowest risk. This scale has not been validated and is only intended for use in conjunction with a complete clinical assessment.

Low Risk

1	Referral from corrections /penal system
2	
3	

4	
5	IV Drug use, history of non-compliance with treatment
6	Recovery (without Methadone) and at risk of relapse
7	
8	IV drug use, history of completing treatment available
9	HIV/VCV Stable but significant health problems Children at risk
10	Pregnant

High Risk

- Crisis assessment is not done by QBH. However, a suicidal and homicidal risk assessment that addresses relative risk to self-and/or others is conducted. If a consumer is referred for admission to a QBH MAT program, or presents at intake, or while in the program with any display of suicidal risk or other danger to self or others, presents with an urgent or critical medical condition, or any other immediate endangerment threat, the consumer will be transported to a hospital or crisis intervention facility, as appropriate to their condition. If the consumer is not stabilized and returned to QBH within 24 hours, they must re-engage with the Bureau or Crisis Intervention program to re-initiate referral to a QBH program.
- Consumers who meet the admission criteria that are referred by the Bureau or a non-QBH Crisis Intervention will be accepted into the MAT program.

INELIGIBILITY/WAIT LIST

- If space is unavailable in the MAT program, the Bureau will add the individual to their wait list; QBH does not maintain a wait list directly. The Bureau follows procedures as set forth by JC and other accreditation programs. When a space becomes available, the Intake Coordinator notifies the Bureau of bed availability.
- Since eligibility is determined by either by the Michigan Institute for Population Health/Bureau of Substance Abuse Prevention, Treatment and Recovery (the Bureau) or a non-QBH Crisis Intervention program, using QBH's admission criteria, any person found ineligible for QBH MAT services is informed of the reasons by whichever of these agencies in assessing eligibility. The agency will inform the person and their family/support system, if applicable, and referral source of the reason for ineligibility and arrange alternative services, unless the person qualifies for the wait list.

INTAKE PROCESS

New consumers will be considered for admission into the QBH MAT Program on a regular basis, if there is space available, unless they fall into the exempt criteria. An intake assessment shall be completed prior to being considered for admission.

- The individual will be contacted with a date and time for a comprehensive biopsychosocial assessment.

- A prospective consumer may arrive for intake by their own arrangement, by transport arranged with QBH, or via medical or police escort.
- When the consumer arrives for an intake into the MAT program, they are met by a Counselor who provides for their orientation and completes the intake process with them.
- The intake begins by reviewing numerous informational and consent related documents with the consumer such as the *Consumer's Rights and Responsibilities, Grievance Process, HIPAA and Confidentiality Notice, Program Rules, Consents to Treatment and Medication, Releases of Information*, as appropriate, etc., obtaining signatures from the consumer or guardian where applicable.
- The consumer must complete the following:
 - A complete medical history and physical examination, and a nursing assessment will be completed.
 - A supervised urine drug screen
 - A full intake biopsychosocial assessment and mental status examination, including the consumer's (and the family's when available) perceptions of his/her needs and goals for MAT
 - One individual counselling session to include review and completion of the Consumer Initial Assessment and the Narcotic Assessment Tool if necessary.
 - Attend an individual or group session, in which the treatment guidelines of the MAT Program will be reviewed. Discussion will occur concerning the need for sharing information about the consumer's history with other community agencies. Authorization for Release of Information will be obtained from the consumer and forwarded to appropriate community partners, i.e., Police, Mental Health, Dept. of Public Safety, Family Physician(s), Pharmacies, and anyone deemed appropriate to substantiate or advocate for their need.
- The consumer will be provided with an appointment at the appropriate hospital or at the MAT Program for urinalysis and pertinent lab work. Admission screening should include, but not necessarily be limited to, Tb skin testing; HIV, HBV, HCV serology; liver function (albumin, INR, AST, ALT, GGT, alkaline phosphatase) and serum BHCG where indicated. Any or all of the above that have been obtained within the preceding 6 months, may suffice, unless otherwise clinically indicated. Baseline ECG is recommended and indicated in any consumer on a methadone dose greater than 150 mg.
- The consumer will be required, after being informed of the possible adverse reactions to methadone and review of the consent form(s), to sign two copies of a consent form that reflects the rules and regulations of the program and their agreement to treatment Consent to Opioid Pharmacotherapy Treatment, and any other forms as developed by QBH. One copy will be filed in the consumer's confidential file and the other given to the consumer.
- The consumer will be provided information concerning harm reduction and safety issues until they are admitted to the program. An *Initial Treatment Plan*, completed at the end of the screening session, will include this information and any other elements for safety as appropriate to the consumer's identified safety concerns, intake evaluation and consumer self-reported concerns. This initial plan remains in effect till the Treatment Plan is developed, but not to exceed 30 days.

- Consumers who are on the list and are being assessed for admission to the OP MAT program will lose their position on that list as a result of activities that indicate a lack of motivation or cooperation. For example, missing intake appointments can result in that individual being replaced by the next person on the list.
- Family members of consumers can be recommended to attend a family group or 1:1 counselling to deal with co-dependency issues. Likewise, if warranted, the consumer is given information about resources available in the community for the care of dependents during scheduled treatment times.
- By the end of intake, a primary counselor is assigned to the consumer who will oversee implementation of their treatment plan and coordinate their care, oversee the consumer's orientation, encourage the consumer and, if applicable, their significant others to participate in all aspects of assessment and treatment, will provide for treatment plan reviews, advocate for the consumer as needed, and coordinate services needed by other community resources.

ADMISSION PROCEDURE

- When the consumer's information is obtained from all sources, including lab results, the individual's case will be reviewed and assessed by the QBH MAT team which is minimally inclusive of the intake worker, nurse and program physician. The team's Medical Director or staff physician will make a decision regarding the consumer's acceptance into the MAT Program, or referral to another program resource (such as In-patient Detox or other Residential Treatment), Outpatient Counselling, or other treatment options as appropriate. This decision of the Medical Director is documented in the consumer's record. In some individual cases, where deemed appropriate, consumers with co-existing physical or mental illness; and/or where social conditions warrant, may be referred to inpatient addiction services, other Mental Health Services, or other health professionals.
- If accepted into the MAT Program, the consumer will be contacted and provided an appointment date and time to meet with the physician at the MAT Program office to be given instructions, prescription for Methadone, and next scheduled appointment for group counselling and/or 1:1 counselling and physician's visit. Based on team decision, it may be necessary for the consumer to be admitted to detox or residential services first for stabilization.
- If not accepted into the MAT Program at this time, the consumer will be contacted and provided with the referral information to another program for either other treatment options or admission to detox or residential addictions treatment, as appropriate.
- Consumers are required to consent to all treatment agreements.
- The procedures for notifying the consumer's identified pharmacy of choice will be developed and followed.
- Family physicians of consumers who have been admitted to the MAT Program will receive a faxed copy of a letter requesting that the family physician NOT prescribe any benzodiazepines or narcotics for this consumer while they are on the Methadone, without consultation with the QBH MAT Program physician. At the discretion of the MAT Program team, the family doctor may also

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MAT REFERRAL, SCREENING, AND INTAKE POLICY

be sent a copy of the consumer's methadone prescription. A similar letter may be forwarded to ER Dept., local Health Clinics and community Pharmacies and other appropriate stakeholders, on a "need to know" basis.

- Specialized Intake Groups will be conducted within five days after intake, limited to five consumers per group for education and an open question and answer session on special issues. Intake Groups include ones for:
 - Smoking cessation
 - Consumers using benzodiazepines, even by prescription, regarding their risk, overdose prevention education, and provision of naloxone.

FORMS:

Consumer Orientation Checklist

Consumer's Rights and Responsibilities List (included in Consumer Handbook)

HIPAA, Notice of Confidentiality, and Individual Rights Notice (included in Consumer Handbook)

Consumer Handbook/Program Rules

Consents to Treatment and Medication

Biopsychosocial Assessment

Medical History and Physical Exam

Psychiatric Exam

Personalized Treatment Plan Form

Drug Screen Results Form

Consent for Contact

Take Care of Business Form

Recipient Rights Notice (included in Consumer Handbook)

Medicaid Recipient of SA Service Complaint/Grievance Rights Process (included in Consumer Handbook)

POLICY: MAT RELAPSE AND EARLY DISCHARGE

It is the policy of QBH that all consumers practice total abstinence from all mind-altering substances, including alcohol. All participants are subject to drug screens at program admission and each visit as requested.

MANAGING RELAPSE

- Program response to relapse is clearly defined and must be enforced. A relapse to a mood-altering substance indicates reduced stability. Every attempt is made to track the consumer's progress closely and re-institute MAT treatment as the first sign of relapse or impending relapse.
- Refusal to submit to a urine test will be considered positive and potential relapse.
 - The treatment team will meet and discuss with the consumer and family, if appropriate, what is the best course of action for this relapsing consumer. The consumer may be subject to discharge from the MAT program. The final decision rests with the Medical Director, after treatment team input.
- Falsification and/or contamination of the specimen sample collected for drug screening is prohibited and may result in termination of treatment.
 - The treatment team will meet and discuss with the consumer and family, if appropriate, what is the best course of action for this relapsing consumer. The consumer may be subject to discharge from the MAT program. The final decision rests with the Medical Director, after treatment team input.
- The staff conducting the drug screen will document the results of a drug screen in the consumer's record as well as treatment team decisions and actions and the consumer's response.
- Steps the treatment team should evaluate and address in treatment planning if relapse occurs shall include:
 - Re-evaluate frequency of counselling and/or the focus of counselling; psychosocial treatment should continue.
 - Consider increasing frequency of urine screening.
 - Consider increasing frequency of medical appointments.
 - No response may be required following a single episode of drug use; this is a treatment team decision.
 - Consider referral to inpatient detox.

INVOLUNTARY DISMISSAL FROM CARE

- The Code of Ethics of the American Medical Association provides that the ethical physician, having accepted professional responsibility for a consumer, will continue to provide services until:

- They are no longer required or wanted,
 - Another suitable physician has assumed responsibility for the consumer, or
 - The consumer has been given adequate notice that the physician intends to terminate the relationship.
- Consumers who are being discharged involuntarily are offered a schedule of medically supervised withdrawal. The consumer should be tapered at a rate of no more than 5 mg every 3-4 days. Clonidine may be used in the last one to two weeks to relieve withdrawal symptoms, at a rate of 0.1 mg p.o. 3 or 4 times a day. The consumer's condition during withdrawal shall be documented in the clinical record. The consumer is provided with referrals to alternate treatment program(s) and those referrals are documented in the clinical record.
 - When practical and considering consumer and staff safety, before administrative discharge, a crisis assessment is done to address suicidal risk, danger to self or others, risk of relapse or overdose, any urgent or critical medical conditions, and immediate threats. [CTS.06.02.01, EP 9, 11-14]
 - If indicated the consumer may be referred to inpatient detox for withdrawal and referral for ongoing counselling or be given information on or referral to other treatment alternatives.
 - All aspects of involuntary dismissal of care shall be documented in the consumer's record.

Early Discharge Criteria

- Upon admission to the MAT Program, consumers may be given a period of adjustment for stabilization to occur before any discharge procedures are considered. Clinical experience suggests that three months will generally suffice for stabilization to occur. However, progress, participation and behavior should be evaluated on an ongoing basis.
- The philosophy of the Medication Assisted Treatment Program is one of harm reduction and every effort will be made to retain the consumer in the program.
- It is important that information about any consumer behavior that may give rise to discharge from the program come from reliable sources.
- Discharge will be a collaborative decision of the treatment team.
- Discharge may occur if there is a continued failure to meet conditions and expectations of the program and the treatment team determines that the risk of continuing Methadone maintenance in relation to the consumer and/or the community at large outweighs the benefits. Any decision should consider, but not be limited to, the following:
 - Clinical treatment non-compliance including, but not limited to:
 - ✓ Treatment goals not achieved within 2 years, unless:
 - ASAM criteria have been met.
 - The consumer provides evidence of willingness to participate in treatment.
 - There is evidence of progress in treatment.
 - Medical necessity can be supported and documented.

- Recommendation is provided by the MAT program physician.
 - ✓ Repeated or continued use of one or more other drugs and/or alcohol which are prohibited in the consumer's treatment plan.
 - ✓ Failure to attend scheduled counselling sessions or psychiatric/psychological appointments.
 - ✓ Other non-compliance with the treatment plan such as repeated failure to follow through on related referrals.
 - ✓ Missing appointments without making prior arrangements (this includes appointments with RN, counselor, physician, or other community partners). (For example, missing 3 appointments within a 2- month period, after stabilization.)
 - ✓ Producing urines that contain cocaine, narcotics, or benzodiazepines. (For example, 3-5 dirty urines in any 2-month period, after stabilization.)
 - Behavioral treatment non-compliance including, but not limited to:
 - ✓ Soliciting urine from other consumers or being caught or suspected of tampering with urine specimens in some way.
 - ✓ Acting in an abusive, disrespectful, or threatening manner towards other consumers, their families or treatment team (to include all staff, physicians, nurses, counsellors, pharmacists, administrative staff, or other community partners)
 - ✓ Loitering on premises without having a reason to be present in the area.
 - ✓ Being implicated in or having evidence found of illegal behaviors, including but not limited to: shoplifting, breaking and entering, drug dealing and/or threatening office staff, physicians, or health care professionals.
 - ✓ Missing 3+ methadone doses.
 - ✓ Soliciting or selling illicit drugs on the QBH premises as verified by staff.
 - ✓ Possession of firearms or weapons on or near QBH property.
 - ✓ Diversion of controlled substances, including methadone.
 - ✓ Attempted diversion and/or adulteration of toxicology samples.
 - ✓ Possession of a controlled substance with intent to use illegally and/or to sell it on QBH property.
 - ✓ Sexual harassment of staff and/or other consumers.
 - ✓ Possession of paraphernalia that resembles firearms or weapons on or near QBH property.
 - ✓ Line jumping and/or exchange of money for place in line during dosing dispensing.
 - Medical treatment non-compliance including, but not limited to:
 - ✓ Failure to comply with necessary medical care for condition(s) diagnosed by a licensed physician (e.g., diabetes, hypertension, heart disease, tuberculosis, etc.)
 - ✓ Failure to use medication prescribed by a physician and/or to keep physician appointments.
 - ✓ Failure to attend prescribed treatment sessions and/or follow up on referrals for evaluation of a medical condition.
 - ✓ Failure to submit to toxicology sampling as requested.
 - Failure to pay fees and accounts receivable.
 - Fraudulent use of insurance to avoid fees.
- There will be Zero Tolerance for any act of violence (including verbal and/or physical threats)

directed towards staff or other consumers while on the QBH premises.

- Depending on the discretion of the staff, the police authorities will be called to assist in removing the consumer from the premises for any of the above violations.

ADMINISTRATIVE TERMINATION

- A major goal for the MAT program is to retain consumers for as long as they can benefit from treatment and express a desire to continue it.
- Because retaining the consumer is not always possible, administrative withdrawal that employs the principals involved in medically supervised withdrawal from medication are followed.
- Administrative withdrawal is usually involuntary. When the MAT program treatment team or physician makes the decision administratively to discharge a consumer from pharmacotherapy, the program offers a humane schedule of medically supervised withdrawal, using sound clinical judgment in conformance to SAMSHA guidelines.
- A guide for a medically supervised withdrawal schedule for administrative withdrawal is generally a minimum of 30 days, but the physician may adjust this timeframe depending on clinical factors.
- The program physician and staff document the consumer's condition during medically supervised withdrawal in the consumer's record.
- On discharge, appropriate alternative referrals are offered, and assistance given, as needed, in arranging those referrals. Given the short timeframe and poor prognosis for the withdrawal procedure, patient referral or transfer to a suitable alternative treatment program is the preferred approach. The consumer is offered the opportunity to continue psychosocial treatment even if they elect to discontinue pharmacotherapy.
- Administrative withdrawal may result from:
 - Nonpayment of fees. Remedies may include referral to a more affordable treatment program. As a last resort, the program provides a humane schedule of medically supervised withdrawal.
 - Disruptive conduct or behavior. Such behaviors may have an adverse effect on the program, staff, or consumer population of such gravity as to justify the involuntary medically supervised withdrawal and discharge of a consumer, despite an extremely poor prognosis.
 - ✓ Disruptive behaviors include violence, direct threat of violence, dealing drugs, repeated loitering, and flagrant noncompliance, resulting in an observable, negative impact on the program, staff, and other consumers.
 - ✓ Consumers who exhibit disruptive behaviors will receive a mental health evaluation and referral, as appropriate, prior to administrative withdrawal.

- Incarceration or other confinement.
- The MAT program treatment team takes into consideration all factors affecting the consumer on a case-by-case basis.
- Efforts made regarding referral or transfer of the consumer to a suitable alternative treatment program shall be documented.
- The program makes specific efforts to see that referrals are followed through to completion for the pregnant consumer in the rare event the pregnant consumer is administratively withdrawn and discharged.
 - QBH MAT counselors carefully follow up with both the consumer's pregnancy and opioid dependency.
 - Prearranged agreements with outside providers for treatment of the pregnant consumer who is administratively terminated have been established for this very purpose.

APPEAL PROCESS

- Consumers terminated from the MAT program will be afforded the opportunity to appeal an early discharge decision within seven business days of the termination.
- The appeal must be submitted to the CEO who may: 1) approve the appeal; 2) request additional information; 3) or review the appeal with the Medical Director; or 4) review and deny the appeal.
- The appeal process shall be completed within seven days of receipt of the appeal letter.
- All consumers with early discharge/termination may submit a written request to use the CEO's open-door policy to discuss the case.
- All consumers with early discharge/termination may submit a Consumer Recipient Rights Complaint.

VOLUNTARY DISCHARGE AMA OR ACA

- See the Discharge AMA-ACA Policy for a discussion of this process.

RELATED FORMS/POLICIES:

Discharge AMA-ACA Policy and Related Forms
Medically Assisted Withdrawal Policy

POLICY: REPORTING ABUSE/NEGLECT

It is the policy of QBH to follow regulatory guidelines and professional ethics in the prompt reporting of any related or recognized abuse or neglect of consumers or staff. Consumers shall be informed during intake of the obligation under state-specific requirements and QBH policy to report suspected child abuse and neglect and other forms of abuse.

DEFINITIONS:

Adult Abuse: Harm or threatened harm to an adult's health or welfare caused by another person.

Examples as defined by MI statute are:

- Intentional infliction of physical harm or allowing another individual to inflict physical harm;
- Causing injury by negligent acts or omissions;
- Unreasonable or unlawful confinement;
- Sexual abuse, assault or misconduct, molestation, incest or prostitution;
- Pattern of ridiculing or demeaning, making derogatory remarks to, verbally harassing, or threatening harm on a consumer.

Neglect: Harm to a consumer's health or welfare caused by the conduct of a person responsible for the Consumer's health or welfare. Neglect includes the failure to provide adequate food, clothing, shelter or medical care.

Serious Injury: Brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocation, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or physical well-being of a adult.

Child: A person under 18 years of age.

Child Abuse: Harm or threatened harm by a person, or the allowing of it by another person, to a child's welfare that occurs through non-accidental physical or mental injury. Examples as defined by AZ statute are:

- Injury or impairment of bodily functions by negligent acts or omissions;
- Pattern of ridiculing or demeaning, making derogatory remarks to, verbally harassing, or threatening harm on a consumer;
- Sexual misconduct, assault or molestation of a child, commercial sexual exploitation, incest, child prostitution;
- Pharmacological abuse.

Child Neglect: Harm to a child's health or welfare by a parent, legal guardian, or a person who has custodial care of the child which occurs through either the following:

- Negligent treatment includes the failure to provide adequate food, clothing, shelter or medical care. A parent or guardian legitimately practicing his religious beliefs who thereby does not provide specified medical treatment for a child, for that reason alone shall not be considered a negligent parent or guardian. This section shall not preclude a court from ordering the provision of medical services or non-medical remedial services recognized by state law to a child where the child's health requires it nor does it lessen the responsibility of a person required to report child abuse or neglect.
- Placing a child at an unreasonable risk to the child's health or welfare by failure of the parent, legal guardian or person who has custodial care of the child to intervene to eliminate that risk when that person is able to do so and has knowledge of the risk.

Intimate Parts: Means the genitalia, buttock, and breast of a human being as well as the groin, inner thigh and rectum.

Serious Injury: Brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocation, sprains, internal injuries, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or physical well-being of a child.

Sexual Abuse or Inappropriate Sexual Act(s): Sexual contact to intimate parts i.e. the genitalia, buttocks and breast of a child as well as the groin, inner thigh and rectum.

- For purposes of this policy the pregnancy of a child less than 12 years of age or the presence of a venereal disease in a child who is over 1 month of age but less than 12 years of age shall be reasonable cause to suspect child abuse and neglect have occurred.

Sexual Contact: The intentional touching or sexual penetration to another's intimate parts or the clothing covering the immediate area of intimate parts if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification.

Sexual Penetration: Sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, into any part of a person's body or insertion of any object into the genital or anal opening if the intrusion can reasonably be construed as being for the purpose of sexual arousal or gratification. Emission of semen is not required.

Sexual Exploitation: Includes allowing, permitting or encouraging a child to engage in prostitution, or allowing, permitting, encouraging or engaging in the photography, filming or depicting of a child engaged in sexual acts.

PROCEDURES:

Conditions for Reporting Abuse

- Any staff member of QBH who has cause to suspect abuse or neglect of a consumer shall immediately report to the Clinical Director and then to Child or Adult Protective Services, as

appropriate, in accordance with Michigan Statutes mandating reporting by Health Professionals and Support Staffs.

- A person who has cause to suspect abuse of a consumer and intentionally violates MI Statutes by not reporting the incident shall be guilty of a misdemeanor and be responsible for civil liability of the damages approximately caused by the violation.
- It is not staff's duty to determine abuse, but to report their suspicions. Adult Protective Services is responsible to determine abuse and its level, if any.
- Criteria for Proving Abuse, Neglect and Sexual Abuse (Classes I, II, AND III) by Staff
 - Class I Abuse: An intentional act, or provocation of another to act, by a professional staff member, support staff, independent contractor, member of the Governing Board, student or volunteer that contributes to serious physical injury, or sexual and abuse to a consumer.

Criteria:

- An intentional act or provocation of another to act.
- By a professional staff, support staff, independent contractor, a Board member, student or volunteer which contributes to.
- Serious physical injury or sexual abuse to a consumer.

Examples of Class 1 Abuse: To hurt, damage or cause pain through any action that does not have a planned goal - the healthful and humane care and treatment of a consumer.

- Staff throwing large, heavy, sharp, or pointed objects at a consumer if resulting in serious physical injury.
 - Staff choking a consumer if resulting in serious physical injury.
 - Staff using weapons on a consumer if resulting in serious physical injury.
 - Staff sexually molesting a consumer in any way.
 - Staff giving alcohol or non-prescribed drugs to a consumer if resulting in serious, physical injury.
 - Staff dragging a consumer along the floor or ground if resulting in a serious physical injury.
 - Staff twisting a consumer's arm or leg and resulting in serious physical injury.
- Class II Abuse: An intentional act, or provocation of another to act, by professional staff member, support staff, independent contractor, a board member, student or volunteer which causes non-serious physical injury to a consumer, or the unreasonable use of force against a consumer with or without apparent injury.

Criteria:

- An intentional act or provocation to act or the unreasonable use of force.
- By a professional staff member, support staff, independent contractor, a Board member, student or volunteer which causes non-serious physical injury to a

consumer, or there is unreasonable use of force against a consumer with or without an apparent injury.

Examples of Class II Abuse:

- Staff hitting or punching a consumer if resulting in other than serious physical injury.
 - Staff slapping a consumer if resulting in other than serious physical injury.
 - Staff kicking a consumer if resulting in other than serious physical injury.
 - Staff biting a consumer if resulting in other than serious physical injury.
 - Staff scratching a consumer if resulting in other than serious physical injury.
 - Staff pinching a consumer if resulting in other than serious physical injury.
 - Staff pulling a consumer's hair if resulting in other than serious physical injury.
 - Staff deliberately depriving a consumer of sleep unless specified as a planned response.
 - Staff yanking or pulling a consumer's pierced earring if resulting in other than serious physical injury.
 - Staff washing a consumer's mouth out with soap, Tabasco sauce, or any other similar substance.
 - Staff forcing consumers to run, stand, sit, jump, unless specified as a planned response.
 - Staff using excessive force (pushing, shoving, unnecessary roughness) when handling a consumer if resulting in other than serious physical injury.
 - Staff using a half-nelson hold on a consumer if resulting in other than serious physical injury.
 - Staff giving alcohol or non-prescribed drugs to a consumer if resulting in other than a serious physical injury.
- Class III Abuse: The use of language, or other means of communication by a professional staff member, support staff, independent contractor, member of a Governing Board, student or volunteer to degrade or threaten a consumer.

Criteria:

- The use of language or other means of communication by a professional staff member, support staff, independent contractor, a Board member, student or volunteer.
- To degrade or threaten a consumer.

Examples of Class III Abuse:

- Staff giving a consumer the finger.
- Staff shaking a consumer.
- Staff striking or kicking a consumer when no physical contact occurs or there is no observable or reported (by consumer) evidence of hurt, damage or pain.
- Staff being sarcastic to consumer.
- Staff calling a consumer names.

- Staff spitting on or at a consumer - staff deliberately permitting a consumer to stay in wet or soiled clothing.
- Staff swearing at a consumer.
- Staff threatening a consumer with physical harm or deprivation of necessities.
- Staff making inappropriate sexual comments (seductive comments) to a consumer.
- Staff teasing a consumer in a harassing or mocking manner.
- Staff making fun of a consumer.

Sexual Abuse: Sexual contact between a consumer and a professional staff, support staff, independent contractor, a Board member, student or volunteer providing services under jurisdiction of the facility; or any other person if the consumer is a minor or does not ascent; or any other person in a supervisory or administrative position over the facility.

Criteria:

- Sexual contact between consumers;
- By a member of the professional staff, support staff, independent contractor, a Board member, student or volunteer providing services under the jurisdiction of the facility.
- Any other person if the consumer is a minor or does not ascent, or any other person in a supervisory or administrative position over the facility.

Class I Neglect: An intentional act or omission by a professional staff member, support staff, independent contractor, a Board member, student or volunteer which denies the standard of care or treatment due the consumer as required by law, rule, policy, guidelines, procedure, written directive, or individual plan of service, which contributes to serious physical injury to the consumer.

Criteria:

- An intentional act or omission.
- By a professional staff member, support staff, independent contractor, a Board member, student or volunteer, which denies the standard of care or treatment due the consumer as required by law, rule policy, guideline, procedure, written directive, or individual plan of service.
- That contributes to serious injury to the consumer.

Examples of Class 1 Neglect:

- Staff permitting a consumer to starve himself/herself if serious injury results.
- Staff permitting a consumer to bang head if serious injury results.
- Staff letting a consumer pick at lesions if serious injury results.
- Staff allowing a consumer to insert foreign objects under the skin or in orifices if serious injury results.
- Staff permitting a consumer to burn himself/herself with a cigarette if serious injury results.

- Staff permitting a consumer to attempt suicide if serious injury results.
- Staff failing to intervene on behalf of a consumer who is being abused by another person if serious injury results.
- Staff depriving a consumer of food, fluids, dessert if injury results unless specified in the consumer's plan of service or treatment plan.
- Staff denying a consumer's request if serious injury results unless specified as a planned response.
- Staff not taking time to find out what a consumer wants/needs if serious injury results.
- Staff allowing a consumer to go out in inappropriate attire for the weather (no coat on in winter) if serious injury results.
- Staff permitting a consumer to continue a behavior that will bring retaliation from other consumers if serious injury results.
- Staff allowing a consumer to set himself/herself up to get hurt if serious injury results.
- Staff sleeping on duty if serious injury results.
- Staff watching TV if serious injury results.
- Staff away from duty area without authorization if serious injury results.
- Staff not asking for help or medical attention for a consumer when it is needed if serious injury results.
- Staff permitting a consumer to bite himself/herself if serious injury results.
- Staff allowing a consumer to eat non-edible substances or to swallow foreign objects if serious injury results.

Class II Neglect: An intentional act or omission by a professional staff member, support staff, independent contractor, a Board member, student or volunteer which denies the standard of care or treatment due the consumer as required by law, rule, policy, guideline, procedure, written directive, or individual plan of service which contributes to non-serious physical injury to the consumer.

Criteria:

- An intentional act or omission
- By a professional staff member, support staff, independent contractor, a Board member, student or volunteer which denies the standard of care or treatment due the consumer as required by law, rule, policy, guideline, procedure, written directive or individual plan of service.
- That contributes to non-serious physical injury to the consumer.

Examples of Class II Neglect:

- Staff denying a consumer's request if non-serious injury results or may result.
- Staff ignoring consumer if non-serious injury results or may result.
- Staff not taking time to find out what a consumer wants/needs if non-serious injury results or may result.
- Staff sleeping on duty if non-serious injury results or may result.
- Staff watching TV if non-serious injury results or may result.

- Staff leaving duty station without authorization if non-serious injury results or may result.
- Staff not attending to a consumer's elimination needs.
- Staff allowing a consumer to go out in inappropriate attire for the weather (no coat in winter) if non-serious injury results or may result.
- Staff allowing a consumer to wet himself/herself.
- Staff not asking for help or medical attention for a consumer when it is needed if non-serious injury results.
- Staff permitting a consumer to bite himself/herself if non-serious injury results or may result.
- Staff allowing a consumer to eat non-edible substances or to swallow foreign objects if non-serious injury results or may result.
- Staff depriving a consumer of food, fluids, and dessert if non-serious injury results or may result unless specified as a planned response.
- Staff failing to intervene on behalf of a consumer being abused by another person if non-serious injury results or may result.

Class III Neglect: An intentional act or omission by a professional staff member, support staff, independent contractor, a Board member, student or volunteer which denies the standard of care due the consumer as required by law, rule, policy, guideline, procedure, written directive or individual plan of service which places the consumer at risk of serious or non-serious physical injury.

Criteria:

- An intentional act or omission.
- By a professional staff member, support staff, independent contractor, a Board member, student or volunteer which denies the standard of care or treatment due the consumer as required by law, rule, policy, guideline, procedure, written directive or individual plan of service that places the consumer at risk of serious or non-serious injury.

Reporting of Abuse by Persons Outside of the Company (Not Staff)

- Suspicion or knowledge of abuse/neglect committed by a non-Company person is also reportable. This procedure is established for the reporting of suspected physical abuse or neglect, sexual abuse, or sexual exploitation to an adult or child who is a consumer when the abuse/neglect is initiated by a person other than a staff member.
- When a staff member suspects that an adult or child is in immediate danger (of injury or loss of life), s/he will immediately report to the Clinical Director and then call the local law enforcement agency to file a report giving pertinent information in accordance with Michigan statutes.
- The Clinical Director, or the staff discovering the abuse if their Clinical Director is unavailable, is required to immediately report suspected adult or child abuse or neglect, sexual abuse or sexual exploitation directly to the CEO who will personally, or by delegation, place a telephone call to the appropriate Protective Services Agency for a verbal report. In a criminal conduct case the local law

enforcement agency will also be contacted. A written report to the appropriate Protective Services Agency and to DBHS will be completed within 24 business hours.

- A person who has cause to suspect abuse of a consumer, and intentionally violates the law by not reporting the incident, shall be guilty of a misdemeanor and be responsible for civil liability of the damages approximately caused by the violation.
- Within 24 hours after making the initial oral report the suspecting staff member, under the CEO's, or designee's, direction, shall file a written report. The written report shall contain the following:
 - The name of the consumer who was abused.
 - The consumer's date of birth.
 - The consumer's social security number (if possible).
 - The name of the person(s) who allegedly abused the consumer.
 - The name of the person/facility responsible for the consumer where the abuse occurred.
 - A description of the abuse.
 - The cause of the abuse.
 - The manner in which the abuse occurred.
 - Other information pertaining to the abuse and how and where it occurred.
 - A statement indicating whether or not it is believed abuse would continue to occur without intervention.
- The report shall contain other information available to the reporting person that might establish the cause of the abuse or neglect, sexual abuse or sexual exploitation and the manner in which the abuse or neglect occurred.
- A copy of this written report is then reviewed with the Clinical Director.
- The Company's Consumer Rights Advocate/Grievance Officer will begin his/her Investigation process concurrently with the Protective Services Agency.
- Coordination between respective investigating agencies shall be maintained during the course of each investigation, including sharing of investigation findings and coordinating referrals to other agencies, such as the police department.

Reporting Abuse/Neglect Committed by a Company Person

- Professional staff, support staff, independent contractors, a Board member, students and volunteers who witness, discover or are notified of suspected physical abuse or neglect, sexual abuse or sexual exploitation of a child by another professional staff, support staff, independent contractor, a Board member, student or volunteer shall:
 - Immediately notify the CEO and Clinical Director, or designee, of the suspected abuse or neglect, and the accuser will complete a Company Incident Report in addition to the steps outlined in procedures for reporting suspicion of abuse and neglect of an adult or child by a non-Company person as described above.
 - In the event the accusation is made against the CEO, the Clinical Director will be notified, and the accuser will complete a Company Incident Report.
 - The CEO or designee will immediately take action to protect, comfort, and assure treatment of consumer if necessary;
 - The CEO or designee will then schedule face-to-face meeting with the accused to discuss the allegation(s) within 24 hours.
 - The CEO shall inform the Chair of the Board of the suspected offense and indicate the date and time the face-to-face meeting is established.
 - In the event the allegation is made against a member of the Board, the Chair will be informed and steps as above will be followed. The Vice-Chair is notified if the Chair is accused.
- During the face-to-face meeting with the suspected offender the CEO or designee will explain the allegations to the accused person. The CEO or designee shall maintain the confidentiality of the reporting person.
- In the event the accused person admits his/her responsibility for the offense, the CEO will (If the Chair or Vice-chair is conducting the activity due to conduct by a Board Member, s/he will follow the steps described):
 - Unless the offense is clearly or possibly or possibly for Self-Defense, the CEO will immediately terminate the employment, independent contract, internship, or volunteer contract agreement, recommend dismissal of a Board member, for the responsible person, as is consistent with Company Policies and Procedures and Governing By-laws.
 - In the absence of the CEO, the designee will authorize a leave of absence until the CEO returns.
 - If the CEO suspects just cause for SELF DEFENSE, s/he will authorize a leave of absence with pay until the issue is reasonably settled.
 - Notify the local authorities, DBHS and the appropriate Protective Services Agency of the offense and complete any written reports necessary to finalize the complaint process.
 - File a copy of all finalized reports in the responsible person's personnel file or contract file.

- Forward a copy of all finalized reports to the Company's Recipient Rights Advisor who will establish a folder on the person containing all information according to procedures established for maintenance and control of consumer grievances/complaints. This folder will be kept secured in his/her office. In the event the Recipient Rights Advisor is the accused, the information is forwarded to the HR Manager who will maintain a record with all information regarding this incident. This file will be kept secured in his/her office.
- Within 24 working hours, notify the Chair of the Board regarding the outcome of the situation. The Chair will call a Board meeting with the accused if the accused is a Board member. If the Chair of the Board is the accused and admits to the offense, the Vice-Chair will then be notified of the outcome.

Staff Rules of Conduct with Consumers and Significant Others

- All responsible persons connected with QBH shall demonstrate respectful, dignified, and safe behavior towards all consumers, guardians, family members and significant others that are receiving services with the Company. Examples of respectful, dignified and safe behavior include (but are certainly not limited to):
 - Speaking in a pleasant, normal voice tone to the person.
 - Addressing person by title (Mr., Ms.) surname or first name if given permission.
 - Returning telephone call.
 - Being available in a timely manner for appointments.
 - Initiating crisis intervention procedures if needed.
 - Following all safety guidelines with the person.
 - Using CPR or first aid, or assisting in obtaining such, as relevant to situations.
 - Initiating or obtaining medical care, if needed.
 - Setting limits with calm, reasonable explanation.
 - Refraining from disciplinary procedures unless these are clearly spelled out in writing in the Company's procedure guidelines; completing an Incident Report on any such occurrence.
 - Examples of acceptable discipline: If a consumer physically struck another consumer, staff would separate the consumer from other people and if relevant, set limits on access to clinic that day. A special treatment meeting would be scheduled to decide upon safety issues and consumer's ability to exhibit safe behavior.
 - Examples of unacceptable discipline: Belittling or making fun of person; verbal humiliation or sarcasm, scolding, swearing; punishment such as marked isolation done to control or embarrass the person; withholding services beyond that of insuring safety of others; any physical hitting, etc.

- Health care professionals are mandated to report as are those who support staff in behavioral health agencies.
- It is not the staff's duty to determine the abuse but to report their suspicions. It is Adult Protective services responsibility to determine the level of abuse, if any.
- If a reasonable belief exists that abuse has occurred by any care taker toward an older adult or an adult who is considered vulnerable or incapacitated, the staff will:
 - Contact the Clinical Director to discuss the details of a possible report.
 - Contact the Adult Protective Services (APS) hotline if it is decided that the information warrants a report. If the information does not warrant a report, the assigned APS case manager will be contacted to staff the information.
 - Report back to the Clinical Director that an APS report has been made.
- Staff will document the call to the APS hotline and the concerns which initiated the reporting.
- Staff will complete an Incident Report after making a hotline call and submit report to the programs supervisor within 5 days from the date of the incident.

EVALUATION:

This policy shall be reviewed by the Clinical Director annually, revised as necessary to conform to law and best practices, and submitted to Clinical Committee for approval.

RELATED POLICIES/FORMS:

Abuse-Neglect Assessment Form
Code of Ethics
Consumer Rights and Responsibilities List

QUALITY BEHAVIORAL HEALTH, INC. MAT TRANSITION/DISCHARGE AND

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POLICY: TRANSITION/DISCHARGE AND FOLLOW-UP

When a consumer served is transferred or discharged, the continuity of care, treatment and services is maintained.

REFERRALS FOR MEDICAL OR COMMUNITY SERVICES

REFERRALS DURING TREATMENT

- If a consumer receiving treatment at QBH needs a medical related referral, that referral shall be ordered by the nurse or physician on the *Medical Order Form*.
- If a consumer receiving treatment at QBH needs a clinical or community service referral, that referral is made by the consumer's assigned Counselor and documented in a progress note.
 - The consumer has input into referrals. The Counselor will check the insurance options for referrals and then select and make the referral in collaboration with the consumer. The consumer will make the call under Counselor supervision if possible.
 - Transport is provided by QBH, if needed, though the consumer is encouraged to arrange transport themselves through family, public transportation (close and available near QBH facilities), or other means available to them if it can be accomplished with undue risk or difficulty.
- A referral order, any instructions to the receiving referent source and/or progress note shall include the reason for the referral, the referent source, the objective(s) for the referral, and how the consumer will be transported if the contact with the referent source is to occur during the consumer's treatment hours at QBH. The document will be signed and dated by the physician or counselor, as appropriate to the referral situation.
- Refer to the Hand-Off Communications Policy for further instruction regarding referrals during treatment.

REFERRALS FOR AFTERCARE POST DISCHARGE

- Referrals needed related to post-discharge recovery needs and maintenance are part of the transition plan, whether treatment or community-based resource needs, and whenever possible initial appointments are made prior to discharge.
- The Counselor/Case Manager provides guidance to the consumer as they make decisions about aftercare referral needs. Information about available resources, consideration of insurance coverage availability, and discussion about what referrals the consumer is most likely to follow-through with, and any transport issues are part of that guidance. The consumer is encouraged to make the appointments themselves, prior to discharge if possible and under Counselor supervision/assistance.
- All referrals, whether appointments were successfully made prior to discharge or not, are included in the *Discharge Plan* and *Transition/Aftercare Plan* and a copy is provided to the consumer at discharge.

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Revised: 2/2023, 1/2024, 1/2025

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- Family, legal entities (when applicable) or significant others may be engaged in this process if the consumer so desires and requests their involvement or if required by law or court order.

TRANSFERS

- Transfer to another level of care must be authorized by the Institute for Population Health/Bureau of Substance Abuse Prevention, Treatment and Recovery (the Bureau); this transfer cannot be done by QBH independent of the Bureau's approval.
 - The Bureau shall provide the consumer with the reason for transfer and alternatives to transfer, if any.
- If a consumer needs a higher level of care while in the MAT program due to an emotional or medical crisis, the QBH staff will call 911 so that Emergency Medical Services (EMS) can pick up the consumer and deliver them to the appropriate higher level care facility.
 - If the consumer can be stabilized within 48 hours, they may return directly to QBH and resume treatment; if not, they must contact the Bureau again and be reauthorized for treatment at QBH.
 - If a medical situation cannot be stabilized with medication or nursing interventions, the consumer will be transferred via EMS to a designated local hospital near the program; there is a written agreement for care with each designated hospital.
 - Should a consumer be eligible for transfer back into a program from the hospital, the care process will continue as planned with closer monitoring. If any hospital discharge instructions are given, those will be followed as well. While the consumer is in the hospital, nursing staff maintain contact to remain aware of the consumer's health status.
- If a consumer is requesting transfer to a like-type service at another agency this will not be allowed by the Bureau unless the request to move to another like-type program is due to a justified grievance or due to a co-morbid medical or emotional condition that has developed during treatment that cannot be treated at QBH.
- Inactive status is not allowed by the Bureau.
- Should an emergency/disaster that interferes with QBH being able to continue service provision, at least temporarily, or permanently occur, consumers will be transferred to the following Release Distributor: US Industrial Technologies, 12000 Globe St, Livonia, MI 48150. Phone: 734-462-4100. The same would apply if QBH were to discontinue services.
 - The Administrator/CEO, or designee, shall make the determination of the need for transfer and shall notify the receiving agency of the need for the transfer of consumers.
 - Clinical records shall be provided to the receiving agency as soon as possible following a disaster/emergency or within 14 days prior to the transfer if business closure is the reason for the transfer.
 - Consumers will be notified in writing of this arrangement, in the event of disaster /emergency, at the time of program admission. If the transfer is due to company or

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program closure, consumers will be given written notice at least 30 days prior to the transfer.

TRANSITION/DISCHARGE PLANNING

- Transition or discharge planning and associated needs or barriers to discharge shall be identified and addressed from the beginning of treatment; the initial plan should be completed by the third visit for the MAT program.
 - Planning is done by the Counselor in collaboration with the consumer.
 - The planning shall address the following critical issues for this population:
 - Relapse prevention
 - Any physical and mental health problems following medically supervised withdrawal such as sleep disorders, depression, etc.
 - Referral for continuing outpatient care after the last dose of medication and planning for re-entry to maintenance treatment if relapse occurs
 - Continuing psychosocial treatment if the consumer opts to discontinue medication assisted therapy
 - Agreed upon means of staying in contact with the consumer and reinstituting medication assisted therapy at the first sign of relapse or impending relapse
 - Mechanism for the consumer receiving only long-term medication assisted therapy to receive psychosocial services in the need emerges
 - Referral of a pregnant consumer being discharged to prenatal care, including documentation of the name, address and phone number of the physician who will be providing her care
 - For the consumer who is discharged following medically supervised administrative withdrawal, referrals to alternative treatment programs
- The *Transition/Aftercare Plan* is reviewed with the consumer, and updated if indicated, at least every thirty days for consumers in the MAT program.
- During transition planning the treatment team is typically comprised of 1) the counselor and case manager; 2) the consumer; 3) the program physician; 4) if mandated, the CEO or other administrative designee may also be involved; 5) the consumer's Case Manager and/or a key referral representative; 6) the consumer's guardian, if applicable; 7) family, if authorized by the consumer to participate; and 8) other community services is appropriate and agreed to by the consumer.
- The treatment team collectively engages in:
 - Assessing of use of and helpfulness of previous therapy and support services.
 - Establishing pre-planning for aftercare arrangements.
 - Determining financial arrangements, housing/placement arrangements, and other social service needs that will require involvement by other community resources.
 - Making recommendations in case of the need for relocation, and any other relevant concerns.
- As a part of service planning, potential impairments to long-term recovery will be assessed, availability of continuing care resources will be discussed, and steps in maintaining continuity of care will be established. Transition goals, objectives and interventions will be addressed in the *Transition/Aftercare Plan* (a separate document but to be considered part of the overall plan for

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treatment).

- When it is determined by the treatment team that the consumer is nearing readiness for discharge (typically **72 hours to one week prior** to discharge) the Counselor will discuss with the consumer and family/guardian (if consumer requests and authorizes) the final transition plans. They will:
 - Identify why discharge is being initiated and any continuing care needs and how they will be met.
 - Assess if there are any changes in aftercare needs that have occurred as a result of treatment.
 - Establish preliminary aftercare resources, including identification of locations and time of appointments with desired support systems. Each consumer, upon request, will be provided with the addresses and phone numbers of the professionals from which they may choose.
 - Assist the consumer in making phone calls for appointments upon discharge. The Counselor will either contact or monitor the consumer's contacts with referring professionals made to accomplish the *Transition/Aftercare Plan*.
 - Assist the family, if needed, to arrange for the services needed to meet the consumers' needs after discharge.
- The *Transition/Aftercare Plan* is also reviewed, with consumer input, a **final time** before transfer to another level of care or before discharge. The plan will be reviewed at this time with particular consideration of:
 - The consumer's personal progress toward recovery and improved well-being.
 - Gains made during this course of treatment.
 - Appointments and other actions to be taken or community resources to be utilized to sustain and progress in recovery.
 - Identification of the consumer's need for support systems or other services that will foster ongoing recovery, well-being, and community integration and where such support is available.
 - Means for continuity in the consumer's medication regimen, if applicable.
 - Clearly identifies referral information, including information such as contact name, phone number, location and hours, days of service, if applicable.
 - Describes information (emergency plan) on options and resources available if symptoms recur, the consumer needs urgent help, or additional service is needed.
 - Includes a summation, at transition, of the consumer's strengths/resources, needs to continue recovery, abilities/capabilities, and preferences the consumer feels will enhance ongoing treatment.
- Just prior to discharge, the Counselor will:
 - Complete and sign the *Transition/Aftercare Plan* and place it in the consumer's medical record.
 - Provide *Consent for Release of Information* forms to the consumer to sign to secure permission to send specified reports to the professionals that the consumer will be seeing, the referral source, and/or the Primary Care Practitioner, if requested. Signed forms are to be placed on the medical record.
 - Send a letter to the professional (either new or referring) letting them know that the consumer will be calling them if contact has not already occurred and an appointment set.
- At discharge the consumer will receive written instructions as to actions s/he needs to take to

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achieve continued stabilization or recovery in the form of a *Transition/Aftercare Plan*. A copy of this plan, signed by the consumer, shall be included in the medical record.

DISCHARGE AT COMPLETION OF METHADONE TREATMENT

- Treatment is successfully completed.
 - Consumers leaving methadone treatment have a high relapse rate; however, those who leave treatment because they have done well and are "ready" have a better prognosis.
 - The ideal candidate for methadone cessation is:
 - ✓ Socially stable
 - ✓ Has supportive relationships with non-drug users
 - ✓ Has discovered alternative ways of dealing with the precipitants to drug use
 - ✓ Is confident and motivated to taper
 - Consumers who are doing well and do not wish to discontinue should not be pressured to do so.

Voluntary taper

- Consumers should be advised against tapering if the physician feels they are not ready, but ultimately it is the consumer's decision to make.
- Consumers who relapse after tapering should be offered re-entry into methadone treatment.
- Taper rate should be a maximum of 5 mg/week.
- Pace to be determined by the consumer and should be halted or reversed at the consumer's request.
- Tapering may have to proceed more slowly when the dose falls below 20 mg.
- Tapers as slow as 1-2 mg every 1-2 weeks have been used successfully.
- *Tapers should be placed on hold or reversed if the consumer experiences severe withdrawal symptoms, drug cravings, or restarts drug use.*

EARLY DISCHARGE

- See the Discharge AMA_ACA Policy for details of the management of this process should the consumer or guardian request an early discharge against medical or counselor advice.

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- See the Relapse and Early Discharge Policy for details of this process and when it might occur.
 - The CEO and/or Medical Director may initiate early discharge at any time based upon the criteria as established in this policy.
- The consumer shall sign that they understand the discharge policy and fully understand that the review of the policy serves as their initial warning that any violation of the rules and this policy will result in termination and/or reduction of dosage to a medication-free tapering state, which shall be expedited within a safe and appropriate manner in conformance with medical detox standards when possible.

DISCHARGE NOTE and SUMMARY

- The Counselor shall write a narrative discharge note when a consumer is discharged from a program that describes the time the consumer left, how and with whom (if applicable) s/he left, whether the discharge was a planned discharge or not, if not and it is known, the reason the consumer left, what documents were provided to the consumer at the time of discharge, and any other pertinent information related to the discharge. See the Medical Record Management Policy for more details regarding discharge planning.
- For consumers in interim maintenance treatment a discharge note is written as opposed to a *Discharge Summary*.
- The Counselor will also complete a ***Discharge Summary prior to the consumer's discharge*** so that they may sign the document, which is placed in the medical record ***the day of discharge***. When a consumer is transferring to any other care provider, an oral discharge summary report will be called to the receiving provider prior to discharge, and a *Discharge Summary* will follow that report ***within 7 days*** of discharge.
- The *Discharge Summary* is concise and includes, minimally:
 - The date of and reason for admission
 - A description of services provided including the program and the days of treatment completed
 - The consumer's presenting condition or reason for admission in the consumer's words
 - A summary of the treatment plan/care provided and related progress toward achievement of goals and objectives
 - A description of the reason for discharge
 - A description of the status of the consumer at last contact before discharge
 - Any information/instructions provided to the consumer/family (i.e., written discharge instructions)
 - A list of recommendations for services and support
 - The date of discharge from the program
 - Information on medications prescribed at discharge and/or administered during treatment, if applicable.
- Nursing also writes a final *Progress Note* ***the day of discharge*** describing nursing and medical services received, the consumer's response, and medical instructions provided at discharge, including any medications the consumer is to continue or resume after discharge. The note

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also addresses whether the consumer had completed treatment prior to their discharge, or if it was a transfer, how they were transferred and where, the consumer's current condition. A *Medication Reconciliation Form* is completed, signed by the consumer, and a copy given to the consumer at discharge. The consumer is directed to confer with their primary care practitioner regarding resumption or continuation of any medications previously used by the consumer.

- If the *Discharge Summary* or *Transition/Aftercare Plan* is to be shared with external sources to facilitate the consumer's transition or discharge, it includes the consumer's identified strengths, needs, abilities and preferences.
- Upon the consumer's discharge or transfer, the Counselor or Case Manager will place a phone call to the person responsible for coordinating the transfer or follow-up care and documents this contact in a progress note.
- If the consumer was seen only for a brief period of treatment, a final progress note may be completed in lieu of a discharge summary.
- If the consumer is transferred to a different program within QBH, and the staff working with the consumer changes, a transfer summary may be substituted for the discharge summary. If the staff working with the consumer in the different program is the same, a progress note will suffice.

AFTERCARE FOLLOW UP

UNPLANNED DISCHARGE FOLLOW-UP

(See also Discharge AMA/ACA Policy)

- When a consumer has an unplanned discharge, follow-up is conducted by the Counselor as soon as possible to attempt to clarify with the consumer the reasons for the unplanned discharge, determine whether further services are needed, and to offer or refer them to needed services when applicable. This contact is documented in a progress note.
- The Counselor also contacts any mandated entity (parole officer, court, guardian, etc.) of the unplanned discharge as soon as possible after the consumer's departure, when applicable.

AFTERCARE FOLLOW-UP

- The assigned Counselor, or qualified designee, shall attempt to maintain contact with the discharged consumer to determine the ongoing effectiveness of treatment received and the consumer's aftercare progress.
- Attempts at contact will be initiated, minimally, at **thirty days after discharge and again at three, six and twelve months**. The counselor shall ask a set of questions, following the guidelines of an *Aftercare Questionnaire*.

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- A narrative *progress note* recording the attempt(s) and/or results of this after care contact shall be included in the medical record.

FORMS:

Aftercare Plan
My Recovery Plan Form
Discharge Summary Form
Progress Note Form
Medication Reconciliation Form (see Medication Management Section of Manual)
Aftercare Questionnaire
Hand-Off Communications Policy
Discharge AMA_ACA Policy
Relapse and Early Discharge Policy