2008 LEVEL OF CARE GUIDELINES: SUBSTANCE ABUSE

Residential Detoxification

Residential detoxification is comprised of services that are provided in a residential setting other than an acute care hospital for the purpose of completing a medically safe withdrawal from substances. Residential detoxification is typically indicated when withdrawal is severe enough to warrant 24-hour care, but on-site access to medical personnel is not essential.

Any one of the following criteria must be met…

1. The member's use of alcohol or drugs is heavy and continuous, and is associated with symptoms of moderate withdrawal that require monitoring and management.
2. The member's history of use or presenting condition indicates that moderate withdrawal is imminent and requires monitoring and management.
3. A Clinical Institute Withdrawal Assessment Scale (CIWA-Ar) score of 8 to 15.

And all of the following...

1. An active goal oriented treatment plan focused on symptom reduction, rapid stabilization, motivational enhancement, relapse prevention, management of co-occurring medical and/or mental health conditions, and anticipated discharge disposition is initiated within the first 24 hours of admission. The treatment plan is updated every 1-2 days to reflect the member's progress as well as any new information related to treatment or discharge ultimately ensuring that an appropriate and final discharge plan is in place prior to discharge. The treatment plan must address all of the following:
   a) Interventions for monitoring and managing vital signs, withdrawal symptoms, co-occurring medical conditions, and medication effects and side effects.
   b) Interventions for managing co-occurring mental health conditions.

c) The plan to contact the member's family and/or social support network, with the member's documented consent, within the first 48 hours of admission to participate in the member's treatment (ideally face-to-face) unless clinically contraindicated.

d) A comprehensive and detailed plan for treatment at the next appropriate level of care and involvement in an age-appropriate organized sobriety support group if clinically indicated, including a recommendation for obtaining an accountability partner such as a sponsor or re-connecting with an accountability partner if the member already has one.

e) The plan to link the member with available community resources including the member's school and community-based sources of structure, therapy, and support with the goal of returning the member to his/her regular social environment as soon as possible.

2. An evaluation by a psychiatrist or addictionologist occurs within the first 24 hours of the admission. Subsequent psychiatric evaluations and consultations are available 24 hours a day and provided in accordance with the member's treatment plan and current clinical need.

3. All relevant general medical services, including assessment and diagnostic, treatment, and consultation services are available as needed, and provided with an urgency that is commensurate with the member's medical need.

4. A discharge plan is initiated within 24 hours of admission with at least preliminary attention to the elements listed below and is finalized during the course of the hospital stay. This plan should be provided to the Care Advocate 24 hours prior to the anticipated date of discharge or as soon as possible prior to discharge so as to leave the Care Advocate ample time to ensure that the discharge plan is appropriate. Whenever possible, the treatment team should meet with the member and the provider at the next level of care prior to discharge to review the discharge plan.

   The plan will address the elements listed below.

   a) Anticipated discharge date.

   b) Next level of care recommended and the rationale for it.

   c) Name(s) of clinician(s) responsible for post-discharge care.

d) Date of first follow-up appointment within 7 days post-discharge. If there is more than one clinician, dates of appointments with each, one of which should be within 7 days. Details of the follow up appointment are to be provided in writing to the member/family.

e) With the member's documented consent, communication of all pertinent clinical information to the provider at the member's next level of care.

f) Modalities of post-discharge treatment to be employed, including the following:

   i) Frequency of each modality.

   ii) If pharmacotherapy is one modality, names, dosages, and frequency of each medication and a schedule for appropriate lab tests when indicated.

   iii) Medications (including quantities and dosages) that will be given to member at discharge.

g) With the member's documented consent discharge planning will include the active involvement of the member's family and/or primary support system.

5. With the member's documented consent, clinicians who were involved with the member's treatment prior to admission are contacted within 48 hours of admission to obtain all relevant information. With the member's documented consent, they should also be contacted prior to discharge for communication of the discharge plan when appropriate.
6. The treatment is not solely due to the member's refusal to comply with an ambulatory detoxification program