Substance Use Disorder Outpatient Treatment Services

Service Definition

The delivery of outpatient services for the treatment of substance use disorders includes screening, assessment, diagnosis and/or treatment of substance use disorders (SUD).

Services may include pre-treatment/recovery readiness programs, harm reduction techniques, behavioral health counseling associated with substance use disorder, outpatient treatment and counseling, medication assisted therapy, neuro-psychiatric pharmaceuticals, and relapse prevention.[1]

Subrecipients providing SUD outpatient treatment services are expected to comply with the Universal Standards of Care, as well as these additional standards:

Standard 1: Subrecipients providing SUD outpatient treatment services ensure services are delivered in accordance with the Wisconsin Ryan White Part B Eligibility and Recertification Policy and Procedures.

Providers are responsible to determine eligibility at enrollment and to confirm eligibility annually.

Documentation

Client records must document that the client is living with HIV, resides in Wisconsin, and has household income under 500 percent FPL at initial enrollment. Client records will document that the client is a Wisconsin resident and has household income under 500 percent FPL in accordance with the Wisconsin Ryan White Part B Eligibility Policy.

Standard 2: A client's potential SUD is identified using an evidence-based screening tool. The results of the screening tool inform available options for care.

Client involvement with alcohol and other drugs must be identified using an evidence-based screening tool. The choice of screening tool should be guided by professional judgment and based on known client characteristics (such as age, self-described drug use, and cultural beliefs).

Clients must be advised on available options based on the screening outcome and the client's stated preferences, including:

- Pre-treatment or recovery readiness.

[1] PCN 16-02, p. 16

- Harm reduction interventions.
- Referral to formal drug treatment (including, but not limited to, medication assisted therapy and substance use disorder treatment and counseling).[2]

Documentation

The client record must document the screening tool used, the results of the screening, and how clients are advised on options and preferences.

Standard 3: Clients who choose to engage in services receive a comprehensive substance use assessment as a basis for further treatment decisions.

Clients must receive a comprehensive substance use assessment, consistent with the outcome of the screening process and the client's readiness to pursue treatment.

Assessors should utilize The American Society of Addiction Medicine (ASAM) Criteria as a comprehensive set of guidelines for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions.[3]

ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care, as seen below:

1	Acute Intoxication and/or Withdrawal Potential	Exploring an individual's past and current experiences of substance use and withdrawal
2	Biomedical Conditions and Complications	Exploring an individual's health history and current physical condition
3	Emotional Behavioral, or Cognitive Conditions and Complications	Exploring an individual's thoughts, emotions, and mental health issues
4	Readiness to Change	Exploring an individual's readiness and interest in changing
5	Relapse, Continued Use, or Continued Problem Potential	Exploring an individual's unique relationship with relapse or continued use or problems
6	Recovery and/or Living Environment	Exploring an individual's recovery or living situation, and the surrounding people, places and things

The client's individualized treatment plan must be informed by the results of the comprehensive assessment.

Documentation

The client record must document the use of a comprehensive assessment and its outcome.

Standard 4: Each client has a comprehensive individualized treatment plan for outpatient services.

Treatment plans must include:

[2] National Part B Program Monitoring Standards, p. 23

[3] www.asam.org/asam-criteria/about

- The level of treatment advisable for the client, based on the comprehensive assessment, availability of services, and/or client right to self-determination.
- Projected treatment start date and, if appropriate, projected treatment end date.
- A process to regularly monitor and assess client progress.

The ASAM Criteria's strength-based multidimensional assessment considers a patient's needs, obstacles and liabilities, as well as their strengths, assets, resources and support structure. This information is used to determine the appropriate level of care across a continuum.[4]

Funding in this service category may be utilized to support three of the five broad levels of care:
- Level 0.5, Early Intervention
- Level 1, Outpatient Services
- Level 2, Intensive Outpatient or Partial Hospitalization Services
- Level 2.1, Intensive Outpatient Services

Funding in this service category may also be utilized to support two additional outpatient services, noted by ASAM:
- Ambulatory Withdrawal Management (with or without extended on-site monitoring)
- Opioid treatment programs (including those offered in physician offices)[5]

Documentation

The client record must include a treatment plan with all of the required elements, consistent with the findings of the ASAM criteria. If ASAM findings are not used due to client self-determination, the client record must document this.

Standard 5: The client must receive substance use treatment consistent with their treatment plan. Unless declined. The treatment plan is reviewed and revised to reflect changes in client's condition or situation.

Clients must have continued access to the treatment level and modality specified in their treatment plan so long as one of the placement criteria are met:

- The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan; OR
- The patient is not yet making progress but has the capacity to resolve their problems; OR
- New problems have been identified that are appropriately treated at the present level of care.

The treatment plan must be continually monitored to ensure that it remains relevant to client needs.

The level of care in the client's treatment plan should be revised based on ASAM-defined criteria:

[4] As described at www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/

[5] Overview of Substance Use Disorder (SUD) Care Clinical Guidelines: A Resource for States Developing SUD Delivery System Reforms, ASAM, April 2017, available at www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/asam-resource-guide.pdf

- The patient has been unable to resolve the problems that justified admission to the present level of care, despite amendments to the treatment plan, indicating another level of care is needed; OR
- The patient has demonstrated a lack of capacity to resolve his or her problems, indicating another level of care is needed; OR
- The patient has experienced an intensification of his or her problems or has developed a new problem and can be treated effectively only at a more intensive level of care.

Documentation

The client record must document one or more criteria for ongoing service.

The client record must* document monitoring of the treatment plan and, when indicated, a revision to the level of care.

Standard 6: A system is in place to ensure coordinator of substance use treatment with other services to improve health outcomes.

Providers of substance use treatment must facilitate client access to a full range of services, including medical care, mental health and psychiatry, case management, harm reduction techniques, criminal justice, social and legal services, rehabilitation and self-help programs, as appropriate.

The subrecipient must coordinate services with other programs needed by patients and there are written policies and procedures regarding care coordination with other service providers.

Documentation

Appropriate releases of information (ROIs) must be in the client record for any incoming and outgoing patient information. The primary HIV outpatient ambulatory medical provider must be identified in each client record.

Client charts must show evidence of case consultation with providers of other systems of care, as appropriate.

Client records must include summary information from other service providers, as appropriate.

Standard 7: When a client needs a translator or interpreter, the subrecipient must make a certified medical interpreter available to the client.

Subrecipients must have available and offer certified medical interpreter services to clients. A client's family members and friends should not be considered as interpreters due to medical technology limitations and should only be considered as interpreters if the client refuses services of a certified medical interpreter.

Subrecipients should proactively inform clients that medical interpretation services are available.

Documentation

Subrecipients must maintain a current contract with a provider of certified medical interpreter services, or maintain medical interpretation certifications of staff employed by the clinic. If the client refuses the use of a certified medical interpreter, the client record must include documentation of client refusal.

Standard 8: Clients that require higher-intensity treatment receive active referrals that are monitored for client follow up.[6]

The ASAM Criteria may indicate that a higher intensity level of service is advisable, including:

- Level 3, Residential Inpatient Services
- Level 4, Medically Managed Intensive Inpatient Services

When clients require higher-intensity services, the provider should provide active referrals to specialty care as agreed upon by the client and the provider.

The referral process may include referral to a named agency, providing an exact address, assisting clients with making and keeping appointments, identifying referral agency eligibility requirements, and assisting clients with gathering any required documents to bring to the appointment.

Documentation

Referrals must be documented in the client record and include all the active elements. The client record should include evidence that outcomes were tracked.

Standard 9: Voluntary client transitions to other providers are seamless and emphasize uninterrupted access to treatment and relapse prevention services, whenever possible.

When clients express an intent to transfer their substance use treatment to another provider, this transition should be handled with courtesy and professionalism.

Whenever possible, all transition of records should happen within 30 days of request and should include all items requested by the client and the provider, within the limits of HIPAA and other laws, Federal Confidentiality 42 CFR Part 2 regulations, and policies.

Documentation

Subrecipients must document how its protocols, policies, and practices regarding voluntary transfers emphasize uninterrupted access to services.

Client records must document steps taken to transfer care to another provider.

Standard 10: Providers must establish and apply criteria by which clients will be transferred to other substance use treatment providers without client request.

Clients may need to be transferred to other providers for a variety of reasons, including client behavior that poses a threat to clinic staff and clients.

Each subrecipient must establish criteria and processes for such transfers and apply it consistently, while still attempting to prevent interruptions in care.

[6] New York State AIDS Institute Substance Use Standards available at www.hivguidelines.org/substance-use/working-with-active-users

Documentation

Subrecipients must document how its protocols, policies, and practices regarding involuntary transfers emphasize uninterrupted access to care.

Client records must document steps taken to transfer care to another provider.

Standard 11: Providers must establish and apply criteria for discharge, while encouraging re-enrollment in services.

Clients may be discharged from services for several reasons, including but not limited to:

- Completion of the goals in the treatment plan.
- Voluntary withdrawal from the service.
- Death of the client.
- Relocation outside of the service area.
- Failure of client to attend appointments and failure to respond to correspondence for an extended time.
- Severe, inappropriate, threatening, or otherwise destructive behavior on the part of the client that makes continuation of services dangerous to the provider or unlikely to be helpful to the client.

Unless it will cause harm to the client or staff, providers should attempt to convey that completion of substance use treatment, and access to relapse prevention, are extremely important and that the provider would be open to re-engagement in care in the future.

Documentation

The clinic must document how its protocols, policies, and practices regarding case closure are reasonable and attempt to motivate the client to re-engage in substance use treatment, continuing care, and relapse prevention services.

Client records must document discharge actions.

Did you know?

Over 90 percent of Ryan White Part B clients accessing substance use disorder outpatient treatment services in Wisconsin have income at or below 100 percent of the federal poverty level.

Source: 2020 RSR

In 2018, an estimated 2.1 million lesbian, gay, and bisexual adults had a substance use disorder. Among this group, 49.7 percent struggled with illicit drugs, 70.2 percent struggled with alcohol, and 19.9 percent struggled with **both** illicit drugs and alcohol; all of these rates were significantly higher than overall U.S. rates.

Women who identify as lesbian or bisexual are more than twice as likely to engage in heavy (alcohol) drinking in the past month than heterosexual women (8.0 percent vs. 4.4 percent). Gay and bisexual men were less likely than heterosexual men (8.6 percent vs 9.9 percent) to engage in heavy drinking in the past month.

Research suggests that lesbian, gay, bisexual, transgender and queer+ (LGBTQ+) individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBTQ+ persons has been associated with high rates of psychiatric disorders, substance abuse, and suicide.

Sources: U.S. Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health Report, (2018), available at www.samhsa.gov/data/report/2018-nsduh-american-indians-and-alaska-natives; American Psychiatric Association, Mental Health Disparities: LGBTQ, (2020). Available at www.psychiatry.org; Mental Health America, LGBTQ+ Communities and Mental Health. Available at www.mhanational.org.

Co-occurring mental health issues are significant factors in driving substance use.

Binge drinking, smoking (cigarettes and marijuana), illicit drug use and prescription pain reliever misuse are more frequent among adults with mental illnesses.

Source: Mental Health America, AA/PI Communities and Mental Health. Available at www.mhanational.org.

In many cases substance abuse, stigma, and experiences of trauma can increase risk for mental illness in people living with HIV (PLWH). Receiving a HIV diagnosis can be a traumatic experience and present an immediate barrier to care.

These risk factors also pose significant barriers to accessing HIV primary care. Incorporating mental health and other substance use disorder screening and care into HIV interventions can improve overall treatment outcomes.

Source: Wisconsin Integrated HIV Prevention and Care Plan 2017–2021, page 68. Available at www.dhs.wisconsin.gov/publications/p01582.pdf.
