



Level of Care for Alcohol and Drug Treatment Referral 3.0

A Client Placement Criteria System for Use in New York State



A New York State Office of Alcoholism and Substance Abuse Services Approved Tool

Contents

- BACKGROUNDANDCONTEXT..... 2
- LOCADTR Guidance..... 4
- LOCADTR Content 7
- LOCADTR LOGIC and QxQ 9
 - QxQ: PRELIMINARY CLIENT INFORMATION 12
 - QxQ: PRELIMINARY ASSESSMENT 14
 - QxQ: CRISIS/DETOX ASSESSMENT 21
 - QxQ: RISK ASSESSMENT 28
 - QxQ: RESOURCE ASSESSMENT 39
 - QxQ: OVERRIDE OPTIONS AND ALTERNATIVE LEVEL OF CARE 46
 - ADDITIONAL CONSIDERATIONS 48
- Appendix A – LOCADTR Consent 49
- Appendix B – Access LOCADTR via the Health Commerce System: A Three Step Process 50
- Appendix C – Level of Care Definitions..... 51
- Appendix D - ASAM Crosswalk with OASAS Levels of Care 56
- Appendix E - Alternative Levels of Care 57
- Appendix F – LOCADTR 3.0 Bibliography 58

Welcome

The New York State Office of Alcoholism and Substance Abuse Services (OASAS), in partnership with The National Center on Addiction and Substance Abuse (CASAColumbia), has designed, built, and tested a web-based tool that will aid substance abuse treatment providers in determining the best level of care for a client with a substance use disorder. This tool is named the LOCADTR, which stands for Level of Care for Alcohol and Drug Treatment Referral. This manual will explain the reasoning behind the LOCADTR, and the logic of the tool, which includes a step-by-step guide through the questions, and answers to Frequently Asked Questions.

Overview of the LOCADTR

- Designed for substance abuse treatment providers and referral sources working with individuals who experience substance use disorders, the LOCADTR guides decision making regarding the appropriate level of care for a client.
- The LOCADTR is meant to ensure that all individuals in need of treatment for a substance use disorder have access to care and are placed in the setting closest to the client's community that provides a safe and effective setting for treatment.,
- In addition to helping providers and clients, the data collected through the LOCADTR will be analyzed to assess provider and system level performance, inform needs assessments, and inform the relationship between Level of Care determinations and client outcomes. All personal health information collected will be protected and never re-disclosed.
- Level of care is determined by a variety of factors, including:
 - Assessment of the clients' need for crisis or detoxification services (for instance, determining possible medical complications from withdrawal);
 - Risk factors (such as the presence of severe medical and psychiatric conditions); and,
 - Resources available to the client (for example, a social or family network who are supportive of recovery goals)

BACKGROUND AND CONTEXT

Introduction

All persons who work with individuals that have a Substance Use Disorder (SUD) have an interest in identifying the most appropriate level of care for that client. Concerned parties include, but are not limited to: family members, significant others, physical health and mental health providers, managed care plans, criminal justice entities, local social service districts, and other referral agencies. OASAS believes that all stakeholders would benefit from a common, standardized tool that would assist in making a level of care decision that takes into account client-centered care, recovery principles, and the client's risks and resources.

OASAS also recognizes the value in using a common assessment tool across all regions and entities so that all decision making is based on the best clinical evidence for level of care available. The goal should always be to provide care at the right time, in the right setting, and for the right duration and intensity. To address these goals, a process was undertaken to ensure that such a tool is available to all NYS substance abuse treatment providers and referring entities.

Process of Developing the Web-Based LOCADTR Tool

The Office of Alcoholism and Substance Abuse Services (OASAS) convened a Clinical Advisory Panel in 2012. The purpose of this panel was to provide recommendations for implementing a standard level of care tool prior to the implementation of the Medicaid managed care for behavioral health services. The Panel acknowledged that accessing the most clinically appropriate level of care in substance use disorder (SUD) services was essential in providing safe and effective SUD treatment. The Panel also recognized that it was crucial to identify one tool that utilized a client-centered approach to assessing level of care need to ensure the use of consistent standards across the state.

The Panel explored all level of care assessment tools that were available at the time. After examination of these tools, the Panel determined that OASAS should revise the LOCADTR 2.0 to include two things:

- 1) New York specific levels of care; and,
- 2) The New York State recovery vision that was based on both risk of harm from substance use AND individual resources that support recovery goals in the community.

As a result, a workgroup was formed to create a tool that met the following goals:

- **User-friendly**: The ability to be completed in minutes using a modern, intuitive web-based platform;
- **Patient-centered**: Based on an individualized clinical assessment;
- **Recovery-oriented**: Inclusion of recovery concepts and encourage the use of community and family supports;
- **Least restrictive**: Logic supports the principle of treating as close to the individual's community as is clinically appropriate;
- **Relevance**: Include Levels of Care known and understood in New York;
- **Reliability**: Predictably and accurately recommends the best level of care;
- **Credibility**: Managed care plans and SUD treatment providers accept the tool and agree that there is evidence to support the tool;
- **Clinical Support**: Provides information to clinicians to support the level of care decisions which are understood by payers and auditors.

Once the workgroup identified the logic structure of the tool, including the topics to be covered and how they would interact with one another, OASAS approached CASAColumbia as a partner in the development of the tool. CASAColumbia would assist to further develop the tool, develop a plan for testing, and translate the tool into an electronic format. The Clinical Advisory Panel, OASAS, and CASAColumbia documented the overall concepts and intentions of the workgroup and then developed the questions that would comprise the LOCADTR tool. CASA Columbia applied techniques in the question development to enhance the psychometric characteristics, such as reliability and validity. The Clinical Advisory Panel, OASAS, and CASAColumbia worked with NYS Information and Technology Services, as well as Flightpath, a technology vendor, to develop a user-friendly web-based tool. This tool is LOCADTR 3.0. The tool has been tested for usability and clinical face validity.

LOCADTR Guidance

LOCADTR is a clinical tool, used in conjunction with a full assessment of an individual presenting for Substance Use Disorder treatment. The purpose of the LOCADTR is to determine the most appropriate recommended level of care based on the clinician's answers to the individual's risks and resources. No tool can replace clinical judgment and there is an option within the tool to override the recommended level of care based on clinical judgment.

Who can use the LOCADTR?

The LOCADTR requires the clinical staff person to complete an assessment of an individual's presenting issues, history, medical, mental health, risk and resource information, and to make clinically informed decisions in order to answer the questions. Staff who are working in an SUD setting with appropriate supervision within the scope of their practice can use the LOCADTR to make level of care recommendations.

Medical staff is required to complete the crisis decision tree where there is a potential for serious or life threatening withdrawal to occur. The recommendation for clinical detoxification should always be made by medical staff working within their scope of practice. Where the history includes frequent use of a substance, in large amounts over a significant period of time including the past several days that is likely to cause serious withdrawal (e.g. alcohol, benzodiazepines, barbiturates), the patient should be evaluated by a program medical staff person, or be referred to a medical staff person or emergency room to assess the need for medical withdrawal management.

When should the LOCADTR be completed?

LOCADTR should be completed upon admission or when a change in level of care is considered. Multiple LOCADTRs from multiple sites are not necessary. For example, if an outpatient provider completes a LOCADTR that indicates inpatient is the recommended level of care, the inpatient provider should receive the report with the referral and can use this report to support the LOC decision. Step-downs from one level of care to another should include a completed LOCADTR to support the transition. Plans may request a completed LOCADTR for concurrent review only if they believe that the level of care is not appropriate. Upon admission means within 24 hours for all levels of care except outpatient where the LOCADTR should be completed within 3 visits.

How should the LOCADTR be documented in the chart?

All of the following are acceptable for maintaining a record of the LOCADTR:

1. Electronic Health Record vendor can use the Comma Separated Value (CSV) file to incorporate LOCADTR output into the record. (Note: OASAS is working to develop a CSV batch download capability.)
2. The LOCADTR report can be printed and scanned into an electronic health record.
3. The LOCADTR report can be attached to the record as a pdf.
4. The LOCADTR can be retrieved from the server via the application at any time so the program can document in a note who completed the LOCADTR, what day and the initial and final recommendations from the report.

Client Consent

There is a LOCADTR consent (see Appendix D) that should be completed prior to entering information into the LOCADTR application. It is necessary to acknowledge the consent in order to move forward in the LOCADTR assessment. The consent provides permission for the personal identifying information to be retained on the OASAS server and used in conjunction with the Client Data System database. If a client does not consent to the use of his or her personal identifying information you can enter dummy information in those fields (first name, last name, date of birth, gender, and social security number as 000-00-0000 in order to move forward in the application.

Accessing the LOCADTR Application On-line

OASAS has partnered with the Department of Health to use the DOH Health Commerce System to provide account set-up and access to LOCADTR. Each user must set up an account in the Health Commerce System to include a username and password in order to log into the LOCADTR application. Each program must establish a Director and HCS Coordinator who then can manage user accounts for the organization. Instructions on how to do this are provided in Appendix X Access LOCADTR via the Health Commerce System. A Three Step Process. These instructions also explain how to link accounts to the LOCADTR application also known as assigning the LOCADTR role.

Unlike other applications in the HCS system, you must use a specific url to reach the LOCADTR application. The url is: <https://extapps.oasas.ny.gov>. You cannot access LOCADTR from the HCS home page. You can only do so with the OASAS application url provided here.

Managed Care Plans

Medicaid managed care plans are required to use the LOCADTR tool for making level of care authorization decisions. Plans will collect assessment information as currently required and will also request a LOCADTR report from the provider supporting the requested level of care. In the event that the plan does not agree with the level of care recommendation based on the clinical assessment information, the plan can complete the LOCADTR tool separately, but based on the clinical assessment information. It is expected that the plan will contact the provider to walk through the answers to the LOCADTR questions and determine the differences in how the assessment is being interpreted. Ideally, this will be a clinically-oriented conversation between the plan and provider and will result in a mutually agreed upon level of care. In the event that there remains a disagreement, the member and provider may initiate the appeal process. Plans are responsible for ensuring that the member has a safe and appropriate link to another level of care and must remain engaged until that linkage is complete. In general, and unless otherwise clinically indicated, the plan will authorize the next highest level of care when the recommended level of care is not available.

OASAS Client Database

All client data that is collected throughout the LOCADTR interview is transmitted to a secure OASAS database. The information will be used to assess provider and system level performance, inform needs assessments, and will ultimately provide data on the relationship of Level of Care determination questions to client level outcomes to improve the tool. The information will be used to improve the system of care and inform OASAS in making oversight decisions.

LOCADTR Content

All information that is entered into the LOCADTR tool is confidential and protected client information. Clients must give consent for the sharing of their information with the database before starting the assessment. Users will have access to their own open and completed assessments, as well as the assessments completed by other staff within their program.

Client history and assessment inform the answers to the LOCADTR questions. This information is needed in order to complete the LOC tool. The first page will allow the user to enter client identifying information. Once this information is completed, the user will enter the interview.

The tool is user-friendly and easy to navigate. Administration time of the tool will vary depending upon the number of questions that need to be answered. The tool is built on a decision tree with logic skip patterns based on responses throughout the interview. This means that the user may not be presented with every single question. Most assessments should be completed within 10 minutes. The user who completed the interview will need to have assessment information available to them in order to answer questions including:

- **Identifying Information**: Name, Date of Birth, Social Security Number, Unique Provider ID
- **Diagnostic Impression**: Information needed to identify symptoms from a checklist that runs parallel to the DSM-V SUD diagnostic criteria. Note that this checklist is not intended to form a diagnosis and is not intended to be substance specific. All criteria that are met for any/all substances of use should be checked.
- **Crisis Service Assessment**: An assessment of need for crisis services based on withdrawal potential
- **Client Risks**: For example, psychiatric, medical, and substance use history; criminal justice, personal relationships, employment, and functioning history
- **Client Resources**: For example, adequate role performance, support network, access to food and shelter, skills to manage triggers
- **Other Clinical Information**: For example, need for referral to a medical or mental health provider

Therefore, in order to answer the questions that cover the above points in the LOCADTR tool, a full assessment of the client is necessary prior to its completion and should include at a minimum:

- Presenting problem and history
- Current substance use and history of use
- Diagnostic Impressions
- Current medical history and symptoms
- Past medical history
- Mental Health screening
- Current and past mental health symptoms
- Legal
- Employment
- Family/social
- Housing

The LOCADTR will record each answer entered and provide a report at the end of the assessment. The report will identify all of the questions endorsed and the initial level of care (LOC) determination. If the user chooses to override the initial LOC, the override recommendation and justification will be included in the report. The report can be saved as a PDF or imported into an electronic record using the CSV option.

LOCADTR LOGIC and QxQ

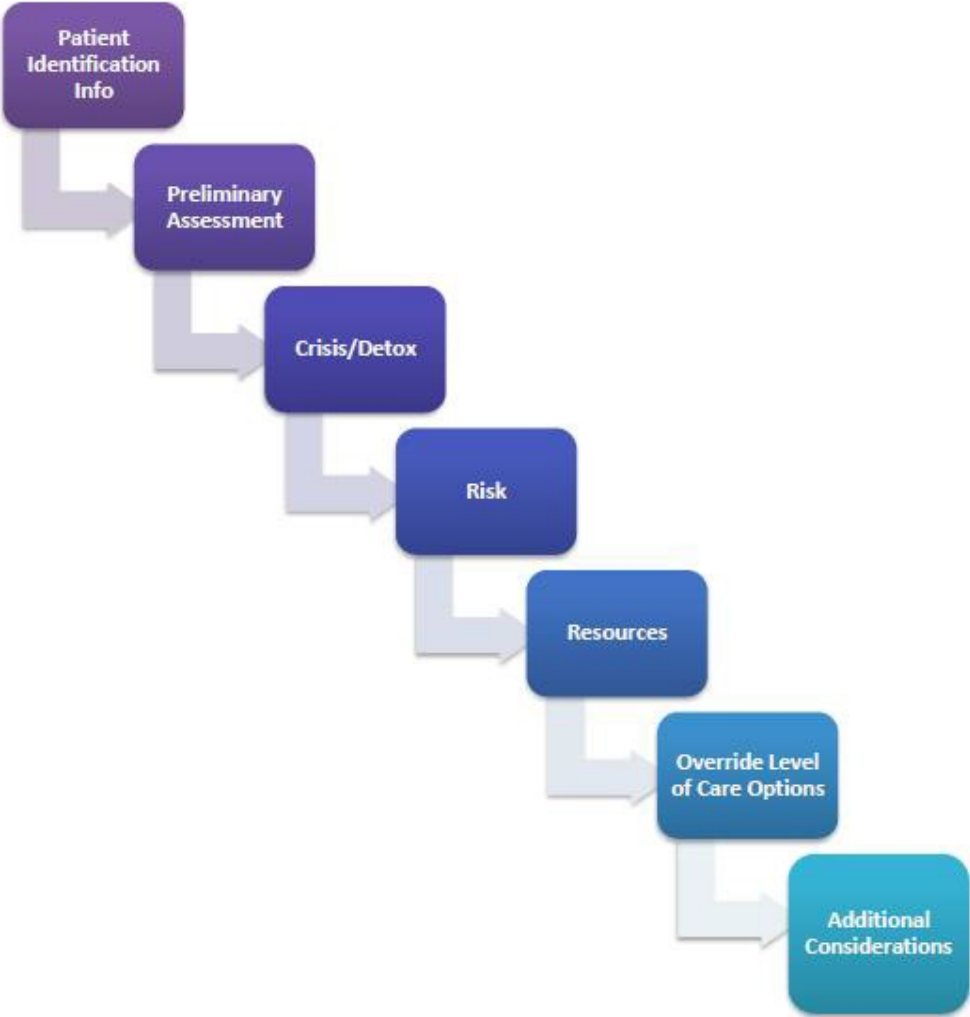
Interview Schema

For providers or other referral sources, the clinical staff person who completes the assessment should also complete the LOCADTR. For managed care plans using the tool for utilization or clinical management, the plan should use the client's history to complete the LOCADTR. The tool covers concepts in the order depicted in the figures below. You will never be asked to complete every question included in the tool. The responses entered will direct which subsequent questions will be asked in the tool. The logic structure of the tool is followed based on the response to each presenting question. As an example, if you endorse the crisis questions for a client, you will not be asked about risks or resources.

LOCADTR ASSESSMENT LAYERS



LOCADTR SCHEMATIC



QxQ: PRELIMINARY CLIENT INFORMATION

Getting Started

Overview:

This section gathers basic information about the client. The assessor will need to have identifying information for the client available to complete the assessment. Identifying information includes: name, gender, social security number, date of birth, Medicaid ID, and provider ID*. You will also be asked to affirm whether the client has given consent for you to complete the LOCADTR and transfer this information to OASAS.

**Note: Medicaid ID and Provider ID are NOT required.*

Client Consent

The consent statement will read as:

I affirm that I have received consent from the client to complete a LOCADTR assessment and transfer this information to the OASAS Client Data System database.

Intent/Key Points:

The interview begins by asking whether the client consented to the sharing of information with the OASAS database. By checking the box, the assessor affirms that the client has given consent to complete the LOCADTR assessment and transfer this information to the OASAS server and used in conjunction with the Client Data System.

Answer Choices:

Check box; if the box is **not** checked the tool will **not** advance

Client's First and Last Name

Intent/Key Points:

Enter the client's first and last name in the respective fields. The last name field may include characters other than letters (e.g., O'Grady) and may include multiple capital letters (e.g., Rivera Ruiz).

Gender

Intent/Key Points:

The intent of the question is to ascertain the client's gender.

Answer Choices:

Male or Female

Social Security Number

Key Points:

Enter the client's social security number in the format: 111-11-1111. If the client does not have a social security number, please enter 000-00-0000. This is a required field. You must enter data into this field to continue with the questionnaire. If the client does not want to provide the full social security number, try to obtain the last four digits.

Date of Birth

Intent/ Key Points:

The intent of the question is to ascertain the client's month, day, and year of birth.

Answer Choices:

Select the client's date of birth (month/day/year) from the drop down menu.

Client's Medicaid ID

Intent/ Key Points:

The intent of the question is to ascertain the client's Medicaid ID. This is not a required field. However, if the client has a Medicaid ID number, please enter the number. This will help with data analysis.

Answer Choices:

Enter the client Medicaid ID in this format: AA#####A. If the client does not have a Medicaid ID, you may leave this empty. This field is not required in order to complete the LOCADTR tool.

Client's Unique ID Number

Intent/ Key Points:

Enter the client's Provider Client ID number. This is a unique number assigned by the program provider for internal tracking purposes. This is not a required field.

Answer Choices:

This number is no more than 12 numbers in length. It is **not** necessary that this number be entered in order to complete of this tool.

QxQ: PRELIMINARY ASSESSMENT

Preliminary Assessment

Overview:

This section contains items that address preliminary information about the client. For example, these questions help to determine whether the client is appropriate for a level of care assessment and whether they need to be assessed for detoxification or crisis services. This section also identifies the client's symptoms of a substance use disorder, as well as the substance that poses the greatest risk of immediate harm to the person. This information drives whether a more or less intensive level of care should be considered.

PR.1

Does the person require immediate hospitalization for a life-threatening medical condition or for **severe psychiatric crisis?**

Intent/ Key Points:

- The intent of this question is to determine if the client needs immediate attention for an emergency medical or psychiatric symptoms. *A life threatening medical condition or severe psychiatric crisis* is a condition for which you would call 911 immediately. Please note: This question is not intended to determine the need for detox services. An assessment for detox services will come later in the tool.

Answer Choices:

- Select "yes" if the client needs to be transported to a hospital via emergency medical vehicle. If you select yes, you will not proceed with completion of the LOCADTR and you will be prompted to contact your local emergency services.
- Select "no" if the client is not in need of immediate emergency medical attention. You will continue on with the LOCADTR tool.

Examples:

- Life threatening medical condition: chest pains, severe injuries, seizures, excessive bleeding
- Severe psychiatric crisis: suicidal or homicidal intentions, severe psychosis

Skip Pattern:

If yes, contact local emergency services.

If no, go to question PR2.

PR.2

Which substance is the person using that has the **most potential to cause harm to self or others?**

Intent/ Key Points:

- While many clients may be using more than one substance, the assessor should choose the substance that is causing, or has the potential to cause, the most harm to the client. You will select only one substance from the list. Points for consideration include the frequency of use, intensity of use, and problems related to the substance including the presenting problems. For example:
 - Which substance is causing or will cause the most harm?
 - What substance does the client use most often (how many days out of 30)?
 - Which substance is used with the greatest intensity (how much on using occasions)?

Points for Consideration:

- In some cases, the pattern of use may not be clear. *Always default to the substance with the highest immediate risk.* In cases where two substances are used with equal frequency and intensity, for instance daily, high level use of alcohol and cannabis, endorse alcohol since there is a higher risk of life threatening withdrawal and other immediate harm. In cases where one substance is used more frequently, but the other has higher risk of immediate harm, for example daily cannabis use, but weekly drinking with instances of DWI, choose alcohol.
- For clients who present with any significant opioid use, the LOCADTR contains specific logic pathways for opioid treatment and, unless another substance is causing immediate harm, opioid should be selected.

Answer Choices and Examples:

- Cannabis: marijuana, hashish
- Sedatives: barbiturates, benzodiazepines
- Stimulants: cocaine, amphetamines, club drugs, methamphetamines, bath salts
- Alcohol: beer, wine, liquor, grain alcohol
- Opioids: heroin; morphine, Dilaudid, Demerol, Darvon, Codeine, Tylenol 2,3,4; Oxycotin/Oxycodone
- Hallucinogens and inhalants

Skip Pattern:

All go to PR3

PR.3

Select all criteria that apply to the individual's substance use.

Intent/ Key Points:

- The intent of this question is to indicate which symptoms of substance use the person is experiencing. The Substance Use Disorder checklist of symptoms is consistent with the 5th Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Substance use disorders span a wide variety of problems arising from substance use and the LOCADTR includes 12 choices. Based in DSM 5, Substance Use Disorder is a pattern of use leading to clinically significant impairment or distress, as manifested by at least 2 criteria occurring within a 12 month period. The clinician should endorse all criteria met at any time including past use as the LOCADTR will ask about remission later in the interview.
- The assessor should choose ALL of the criteria that apply to the client. It is important to evaluate each criterion and check all that apply as the criteria link to the logic structure and affect the question flow. For example, if the clinician does not choose tolerance or withdrawal as a criterion, the logic will skip the questions regarding need for detoxification. Two criteria need to be checked to indicate a positive result for this question. A diagnosis of a Substance Use Disorder is likely when at least 2 criteria are endorsed; if only one criterion is chosen, the assessment will end with a brief intervention as the recommended level of care. If two or more criteria are chosen AND include either the tolerance or withdrawal criteria you will be directed to questions assessing the need for crisis/detox services. If tolerance and withdrawal are not endorsed the next question asked will be risk question #1 (RK1).

Answer Choices and Examples:

- For this question, you will select all criteria that apply to the client. Here are the criteria options:
 1. Loss of control over use after starting.
 2. Desire to control use or unsuccessful attempts to limit use.
 3. Extensive time spent in getting or using substance.
 4. Craving/extensive thoughts and/or emotions driving desire to use substance.
 5. Failure to fulfill major role obligations at work, school, or home.(e.g., repeated absences from work, or poor work performance related to substance use, substance use related absences, suspensions, or expulsions from school, neglect of children or household).
 6. Continued substance use despite social or interpersonal problems. (e.g., arguments with a spouse about consequences of intoxication; physical fights).
 7. Use interferes with other important activities.
 8. Pattern of use in physically hazardous situations. (e.g., driving an automobile or operating a machine when impaired by the substance).

9. Substance use is continued despite awareness of problems created by use.
10. Physiological tolerance (see definitions below)
11. Withdrawal symptoms (specific to substance, see below)
12. None of the above

Definitions:

- **Impairment:** Decrease in ability to make sound, reasoned decisions through intact executive functions of observation, analysis, impulse control, and awareness of self and surroundings.
- **Tolerance:** 1) A need for markedly increased amounts of the substance to achieve intoxication or desired effect and 2) A markedly diminished effect with continued use of the same amount of the substance.
- **Withdrawal:** Manifested by either of the following (specific to substance): 1. The characteristic withdrawal syndrome for the substance (if indicated – refer to the criteria set by the DSM for the specific substance below). 2. Substance (or closely related substance) is taken to alleviate or avoid withdrawal symptoms.

Withdrawal Symptoms:

- **Alcohol Withdrawal Symptoms**
 - Autonomic hyperactivity (e.g. sweating or pulse rate greater than 100)
 - Increased hand tremor
 - Insomnia
 - Nausea or vomiting
 - Transient visual, tactile, or auditory hallucinations or illusions
 - Psychomotor agitation
 - Anxiety
 - Generalized tonic-clonic seizures
- **Cannabis Withdrawal Symptoms**
 - Irritability, anger, or aggression
 - Nervousness or anxiety
 - Sleep difficulty (e.g., insomnia, disturbing dreams)
 - Decreased appetite or weight loss
 - Restlessness
 - Depressed mood
 - Physical symptoms causing significant discomfort including: abdominal pain, shakiness/tremors, sweating, fever, chills, or headache
- **Opioid Withdrawal**
 - Dysphoric mood
 - Nausea or vomiting
 - Muscle aches

- Tearing or runny nose
- Dilation of pupils, goose bumps, or sweating
- Diarrhea
- Yawning
- Fever
- Insomnia
- Sedative, Hypnotic or Anxiolytic Withdrawal
 - Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100 bpm)
 - Hand tremor
 - Insomnia
 - Nausea or vomiting
 - Transient visual, tactile, or auditory hallucinations or illusions
 - Psychomotor agitation
 - Anxiety
 - Grand mal seizures

Skip Pattern:

If at least two criteria selected, go to PR4

If less than two criteria selected, LOC Brief Intervention

PR.4

Is the person in full remission from a Substance Use Disorder?

Intent/ Key Points:

- Substance use disorder can be in various stages of activity or remission. The intent of this question is to determine whether the symptoms of the client's substance use disorder have been active or if the client does *not* meet any criteria in a recent 12 month period.

Answer Choices:

- Select "yes" if the client has NOT MET any criteria for substance use disorder during the past 12 months or longer. Note that the client may meet criterion number 4 – cravings and still be in remission.
- Select "no" if the client HAS met any of the substance use disorder criteria over the past year. Unless the only criterion met is 4- cravings and then the answer is "yes:" to remission.

Definitions:

- Full remission: not meeting criteria for a substance use disorder during the past 12 months.

Skip Pattern:

If yes, go to PR5.

If no, and tolerance or withdrawal selected in PR3, go to CD1.

If no and tolerance or withdrawal NOT selected in PR3, go to RK1

PR.5

Does the person have strong desires or urges to use a substance that are distressing and affect their ability to maintain sobriety OR is the remission due to being in a controlled environment or on Medication Assisted Treatment?

Intent/ Key Points:

- The intention of this question is to determine if the client needs further assessment or supports despite being in full sustained remission. This question has two parts:
 - To determine if the person is having urges or cravings to use a substance that may lead to using substances after a period of sobriety and remission; and/or
 - To determine if remission was due to being in a controlled environment or Medication Assisted Treatment.
- A “no” to this question will end the assessment and recommend “recovery supports” as the level of care. The rationale is that treatment is not necessary if there is a sustained remission, unless: the client is experiencing symptoms that put that remission in jeopardy; the remission occurred in a controlled environment and there is a need to transition safely to the community; or the remission is supported by MAT.

Answer Choices:

- Select “yes” if the client has urges or cravings to use that are distressing
- Select “yes” if the client is in remission due to being in a controlled environment or is on Medication Assisted Treatment
- Select “no” if the client IS NOT experiencing urges or cravings AND the client IS NOT in remission due to being in a controlled environment or on Medication Assisted Treatment

Definitions and Examples:

- **Remission:** No symptoms of substance use disorder have appeared at any time during the last year or longer
- **Controlled Environment:** An environment where access to substances is restricted. For example: jails/prisons, therapeutic communities, locked hospital units.
- **Medication Assisted Treatment:** Facilitation of the effective use of medication to manage symptoms including urges and cravings to use, emotional regulation, and physical symptoms of underlying disease. Medication examples, methadone, buprenorphine, naltrexone.

Skip Pattern:

If yes to any, go to RK1.

If no to all, LOC Recovery Supports

QXQ: CRISIS/DETOX ASSESSMENT

Overview:

If the assessor endorsed tolerance or withdrawal in Question PR3, the assessment will go to questions that address the need for a crisis/detox placement. This logic is meant to triage the clients with a risk of serious withdrawal to inpatient settings and clients who have symptoms that can be medically managed through ancillary or outpatient withdrawal to the appropriate setting. Since clients can experience tolerance or a withdrawal syndrome without the risk of medical complications, the first question identifies those in need of further consideration for a detox/crisis level of care.

If the substance or pattern of use does not pose a significant risk of medical complications, the assessment moves out of the crisis section and into the risk and resource questions. If there is a risk of medical complications, there will be a need to treat symptoms of withdrawal in the appropriate setting. Therefore, the remaining crisis/detox questions are meant to determine the most appropriate stabilization setting. For clients who need to stabilize in an inpatient, residential, or outpatient setting with Medication Assisted Treatment (MAT), the LOCADTR will recommend one of these levels of care. Once a client is stabilized in one of these settings, the LOCADTR should be repeated to determine the next most appropriate LOC treatment setting.

If there is no need for inpatient detoxification, and the client is not appropriate for outpatient MAT stabilization for an opiate disorder, the symptoms of withdrawal will be managed in whichever setting is deemed appropriate following the risk and resource series of questions. In this case, the LOCADTR tool will add ancillary withdrawal to the level of care determination. The purpose of this is to ensure that the clients with low or moderate withdrawal needs are treated within the most appropriate treatment setting. When making a referral to a level of care where ancillary withdrawal is needed, the clinician must ensure that the accepting program can manage the ancillary withdrawal needs of the client.

CD.1

Is the person using substances with risk of medical complications from withdrawal?

Initial determination

Intent/ Key Points:

- The intent of this question is to assess whether there is any level of medical risk related to withdrawal, in order to determine appropriate level of crisis or detoxification services needed. Is the person likely to experience physiological discomfort when they discontinue the substance?
- Answer Choices:
 - Select “Yes” if the client is using substances with a risk of medical complications from withdrawal
 - Select “No” if the client is **NOT** at risk for medical complications from withdrawal.

Examples:

- Medical complications: Any set of symptoms related directly to the withdrawal like vomiting, delirium tremens, body aches and pains etc., or an existing medical condition likely to be made worse by withdrawal, e.g., hypertension (high blood pressure).

Continuing care

- Select yes if the client continues to experience any withdrawal, would experience withdrawal if medication to treat the withdrawal symptoms are discontinued, or if the client has not yet stabilized medically and or psychiatrically from discontinuation of substance.

Skip Pattern:

If yes, go to CD2.

If no, go to RK1.

CD. 2

Does the person have serious psychiatric or medical symptoms that would require 24-hour inpatient medical management in a hospital setting where a physician is in attendance daily?

- Vital signs need to be monitored at least every 6 hours or more;

- Medication administration (detoxification medications) to prevent or modify withdrawal is prescribed and client is monitored to adjust medication; **and at least one of the following is required:**
 - (A) long-term history of use (document substance, amount and duration) that is likely to lead to serious medical symptoms; or
 - (B) history of seizures in the absence of a seizure disorder, or delirium tremens or hallucinations related to alcohol or sedative withdrawal; or
 - (C) acute intervention needed for co-occurring medical (including seizure disorder) or psychiatric disorder; or
 - (D) severe withdrawal (continued vomiting, continued diarrhea, abnormal vital signs) requiring intravenous medication and/or fluids that cannot be handled at a lower level of care; or
 - (E) pregnancy, if the client cannot take oral medication, history or expectation of serious vital sign liability on substance discontinuation especially alcohol.
-

Intent/ Key Points:

The intent of this question is to determine whether serious psychiatric or medical conditions would require 24-hour inpatient medical management in a hospital setting where a physician is in attendance daily, where vital signs are monitored at least every 6 hours, and medication is administered. This is the highest level of detox/crisis care. The client requires a hospital setting due to the high risk of life threatening withdrawal. The withdrawal syndrome itself is expected to be life threatening or the withdrawal in combination with a medical/psychiatric condition needs to be managed in a hospital setting.

Answer Choices

- Select “Yes” only if the client meets the conditions in the questions above. If you answer “yes” you will be required to enter the rationale from the client medical

history that supports a “yes” answer. A medical consult should be conducted to support and justify a yes response.

- Select “No” if the client DOES NOT meet the criteria as described above.

Examples

- Serious medical conditions: insulin dependent diabetic with lack of control over blood sugar, hypertension that is not controlled or expected to be very unstable, COPD with restricted air flow.
- Serious psychiatric conditions: suicidality, psychosis.

Continuing care

- Answer yes if the continuation of treatment is needed to maintain or achieve stabilization of serious withdrawal. If the treatment was removed would the client destabilize? Answer no if the withdrawal has been successfully stabilized. It is important to consider whether an appropriate discharge plan is in place. Can the person be managed in the same setting at the lower Medically Supervised level of care? What supports can be put into place to increase linkage to the next level of care (health home, peer supports)?

CD.3

Is the risk of withdrawal limited to opioids?

Intent/ Key Points:

- The intention of this question is to determine if the **only** substance that the client is at risk of withdrawal from is an opioid. This may not be the only substance that is used, but the only substance for which there is likely to be a withdrawal syndrome on discontinuance. For example, the client uses opioids daily and cocaine once per month. The answer to this question would be “yes”.

Answer Choice:

- Select “Yes” if the client is only at risk for withdrawal from opioids.
- Select “No” if the client is at risk for withdrawal from other substances, either instead of, or in addition to, opioids.

Skip Pattern:

If yes, go to CD4.

If no, go to CD5.

CD. 4

Can the person be managed in an outpatient setting through medication assisted treatment (MAT)?

Intent/ Key Points:

- This question is meant to determine if the client's symptoms from opioid withdrawal can be managed with medication assisted treatment (e.g., methadone, buprenorphine) in an outpatient setting. This would include considering whether MAT is available and if the patient is willing to pursue medication assisted treatment.

Answer Choices:

- Select "Yes" if the client's symptoms can be managed with medication in an outpatient setting, the treatment is available and the patient is willing to access MAT;
- Select "No" if the client's symptoms CANNOT be managed in an outpatient setting with medication.

Definitions/Examples:

- Medication assisted treatment: facilitation of the effective use of medication to manage symptoms including urges and cravings to use, emotional regulation, and physical symptoms of underlying disease. Medication examples: methadone, buprenorphine, suboxone, naltrexone, vivitrol.

Skip Pattern:

If yes, LOC is Outpatient Treatment or Outpatient with MAT.

If no, go to CD5.

CD.5

Does the person require medical supervision and stabilization in an inpatient setting with 24-hour medical oversight and vital sign monitoring to manage withdrawal?

The person needs 24-hour medical supervision, but does **not** require on-site emergency medical intervention based on the following:

- the presence of moderate to severe withdrawal symptoms judged to be treatable at a medically supervised level of care; **and**,
- the expectation or a history of moderate to severe CIWA score of at least 8 with the expectation of an increasing CIWA score based on the amount of alcohol

- and/or other substances used by the client; **or**
 - history of past withdrawal syndromes with serious symptoms; **or**
 - with pregnancy, there is a history of moderate withdrawal from alcohol or withdrawal symptoms are expected based on pattern of use.
-

Intent/ Key Points:

- The intent of this question is to determine whether a client is likely to experience moderate withdrawal with the need for medical oversight, but is not likely to experience life threatening withdrawal symptoms. Withdrawal can be managed in a lower level of care in a community (rather than hospital) based setting.

Answer Choices:

- Select “Yes” if the client DOES require medical supervision with 24-hour medical oversight and vital sign monitoring to manage withdrawal.
- Select “No” if the client DOES **NOT** require this intensive level of medical supervision with 24-hour medical oversight and vital sign monitoring to manage withdrawal.

Continuing Care

- Answer yes if the continuation of treatment is needed to maintain or achieve stabilization of withdrawal. If the treatment was removed would the client destabilize? Answer no if the withdrawal has been successfully stabilized. It is important to consider whether an appropriate discharge plan is in place. Can the person be managed in the same setting at the lower stabilization in residential or ancillary withdrawal level of care? What supports can be put into place to increase linkage to the next level of care (health home, peer supports)? Answer no if withdrawal symptoms are no longer present or can be managed safely with continuing treatment in a lower level of care that is available and accessible.

Skip Pattern:

If yes, LOC is Medically Supervised Withdrawal Service.

If no, go to CD6.

CD.6

Does the person have a safe environment that can support outpatient treatment which includes outpatient management of mild withdrawal symptoms?

Intent/ Key Points:

- The intent is to determine if the client lives in a safe environment in which mild or moderate withdrawal symptoms are manageable through medication on an outpatient basis. Clients who are not in need of 24 hour medical monitoring for withdrawal symptom management, but who do not have a safe environment may require residential services in which they can stabilize.

Answer Choices:

- Select “Yes” if the client DOES have a safe environment
- Select “No” if the client DOES NOT have a safe environment

Skip Pattern:

If yes, go to CD7.

If no, LOC is Stabilization in a Residential Setting.

CD.7

Are ancillary withdrawal services available to the client?

Intent/ Key Points:

- This question is intended to determine if there are ancillary withdrawal services available and accessible to the individual in the community.

Answer Choices:

- Select “Yes” if there are ancillary withdrawal services available.
- Select “No” if there are NOT ancillary withdrawal services available.

Skip Pattern:

If yes, go to RK1 with Ancillary withdrawal as part of LOC recommendation.

If no, LOC is Stabilization in a Residential Setting.

QxQ: RISK ASSESSMENT

Overview:

This section assesses various risk factors that may increase the need for more intensive levels of care. These factors include medical and psychiatric conditions, drug use patterns, personal and interpersonal skills deficits, predatory behavior, and strong urges and cravings to use.

RK.1

Does the person have serious medical symptoms that need to be managed in an inpatient rehab setting for SUD treatment to be effective?

Intent/ Key Points:

- The intent of this question is to identify whether the client has significant medical conditions that may require treatment in an inpatient rehab setting. Many clients will have co-existing medical conditions that are mild to moderate in severity. You are not being asked to diagnose or evaluate the medical status of the client, but to use your clinical judgment about potential risk to the client if they continue with the current pattern of substance use alongside what you know of the complicating medical condition.
- When there is any medical condition, the clinician should contact the treating medical professional to coordinate care and to determine if the condition is stable. Some examples of medical conditions that would cause significant risk in an outpatient setting are: alcohol dependence with uncontrolled high blood pressure, seizure disorder, or diabetes.
- The fact that there is a history or current diagnosis by itself is not enough to meet the intent of this question. The medical condition must cause significant immediate risk to the client. If the client has high blood pressure and alcohol is the substance for which the client is being treated, an inpatient stay may be needed if blood pressure is currently elevated or unstable.

Answer Choices:

- Select “Yes” if the client has a significant medical condition that would need to be managed in an inpatient setting. Text box will open.
- Select “No” if the client does NOT have a significant medical condition that would require inpatient treatment.

Definitions/Examples:

- Significant medical condition: uncontrolled or untreated high blood pressure, diabetes, or cardiovascular disease.

Continuing stay

- Answer yes if the medical condition has not yet stabilized or if it is likely to return to pre-admission level of instability if the client left the rehab facility. Treatment should include developing skills to manage chronic health condition including treatment for managing substance use disorder. Discharge plan should include health home care manager, linkage to next level of care, peer or other recovery supports to encourage ongoing treatment for SUD and medical condition.

Skip Pattern:

If yes, enter a detailed description of the medical condition and go to RK2.
If no, go to RK2.

RK.2

Does the person have serious psychiatric symptoms that need to be managed in an inpatient rehab setting for SUD treatment to be effective?

Intent/ Key Points:

- Many clients will have co-occurring psychiatric disorders with current symptoms of the disorder, often related to SUD. This question asks about the client's RISK that a serious psychiatric disorder would interfere with successful SUD treatment in an outpatient setting. The clinician is not being asked to diagnose or evaluate the psychiatric status of the client, but to use clinical judgment about the client's presentation and current pattern of substance use to determine if there is a significant risk to the client if they continue to use alongside the current psychiatric symptoms. When there is a co-occurring psychiatric condition, the assessment process should include contact with the treating mental health professionals. The SUD provider should coordinate care with all treatment providers and consider all relevant history and current functioning as reported by other professionals providing treatment or coordinating care including health home staff. An example:
 - A client with bipolar disorder who is showing signs of a manic episode and is using cocaine and alcohol. In this case, the manic episode includes risky behaviors, and mild disturbance of thought.

Answer Choices:

- Select "Yes" if the client has a significant psychiatric disorder that would need to be managed in an inpatient setting. Text box will open.
- Select "No" if the client DOES NOT have a significant psychiatric disorder that would require inpatient treatment.

Definitions and Examples:

- *Significant psychiatric disorder:* Mild psychosis, depression that interferes with functioning, chaotic behaviors or cognitive disturbances that seriously interfere with judgment and functioning.

Continuing Care

- Answer yes if the psychiatric condition has not yet stabilized or if it is likely to return to the pre-admission level of instability if the client left the rehab facility. Treatment should include developing skills to manage chronic psychiatric condition including treatment for managing substance use disorder. Discharge plan should include health home care manager, linkage to next level of care, peer or other recovery supports to encourage ongoing treatment for SUD and psychiatric condition.

Skip Pattern:

If yes, enter a detailed description of the medical condition.

If yes to RK 1 or RK2, go to RSC1.

If no, go to RK3.

RK.3

Does the person use in hazardous situations, in amounts or frequencies likely to **imminently** cause severe physical or emotional harm to self or others?

Intent/ Key Points:

- The intent of this question is to determine whether the client may be in immediate danger of causing severe emotional or physical harm to themselves or others. Use of any substance carries risk to the client or others; however, this question qualifies the degree of risk associated with the current pattern of use. Examples of immediate danger of severe harm include:
 - currently driving under the influence of alcohol or other substances;
 - using substances through routes of administration or in quantities that are likely to cause an immediate risk; or,
 - using substances to the point of serious impairment while responsible for the care of children.
- Examples of patterns of use that would NOT meet the threshold are included in the list below. Any of these examples could potentially lead to harm to the client or others, but the risk of immediate severe harm is low. Examples:
 - heavy use of alcohol at home or in an environment that would not likely lead to serious harm;
 - use of cocaine or amphetamine on weekends in moderate amounts; or,
 - use of marijuana with no driving or operating heavy equipment.

Answer Choices:

- Select “Yes” if the client IS in imminent danger of harming self or others due to substance use in hazardous situation, amount of substances used, or frequency of substance use.
- Select “No” if the client is NOT in imminent danger of harming self or others due to

substance use in hazardous situation, amount of substances used, or frequency of substance use.

Definitions/Examples:

- Hazardous situations or in amounts or frequencies: when there is a risk of harm to self or others. For example, using in a dangerous location, driving under the influence, increasing amounts of substance, intoxicated and unable to provide for children in their direct care.
- Imminent severe physical or emotional harm: serious bodily or psychological injury or risk of death that will occur at any moment.

Continuing care

- Answer yes if the individual is likely to return to the same or a similar hazardous use pattern if treatment is removed. The treatment should address the substances and pattern of use that are causing the imminent threat to life and the triggers, urges and cravings to use. Individual treatment plan should address long term management of use and the discharge plan should help the client maintain the positive gains made during treatment by including adequate living environment and recovery supports. Medication management and behavioral interventions to address cravings and urges to use should be considered prior to discharge.

Skip Pattern:

If yes, and opioid is the primary substance, go to RK4.

If yes, and opioid is NOT the primary substance, go to RK9.

If no, go to RK5.

RK.4

Do any of the following apply? (Please check all that apply.)

- Is medication-assisted treatment (MAT) available in the community?
 - Is the person willing to utilize it on an outpatient basis?
 - Is the person expected to stabilize on medication on an outpatient basis?
-

Intent/ Key Points:

- This question will only be asked if the primary substance chosen is opioid. The purpose of this question is to identify opioid users who can appropriately access methadone, buprenorphine, or naltrexone/vivitrol medications in a community setting, even if there are risks present. Considerations of whether a client with opioid use disorder is appropriate for outpatient treatment with MAT include: availability of MAT to the client, willingness of the client to use MAT as an outpatient, and the expectation that the client's withdrawal symptoms, urges, and cravings would be stabilized on MAT. The last point in the question is based on your clinical judgment. It is important that the clinical staff person making this determination is familiar with medication assisted treatment and understands medications and effects, as well as behavioral and social treatments.

Answer Choices:

- Check ALL the responses that apply to the client among the following response choices:
 - Is medication-assisted treatment (MAT) available in the community?
 - For example, are there providers in a reasonable proximity that offer MAT induction and maintenance? Is there a waitlist to access those services?
 - Is the person willing to utilize it on an outpatient-basis?
 - This may require a conversation and education about MAT with the client before the clinician can answer about the client's willingness to utilize medication assisted treatment.
 - Is the person expected to stabilize on medication on outpatient basis?

Definitions/Examples:

- Medication assisted treatment: methadone, buprenorphine, suboxone, naltrexone and vivitrol
- Stabilization: return to a normal physical, mental or emotional state without imminent risk of harm.

Skip Pattern:

If yes to RK3, opioid **is** the primary substance, and **yes** to all RK4, go to RSC1.
If yes to RK3, opioid **is** the primary substance, and **no** to any in RK4, go to RK9.
If no to RK3, no to all in RK5, opioid is the primary substance, yes to all in RK4, go to RSC 1.
If no to RK3, no to all in RK5, opioid is the primary substance, RK4 NO to any, go to RK9.

RK.5

Does the person have any interpersonal or personal skills deficits indicated by: (Please check all that apply.)

- An inability to establish and maintain stable employment.
 - An inability to establish and maintain stable relationships.
 - Persistent disregard for social norms, rules and/or obligations. For example, history of repeated arrests or involvement in the criminal justice system.
-

Intent/ Key Points:

- This question is intended to determine whether a client has skills deficits that may require the support of a residential setting, instead of an outpatient setting. Many individuals who are using substances will have some functional impairment that results from that use, however, this question relates to the serious deficits in functioning that have impacted the client so significantly that they have not been able to successfully achieve normal role expectations due to interpersonal and personal skills deficits. Examples of interpersonal and personal skills deficits are:
 - Someone who has been fired several times in the past due to an argument with an authority figure, stealing, or attendance problems
 - Dependency *
 - Angry Outbursts *
 - Social withdrawal*
 - Persistent disregard for social norms, rules, and/or obligations
 - Several arrests for multiple offenses
 - Avoidance of child support payment when able to pay
 - Incidents of domestic violence
 - Probation or parole violations

**Note: This should be serious enough that it has negatively impacted more than one or two relationships in the client's life over time.*

Answer Choices:

- Check ALL the responses that apply to the client of the following response choices:
 - Does the person have an inability to establish and maintain stable employment?
 - Does the person have an inability to establish and maintain stable relationships?
 - Does the person have persistent disregard for social norms, rules, and/or obligations?

Skip Pattern:

If yes, to any, go to RK6.

If no, and opioid IS the primary substance, go to RK4.

If no, and opioid is NOT the primary substance, go to RSC 6.

RK6

Does the person exhibit predatory behavior that is likely to cause harm to others in a congregate setting?

Intent/ Key Points:

- This question intends to determine the type of residential setting that the client may need based on the potential of the individual to exploit others. The threshold for a positive answer is set high. The client would have to be judged to be a high current risk to exploit others through sexual violence or manipulation of more vulnerable individuals, threats of violence or harm, a current risk of arson based on history and context of previous arson behaviors, or other serious behaviors that are not likely to respond to community treatment approaches. These behaviors are common in people who score very high on measures of sociopathy. When answering this question, the clinician should consider whether past harm caused to others was accidental, solely related to the SUD, if there was considerable remorse, and if responsibility was taken by the client for the harm.

Answer Choices:

- Select “yes” if the client DOES exhibit predatory behavior that could cause harm to others if the person were in a congregate care setting.
- Select “no” if the client does NOT exhibit predatory behavior that could create a risk of harm to others.

Skip Pattern:

If yes, go to RK7.

If no, go to RK8.

RK.7

Does the person have a psychiatric condition that requires 24-hour care in a secured environment?

Intent/ Key Points:

- This question is designed to rule-out those clients who have severe mental health disorders from community residential settings. A client may require 24-hour care in a locked facility due to a psychiatric condition. It helps to determine whether a secure facility is required for the client's and other's safety, or if the person is not a risk to self or others in a less restrictive environment. In order to be tracked to this question, the clinician has determined that the client has significant functional impairment.

Answer Choices:

- Select "Yes" if the client DOES have a psychiatric condition that requires 24-hour care in a secured environment.
- Select "No" if the client does NOT have a psychiatric condition that requires 24-hour care in a secured environment.

Definition/Example:

- Secured environment: A place where an individual must receive permission to leave as from a doctor, psychiatrist, or law enforcement authority.

Skip Pattern:

If yes, LOC Secure Psychiatric Facility.

If no, LOC Individualized Care Plan with Supportive Housing.

RK.8

Does the person have any of the following that would require stabilization with medical oversight in a residential setting?

- Strong cravings or urges to use that are unmanageable;
 - Behavioral or emotional instability.
-

Intent/ Key Points:

- The intent of this question is to determine the type of residential setting that is most appropriate for the client. The clinician will be directed to this question because the client does not have a severe psychiatric or medical condition, but does have interpersonal and personal skills deficits. Knowing if the client has strong urges or cravings of their substance of choice and/or if the client requires medical observation and stabilization within a residential setting will help to determine the type of residential setting most appropriate for the client.

Answer Choices:

- Select “Yes” if the client has strong urges and/or cravings to use.
- Select “Yes” if the client has psychiatric conditions that require stabilization with medical oversight within a residential setting.
- Select “No” if the client does NOT have strong urges and/or cravings that are unmanageable AND if the client also does NOT require stabilization with medical oversight for behavioral or emotional instability.

Definitions/Examples:

- Stabilization: A return to normal physical, mental or emotional state without imminent risk of harm.

Continuing Stay

- Answer yes if the client has continuing signs of instability. Examples include: strong cravings or urges to use that are not yet manageable; distortions in cognitive functioning that interfere with decision making and goal setting; or, behavioral instability such as unprovoked, angry outbursts, serious emotional over reaction to small frustrations, or emotional lability. Answer yes, if individual is likely to experience a return to instability if current treatment is discontinued.

Skip Pattern:

If yes, LOC Stabilization in a Residential Setting.
If no, go to RSC6.

RK.9

Does the person need to be managed in an inpatient rehab setting in order to safely address the cognitive/behavioral impairment leading to hazardous use?

Intent/Key Points:

- The intent of this question is to determine if a client who is using hazardously (“Yes” to RK3) has a cognitive or behavioral impairment that would interfere with safely working towards recovery goals in an outpatient setting. Answering “Yes” to this question will lead to an inpatient level of care. A “No” would further explore the best options for the client including intensive outpatient or residential stabilization.

Answer Choices:

- Answer “Yes” if the client needs 24-hour medical monitoring in a structured setting.
- Answer “No” if the client does NOT need 24-hour medical monitoring in a structured setting.

Definitions/Examples:

- *A client who is using hazardously in the community is not able to concentrate or organize life to attend outpatient treatment.* It also includes an individual who does not recognize a hazardous pattern of use or who is not able to interrupt the current pattern of use.

Continuing stay

- Answer yes if the client continues to present with cognitive distortions or behavioral impairment that is likely to lead to a relapse in the hazardous pattern of use if the current treatment is removed. Treatment should address thinking patterns and beliefs that contribute to patterns of use and develop coping skills to decrease dangerous behaviors. Discharge plan should include ensure a safe living environment, recovery supports and support linking to the next level of care through a warm hand off, peer supports, and a health home care manager.

Skip Pattern:

If yes, go to RSC1.
If no, go to RK10.

RK.10

Can the person be managed in an outpatient setting?

Intent/Key Point:

- The intent of this question is to determine if a client who has indicated that opioids are the primary substance, MAT will be used, and the person does not need 24-hour medical monitoring in an inpatient setting is able to manage in an intensive outpatient setting. If not, the client would need to receive treatment in a stabilization/residential setting.
- *Answer Choices:*
 - Answer “Yes” is the client can be managed in an outpatient setting
 - Answer “No” if the client **cannot** be managed in an outpatient setting

Skip Pattern:

If yes, LOC Intensive Outpatient.

If no, LOC Stabilization Services in a Residential Setting.

QxQ: RESOURCE ASSESSMENT

Overview:

This section assesses various resources that may decrease the need for higher levels of care. These factors include adequate role performance, self-efficacy or confidence, social or family connections, past therapeutic alliances, and the use of additional recovery supports. Though you may have indicated that the client had some risk factors, some resources or combinations of resources may mitigate the need for a higher level of care.

The resource questions consider what assets the client has to support recovery. Clients who have high risk, but also have high levels of support in the community may be able to utilize these supports to be successful in a lower level of care. Clients who have lower risks, but very little resources to support recovery may need a higher level of care to support early recovery or may benefit from additional community supports to be successful. Resource questions will modify the initial level of care track and build on the information obtained through the previous questions.

The LOCADTR logic is designed to identify the most appropriate setting, closest to the community in which the client is likely to be successful. Clinical staff should consider natural supports like family, faith-based and community groups, as well as organizational supports that include recovery centers, peer supports, mutual help groups, and care coordination or case management entities when assessing the level of support available to the client.

There are four logic pathways through the Resource section of the LOCADTR instrument. Due to the number of options for the question sequence, the skip pattern is not presented in this section.

RSC.1

Is the person adequately performing responsibilities in their work, social and family roles?

Intent/ Key Points:

This question is intended to determine whether the client is maintaining adequate functioning in the areas of work, social, and family life. Only assess areas that are relevant to the client. For example, if the client did not recently or currently does not have a job, do not consider work in your assessment. The person must be adequately performing in **all** applicable life areas to qualify for a “yes” to this question. It is important to understand the client’s functioning in these areas because clients who remain connected to family and work and are functioning in these roles have skills they may be able to transfer to the treatment setting, and

therefore, could manage well in a lower level of care. Support from the people within family, social, and work roles can be very helpful as the client enters into treatment both formally, as collateral or significant others in treatment, or informally, as the client learns to use his or her network to support recovery goals.

Answer Choices:

- Select “Yes” if the client IS adequately performing responsibilities in all applicable role areas.
- Select “No” if the client is NOT adequately performing responsibilities in all applicable role areas.

Definitions and Examples:

- Adequately performing responsibilities: The ability to perform behaviors necessary for consistent achievement of standard or average performance of role or responsibilities. For example, is the person going to work regularly with no discipline problems, or the family reports that the person is dependable and reliable.

Continuing Stay

- Answer yes if the client has developed skills to return to functioning in social and family roles or if they have continued to do so regardless of current treatment setting. Is the client connected to children and parenting, able to return to work or to find work or other meaningful activity?

RSC.2

Does the person have strong self-efficacy or confidence that he/she can pursue recovery goals outside of a highly structured setting?

Intent/ Key Points:

- The intent of this question is to determine whether the client believes they are able to follow the treatment plan and goals in a less structured environment (e.g., outpatient) rather than a more structured environment (e.g., intensive outpatient). Self-efficacy is an important component of successful treatment. This question asks for the client’s perception of their confidence in pursuing recovery goals outside of a structured setting. The clinician may or may not be in agreement with the client’s perception and may believe the client’s confidence level is not warranted. However, it is the client’s belief that is being asked about in this question. The question should be answered affirmatively if the client believes in his ability to achieve goals outside of a structured setting.

Answer Choices:

- Select “Yes” if the client HAS strong self-efficacy in the pursuit of recovery goals.
- Select “No” if the client does NOT have strong self-efficacy in the pursuit of recovery goals.

Definitions/Examples:

- Self-efficacy: A person’s belief that they can be successful in completing an act or task. This could also be a person’s belief in their ability to attain a goal.

RSC.3

Is the person connected to a social or family network supportive of recovery goals?

Intent/ Key Points:

The intent of this question is to determine whether the social network/family is supportive of recovery goals. For example, do they encourage the client to follow the treatment plan? Do they interact with the client in a safe environment? This asks the clinician about the social connection the client reports. There are many ways of evaluating this within the assessment, including direct questioning, or use of clinical judgment based on how the client answered questions in the family and social sections of the full assessment.

Answer Choices:

- Select “Yes” if the client HAS a connection to a supportive network.
- Select “No” if the client does NOT have a connection to a supportive network.

Definitions/Examples:

- Social/family network: A group of individuals and/or organizations with whom there is two-way communication with the client.

RSC.4

Has the person demonstrated a therapeutic alliance with at least one professional helper in the past?

Intent/ Key Points:

The intention of this question is to determine whether the client has been able to maintain a trusting and productive relationship with at least one helping professional in the past. The ability to form a therapeutic alliance with a professional helper at some point requires assets that will be helpful to achieving recovery goals. Skills include the ability to make a connection to someone who has offered help, trust in someone to help, and work with the person toward a personal goal. All of these skills will be assets when building a recovery support network.

Answer Choices:

- Select “Yes” if the client HAS demonstrated a therapeutic alliance with at least one professional helper in the past.
- Select “No” if the patient has NOT demonstrated a therapeutic alliance with at least one professional helper in the past.

Definitions/Examples:

- Therapeutic alliance: The client has trust and confidence in a helping professional and that the work they do together will result in the client’s goal attainment.
- Professional Helper: A helping professional could include case workers, counselors, probation/parole officers, religious leaders, doctors, nurses, or therapists.

RSC.5

Can the person be managed in an outpatient setting with additional recovery supports?

Intent/ Key Points:

- The intention of this question is to determine whether the provision of additional resources may allow for the client to receive treatment in an outpatient, rather than an inpatient setting. Some clients may lack natural supports and could receive treatment in an outpatient setting with additional supports in the community. For example, a client who is at risk of losing housing due to substance use with little family or community support, who feels confident that they can achieve recovery goals within the community and who has made connections with peers or other helpers to achieve success in the past. This client may be able to succeed in the community with the help of housing case management and peer services. This question is based on the judgment of the clinical staff person who is completing the LOCADTR.

Answer Choices:

- Select “Yes” if the client CAN be managed in an outpatient setting with additional recovery supports.
- Select “No” if the client CANNOT be managed in an outpatient setting with additional recovery supports.

Definitions/Examples:

- Recovery Support: Services available through community service providers including recovery centers, recovery coaching, and mutual help groups.

RSC.6

Can the person manage triggers for substance use in their environment?

Intent/ Key Points:

- The intent of this question is to determine if the client can avoid engaging in substance use despite stimuli in their environment that initiates the desire to use. Environmental triggers may include people the client interacts with and/or the places they spend their time such as work, home, or regular social situations that are part of everyday life. Some triggers may be:
 - The active use of substances by family members;
 - The availability of the substance in the neighborhood;
 - And use of substances by people within the client’s social network.
 - Internal urges or cravings or desire to use.
- The ability to manage triggers for substance use is important to gaining stability early in recovery. Answering this question requires clinical judgment and should be informed by what the client reports. It is important to note that this question is not asking whether the client is currently managing, but whether they can learn the skills to manage triggers. This includes learning new ways of thinking and interacting with others.

Answer Choices:

- Select “Yes” if the client CAN manage triggers for substance use in their environment
- Select “No” if the client CANNOT manage triggers for substance use in their environment

RSC.7

Does the person have stable access to food and shelter?

Intent/ Key Points:

- The intent of this question is to determine if the client has a stable source of food and shelter. This helps to determine whether they may be in need of supportive living or residential services.

Answer Choices:

- Select “Yes” if the client HAS stable access to food and shelter.
- Select “No” if the client DOES NOT have stable access to food and shelter.
 - This is not a question of whether the client is technically homeless, but whether they have stable shelter that is reliable. For some, a homeless shelter is stabilizing and will provide enough access to food and shelter to allow them to begin to participate successfully in treatment. For some, staying with a relative is not as reliable. The worry over the long-term commitment of family in providing food and shelter results in instability and inability to successfully participate in outpatient treatment.

Definitions/Examples:

- Stable access to food: The person has sufficient access to food in order to avoid hunger, whether food is purchased or obtained through a food pantry, soup kitchen, or other community support.
- Stable access to shelter: Stable access to shelter means consistent housing or place of residence which the individual is not at risk of losing. This can include shelters.

RSC.8

Is the person able to meet recovery goals in an independent living environment with supports?

Intent/ Key Points:

- The intent of the question is to determine the level of support the client needs in order to maintain their recovery goals in a stable residential setting. For example, can the client work toward their recovery goals while living in an environment that does not provide support, assistance, and guidance from residential staff on a 24 hour/7 day per week basis? Is the client able to safely access services in the community and independently seek help when needed in order to support recovery goals?

Answer Choices:

- Select “Yes” if the client IS able to meet recovery goals in an independent living environment.
- Select “No” if the client IS NOT able to meet recovery goals in an independent living environment.

QxQ: OVERRIDE OPTIONS AND ALTERNATIVE LEVEL OF CARE

Overview:

After the initial recommendation, the clinician will be asked to confirm that this is the appropriate level of care for the client. The clinician can choose to accept the recommendation or to override it.

If the clinician decides to keep the initial recommendation, it will become the final level of care recommendation. This recommendation will be presented on the Final Report along with the responses to each of the questions asked in the assessment. The clinician does have the option to override the level of care recommendation for any of the following three reasons. These include:

- Level of care not available in the community;
- Clinical justification for a different level of care;
- Client is mandated to another level of care.

You can indicate more than one reason for needing to conduct an override as there could be a number of reasons why the client cannot utilize the initial level of care.

After selecting the reason for the override, the clinician will select the alternative level of care from a list that includes a definition of each level of care. (See Appendix C for a complete list of Level of Care Definitions.) This list includes combinations of settings with qualifiers including medication assisted treatment and recovery supports.

Finally, the clinician will need to provide a written explanation of why the recommended level of care was not appropriate and how the alternative recommended level of care addresses the client's level of care need.

If the reason for the override is due to clinical justification for an alternative level of care, the clinician will be asked to enter the clinical rationale in the text box. For example, the LOCADTR recommends inpatient; however, the client has family responsibilities that are not able to be overcome to allow for the inpatient stay. In this case, the clinician and the client identified a plan for increased recovery support and intensive outpatient that both think will be sufficient support to meet the client's needs. The clinician would document the family responsibility as the barrier to an inpatient level of care.

The LOCADTR Level of Care is not available

Intent/Key Points:

- There is no program of this type within the community or region or the person cannot access this service within a reasonable waiting time.

There are additional clinical factors that impact the client's ability to meet goals at the LOCADTR Level of Care

Intent/Key Points:

- There were factors that the LOCADTR did not assess that are clinically important and will have a negative effect should the client pursue the LOCADTR recommended level of care.

Definitions/Examples:

- No child care, client preferences for treatment setting.

There are external sources requiring a different Level of Care for compliance with a mandate

Intent/Key Points:

- There is a legal document that requires the client to enter a specific level of care that was not recommended by the LOCADTR.

What is the suggested alternative Level of Care? Please document justification for this alternative Level of Care.

Intent/Key Points:

- You will select the alternative level of care from a list.

ADDITIONAL CONSIDERATIONS

Overview:

There may be additional factors that were not taken into consideration for level of care, but may still be important for the client's treatment plan. You will check all additional considerations that apply. Please note that selection of one or more of these additional considerations will not change the recommended LOCADTR level of care. In this section, you will select considerations that you feel will be important for the treatment plan and/or referrals for additional care.

Following the final level of care, the clinician will be asked about additional clinical considerations. These include, but are not limited to, co-occurring disorders and the presence of urges and cravings to use substances. The purpose of these clinical questions is to identify issues for treatment planning, alert the clinical staff person who receives the level of care report, and include in the client record. The additional considerations section draws attention to these concerns and serves as a note to the treatment provider for follow up.

Client has a history or symptoms of a psychiatric condition that requires further assessment

Intent/Key Points:

- Select this option if your assessment of the client indicates the need for referral for a psychiatric assessment.

Definitions/Examples:

- *Psychiatric condition:* include any significant psychiatric diagnosis; trauma history, positive screening result, or current symptoms that may indicate a psychiatric condition.

Client has a chronic health condition that is not well controlled

Intent/Key Points:

- Select this option if your assessment of the client indicates the need for a referral to a medical professional to control symptoms of a chronic health condition such as diabetes or hypertension.

Definitions/Examples:

- High blood pressure, low or high blood sugar.

Client has strong desires or urges to use substance that are distressing and affect their ability to maintain sobriety.

Intent/Key Points:

- Select this option if your assessment of the client indicates the need for Medication Assisted Treatment (e.g., vivitrol, naltrexone, acamprosate) in order to help the client's urges and cravings become better controlled, but the LOCADTR level of care determination did not include MAT.

Appendix A – LOCADTR Consent

TRS-62 Forms can be found on the OASAS Website at <http://www.oasas.ny.gov/mis/forms/trs/index.cfm>.

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

**CONSENT TO RELEASE OF INFORMATION
CONCERNING
ALCOHOLISM/DRUG ABUSE PATIENT
LOCADTR ASSESSMENT**

Revoked On: _____ Staff Initials: _____

Patient's Last Name	First	M.I.
Case Number		
Facility	Unit	

INSTRUCTIONS:

GIVE A COPY OF THIS FORM TO PATIENT! Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED:

All information necessary to complete a personalized Level of Care for Alcohol and Drug Treatment Referral "LOCADTR" assessment.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION:

I consent to the disclosure of confidential information to, and between, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the OASAS-Certified treatment facility identified above of my clinical treatment including information from the OASAS Client Data System (CDS) and my Social Security Number.

I understand that the level of care determination assessment will only be shared with me and the OASAS treatment facility identified above. Unless I have given written permission to share the information with other agencies, programs or payers.

I further understand that non-personal identifying information may be evaluated so that the effectiveness of the LOCADTR assessment tool can be evaluated.

I, the undersigned, have read the above and authorize the New York State Office of Alcoholism and Substance Abuse Services and the staff of the OASAS-certified treatment facility named above to disclose and obtain such information as herein specified.

I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient (TRS-1)**

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form.

(Signature of Patient)

(Signature of Parent/Guardian)

(Print Name of Patient)

(Print Name of Parent/Guardian)

(Date)

(Date)

Appendix B – Access LOCADTR via the Health Commerce System: A Three Step Process

Access LOCADTR via the Health Commerce System (HCS)		
Step 1 Affiliate your Clinic with the HCS	Step 2 Enroll user accounts on the HCS at your Clinic (HCS Coordinator must enroll users)	Step 3 Add users to the LOCADTR role for your Clinic (HCS Coordinator must assign roles)
<ul style="list-style-type: none"> Send an email to locadtr@oasas.ny.gov asking to affiliate your clinic on the HCS. OASAS will send you an email asking you for clinic, Director and Coordinator information that you will have to fill out and email back. Once OASAS receives your email with the requested information, they will generate an HCS Director and Coordinator account request and you will receive an email with 3 PDF attachments: <ul style="list-style-type: none"> Document 1 SAUP (SAUP means Security and Use Policy) – about roles and responsibilities. Document 2 SAUP – about security 'do not share your account'. Barcoded account form. Read and retain the SAUPs to reference. Sign the form, have your signature notarized, the notary section must be complete (forms are rejected if it is not complete), keep a copy for account activation. <ul style="list-style-type: none"> The Director form is the binding organizational agreement with the HCS. The Coordinator form will require the Director's signature authorizing the Coordinator for the clinic. Mail both the Director and Coordinator forms together to the address provided in the lower left corner of the form. The Director form must be processed first as the binding agreement. Once the Commerce Accounts Management Unit (CAMU) processes your form, you will receive a PIN letter with account activation instructions. 	<ul style="list-style-type: none"> Your user must register for an account: https://apps.health.ny.gov/pub/usertop.html NOTE: must have a Valid Photo ID to register (see below for a list of Valid Photo IDs). Once they register, you must enroll the user on the HCS for your clinic: <ul style="list-style-type: none"> Sign on the HCS Click "Coord Account Tools- HCS" under My Applications on the left Click "User" under Account Request section If the user has a Valid Photo ID, click "Yes, they have a Valid Photo ID" and follow the steps. <p>Here is a list of Valid Photo IDs:</p> <ul style="list-style-type: none"> US Passport, with photograph and name US Driver License with photograph and name US Federal, NY State ID card with photograph Driver License issued by Canada Govt. Unexpired foreign passport with I-551/I-94) Alien Registration Card with photograph Unexpired Temporary Resident Card (INS I-688) Unexpired Employment Card (INS I-688A) Unexpired Reentry Permit (INS I-327) Unexpired Refugee Travel Document (INS I-571) Unexpired Employment Documents (INS I-688B) <ul style="list-style-type: none"> If they do not have a Valid Photo ID, click "No, they do not have a Valid Photo ID" and follow the steps. 	<ul style="list-style-type: none"> Sign on the HCS Click "Coordinator's Update Tool" under My Applications on the left Select your clinic. Click "Manage Role Assignments" tab Click "Modify" next to the LOCADTR role Check the box next to each person that you wish to assign the LOCADTR role and click "Add Role Assignment": <ul style="list-style-type: none"> If you do not see the person, their primary organization is under another facility. You can do a search for them by Last Name below. Look for a name with a userID, NOT one with a "na" that means No Account. If you assign roles to users with no accounts, they will not be able to log into the HCS.
<p>How do I find out if I already have an HCS account? Who is my HCS Coordinator? Who do I contact to change my password?</p>	<p>Commerce Accounts Management System (CAMU) 1-866-529-1890 option 1 M-F 8:00AM-4:45PM (excluding weekends and holidays)</p>	<p>LOCADTR questions email: locadtr@oasas.ny.gov</p>

Appendix C – Level of Care Definitions

Ancillary Withdrawal Service (ASAM 1A) – Ancillary withdrawal services are the medical management of mild or moderate symptoms of withdrawal within in an OASAS-certified setting. Medical staff monitor withdrawal symptoms. Providers must have a protocol for providing ancillary withdrawal services approved by the OASAS Medical Director. The protocol must include a physician director of the service, medication and counseling protocol for managing withdrawal and 24 hour emergency plan. Staffing will include a physician, physician extenders, registered nurse, clinical staff. Treatment plan will include the medication protocol to achieve safe withdrawal management, clinical interventions to provide engagement, management of urges and cravings, addresses cognitive and behavioral issues and recovery supports.

Brief Intervention - Outpatient pre-admission service. This service is a one to three session brief intervention provided to people who do not meet the diagnostic criteria for admission to SUD services, but meet at least one criteria for an SUD based on DSM 5, or who have screened as high risk through an agency screening process. The intervention educates them about their substance use, alerts them to possible consequences, and motivates them to change their behavior. A brief intervention may follow a screening where some risky use has been identified, but the individual does not need or accept a referral to treatment.

Hospital Based Inpatient Detoxification – Medically managed withdrawal and stabilization in a hospital setting certified as an Article 28 by the Department of Health and Medically Managed Withdrawal Services by OASAS. Medically managed withdrawal and stabilization services are designed for individuals who are acutely ill from alcohol- related and/or substance-related addictions or dependence, including the need for medical management of persons with severe withdrawal or risk of severe withdrawal symptoms, and may include individuals with or at risk of acute physical or psychiatric co-morbid conditions. This level of care includes the 48-hour observation bed. Individuals who have stabilized in a medically managed detoxification service may step-down to a medically supervised service within the same service setting or may be transferred to another service setting.

Individualized Care Plan, Consideration of Supportive Housing – Individuals are excluded from residential programs due to potential of harm to others. They are in need of housing support, individualized treatment and recovery supports. They will need to work with a clinical person in an outpatient level of care and a care manager to develop a plan to meet recovery and clinical needs. This level of care is individualized and should meet the needs of the presenting individual and consider the needs of others. This plan should address the full range of client needs including a treatment track that will address the cognitive and behavioral patterns that lead to the predatory behavior and may include treatments such as Thinking 4 Change or a treatment track addressing criminogenic thoughts and behaviors.

Inpatient Rehabilitation –OASAS-certified 24-hour, structured, short-term, intensive treatment services provided in a hospital or free-standing facility. Medical coverage and individualized treatment services are provided to individuals with substance use disorders who are not in need of medical detoxification or acute care and are unable to participate in, or comply with, treatment outside of a 24-hour structured treatment setting. Individuals may have mental or physical complications or comorbidities that require medical management or may have social, emotional or developmental barriers to participation in treatment outside of this setting. Treatment is provided under direction of a physician medical director and the staff includes nursing and clinical staff 24 hours 7 days per week. Activities are structured daily to improve cognitive and behavioral patterns and improve functioning to allow for the development of skills to manage chronic patterns of substance use and develop skills to cope with emotions and stress without return to substance use. People who are appropriate for inpatient care have co-occurring medical or psychiatric conditions or who are using substance in a way that puts them in harm. Many experience decreases in ability to reason and have impaired judgment that interfere with decision making, risk assessment and goal setting and need a period of time for these consequence of substance use to diminish.

Intensive Outpatient Service - An OASAS-certified treatment service provided by a team of clinical staff for individuals who require a time-limited, multi-faceted array of services, structure, and support to achieve and sustain recovery. Intensive outpatient treatment programs schedule a minimum of 9 service hours per week delivered during the day, evening or weekends. This service is provided in a certified outpatient clinic under the direction of a physician medical director. A team of clinical and medical staff must provide this service including credentialed alcohol and substance abuse counselors and other qualified health professionals. The treatment program consists of, but is not limited to: individual, group and family counseling; relapse prevention and cognitive and behavioral interventions; motivational enhancement; and the development of coping skills to effectively deal with emotions and environmental stressors.

Medically Supervised Inpatient Detoxification – This service provides treatment of moderate withdrawal symptoms and non-acute physical or psychiatric complications. This service is physician directed and staffed 24 hours a day 7 days be week with medical staff and included 24 hour emergency medical coverage. Medically supervised withdrawal services provide: bio-psycho-social assessment, medical supervision of intoxication and withdrawal conditions; pharmacological services; individual and group counseling; level of care determination; and referral to other appropriate services. Medically supervised withdrawal and stabilization services are appropriate for persons who are intoxicated by alcohol and/or substances, who are experiencing or who are expected to experience withdrawal symptoms that require medical oversight. Individuals who have stabilized in a medically managed or medically supervised inpatient withdrawal service may step-down to a medically supervised outpatient service.

Opioid Treatment Program (OTP) – OASAS-certified sites where methadone or other approved medications are administered to treat opioid dependency following one or more medical treatment protocols as defined by 14 NYCRR Part 822.. OTPs offer medical and support services including counseling and educational and vocational rehabilitation. OTP also includes the Narcotic Treatment

Program (NTP) as defined by the federal Drug Enforcement Agency (DEA) in 21 CFR Section 13. A physician serves as medical director and physician and nursing staff assess each individual and approve the plan of care. Clinical staff provide individual, family and group counseling. Patients are prescribed and delivered medication assisted treatment which is expected to be long term medication management of a chronic disorder. Many patients are provided treatment over a lifetime similar to chronic management of diabetes or a heart condition.

Outpatient Clinic – OASAS-certified outpatient services have multi-disciplinary teams that include medical staff and a physician who serves as medical director. These programs provide treatment services to individuals who suffer from substance use disorders and their family members and/or significant others. Outpatient services may be delivered at different levels of intensity responsive to the severity of the problems presented by the patient. The length of stay and the intensity (as measured by frequency and duration of visits) will vary during the course of treatment. In general, persons are engaged in more frequent outpatient treatment visits earlier in the treatment process; visits generally become less frequent as treatment progresses. Treatment includes the following procedures: group and individual counseling; education about, orientation to, and opportunity for participation in, relevant and available self-help groups; alcohol and substance abuse disorder awareness and relapse prevention; HIV and other communicable disease education, risk assessment, supportive counseling and referral; and family treatment. In addition, social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation must be available either directly or through written agreements. Procedures are provided according to an individualized assessment and treatment plan.

Outpatient Rehabilitation - OASAS-certified services designed to assist individuals with chronic medical and psychiatric conditions. These programs provide: social and health care services; skill development in accessing community services; activity therapies; information and education about nutritional requirements; and vocational and educational evaluation. Individuals initially receive these procedures three to five days a week for at least four hours per day. There is a richer staff to client ratio for these services compared to other outpatient levels and these services are required to have a half-time staff person qualified in providing recreation and/or occupational services and a half-time nurse practitioner, physician's assistant, or registered nurse. Like medically supervised outpatient, outpatient rehabilitation services require a physician medical director and medical staff are part of the multi-disciplinary team. The clinical team includes credentialed alcohol and substance abuse counselors and other qualified health professionals. A treatment plan is required to address functional needs of the individual including cognitive, behavioral, employment, and interpersonal.

Recovery Support - Services available through community service providers including: recovery centers, recovery coaching, case management and mutual help groups. These supports include 1915(i) like services. Individuals are eligible for 1915(i) like services if they meet the functional criteria and are enrolled in a Health and Recovery Plan (HARP). Individuals can also access:

- Peer services through outpatient clinics and opioid treatment programs (OTP);
- Recovery Center as a recovering member of the community;
- Housing Supports through the case management associated with supportive housing.

Recovery supports may enable a person who lacks social, emotional and community resources in the natural environment to maintain community based living, if the additional supports will help to stabilize them and provide enough support to enable them to manage early recovery in an ambulatory setting.

Rehabilitative Services in a Residential Setting – Certified OASAS providers of residential programs that also provide rehabilitative services for individuals who are stable enough to manage emotional states, urges and cravings, co-occurring psychiatric symptoms and medical conditions within the safety of a residential setting. This service requires a physician who will serve as medical director, nurse practitioner, psychiatrist and nursing staff on site daily and clinical staff provide monitoring for medical and psychiatric symptoms that are stable. Services include medical monitoring of chronic conditions including routine medication management and individual, group and family counseling focused on rehabilitation. The service requires a treatment plan to address functional needs including personal and interpersonal functioning. The treatment program teaches individuals to manage self and interactions with others with increasing independence.

Reintegration Services in a Residential Setting – Certified OASAS providers of residential programs that also provide reintegration services to transition from structured treatment environments to more independent living. This setting does not require a physician to serve as medical director and staff coordinate treatment services but do not provide direct clinical care. Most services are provided in the community and include clinical and social services. Individuals are provided a safe living environment with a high degree of behavioral accountability. Services include medical and clinical oversight of chronic but stable medical and psychiatric symptoms and conditions in a community treatment program including an outpatient Substance Use Disorder treatment program. Services also include: community meetings; activities of daily living (ADL) support; case management; and vocational support and clinical services to support transition to independent living.

Secure Psychiatric Facility – Psychiatric facility for individuals who have been involuntarily committed due to a danger to self or others. Individuals who qualify for this level of care need court ordered or other involuntary placement due to severe psychiatric symptoms that cause a serious risk of harm to self and/or others.

Stabilization Services in a Residential Setting – OASAS-certified providers of residential programs that also provide medical and clinical services including: medical evaluation; ongoing medication management and limited medical intervention; ancillary withdrawal and medication assisted substance use treatment; psychiatric evaluation and ongoing management; and group, individual

and family counseling focused on stabilizing the individual and increasing coping skills until the individual is able to manage feelings, urges and craving, co-occurring psychiatric symptoms and medical conditions within the safety of the residence. This service has a physician who serves as medical director, psychiatrist, nurse practitioner and/or physician assistants to provide and oversee medical and psychiatric treatment. Medical staff are available in the residence daily, but 24-hour medical/nursing services are not. There is medical staff available on call 24/ 7 and there are admitting hours 7 days per week.

Supportive Living - OASAS-certified programs that are designed to promote independent living in a supervised setting for individuals who have completed another course of treatment, are making the transition to independent living, and whose need for services does not require staffing on site on a 24-hour a day basis. These services provide a minimum level of professional support, which includes a weekly visit to the site and a weekly contact of the resident by a clinical staff member. These treatment services are for individuals who either require a long-term supportive environment following care in another type of residential service for an undetermined length of stay, or who are in need of a transitional living environment prior to establishing independent community living.

Combination Services Recommendations

- Intensive Outpatient Clinic with Medication Assisted Treatment (MAT)
- Intensive Outpatient Clinic with Reintegration Residential
- Intensive Outpatient Clinic with Supportive Living
- Intensive Outpatient Clinic with Medication Assisted Treatment (MAT) and Reintegration Residential
- Intensive Outpatient Clinic with Medication Assisted Treatment (MAT) and Supportive Living
- Opioid Treatment Program (OTP) or Outpatient Clinic with Medication Assisted Treatment (MAT)
- Outpatient Clinic with Medication Assisted Treatment (MAT)
- Outpatient Clinic with Reintegration Residential
- Outpatient Clinic with Supportive Living
- Outpatient Clinic with Medication Assisted Treatment (MAT) and Reintegration Residential
- Outpatient Clinic with Medication Assisted Treatment (MAT) and Supportive Living
- Outpatient Rehabilitation with Reintegration Residential
- Outpatient Rehabilitation with Supportive Living

Appendix D - ASAM Crosswalk with OASAS Levels of Care

The standard instrument used in NYS is LOCADTR 3.0 which defines appropriate placement of clients into approved NYS LOCs. These LOCs are consistent with ASAM LOCs. However, there are New York State specific level of care attributes. *A full description of the levels of care are included in Appendix C of this document.* Entities insuring patients in NYS will need to comply with NYS specific LOCs.

This table provides a listing of OASAS certified programs; the applicable authorizing New York State program regulation; and where appropriate, a cross walk to an ASAM level of care.

OASAS Program Type	New York State Regulation	ASAM
Outpatient		
Outpatient Clinic	Title 14 NYCRR Part 822	Level I
Outpatient Day Rehabilitation	Title 14 NYCRR Part 822	Level 2.5
Intensive Outpatient	Title 14 NYCRR Part 822	Level 2.I
Opioid Treatment Programs	Title 14 NYCRR Part 822	Level I
Medically Supervised Outpatient Withdrawal	Title 14 NYCRR Part 822	Level 2-WM
Clinical Services in a Residential Setting		
Stabilization Services in a Residential Setting	Title 14 NYCRR Part 820	Level 3.5
Rehabilitation Services in a Residential Setting	Title 14 NYCRR Part 820	Level 3.3
Reintegration in a Residential Setting.	Title 14 NYCRR Part 820	Level 3.1
Inpatient		
Medically Managed Inpatient Detoxification	Title 14 NYCRR Part 816	Level 4-WM
Medically Supervised Inpatient Detoxification	Title 14 NYCRR Part 816	Level 3.7-WM
Inpatient Treatment and Residential Rehabilitation for Youth	Title 14 NYCRR Part 818	Level 3.7

Appendix E - Alternative Levels of Care

The LOCADTR was developed to recommend a level of care that best meets the individual’s needs based on answers to a series of questions. The level of care that is recommended may not be available in the community or there may be other clinical reasons to recommend an alternative level of care. There is no tool that can replace clinical judgment and the clinician is able to choose the level of care that best fits the clinical presentation. The following table provides a cross walk of recommended levels of care and most likely alternatives.

LOCADTR Recommendation	Likely Alternative
Hospital Based Crisis	Scatter bed hospital admission
Medically Supervised Inpatient Crisis	Hospital based Crisis
Ancillary withdrawal – outpatient	Medically Supervised Outpatient Crisis
Ancillary withdrawal – inpatient	Stabilization in residential Medically Supervised Inpatient Detox
Inpatient Rehab	Stabilization or Rehabilitative Services in Residential
Stabilization Services in Residential Setting	Inpatient Rehab Ancillary Withdrawal Inpatient Rehab
Rehabilitative Services in Residential Setting	Intensive Residential (Part 819.8) Re-integration Services in Residential Setting Outpatient Rehabilitation
Reintegration Services in Residential Setting	Community Residence (Part 819.9) Supportive Living (Part 819.10) Rehabilitative Services in Residential Setting Supportive Housing with outpatient treatment or individualized plan
Outpatient Rehabilitation	Intensive Outpatient Services
Intensive Outpatient Services	Outpatient Services Outpatient Rehabilitation
Outpatient (MAT)	OTP Intensive Outpatient with MAT
Outpatient	Intensive Outpatient Outpatient with MAT

Appendix F – LOCADTR 3.0 Bibliography

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