Substance Use Disorders Services Policy and Clinical Assumptions Grid

All Providers must adhere to state licensing requirements for their respective level(s) of care. As set forth in the Connecticut Medical Assistance Program (CMAP) provider enrollment agreement, providers must comply with all applicable federal and state statutes, regulation, and other requirements.

Outpatient Levels of Care

	Intensive Outpatient Treatment (IOP) (ASAM 2.1)	Partial Hospitalization (ASAM 2.5)
Brief Service Description	Intensive Outpatient (IOP) provides 6-19 hours of clinically intensive programming per week (minimum of three contact days per week) for adolescents and 9-19 hours (minimum of three contact days per week) for adults based on individual treatment plans. IOP provides professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized, non-residential treatment setting. Intensive outpatient services are organized activities, which may be delivered in any appropriate	Partial Hospitalization Program (PHP) provides 20 or more hours of clinically intensive programming per week (minimum of four contact days per week) based on individual treatment plans. Programs have ready access to psychiatric, medical, and laboratory services. Intensive services at this LOC provide comprehensive bio-psychosocial assessments and individualized treatment and allow for a valid assessment of dependency. This LOC also provides for frequent monitoring/management of the client's medical and emotional concerns in order to avoid hospitalization. These services include, but are not limited to individual, group, family counseling, and psychoeducation on

Updated: 11/19/2021

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	community setting that meets State licensure. All outpatient SUD programs are regulated by the State licensure agency. Services include, but are not limited to individual, group, and family counseling including psychoeducation on recovery. Intensive outpatient program services should include evidence-informed practices. Services also include monitoring of alcohol/drug use and orientation and referral to community-based support groups, as appropriate and indicated by the individual's treatment plan. Timely access to additional support systems and services, including medical, psychological, and toxicology services, are available through consultation or referral.	recovery, as well as monitoring of alcohol/drug use, medication management, medical, and psychiatric examinations, crisis intervention, and orientation to community-based support groups. For adolescents, partial hospitalization often occurs during school hours; such programs typically have access to educational services. Programs that do not provide educational services should coordinate with a school system in order to assess and meet the adolescents' educational needs. Partial hospitalization services should include evidence-informed practices.
Ages Served	Age 12 and older	Age 12 and older
Admission Criteria	1. **Acute intoxication and/or withdrawal potential:** No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in a Level 2.1 setting. 2. **Biomedical conditions and complications:** None, are stable or are being addressed concurrently and thus will not interfere with treatment. 3. **Emotional, behavioral, or cognitive conditions and complications:** None to moderate. If present, the individual must be admitted to either a co-occurring disorder capable or co-occurring disorder enhanced program, depending on their level of function, stability, and degree of impairment. 4. **Readiness to change:** The individual requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care have failed. Alternatively, the individual's perspective inhibits their ability to make behavioral changes without repeated, structured, and	1. **Acute intoxication and/or withdrawal potential:** No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in a Level 2.5 setting. For adolescents: the individual is experiencing acute or subacute withdrawal, marked by mild symptoms that are diminishing. The adolescent is able to tolerate mild withdrawal symptoms and is likely to attend, engage and participate in treatment. 2. **Biomedical conditions and complications:** None, or not sufficient to interfere with treatment, but are severe enough to distract from recovery efforts and require medical monitoring and/or medical management which can be provided by a Level 2.5 program either directly or through an arrangement with another treatment provider. 3. **Emotional, behavioral, or cognitive conditions and complications:** None to moderate. If present, the individual must be admitted to either a co-occurring disorder capable or co-

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	clinically directed motivational interventions. Such interventions are not feasible or are not likely to succeed in a Level 1 program. However, the individual's willingness to participate in treatment and to explore their level of awareness and readiness to change suggest the treatment at Level 2.1 can be effective. 5. **Relapse, continued use, or continued problem potential:** The individual is experiencing an intensification of symptoms related to substance use, and their level of functioning is deteriorating despite modification of the treatment plan. Alternatively, there is a high likelihood of relapse or continued use or continued problems without close monitoring and structured therapeutic services, as indicated by their lack of awareness of relapse triggers, difficulty in coping, difficulty postponing immediate gratification, or ambivalence toward treatment. 6. **Recovery environment:** Continued exposure to the individual's current school, work or living environment will render recovery unlikely. Alternatively, the individual lacks social contacts, has unsupportive social contacts that jeopardize recovery, or has few friends or peers who do not use alcohol or other drugs. In either case, the individual lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a Level 2.1 program. • NOTE: An adolescent may require Level 2.1 services in addition to an out-of-home placement (e.g., a group home or a non-treatment residential setting such as a detention program). If their present environment is supportive of recovery but does not provide sufficient addiction-specific services to foster and sustain recovery goals, the adolescent's needs in Dimension 6 may be met	occurring disorder enhanced program, depending on the individual's level of function, stability, and degree of impairment. 4. **Readiness to change:** The individual requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care have failed. Such interventions are not feasible or are not likely to succeed in a Level 2.1 program. Alternatively, the individual's perspective and lack of impulse control inhibit their ability to make behavioral changes without repeated, structured, and clinically directed motivational interventions. Such interventions are not feasible or are not likely to succeed in a Level 1 or Level 2.1 program. However, the individual's willingness to participate in treatment and to explore their level of awareness and readiness to change suggest the treatment at Level 2.5 can be effective. 5. **Relapse, continued use, or continued problem potential:** The individual is experiencing an intensification of symptoms related to their substance-related disorder and their level of functioning is deteriorating despite modification of the treatment plan and active participation in a less intensive level of care. Alternatively, there is a high likelihood of relapse or continued use or continued problems without close monitoring and structured therapeutic services, as indicated by their lack of awareness of relapse triggers, difficulty in coping, difficulty postponing immediate gratification or ambivalence toward treatment. 6. **Recovery environment:** Continued exposure to the individual's current school, work or living environment will render recovery unlikely. The individual lacks the resources or skills necessary to maintain an adequate level of functioning without the services of a Level 2.5 program. Alternatively, the individual has family members and/or significant other(s) who live with them and are not supportive of their recovery goals or are passively opposed to their treatment. The individual requires the intermittent structure of Level 2.5 treatment services and relief from the home environment in

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	through an out-of-home placement, while other dimensional criteria would indicate the need for care in a Level 2.1 program.	order to remain focused on recovery but may live at home because there is no active opposition to, or sabotaging of, their recovery efforts. For adolescents: the individual lacks social contacts, has high-risk social contacts that jeopardize recovery, or has few friends or peers who do not use alcohol or other drugs. Individuals who meet Level 2.1 criteria in Dimensions 4, 5, or 6 and who otherwise would be placed in a Level 2.1 program may be considered for placement in a Level 2.5 program if they reside in a facility that provides 24-hour support and structure and that limits access to alcohol and other drugs, such as a correctional facility or other licensed health care facility or a supervised living situation.
Provider Qualifications/ Staffing	Level 2.1 IOP services may be provided by an array of licensed and unlicensed practitioners operating within their respective scope of practice. • Clinical hours must be provided by an independently licensed or associate licensed masters level behavioral health practitioner. • Non-clinical hours may be provided by a peer, or a non-licensed professional. • Certified peers may provide group services and/or meet with individuals one-on-one as part of the non-clinical hours during an IOP day. • A Physician (or NP/PA) is available to conduct activities of medical necessity review, review of the biopsychosocial assessment and coordination with the individual's personal physician, when applicable and available on-call when not physically present. Direct clinical services (e.g. physical evaluation, psychiatric evaluation) provided by the physician and/or psychiatric staff is billed for outside of the rate.	Level 2.5 PHP services may be provided by an array of licensed and unlicensed operating within their respective scope of practice. • Clinical hours must be provided by an independently licensed or associate licensed masters level behavioral health practitioner. • Non-clinical hours may be provided by a peer, or a non-licensed professional. • Certified peers may provide group services and/or meet with individuals one-on-one as part of the non-clinical hours during a PHP day. • A Physician (or NP/PA) is available to conduct activities of medical necessity review, review of the biopsychosocial assessment and coordination with the individual's personal physician, when applicable and available on-call when not physically present. Direct clinical services (e.g. physical evaluation, psychiatric evaluation) provided by the physician and/or psychiatric staff is billed for outside of the rate. • A dedicated Service Coordinator on-site 40 hours per week that manages incoming referrals and discharge plans is

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	• A dedicated Service Coordinator on-site 40 hours per week that manages incoming referrals and discharge plans is required for each facility. The purpose of the Service Coordinator is to promote engagement and retention in treatment and facilitate an effective discharge plan whereby the individual successfully connects to the next level of care. The service coordinator facilitates referral arrangements and coordination with aftercare. ○ The Service Coordinator may be a licensed practitioner, unlicensed counselor, or certified peer. Program staff are able to obtain and interpret information regarding the individual's biopsychosocial needs. Some, if not all, program staff should have sufficient cross-training to understand the signs and symptoms of mental disorders and to understand and be able to explain the uses of psychotropic medications and their interactions with substance use and other addictive disorders. Staff in adolescent programs should be knowledgeable about adolescent development and experienced in engaging and working with adolescents. Clinical staff who assess and treat adolescents are able to recognize the need for specialty evaluation and treatment for intoxication or withdrawal and are able to arrange for such evaluation or treatment in a timely manner. In Level 2.1 programs, necessary support systems include: • Medical, psychological, psychiatric, laboratory, and toxicology services, which are available through	required for each facility. The purpose of the Service Coordinator is to promote engagement and retention in treatment and facilitate an effective discharge plan whereby the individual successfully connects to the next level of care. The service coordinator facilitates referral arrangements and coordination with aftercare. ○ The Service Coordinator may be a licensed practitioner, unlicensed counselor, or certified peer. Program staff are able to obtain and interpret information regarding the individual's biopsychosocial needs. Some, if not all, program staff should have sufficient cross-training to understand the signs and symptoms of mental disorders and to understand and be able to explain the uses of psychotropic medications and their interactions with substance use and other addictive disorders. Staff in adolescent programs should be knowledgeable about adolescent development and experienced in engaging and working with adolescents. Clinical staff who assess and treat adolescents are able to recognize the need for specialty evaluation and treatment for intoxication or withdrawal and are able to arrange for such evaluation or treatment in a timely manner. In Level 2.5 programs, necessary support systems include: • Medical, psychological, psychiatric, laboratory, and toxicology services, which are available through consultation or referral. Psychiatric and other medical consultation is available within 8 hours by telephone and within 48 hours in person. • Emergency services, which are available by telephone 24 hours a day, 7 days a week when the treatment program is not in session.

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	consultation or referral. Psychiatric and other medical consultation is available within 24 hours by telephone and within 72 hours in person. • Emergency services, which are available by telephone 24 hours a day, 7 days a week when the treatment program is not in session. • Direct affiliation with (or close coordination through referral to) more and less intensive levels of care and supportive housing services.	• Direct affiliation with (or close coordination through referral to) more and less intensive levels of care and supportive housing services.
Interventions	• An individual biopsychosocial assessment of each individual, which includes a comprehensive substance use and addictive behaviors history obtained as part of the initial assessment and reviewed by a physician (or NP/PA), if necessary. • A physical examination may be performed within a reasonable time, as determined by the individual's medical condition. Such determinations are made according to established protocols, which include reliance on the individual's personal physician (or NP/PA) whenever possible. • An individualized treatment plan, which involves problems, needs, strengths, skills, and priority formulation. Short-term, measurable treatment goals and preferences are articulated along with activities designed to achieve those goals. The plan is developed in collaboration with the individual and reflects the individual's personal goals. • Treatment plan reviews are conducted every 30 days or more frequently as determined by the appropriate credentialed professional. • Monitoring, including the review, interpretation and documentation of any biomarkers and/or toxicology	• An individual biopsychosocial assessment of each individual, which includes a comprehensive substance use and addictive behaviors history obtained as part of the initial assessment and reviewed by a physician (or NP/PA), if necessary. • A physical examination may be performed within a reasonable time, as determined by the individual's medical condition. Such determinations are made according to established protocols, which include reliance on the individual's personal physician (or NP/PA) whenever possible. • An individualized treatment plan, which involves problems, needs, strengths, skills, and priority formulation. Short-term, measurable treatment goals and preferences are articulated along with activities designed to achieve those goals. The plan is developed in collaboration with the individual and reflects the individual's personal goals. • Treatment plan reviews are conducted every 30 days or more frequently as determined by the appropriate credentialed professional. • Monitoring, including the review, interpretation and documentation of any biomarkers and/or toxicology testing; any laboratory services, including toxicology, should be billed for outside of the rate.

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	testing; any laboratory services, including toxicology, should be billed for outside of the rate.	• For adolescents, information for assessment and treatment planning may be obtained from a parent, guardian, or other important resource (such as a teacher or probation officer). Elements of the assessment and treatment plan review should also include: ○ An initial withdrawal assessment, including a medical evaluation at admission (or medical review of an evaluation performed within the 48 hours preceding admission, or within 7 days preceding admission for an individual who is stepping down from a residential setting). ○ Ongoing withdrawal monitoring assessments, performed several times a week. ○ Ongoing screening for medical and nursing needs, with medical and nursing evaluation available through consultation or referral.
Treatment Services	Intensive outpatient programs offer comprehensive, coordinated, and defined services that may vary in level of intensity but must be nine or more contact hours per week for adults (age 18 years and older), with a minimum contact of three days per week (not to exceed 19 hours per week) or must be six or more contact hours per week for adolescents (ages 12-17 and inclusive of individuals age 18 transferring from the child system to the adult system), with a minimum of contact three days per week (not to exceed 19 hours per week). Each IOP day at an adult IOP program, must be at least 3 hours of programmed hours, of which 2.5 must be clinical. Each IOP day at an adolescent IOP program, must be at least 2 hours of programmed hours, of which 1.5 must be clinical. This level consists of a scheduled series of face-to-face sessions, in person or via telehealth per the current telehealth policies, appropriate to the individual's treatment plan.	Partial hospitalization programs, known in some areas as "day treatment," generally feature 20 or more hours of clinically intensive programming per week with a minimum contact of four days per week, as specified in the individual's treatment plan. Level 2.5 partial hospitalization programs typically have direct access to psychiatric, medical, and laboratory services, and thus are better able than Level 2.1 programs to meet needs identified in Dimensions 1, 2, and 3, which warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting. Each PHP day must be at least four hours of programmed hours, of which 3.5 hours must be clinical. Services include, but are not limited to individual, group, and family counseling including psychoeducation on recovery. These are provided in the amounts, frequencies, and intensities appropriate to the

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	These programs may be provided for persons at risk of being admitted to more intensive levels of care, such as residential, inpatient, or withdrawal management, or for continuing care for those who require a step-down following a more intensive level of care and require support to avoid relapse. Services are provided in amounts, frequencies and intensities appropriate to the objectives of the treatment plan and adapted to the individual's developmental stage and comprehension level. Motivational interviewing, enhancement and engagement strategies are used in preference to confrontational approaches. Services can be provided concurrently with medication for addiction treatment (MAT) and/or ambulatory withdrawal management; these hours are separate from the hours of counseling services for IOP. There are occasions when the individual's progress in IOP no longer requires the total number of weekly programming hours (nine hours per week of treatment for adults or six hours per week for adolescents) but they have not yet made enough stable progress to be fully transferred to a Level 1 program. In such cases, less than nine hours per week for adults and six hours per week for adolescents as a transition step down in intensity should be considered as a continuation of the IOP program for one or two weeks. Such continuity allows for a smoother transition to Level 1 to avoid exacerbation and recurrence of signs and symptoms.	objectives of the individual's treatment plan. Services are adapted to the individual's developmental stage and comprehension level. Motivational enhancement and engagement strategies are preferred over confrontational approaches. Adolescent program also provide educational services when such services are not available through other resources, which are designed to maintain the educational and intellectual development of the individual and, when indicated, to provide opportunities to remedy deficits in the adolescent's education.
Direct Care Staff to Client Ratio	• Clinical group size should not exceed 12 individuals per counselor, regardless of payer. • Psychoeducational groups limited to 25 individuals, regardless of payer.	• Clinical Group size should not exceed 12 individuals per counselor, regardless of payer. • Psychoeducational groups limited to 25 individuals, regardless of payer.

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Documentation	Programs will maintain individualized records which shall include: • The individual's Medicaid eligibility status • An individualized, comprehensive bio-psychosocial assessment which includes assessment in each of the ASAM six dimensions; this assessment must be compliant with the most recent edition of ASAM. ○ Documentation of any mental health and SUD diagnoses ○ Minimum credentials for the staff conducting or updating the assessment shall be a master's prepared behavioral health practitioner with a minimum of an associate license (LMSW, LPCA, MFTA) who is knowledgeable about addiction treatment and co-occurring disorders; credentials of the completing practitioner must be documented on the assessment. ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • Individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals. ○ Discharge planning is integrated into the treatment plan. ○ Minimum credentials for staff developing the treatment plan shall be a Master's prepared behavioral health practitioner with a minimum of an associate license; credentials of the practitioner must be documented on the treatment plan. ○ Review and signature of an independently licensed behavioral health practitioner/clinical supervisor.	Programs will maintain individualized records which shall include: • The individual's Medicaid eligibility status • An individualized, comprehensive bio-psychosocial assessment which includes assessment in each of the ASAM six dimensions; this assessment must be compliant with the most recent edition of ASAM. ○ Documentation of any mental health and SUD diagnoses ○ Minimum credentials for the staff conducting or updating the assessment shall be a master's prepared behavioral health practitioner with a minimum of an associate license (LMSW, LPCA, MFTA) who is knowledgeable about addiction treatment and co-occurring disorders; credentials of the completing practitioner must be documented on the assessment. ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • Individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals. ○ Discharge planning is integrated into the treatment plan. ○ Minimum credentials for staff developing the treatment plan shall be a Master's prepared behavioral health practitioner with a minimum of an associate license; credentials of the practitioner must be documented on the treatment plan. ○ Review and signature of an independently licensed behavioral health practitioner/clinical supervisor. ○ Treatment plan reviews are conducted every 30 days or more frequently as determined by the appropriate credentialed professional. • Individualized progress notes that clearly reflect implementation of the treatment plan and the individual's

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	○ Treatment plan reviews are conducted every 30 days or more frequently as determined by the appropriate credentialed professional. • Individualized progress notes that clearly reflect implementation of the treatment plan and the individual's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. ○ Credentials of the practitioner completing ○ Notes for clinical services provided by a master's prepared behavioral health practitioner with an associate license shall have the review and signature of an independently licensed behavioral health practitioner/clinical supervisor. • Administration of toxicology screens and the test results. • Discharge summary which has been written within 15 working days of the individual leaving the program. This summary shall: ○ Address original reason for referral. ○ Indicate the individual's progress towards the established plan. ○ Describe the type, frequency and duration of treatment or services. ○ Specify reason(s) for discharge ○ Indicate the individual's participation in discharge planning. ○ Include information regarding release(s) of information obtained and aftercare services referred to. ○ Include the credentials of the practitioner completing. Minimum credentials for staff completing the discharge summary shall be a Master's prepared behavioral health practitioner with a minimum of an associate license.	response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. ○ Credentials of the practitioner completing ○ Notes for clinical services provided by a master's prepared behavioral health practitioner with an associate license shall have the review and signature of an independently licensed behavioral health practitioner/clinical supervisor. • Administration of toxicology screens and the test results. • Discharge summary which has been written within 15 working days of the individual leaving the program. This summary shall: ○ Address original reason for referral. ○ Indicate the individual's progress towards the established plan. ○ Describe the type, frequency and duration of treatment or services. ○ Specify reason(s) for discharge ○ Indicate the individual's participation in discharge planning. ○ Include information regarding release(s) of information obtained and aftercare services referred to. ○ Include the credentials of the practitioner completing. Minimum credentials for staff completing the discharge summary shall be a Master's prepared behavioral health practitioner with a minimum of an associate license. ○ Include review and signature of an independently licensed behavioral health practitioner/clinical supervisor.

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	○ Include review and signature of an independently licensed behavioral health practitioner/clinical supervisor.	
Supervisor Qualifications	Supervisors must be licensed professionals working within the scope of their license and with a minimum of three years of experience in SUDs/co-occurring treatment.	Supervisors must be licensed professionals working within the scope of their license and with a minimum of three years of experience in SUDs/co-occurring treatment.
Direct Care Workers per FTE Supervisor	1:9 Supervisors conduct and document face-to-face clinical supervision a minimum of: • Two hours per month for independently licensed clinical staff. Group supervision may be utilized once per month. • One hour per week for associate licensed and unlicensed staff. Group supervision may be utilized once per month. • Certified peers with lived experience receive clinical supervision 1 hour weekly, of which group supervision may be utilized once a month	1:9 Supervisors conduct and document face-to-face clinical supervision a minimum of: • Two hours per month for independently licensed clinical staff. Group supervision may be utilized once per month. • One hour per week for associate licensed and unlicensed staff. Group supervision may be utilized once per month. • Certified peers with lived experience receive clinical supervision 1 hour weekly, of which group supervision may be utilized once a month
Target Length of Stay	The duration of treatment varies with the severity of the individual's illness and their response to treatment.	The duration of treatment varies with the severity of the individual's illness and their response to treatment.