NEW YORK STATE | Office of Alcoholism and Substance Abuse Services

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Continuing Care Guidance

Background

NIDA defines Substance Use Disorder as a "chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences". SUD treatment is generally provided as an acute care model. Individuals enter treatment at a residential, inpatient or outpatient level of care, receive care that consists of group and individual therapy, medication assisted treatment, peer counseling and where available, recovery support services such as vocational or housing supports. Once stable, the individual is discharged with a referral to mutual aid groups, mental health counseling or other community supports. OASAS has long recognized that the current pattern of acute episodes of care are in contrast to the chronic nature of addiction.

In order to allow for continuous connection to treatment over time, OASAS has included continuing care in the new PART 822 regulations http://www.oasas.ny.gov/regs/index.cfm. This will allow programs to discharge an individual from an outpatient episode of active care in an outpatient setting (outpatient clinic or Opioid Treatment Program) into continuing care. The person will be able to access counseling, peer services, medication assisted treatment and recovery supports following treatment for an indefinite period of time. For some, this may be for only a few months as they transition to recovery supports in the community for others it may be for many years. See below for patient examples of appropriate use of continuing care.

Documentation Requirements

Individuals need to be discharged from outpatient or opioid treatment program following all of the existing requirements including a discharge plan, discharge summary and completion of OASAS reporting for discharge. The OASAS discharge reporting form is in the process of being updated to add a discharge category for continuing care. The clinician should note in the patient chart that the individual will be followed in continuing care and identify the clinical reason(s) for continuing care, for example, Patient meets **any** of the criteria below:

- Patient has completed goals of outpatient treatment episode and will be followed for ongoing medication assisted treatment.
- Patient has completed goals of outpatient treatment and needs continued support from peer and individual counselor to maintain the gains made in treatment.
- Patient has completed some goals during this episode of outpatient treatment and has attained all of the benefit of active treatment that is desired, patient will continue to employ skills learned and return as needed for additional support.
- Patient has completed this episode of SUD treatment, it is expected that the patient will benefit from ongoing check- ins with counselor (peer); especially for times when the patient is experiencing urges to return to use, has relapsed or is experiencing increased stress.
- Patient requests ongoing support from outpatient program as needed.
- Patient and counselor agree that routine check-in would be beneficial.

The individual counselor must identify the goals of continuing care and expected frequency of visits. Patients may be seen for counseling, medication and/ or peer services within the same month. The continuing care plan should be reviewed once per year and updated as needed. A note in the patient chart is sufficient to meet this requirement.

Programs should develop a policy and procedure on continuing care and develop and internal tracking system for keeping a current roster of individuals who are in continuing care. The policy and procedures must include a procedure for updating the roster and a method for determining when an individual will be removed from the roster. Programs will need to provide a roster of individuals in continuing care upon sire review.

Services

Programs may bill for any HCPCs or CPT code allowable through the APG methodology that is delivered per the continuing care plan. However, if an individual is in need of active treatment at any time during continuing care they must be admitted to active treatment. Individuals who are receiving more services or who are in need of more service than is allowed in continuing care must be admitted to active treatment. Individuals who have a change in severity or treatment needs beyond the continuing care plan should be admitted to active care. Services provided must be aligned with the identified goals of continuing care.

Clinical Examples:

John has completed 6 months of outpatient therapy following an inpatient treatment episode for stimulant use disorder. The patient has a history of doing well for extended periods and then relapsing generally "when things are going good again". John is open to returning for "check-up" appointments for support for maintaining the skills learned and for support of ongoing recovery. He has a good therapeutic alliance with his primary therapist and was given an appointment to return in 6 weeks for his first continuing care visit with instructions to call earlier if needed.

Sherra has completed 12 weeks of intensive outpatient and an additional 4 months of outpatient treatment and had completed all goals. She is continuing with ongoing buprenorphine treatment and will continue with regular monthly appointments for medication management with the physician. (Note- It is allowable for the continuing care plan to include only visits with a prescribing medical staff person)

Li has attended outpatient treatment as a condition of probation and has completed some of the goals of treatment. He has struggled to maintain abstinence over the 12 months of active treatment and has finished his probation and is no longer required to attend. He is not interested in additional active treatment and remains ambivalent about the need for abstaining from substances. He has gained support for trauma that he shared while in treatment. He would like to return to talk with a counselor if needed.

Jen sought treatment for cannabis and alcohol disorder. She was sporadic in attendance in active treatment and did not achieve goals. She is no longer interested in active treatment but did make some connection with a therapist and a peer. She acknowledges her ambivalence and the eventual need for making some changes and would like to stay connected. She is open to talking with someone when a new stressor or crisis arises. Her counselor opens her in continuing care with the goal of encouraging active treatment through the use of motivational interviewing.