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Owner	Kelly Myricks: SUD Initiatives Administrator
Policy Area	Substance Use Disorders
Applicability	Detroit Wayne Integrated Health Network
References	42 CFR 438, ASAM, MDHHS + 1 more

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Level of Care Change for Individuals Receiving Substance Use Disorder Services Standard Operating Procedure

PROCEDURE PURPOSE

To provide guidelines for establishing a standardized, clinically appropriate, person-centered process for determining, documenting, and implementing changes in Level of Care for individuals receiving Substance Use Disorder (SUD) services, including Step-Up, Step-Down, and relapse-based criteria for increased care.

EXPECTED OUTCOME

Ensure consistent, clinically appropriate, and timely Level of Care changes that improve treatment continuity, enhance member safety, strengthen documentation quality, and support person-centered decision-making across all SUD Providers.

PROCEDURE

1. **Guiding Principles**
    1. All Level of Care decisions are based on ASAM multidimensional assessment and

clinical judgment.

2. The process must remain person-centered and trauma-informed.
3. Changes in Level of Care must be responsive, timely, and documented thoroughly.
4. A relapse does not automatically require a higher level of care unless clinically indicated.

2. **Step-up Criteria:** A Step-Up may be initiated when an individual demonstrates increased clinical severity, safety concerns, or reduced ability to engage in the current level of care. The following criteria guide a Step-Up decision:
    1. Relapse Related Criteria for Step-Up — A step-up is indicated when relapse results in any of the following:
        a. Increased risk of overdose, medical complications, or withdrawal risk.
        b. Use that leads to loss of housing, legal consequences, or major functional decline (e.g., impacts on Activities of Daily Living (ADLs), employment issues, Cognitive/Behavioral, Interpersonal (family or friends), and Physical Health).
        c. Use in high-risk settings (e.g., Driving Under Influence (DUI)/Operating While Intoxicated (OWI), using while caring for children or other vulnerable individuals, use before or during activities such as work, school, or medical responsibilities) or patterns indicating loss of control (e.g., binge episodes, daily use after stability, using despite physical, mental, legal, or relationship issues).
        d. Cravings, urges, or psychiatric symptoms that exceed current Level of Care capacity
        e. Safety concerns, including suicidal ideations or behaviors linked to substance use
    2. Non-Relapse Clinical Factors Worsening mental health symptoms require increased structure; symptoms include the following:
        a. Changes in Mood
            i. Heightened anxiety
            ii. Persistent sadness or hopelessness
            iii. Rapid mood shifts
            iv. Feeling emotionally overwhelmed
        b. Changes in Thinking
            i. Racing thoughts
            ii. Increased negative self-talk
            iii. Paranoia or suspicious thoughts
            iv. Trouble making decisions
        c. Changes in Behavior
            i. Avoiding responsibilities

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ii. Sleeping too much or too little
iii. Increased agitation or restlessness
iv. Decline in personal care or daily functioning

d. Changes in Physical Presentation
    i. Changes in appetite and/or weight
    ii. Physical complaints without clear cause (e.g., headaches, stomach pains, etc.)

e. Risk-Related Symptoms
    i. Thoughts of self-harm or harm to others
    ii. Engaging in risky or impulsive behaviors

Inadequate response to current treatment intensity. Examples include, but not limited to the following:

a. Escalating Substance Use
    i. Continued use despite treatment participation
    ii. Increase in frequency or quantity of substance use
    iii. Despite an increase or change in interventions to address substance use, lapses/relapses continue to occur.
    iv. Using before or after treatment sessions

b. Failure to apply coping skills outside of treatment
    i. Reliance solely on sessions, without use of relapse-prevention skills between appointments
    ii. Unable to manage cravings or triggers independently
    iii. Reports “knowing what to do” but unable to put it into practice

c. Inability to maintain stability between sessions
    i. Crises occurring repeatedly between sessions
    ii. Significant difficulty maintaining abstinence for even short periods
    iii. Frequent emotional or psychiatric distress that disrupts functioning

d. Insufficient treatment progress
    i. Missing sessions beyond what the treatment plan indicates
    ii. Trouble completing homework and recovery tasks or treatment assignments
    iii. Limited participation in individual or group sessions
    iv. Lack of follow-through on referrals given (e.g., behavioral health evaluations/services, MOUD evaluations, transportation, etc.)

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e. Inadequate or collapsing supports outside of treatment
    i. No safe, stable recovery supporting environment
    ii. Lack of sober support despite treatment efforts
    iii. High-risk people or environments remain unchanged and overwhelming treatment gains

f. Co-Occurring concerns exceed current Level of Care
    i. Anxiety, depression, trauma, or psychosis interfering with treatment engagement
    ii. Increased safety concerns
    iii. Need for more structured or coordinated care

g. Continued functional impairments
    i. Ongoing legal, employment, housing, or relational problems
    ii. Functional decline despite stable participation in treatment
    iii. Unable to maintain daily structure or self-care

h. The current Level of Care lacks structure needed to meet members' needs.
    i. Member reports too much unstructured time
    ii. High-risk behaviors occurring during gaps between sessions
    iii. Needs for monitoring, support, or accountability exceed outpatient capacity.

i. Significant instability in ASAM Dimensions 3, 4, 5, or 6

3. **Step-Down Criteria:** Step-down occurs when the individual demonstrates sufficient stability, skill acquisition, and readiness for a less intensive Level of Care.
    1. Indicators for Step-Down
        a. Consistent attendance and engagement in treatment
        b. Demonstrated coping skills and relapse prevention strategies
        c. Reduced cravings or improved symptoms management
        d. Stabilization across ASAM dimensions
        e. Individual preference and readiness aligned with clinical judgment.
        f. Completion of therapeutic goals at current Level of Care

    Step-Down must not occur when doing so would place the individual at risk of relapse, harm, or functional deterioration.

4. **Procedure for Initiating Level of Care Change**
    1. Staff Identification and Initial Review
        a. Any provider may identify the need for a Level of Care change based on ongoing assessment.
        b. Staff must document any observed concerns or lack of progress no later

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than 24 hours from the time the concern is identified, and the entry must be recorded in the member's clinical record within that same 24-hour period.

c. ASAM dimensions must be updated prior to review.

2. Clinical Review Team (CRT) Consultation
    a. The CRT reviews the updated assessment within 2 business days.
    b. The team determines if the criteria for Step-Up or Step-Down are met.
    c. If urgent safety concerns exist, review occurs immediately.
3. Member Participation
    a. The member must be informed of the proposed change.
    b. Staff must obtain input, discuss preferences, and document informed consent whenever possible.
    c. When consent cannot be obtained due to safety risk, staff must document rationale immediately and must make an immediate attempt to obtain and document consent within 24 hours, or as soon as the member is stable and able to participate.
4. Authorization and Documentation Required documentation includes:
    a. Submission of Level of Care Change within MHWIN
    b. Rationale for Level of Care change tied to specific criteria
    c. Safety concerns when applicable
    d. Member participation and preferences
    e. New Master Treatment Plan outlining goals and interventions
    f. Transition or admission orders
5. Coordination and Transition
    a. Staff must coordinate transfer logistics (bed availability, transportation, medication continuity, care coordination, hand-offs).
    b. Step-Up transitions should occur within 24–72 hours depending on safety level.
    c. Step-Down transitions should be scheduled collaboratively to avoid service gaps.

5. **Special Considerations**
    1. Relapse in Recovery Housing or Outpatient Levels
        a. Immediate assessment for withdrawal or safety risk
        b. Determine whether relapse can be managed with enhanced support before a Step-Up
        c. Coordinate with housing operators or outpatient teams as required
    2. Co-Occurring Mental Health Conditions

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a. If mental health symptoms drive instability, consider integrated or dual-diagnosed Level of Care

b. Psychiatric consultation should be obtained when needed.

3. Cultural and Person-Centered Factors

a. Communication and Language Access

i. Staff must ensure that interpretation services are offered and provided whenever preferred by the member.

ii. Explanation of Level of Care changes must be provided in the member's preferred language whenever possible.

iii. Staff must use clear, plain, and culturally respectful language when discussing assessment results and recommendations.

b. Cultural Beliefs About Treatment

i. Staff must explore how the member's cultural worldview influences their understanding of substance use, recovery, medication, and the role of treatment.

ii. When cultural beliefs conflict with standard treatment expectations, staff must collaborate with the member to find acceptable alternatives that remain clinically appropriate.

c. Engagement and Stigma Considerations

i. Staff must consider how cultural stigma, distrust of systems, or historical trauma may influence engagement patterns (e.g., missed appointments, reluctance to disclose information, etc.)

ii. These factors must not be interpreted as resistance or lack of motivation without further exploration.

iii. Staff must discuss engagement challenges in a culturally sensitive and nonjudgmental manner.

d. Cultural Social Determinants of Health Staff must consider the following factors when recommending or changing Level of Care to ensure recommendations are realistic:

i. Housing instability

ii. Economic barriers

iii. Immigration or legal concerns

iv. Community safety

v. Experiences of discrimination

vi. Transportation access

6. **Warm Handoff Protocol** — When a member steps up, steps down, or transfers between providers within the same Level of Care, the transferring provider must complete the following care coordination actions:

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1. Consents: Complete and file the MDHHS 5515 form. Securely transfer necessary clinical records, current treatment plans, discharge summary, and safety plans directly to the receiving provider.
2. Direct Provider-to-Provider Communication: Conduct a direct clinical conversation (via phone or secure videoconference) between the outgoing and incoming clinical teams to review treatment history and high-risk flags, medication-assisted treatment details, and immediate care needs.
3. Member Centered Bridge: Engage the member in the transition. Ensure they understand their new appointment details, transportation plan, and point of contact at the receiving agency.
4. Conflicting Schedule Support: Maintain responsibility for the members' care until the receiving provider has officially completed the admission and intake assessment
5. Post Transfer Verification: Contact the receiving provider within 24 to 48 hours post-referral to verify that the member attended their scheduled appointment and successfully engaged in care.

7. **Appeals:** When a provider action on a member's behalf disagrees with a Utilization Management authorization decision, they have the right to appeal and request a formal review. All appeals must be submitted through appeals@dwihn.org. The appeal must include the following information:
    1. Member ID: Mental Health Wellness Information Network (MHWIN) Member ID
    2. Authorization Number: From denied authorization
    3. Provider Information: Contact information for additional questions or follow-up
    4. Clinical Justification: Reasoning to support appeal

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MONITORING STEPS

Who monitors this procedure:	DWIHN and Providers
Department:	SUD, Access, and Utilization Management
Frequency of monitoring:	Daily
Reporting provided to:	SUD Initiatives Administrator
Comments:	

Approval Signatures

Step Description	Approver	Date

VP of Clinical	Erik Hutchison: Vice President of Clinical Operations	Pending
Unit Review and Approval	Matthew Yascolt: Director of Substance Use Disorder	08/2026

Applicability

Detroit Wayne Integrated Health Network

References

42 CFR 438, ASAM, MDHHS, SAMSHA

Standards

No standards are associated with this document

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