Proposed New Measure for HEDIS®[1] 2020:
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

NCQA seeks comments on a proposed new measure for potential inclusion in the HEDIS 2020 measurement set:

Follow-Up After High-Intensity Care for Substance Use Disorder: The percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder (SUD) that result in a follow-up visit or service for substance use disorder among members 13 years of age and older. Two rates are reported:

1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge.
2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.

Timely follow-up after care for SUD delivered in high-intensity settings is critical: Individuals receiving SUD care in these settings are especially vulnerable to losing contact with the health care system after discharge. Lack of timely follow-up can result in negative outcomes, such as continued substance use, relapse, high utilization of intensive care services and mortality.[2] Although clinical practice guidelines and expert consensus do not define the ideal timing for follow-up, guidelines recommend that individuals with SUD receive patient-centered, timely follow-up care in an appropriate care setting, to ensure ongoing treatment and management.[3,4]

The intent of this proposed new measure is to assess timely follow-up and continued contact with the health care system following a high-intensity visit for a principal diagnosis of SUD. Continued treatment of this vulnerable and diverse population is contingent on the member's physical and psychosocial needs at the time of discharge. To be responsive to the various needs of this population, this measure includes follow-up care for a principal diagnosis of SUD delivered in a variety of treatment settings including outpatient visits, partial hospitalizations, observation stays, telehealth encounters, inpatient hospitalizations and residential treatment. Follow-up may also take the form of a dispensed or administered pharmacotherapy for the treatment of opioid or alcohol use disorder.

This new measure is expected to complement the current HEDIS measure *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* and fill an existing gap in measurement. NCQA envisions that these two SUD measures will work in concert, similar to *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Hospitalization for Mental Illness*.

NCQA field-tested this measure concept in fall 2018 using Medicare, commercial and Medicaid managed care claims data. Field-testing demonstrated that the measure can be feasibly calculated at the health-plan level of accountability, with a sufficient denominator size for HEDIS reporting. Testing also demonstrated that there is variation in performance both within and across product lines, which suggests

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[2] Schmidt, E.M., S. Gupta, T. Bowe, L.S. Ellerbe, T.E. Phelps, J.W. Finney, S.M. Asch, K. Humphreys, J. Trafton, M. Vanneman, and A.H.S. Harris. 2016. "Predictive Validity of a Quality Measure for Intensive Substance Use Disorder Treatment." *Substance Abuse* 38:3, 317–23, DOI: 10.1080/08897077.2016.1212779. https://www.tandfonline.com/doi/full/10.1080/08897077.2016.1212779?scroll=top&needAccess=true

[3] National Institute on Drug Abuse (NIDA). 2018b. *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition).* National Institute on Drug Abuse, 17 Jan. 2018. https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition

[4] Work Group on Substance Use Disorders. 2006. *Practice Guideline for the Treatment of Patients With Substance Use Disorders Second Edition.* American Psychiatric Association (APA); 2006 Aug. 276 pg. [1789 references]. Retrieved from https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf

a significant gap in care and room for improvement. Average plan-level performance indicated that 18.5% of Medicare, 26.9% of commercial and 32.7% of Medicaid visits or discharges from high-intensity care settings for a diagnosis of SUD result in follow-up care within 7 days. 33% of Medicare, 53.9% of commercial and 56.1% of Medicaid visits or discharges from high-intensity care settings for a diagnosis of SUD result in follow-up care within 30 days.

NCQA seeks general feedback on the new measure and feedback on the following question:

1. The proposed measure currently includes billing codes for residential treatment discharges from inpatient hospital settings. During development, members of NCQA measurement advisory panels suggested that NCQA consider adding per diem residential treatment that does not result in overnight stays as an appropriate follow-up option for the measure numerator.

   NCQA seeks feedback on how this treatment setting is used and how care rendered in this setting is reimbursed.

2. Currently, in the United States, both psychosocial pharmacological treatments for SUD can be provided in opioid treatment programs (OTP). NCQA recognizes the current challenges surrounding the use of administrative billing codes used in OTPs. NCQA seeks feedback on the current list of administrative billing codes included in the measure related to care provided in the OTP setting.

Supporting documents include the draft measure specification and evidence workup.

NCQA acknowledges the contributions of the Geriatric Measurement Advisory Panel, the Technical Measurement Advisory Panel and the Behavioral Health Measurement Advisory Panel

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

SUMMARY OF CHANGES TO HEDIS 2020

- First-year measure.

Measure Description

The percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder that result in a follow-up visit or service for substance use disorder among members 13 years of age and older. Two rates are reported:

1. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge.
2. The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.

Measure Definitions

Episode Date

The date of service for any acute inpatient discharge, residential treatment discharge or detoxification visit with a principal diagnosis of substance use disorder.

For an acute inpatient discharge or residential treatment discharge, the Episode Date is the date of discharge.

For direct transfers, the Episode Date is the discharge date from the transfer admission.

For a detoxification visit, the Episode Date is the date of service.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*

Product lines

Commercial, Medicaid, Medicare (report each product line separately).

Ages

13 years and older as of the date of discharge, stay or event. Report three age stratifications and total rate.

- 13-17 years.
- 18-64 years.
- 65 years and older.
- Total

The total is the sum of the age stratifications.

Continuous enrollment

Date of episode through 30 days after episode (31 total days).

Allowable gap

No gaps in enrollment.

Anchor date

None.

Benefits

Medical, chemical dependency, and pharmacy.

Event/diagnosis

An acute inpatient discharge, residential treatment or detoxification event for a principal diagnosis of substance use disorder on or between January 1 and December 1 of the measurement year. Any of the following code combinations meet criteria:

- An acute inpatient discharge or a residential behavioral health stay ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set). To identify acute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays other than behavioral health (Nonacute Inpatient Stay Other Than Behavioral Health Accommodations Value Set).
  3. Identify the discharge date for the stay.
- A detoxification visit (Detoxification Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).

The denominator for this measure is based on episodes, not on members. If members have more than episode, include all that fall on or between January 1 and December 1 of the measurement year.

Direct transfers

Identify direct transfers to an acute inpatient care or residential setting during the 30-day follow-up period. If the direct transfer to the acute inpatient or residential care setting was for a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set), use the date of last discharge.

A **direct transfer** is when the discharge date from the first acute inpatient or residential care setting precedes the admission date to a second acute inpatient or residential care setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify direct transfers:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays other than behavioral health (Nonacute Inpatient Stay Other Than Behavioral Health Accommodations Value Set).
3. Identify the admission date for the stay.

Exclude both the initial discharge and the direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

If the direct transfer to the acute inpatient or residential behavioral health care setting was for any other principal diagnosis, exclude both the original and the direct transfer discharge.

Multiple discharges, visits or events in a 31-day period

If a member has more than one episode in a 31-day period, using the discharge date, include only the first eligible episode. For example, if a member is discharged from a residential treatment stay on January 1, include the January 1 discharge and do not include subsequent episodes that occur on or between January 2 and January 31; then, if applicable, include the next episode that occurs on or after February 1. Identify episodes chronologically including only the first episode per 31-day period.

Note: *Removal of multiple episodes in a 31-day period is based on eligibility. Assess each episode for exclusions before removing multiple episodes in a 31-day period.*

Administrative Specification

Denominator The eligible population.

Numerators

30-Day Follow-Up A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 30 days after an episode for substance use disorder. Do not include visits that occur on the date of the denominator episode.

7-Day Follow-Up A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 7 days after an episode for substance use disorder. Do not include visits that occur on the date of the denominator episode.

For both indicators, any of the following meet criteria for a follow-up visit.

- An acute or nonacute inpatient discharge or residential behavioral health stay ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set). To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a principal diagnosis of substance use disorder. Any of the following code combinations meet criteria:
  - IET Stand Alone Visits Value Set ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
  - IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
  - IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An observation visit (Observation Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- An online assessment (Online Assessments Value Set) ***with*** a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medication List; Opioid Use Disorder Treatment Medication List) or medication treatment event (AOD Medication Treatment Value Set).

Note: *Follow-up does not include detoxification. Exclude all detoxification events (Detoxification Value Set) when identifying follow-up care for numerator compliance.*

Opioid Use Disorder Treatment Medications

Description	Prescription
Antagonist	• Naltrexone (oral and injectable)
Partial agonist	• Buprenorphine (sublingual tablet, injection, implant)[1] • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

[1]Buprenorphine administered via transdermal patch or buccal film are not included because they are FDA-approved for the treatment of pain, not for opioid use disorder.

Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral and delayed-release tablet)

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).*
- *Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. A pharmacy claim for methadone would be more indicative of treatment for pain than for an opioid use disorder; therefore, is not included on medication lists. The AOD Medication Treatment Value Set includes codes that identify methadone treatment for opioid use disorder because these codes are used on medical claims, not on pharmacy claims.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUI-1/2/3: Data Elements for Follow-Up After High Intensity Care for Substance Use Disorder

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	*For each age stratification and total*
Number of required exclusions	*Each rate, for each age stratification and total*
Numerator events by administrative data	*Each rate, for each age stratification and total*
Numerator events by supplemental data	*Each rate, for each age stratification and total*
Reported rate	*Each rate, for each age stratification and total*

Follow-Up After High Intensity Care for Substance Use Disorder (FUI)
Measure Workup

Topic Overview

In 2016, 20.1 million U.S. residents 12 years of age and older (7.5% of the population) were classified as having a substance use disorder (SUD) within the past year (SAMHSA, 2017). SUDs are a significant contributor to morbidity and mortality in the United States and cost the health care system billions of dollars per year in direct and indirect expenditures. Although clinical guidelines recommend follow-up care after "high intensity" treatment for a SUD (e.g. inpatient hospitalization, medically managed withdrawal/ detoxification, residential treatment visit or stay) in order to reduce negative health outcomes, few individuals receive any treatment or follow-up care.

Prevalence and Importance

An SUD is defined as recurrent use of alcohol and/or drugs that causes significant clinical and functional impairment (SAMHSA, 2015). Commonly abused substances include alcohol and illicit drugs such as marijuana, cocaine, methamphetamine, nonprescription opioids and stimulants (SAMHSA, 2017). SUDs can be mild, moderate or severe, according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (SAMHSA, 2015).

According to the National Survey on Drug Use and Health (NSDUH), the number of Americans classified with an SUD has remained relatively steady from 2002–2016 (20.6 million–22.7 million) (SAMHSA, 2015; SAMHSA 2017). In 2016, 15.1 million individuals 12 and older reported an alcohol use disorder and 7.4 million reported an illicit drug use disorder (SAMHSA, 2017). An estimated 2.3 million individuals with an SUD reported both alcohol use and illicit drug use disorders within the past year (SAMHSA, 2017).

Despite the relatively steady prevalence of SUDs in the U.S., SUD-related mortality and overdose rates have risen significantly in the past decade (Mack et al., 2017; Dart, et al., 2015; NCHS, 2017). Today in the U.S., drug overdose is the leading cause of injury and an estimated ten percent of deaths among working adults are due to excessive drinking (CDC, 2017; Stahre et al., 2014). In 2016, 63,000 deaths were due to a drug overdose (NCHS, 2017).

Individuals with SUD have higher utilization of high-intensity care setting treatment, such as inpatient hospitalizations. National Survey on Drug Use and Health (NSDUH) data from 2009–2013 indicated that people with SUDs had higher rates of hospitalization than those without SUDs (Gryczynski et al., 2016). In 2011, alcohol-related disorders and substance-related disorders accounted for 26.1% and 18.5% of readmissions in the Medicaid population, respectively (Hines, et al., 2014).

Health importance

Individuals with SUD are at increased risk of overdose, injury, soft tissue infections and mortality (Bahorik, A.L, 2017). Guidelines recommend that individuals with SUD receive patient-centered and timely follow-up care to reduce negative health outcomes, such as disengagement from the health care system and substance use relapse (**Table 1**). There is consensus in the medical field that comprehensive and individualized assessments and treatment plans for adolescents and adults with SUD are needed to provide appropriate services and ongoing care for this vulnerable population (ASAM, 2014).

The primary goals of alcohol and drug abuse or dependence treatment are abstinence, relapse prevention, rehabilitation and recovery (NIDA, 2018a). Research supports the need for individuals with SUD to not only receive timely follow-up care following treatment in a high-intensity care setting (e.g. hospitalization, medically managed withdrawal/detoxification, residential treatment visit), but also to stabilize or cease using the substance(s) and engage in ongoing treatment to prevent relapse (NIDA, 2018a; Proctor & Herschman, 2014). Individuals who receive timely follow-up care may be more likely to complete treatment or receive more days of treatment than those who leave care prematurely (Proctor & Herschman, 2014).

Financial importance and cost-effectiveness

Total overall costs of substance misuse and substance use disorders in the U.S., including loss of work productivity, direct health care expenditures and crime-related costs, exceeds $400 billion annually (NIDA, 2017). Conservative estimates suggest that for every dollar invested in addiction treatment programs, between $4 and $7 are directly returned in decreased drug-related crime, criminal justice costs and theft (NIDA, 2018b).

Using NSDUH data from 2009–2013, annual hospitalization costs were estimated to be $1,122 per person among those with an alcohol use disorder (17.6 million people) and $2,783 per person among those with a SUD involving another illicit drug (3.5 million people) (Gryczynski et al., 2016). In 2011, Medicaid readmissions for alcohol-related disorders and substance-related disorders cost $141 million and $103 million, respectively (Hines, et al., 2014).

Opportunities for Improvement

Potential for Improvement

Several studies have found that timely follow-up after treatment in an intensive care setting for SUD is an effective method for improving patient outcomes, reducing health care utilization and decreasing the overall cost of care for patients with SUD. Patients can receive needed services to help manage their condition and reduce the likelihood of relapse, readmissions and utilization of other intensive services (Lee et al., 2014; VA/DoD, 2015; NIDA, 2018a; Reif, 2017).

Gaps in care

Despite the high prevalence of SUDs in the U.S., only about 18% of individuals with SUD received treatment in 2016 (SAMHSA, 2017). Of those who needed treatment, only 10.6% received treatment in a specialty substance use facility such as a hospital, drug or alcohol rehabilitation facility or mental health center (SAMHSA, 2017).

A study of individuals in five states found that follow-up rates within 14 days of detoxification treatment were between 12.5% and 45.5%, depending on the state (Lee et al., 2014). Another study of Medicaid enrollees with SUDs concluded that two-thirds of enrollees received no follow-up services within 14 days of discharge from an inpatient stay or residential detoxification facility (Reif et al., 2017).

Survey data of individuals 12 years and older during the period 2010–2013 indicate several common reasons for not receiving treatment for a SUD. Coverage was one: 37% stated that they could not afford treatment or did not have health coverage and 8% reported having health coverage that did not cover SUD treatment. Another reason is readiness for change. Nearly 25% of individuals in the study reported not receiving treatment because they were not ready to stop using substances (SAMHSA, 2014a). 9% of individuals reported that they did not seek treatment because they did not know where do go to for treatment; 8% said they lacked transportation and/or that treatment occurred during inconvenient hours (SAMHSA, 2014a).

Health care disparities

Several patient characteristics are associated with increased prevalence and risk of SUD, including age, gender, ethnicity/race and geography. In 2014, SAMHSA reported that 10% of Native Hawaiians/Pacific Islanders were affected by substance abuse or dependence, compared with 4.5% of Asian Americans (SAMHSA, 2015). Research has also shown that African Americans and women have higher probabilities of developing damaging health conditions from long-term use of alcohol (Le Fauve et al., 2003; NIAAA, 1999).

In 1999, drug overdose rates in metropolitan areas were higher than in nonmetropolitan areas; however, in 2015, drug overdose rates in nonmetropolitan areas surpassed rates for urban areas (Mack, et al., 2017). Lower levels of education have also been associated with higher risk and prevalence of SUDs (SAMSHA, 2014b; Latvala et al., 2009; Crum et al., 1993).

Data shows significant differences in access to SUD treatment programs, based on race/ethnicity, age, education and geography. Individuals between 25 and 29 years of age have higher rates of admission to SUD treatment programs than other age groups (NIDA, 2011). Literature suggests that African Americans and Hispanics have lower rates of treatment for SUDs than other racial/ethnic groups (Saloner & Cook, 2013; Cummings, et al., 2011; Mennis & Stahler, 2016).

In a study of the 2009 Treatment Episode Data Set, rural admissions were more likely than urban admissions to report primary abuse of alcohol (49.5 vs. 36.1 percent) or non-heroin opiates (10.6 vs. 4.0 percent); urban admissions were more likely than rural admissions to report primary abuse of heroin (21.8 vs. 3.1 percent) or cocaine (11.9 vs. 5.6 percent) (SAMSHA, 2012). Rural admissions were more likely to have attained a high school education or GED than urban admissions; urban admissions were more likely to have less than a high school education (SAMHSA, 2012).

Guideline Recommendations

Table 1. Guideline Recommendations

Organization	Year	Recommendation	Grade	Strength
American Society of Addiction Medication	2014	ASAM's treatment criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided and the intensity of treatment services provided.	NA	NA
Substance Abuse and Mental Health Services Administration (SAMHSA)	2015	The results of laboratory work as well as the following services: psychosocial assessment; preliminary treatment plan; and patient orientation should be completed within 14 days of admission [to an OTP]. OTPs should include recovery support services in their patient's treatment plan. Recovery support services may involve follow-up phone calls; face-to-face meetings; e-mails; and connecting patients to peer-to-peer services, 12-step, faith-based, and community groups. Furthermore, under the ROSC framework, OTPs provide patients with continuing care. This includes a discharge plan, referrals to continuing outpatient care, procedures that address patients' physical and mental health problems following medically supervised withdrawal, plans for reentry to maintenance treatment if relapse occurs, and ongoing recovery management. OTPs also are encouraged to offer supportive counseling as a transitional service.	NA	NA
National Institute on Drug Addiction (NIDA)	2018	The clinician should ensure that a treatment plan is developed cooperatively with the person seeking treatment, that the plan is followed, and that treatment expectations are clearly understood. Medical, psychiatric, and social services should also be available. Following stays in residential treatment programs, it is important for individuals to remain engaged in outpatient treatment programs and/or aftercare programs. These programs help to reduce the risk of relapse once a patient leaves the residential setting	NA	NA
Veterans Affairs (VA)/Department of Defense (DOD)	2015	For patients with a diagnosis of a SUD, the Work Group suggests offering referral for specialty SUD care based on willingness to engage in specialty treatment. The Work Group suggests assessing response to treatment periodically and systematically, using standardized and valid instrument(s) whenever possible. Indicators of treatment response include ongoing substance use, craving, side effects of medication, emerging symptoms, etc. For patients who have initiated an intensive phase of outpatient or residential treatment, the Work Group recommends offering and encouraging ongoing systematic relapse prevention efforts or recovery support individualized on the basis of treatment response.	Weak For; Not reviewed, Amended Weak For; Reviewed, New-replaced Strong For; Not reviewed, Amended	See grade

Organization	Year	Recommendation	Grade	Strength
		For patients in SUDs specialty care, the Work Group recommends against automatic discharge from care for patients who do not respond to treatment or who relapse.	Strong Against; Not reviewed, Amended	
American Psychiatric Association (APA)	2006	It is important to intensify the monitoring for substance use during periods when the patient is at a high risk of relapsing, including during the early stages of treatment, times of transition to less intensive levels of care, and the first year after active treatment has ceased.	[I]	A, A-, B, C, D, E, F, G
		Outpatient treatment of substance use disorders is appropriate for patients whose clinical condition or environmental circumstances do not require a more intensive level of care.	[I]	
		Most treatment for patients with alcohol dependence or abuse can be successfully conducted outside the hospital (e.g., in outpatient or partial hospitalization settings).	[II]	
		Hospitalization is appropriate for patients who: 1. Have a substance overdose who cannot be safely treated in an outpatient or emergency department setting; 2. Are at risk for severe or medically complicated withdrawal syndromes (e.g., history of delirium tremens, documented history of very heavy alcohol use and high tolerance); 3. Have co-occurring general medical conditions that make ambulatory detoxification unsafe; 4. Have a documented history of not engaging in or benefiting from treatment in a less intensive setting (e.g., residential, outpatient); 5. Have a level of psychiatric comorbidity that would markedly impair their ability to participate in, adhere to, or benefit from treatment or have a co-occurring disorder that by itself would require hospital level care (e.g., depression with suicidal thoughts, acute psychosis); 6. Manifest substance use or other behaviors that constitute an acute danger to themselves or others; or 7. Have not responded to or were unable to adhere to less intensive treatment efforts and have a substance use disorder(s) that endangers others or poses an ongoing threat to their physical and mental health.	[II]	

Recommendation Categories and Evidence Types

VA/DoD Recommendation Categories

- Weak For; Not reviewed, Amended.
- Weak For; Reviewed, New-replaced.
- Strong For; Not reviewed, Amended.
- Strong Against; Not reviewed, Amended.

The relative strength of the recommendation is based on a binary scale, "Strong" or "Weak." A strong recommendation indicates that the Work Group is highly confident that desirable outcomes outweigh undesirable outcomes. If the Work Group is less confident of the balance between desirable and undesirable outcomes, it presents a weak recommendation.

The grade of each recommendation is presented as part of a continuum:

- Weak For (or "The guideline panel suggests offering this option…").
- Strong Against (or "The guideline panel recommends against offering this option…").

Table 2. VA/DoD Recommendation Categories

Evidence Reviewed	Recommendation Category	Definition
Reviewed	New-replaced	Recommendation from previous Clinical Practice Guidelines (CPG) that has been carried over to the updated CPG that has been changed following review of the evidence.
Not reviewed	Amended	Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has not been reviewed and a minor amendment has been made.

VA/DoD Evidence Type

Overall, 135 studies (in 136 articles) addressed one or more Key Questions (KQ) and were considered as evidence in this review. Criteria for Study Inclusion/Exclusion:

- *General Criteria*
  - Clinical studies or systematic reviews (SR) published on or after November 1, 2007.
  - Studies published in English.
  - Publication was a full clinical study or SR; abstracts alone were not included. Similarly, letters, editorials and other publications that are not full-length clinical studies were not accepted as evidence.
  - Studies enrolled adults 18 years and older. In studies that mixed adults and children, at least 80% of the enrolled patients were 18 years or older.
  - Studies enrolled a patient population where at least 80% of patients met the required diagnostic criteria.
  - Studies of intervention outcomes followed patients for at least 12 weeks post-randomization, unless otherwise noted (KQ 5, 6, 11 and 12 are exempt from this requirement).
  - Studies that focus on incarcerated substance use offenders or driving while intoxicated/driving under the influence offenders were excluded.

- *Pharmacotherapy/Nonpharmacologic Therapy for SUD (KQs 1–4, 6–10)*
  - Studies were randomized control trials (RCT) or SRs of RCTs. In the absence of such evidence, prospective comparative studies will be reviewed.
  - Randomized crossover trials were considered only if data from the first treatment period were reported separately.
  - Studies enrolled ≥10 patients per treatment arm.
- *Criteria for Determining Appropriate Initial Intensity and Setting of Specialty Substance Use Care (KQ 5)*
  - Studies compared different criteria and enrolled ≥10 patients per treatment arm.

American Psychiatric Association (APA) Recommendation Categories

- [I] Recommended with substantial clinical confidence.
- [II] Recommended with moderate clinical confidence.
- [III] May be recommended on the basis of individual circumstances.

American Psychiatric Association (APA) Evidence Type

The following coding system is used to indicate the nature of the supporting evidence in the summary recommendations and references:

- [A] Double-blind, randomized clinical trial. A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; both the subjects and the investigators are blind to the assignments.
- [A-] Randomized clinical trial. Same as above but not double-blind.
- [B] Clinical trial. A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally; study does not meet standards for a randomized clinical trial.
- [C] Cohort or longitudinal study. A study in which subjects are prospectively followed over time without any specific intervention.
- [D] Case-control study. A study in which a group of patients is identified in the present and information about them is pursued retrospectively or backward in time.
- [E] Review with secondary data analysis. A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.
- [F] Review. A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.
- [G] Other. Textbooks, expert opinion, case reports, and other reports not included above.

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