

**Medicaid Innovation Accelerator Program (IAP) Introduction to the American Society of Addiction  
Medicine Criteria for Clinical and Program Standards April 19, 2017**

Chiara Corso (CC): NASHP  
Tyler Sadwith (TS): CMS  
John O'Brien (JO): moderator  
Dr. George Kolodner (GK):  
Dr. David Gastfriend (DG):

Chiara Corso (CC): [Intro]

Tyler Sadwith (TS): Thanks, Chiara and welcome to everyone joining us. My name's Tyler Sadwith and I'm the project lead for the Substance Use Disorder (SUD) Track of the Medicaid Innovation Accelerator Program (IAP). We're glad you could join us for this national webinar on the Introduction to the American Society of Addiction Medicine Criteria (ASAM). Today's webinar is part of our effort to highlight what we've learned from working with states on SUD Delivery System Reforms under the IAP. We know as Medicaid agencies and substance abuse authorities plan and administer their SUD systems of care we've heard lots of interest in aligning those systems with recovery-oriented models of care. This webinar is the first part of a short series where states and presenters will describe how the nationally developed treatment guidelines, published by ASAM, can support states to develop their benefits, program standards, and provider networks consistent with the full continuum of care and industry standards for addiction treatment.

Turning to the agenda, in order to provide an introduction to the ASAM Criteria, we asked several of its authors to provide an overview of the levels of care outlined in the criteria and to touch upon some of the more complex levels of care, including: withdrawal management, early intervention, partial hospitalization, and clinically managed low-intensity services.

The speakers will describe the clinical standards in the ASAM Criteria including the biopsychosocial assessment used to identify appropriate levels of care for individuals with SUD. Under the IAP we're offering several resources as part of this webinar that provide helpful information about the ASAM Criteria.

These resources include an overview of the multi-dimensional patient assessment framework, which one of our speakers will describe today, and this was emailed earlier yesterday to folks who registered for this webinar.

We're also posting a document on the IAP's website on Medicaid.gov, which describes the ASAM levels of care and clinical guidelines. We'll send a follow-up email shortly with a link to that document.

Looking to the future, in early May we're hosting a webinar where several state speakers will describe their approaches for understanding and assessing their treatment provider capacity and their SUD service needs within the framework of the continuum of care. Later in that month we're planning a follow-up webinar where several states will describe how they're implementing and applying the ASAM Criteria to their SUD delivery systems, including strategies for conducting assessments, making referrals,

and delivering services at appropriate levels of care given realities of treatment provider shortages and infrastructure challenges.

Today we are glad to be partnering with ASAM to lay the groundwork for those dialogues, so let me introduce our speakers and then we can get started.

George Kolodner is an addiction psychiatrist specializing in outpatient treatment of SUD. In 1973 he began to develop a new intensive outpatient model for addiction treatment and has continued to refine this model over the past 44 years. Dr. Kolodner serves on the steering committee of the ASAM Criteria and was the lead author of the 2013 ASAM Criteria chapter on Withdrawal Management. He is the immediate past president of the Maryland chapter of ASAM and is currently a clinical professor of psychiatry at Georgetown University and the University of Maryland, School of Medicine.

David Gastfriend is the chief architect of CONTINUUM, which is the ASAM Criteria Decision Engine. Dr. Gastfriend is developing the Decision Algorithm, guiding programming, and leading its national implementation. Dr. Gastfriend consults with federal, state, and county governments as well as treatment systems on the adoption of a national standard for addiction treatment assessment, placement, and utilization. He's a scientific advisor for the Treatment Research Institute and the vice president of the Washington Circle group.

John O'Brien will serve as our moderator today. John brings more than 30 years of experience in behavioral health systems design, financing, and implementation. He's worked with Medicaid, mental health, and substance abuse authorities in many states to develop Medicaid waivers, state plan amendments, and federal grant applications. John directs tax work on SUD with an emphasis on helping states increase access, integrate with primary care, and reduce unnecessary costs. In addition, John works with tax homeless and housing experts to help systems strengthen their ability to meet affordable housing and service needs of people with SUD.

With that, I'd like to turn it over to John O'Brien to get us started.

John O'Brien (JO): Thanks, Tyler and good afternoon everyone. Over the past several years there's been an increased focus on the intersection of SUD and insurance, including Medicaid. A good deal of that has been driven by the opiate crisis, the increased number of individuals with SUDs being insured and last fall's Surgeon General Report. These and other efforts have provided more clarity on supporting the field in creating access and choosing quality SUD services, including both treatment and recovery services.

Payers are moving in the direction of supporting the CONTINUUM and bringing industry standards to SUD as they do with many other diseases. For instance, many payers, as part of their contracts, are requiring their MCOs to include SUD and offer the comprehensive continuum of care that is based on industry standards. They're also enhancing clinical practices and promoting some of the clinical guidelines that we're going to talk about today that really are key decision-making tools for serving both youth and adults with SUD.

In addition, there is more emphasis on what the competencies are at the provider level to deliver SUD services and what some of the ways are to be able to determine whether or not some of those competencies are consistent with some of the industry standard models, such as ASAM Criteria that we are going to talk about today.

Lastly, and as importantly as offering the practices and clinical guidelines for SUD, is the process by which to ensure that both providers and practitioners are meeting those industry standards.

It's been a journey, to say the least, over the past three decades to reach some clarity regarding industry standards, both clinical and program standards for SUDs. As this slide shows, back in the eighties we had many instruments and tools; some of them well-researched, some of them more home-grown. All of them tried to link need, that is, individual need with the services that someone would get.

Over the past 20 years and, in particular, the nineties with leadership from the addiction and the medical community there began to be a closer look at having a more consistent tool, a more valid reliable tool for providers and payers to make good clinical decisions based on a multi-domain assessment. This culminated in the ASAM Patient Placement Criteria and, later, in provider requirements for different levels of care.

The guiding principles that you see on this slide for the ASAM for some of those guidelines are pretty straightforward. Certainly in terms of treatment approaches shifting from what the programs do versus what did people need was a big shift as part of the principles that ASAM used in the development of their criteria. Like the services, in many cases you had to be in a level of care for X amount of days or it was considered a failure, or in some situations, you had to move through the continuum of residential and outpatient to be deemed successful. Some of the guiding principles really have been important in moving the industry forward around both the clinical guidelines and the program criteria.

This slide displays the care continuum that's developed by ASAM. There are five broad levels of care and that includes what you see on the far left-hand side of early intervention. Within the five levels of care you have sub-levels of care that are based on what an individual may need, what are some of the risks, what are their skills, and what are some of their available resources.

For today's purposes, while this will be focusing on treatment, it's important to note there are recovery supports and how important recovery supports are to the continuum of care and I know David's going to talk a little bit about that towards the end of our conversation. For the purposes of today we're going to take a closer look at levels 0.5, 2.5, 3.1, and withdrawal management.

In addition to clinical guidelines there are service specifications that ASAM has set forth. There are six areas for each one of those levels of care you saw in the previous slide.

- Settings: outpatient or residential
- Support Services
- Staff: the licensed professional or other types of staff that can be used to deliver the services.
- Therapies: different types that should be available to individuals that participate in each level of care and some sense of the intensity of those therapies.

- Assessment
- Documentation

Many states and some payers have used these service-specific criteria over the years in their contracts, as part of their state regulations, perhaps their private provider manual, to communicate the specifications to their network. With that frame I'd like to turn it over to Dr. George Kolodner who will walk us through the levels of care around withdrawal management.

Dr. George Kolodner (GK): Can everybody hear me okay? The two primary purposes today are to describe the different levels of care and, specifically, how to figure out where someone belongs, but I wanted to start off with a general context, which is that people with addictions generally have good treatment outcomes, but the problem is that not enough people with addictions get into treatment. When someone has withdrawal symptoms it presents a unique opportunity to get them into the treatment system; what seems to the patient to be a problem to us is also an opportunity.

We've divided the levels of withdrawal management settings into five settings, two ambulatory and three residential inpatient, which I'll go into more details about.

The biggest differentiator is how much medical care there is at different levels. We use the words clinically managed, then medically managed, to differentiate two of the inpatient levels of care. Clinically managed means that either the patients don't get any medication or if they get medication, it's self administered so it's overseen by non-physicians, but there are not medical personnel on staff in the clinically managed as opposed to the medically managed where there are medical staff - nurses and physicians - there to a different degree depending on what the level of care is.

Two of the principles that guide us in our decisions are to put people in the lowest level of the intensity of care in which they can be effectively treated. There is also a general finding that if you don't match people properly, the level of intensity is either too high or too low, and the treatment outcome is not as good.

When we talk about people coming into withdrawal, as I said, the withdrawal symptoms are an opportunity and what you want to do is make sure the person continues into psychosocial treatment of their addiction after the withdrawal is managed. There is an enormous amount of waste by people simply getting their withdrawal symptoms even well treated, but with no follow-up; the data is, generally, that there is about a 90% relapse rate if there is no follow-up from withdrawal management or detox. That's what makes it so critical to have follow-up. Again, the trouble is either people don't get to treatment or if they come in, they drop out prematurely for various reasons, either because they become so comfortable so quickly or they generally underrate the severity of their illness. One of the problems with people who are being detoxified is that they get only medical services at the time; they don't get any psychosocial services and the ideal is to deliver the psychosocial rehab at the same time that they're getting their withdrawal management services.

We've made so much progress with withdrawal management protocols these days that people, within hours, can reach a level of comfort and coherence, except in the most severe cases, but generally can be managed and moved into a psychosocial setting at the same time that they're being medicated. The

longer you wait to get people into psychosocial rehab, the more likely is that they'll drop out and, again, if they drop out the likelihood of relapse is very high.

These are two slides on the different levels of care. We're going to start with the higher levels of care before we move to the outpatient levels. You can see that we use numbers and decimal points to differentiate the level of care. Generally, level one is non-intensive outpatient, level two is an intensive outpatient, level three is a residential level of care, and level four is what used to be called inpatient; we use the words more interchangeably these days, but that was the old language.

You can see on this slide, level 3.2 is the clinically managed residential; that's one I mentioned before where there is no medical staff though there may be medication if the medication is prescribed to them and they may self-administer. The medically-monitored does have ongoing medical staff.

The difference between 3.7 and 4.0 has to do with the intensity of the medical staffing. There's a lot of overlap between these, but we're trying to differentiate them more specifically than probably you'd actually find. Level 4.0 is generally an acute care hospital, whereas level 3.7 is either an addiction rehab facility or a free-standing withdrawal management facility or a psychiatric hospital.

In the outpatient level there are two levels of withdrawal management and they're differentiated without extended on-site management or with extended on-site management. The first, the least intensive, is someone who goes into a physician's office or even someone who is visited at home; they're seen for an office visit and they don't stay, so the visit would be more in the range of minutes to an hour or so, whereas with the extended on-site management the person can stay for several hours or an entire day, but not overnight, which differentiates it as ambulatory. These settings are generally more accessible and it's much easier to provide simultaneous psychosocial services at the same time. Again, you have less of a transfer issue as people are stepped down to less intensive levels of care so there's less of a tendency to drop out.

That's a very quick summary of the levels of care. This talks about how you do the matching. What we use is a concept of risk rating. You assess the patient and try to put them into one of five levels of risk. The five levels are:

- No risk
- Mild risk
- Moderate risk
- Significant risk
- Severe risk

Those are all defined in more detail in the criteria themselves; what their clinical state is to fit that category. There is some variation by substance. The way you do this is the first thing you do, as you all know, there are six dimensions of assessing patients.

Dimension one is the withdrawal potential. The way you match the person is you start off with determining what their severity is just within that single dimension and once you come with a number, then you look at dimensions two through six. If those are significant, then you adjust the rating that

you've given the patient simply on their withdrawal potential; usually it's an adjustment upwards. Then there's a matrix, which is available in the criteria, a couple of which are associated with specific substance so you can match the person with the level of care that fits their final risk rating.

That's pretty abstract, but what I've done is to give you a couple of examples here around specific substances that I could walk you through.

If we look at the opioids, if you have a patient, for example, that presents and is nauseous, has diarrhea, body aches, they're anxious, restless, and irritable, that matches what we would determine to be a moderate risk, which would be a risk rating of two. But if you then look at this patient and find that during a previous withdrawal they had much more severe symptoms, they were entirely debilitated, and now the person has a low level of commitment to treatment and their cooperation with following instructions is questionable, then that increases the risk rating; it would bump them up to a risk rating of three, which we would regard as a significant risk.

Then you would look at the matrix and say okay somebody with opioids with a risk rating of three, what would be the appropriate level of care. In this case there are two possible levels of care: one would be the ambulatory withdrawal management with extended on-site monitoring; the other would be the 3.7, medically monitored inpatient withdrawal management.

If we then did the same process, but used somebody who came in with alcohol, you would start off once again with what is their risk rating, just looking solely at dimension one, withdrawal potential, and let's say we have a patient who is moderately anxious, they're sweating, they have insomnia, and they have a mild tremor. Those characteristics would put a person at a risk rating of two, which is a moderate risk, but then you would look at the rest of the dimensions and you hear, in the case of this patient, during a previous withdrawal they had a seizure and now in addition to their alcohol use disorder they have a depression of moderate intensity. With those complicating factors the person's risk rating is increased to a three level, which would be a significant risk rather than a moderate risk, and as was the case with the opioid person, this gives you two possible levels of care: the ambulatory withdrawal management with extended on-site monitoring or the 3.7 medically monitored inpatient.

I picked that kind of description with both these people just to show you the kind of complications and options that you would have; you're not limited to just one treatment level for these people.

That's the end of my presentation except for questions. Did someone want to cover this next slide?

JO: Sure, that was terrific George. We do have a polling question for participants and it's pretty straightforward: which levels of withdrawal management is or are your states currently covering?

- Level 1: ambulatory without extended on-site monitoring
- Level 2: ambulatory with extended on-site monitoring
- Level 3.2: clinically managed residential
- Level 3.7: medically monitored intensive inpatient
- Level 4: medically managed intensive inpatient
- Not sure

We'll give folks a few moments to respond to the poll. It looks like we've got a significant number of respondents that are offering most of those levels of withdrawal management so that's terrific.

Let's go to some questions for George. George there is a couple questions that have come in over the last 20 minutes or so that it may be helpful for you to weigh in on. One of the questions is one I often hear, which is: for many years we've used the term detoxification and, certainly, over the last four years, if not longer, the term withdrawal management has come into the vernacular. Is there a difference between detoxification and withdrawal management? If so, can you give us a sense of those differences?

GK: The short answer is that they are the same. This was an editing issue when we wrote the chapter and sent it out for comment, a number of our people objected and said the word detoxification is the word we're used, but the body detoxifies, clinicians don't detoxify; they manage the withdrawal. We're trying to change our use of language to refer to the exact same process, but people are used to the old language and it's easy just to say the word detox instead of withdrawal management. I'm sorry that's created confusion. We're trying to be more precise, but it's the same process.

JO: In one of your examples you talked about the difference between some of the individuals that may have done between a level 2.0 withdrawal management and a level 3.7 withdrawal management; can you talk a little bit about what would tip the scale between someone who needed a level two withdrawal management and a level 3.7 withdrawal management?

GK: There is certainly an issue of choice and availability, there's an issue about cost. I think preference is important, but in general my practice is to manage as many people on a level two as possible because it is so much easier to get them into psychosocial and it's much less expensive. There are other considerations. Clearly, if somebody can't ambulate or is in a toxic home environment their assessment would change so they'd be moved to a level that would require inpatient. To some extent it's a matter of availability and sometimes it's a matter of what people are comfortable doing. It's not hard and fast.

JO: Similar to the first question, there seems to also be some questions about the term social detoxification and clinically managed residential detoxification; are those fairly similar or are they different and, if so, can you talk about those differences?

GK: They're pretty much the same. Years ago there was a movement to use what was called social detox routinely where medications were not available because most people, when it comes to alcohol in particular, can be withdrawn without medication and, even though they're uncomfortable, it's not dangerous. There are a small percentage of people who do have seizures and that practice of trying to avoid medications has diminished. Since so many people don't need them there are facilities that can manage them without the medication, but it is important that those people who need medication get it, and even those social settings there be clear protocols and knowledgeable staff who can move people up to a more medically managed level when there are clear indicators.

Part of the problem we've had even after all these years with assessing needs for withdrawal management is that there are not really good tools to predict who's going to have severe withdrawal and who's not. When someone presents initially you have certain indicators such as the history of the

past, but there is a new tool that's been developed in the past few years out at Stanford by a doctor name Jose Maldonado and its acronym is PAWSS (Prediction of Alcohol Withdrawal Severity Scale). He's published this and feels it is a good indicator, but it's something we all need to make those decisions about who's going to have a serious need for withdrawal symptoms. The crudest we have now is that someone has a blood alcohol level of .2, for example, and has significant tremor; that's a person you can be pretty sure is going to need to have a more intensive medical level of care.

JO: Back to the example you had around withdrawal management and alcohol. Would there be a place for a level 3.2 program to fit into the example you had regarding alcohol?

GK: I would not because this person already has a visible tremor and we knew he had a seizure previously so I think it would behoove you to be very aggressive in medicating that person because you can't prevent a seizure once it's happened; then once a person has a seizure they're more likely to have another one. Just because they've had a seizure doesn't mean they have to go into an inpatient setting, you can manage that outpatient, but somebody like that would have to be medicated. If they didn't have those demonstrable signs, for example, if the risk rating from the withdrawal potential alone was only one and the person was a little anxious or sweating and had no tremor you could maybe make a case for moving him to social detox. I think the prevention of seizures is so important that I would go ahead and medicate that person.

JO: George, do you have time for a couple more questions? Are there medical doctor requirements for all withdrawal management levels of care? If there are, do the requirements for medical doctors differ between withdrawal management levels of care?

GK: The only one where's there's not a physician need is the clinically monitored, the clinically managed or 3.2. Clearly if someone is taking medication it has to be prescribed by a physician, but it can be self-administered and overseen by a non-medical person. In terms of the other levels of care, what defines them is the intensity of the medical care, for example between a 3.7 and a 4.0, the 4.0 would have a nurse there 24-hours-a-day where a 3.7 would have a nurse available and overseeing it. A physician or a physician extender would have to do a physical exam at a level 3.7 within 24 hours, whereas a level four would be 12 hours. There are some technical differences and there is an attempt to divide the different categories, but in practice I think a lot of these levels blur into each other.

JO: An additional question was around ambulatory detoxification and, if I understand the question correctly, how can ambulatory detoxification services, the levels within the ambulatory detoxification, be utilized in a hospital setting?

GK: You would define the ambulatory that the person wouldn't stay overnight. There are certainly situations in emergency rooms now where people aren't formally admitted, but they stay overnight, so the technical part of being admitted and overnight has been blurred. If a hospital had the capacity to manage somebody for several hours like an urgent care setting, without actually admitting him to a bed in the hospital that would be an example of doing ambulatory withdrawal within a hospital setting.

JO: There's one last one and I think this will be the last one because we need to move on with our presentation and either you or David can weigh in on this, but there is certainly terminology around

inpatient for SUD services that is reflective both of level 4.0 and is also mentioned in 3.7. In the ASAM criteria when they talk about inpatient residential offered in 3.7, is that technically an inpatient hospital unit or is that something else?

GK: David may be able to speak more definitively to that, but I think that's another language question that there used to be a distinction between a residential and hospitalization that's gotten blurred now. I think inpatient could cover both the hospital level and the residential level, but David may take that differently.

Dr. David Gastfriend (DG): George, you're absolutely right. We use the inpatient term for both settings, but the critical distinction is that in 3.7 withdrawal management it is medically monitored, but you don't have 24/7 presence of medical staff. If the patient has frank psychosis or acute suicidality or acute pancreatitis or another medical condition, endocarditis, where they need 24-hour-a-day nursing and medical attention that is medically managed intensive residential or inpatient care and that's a 4.0 hospitalization for withdrawal management.

JO: Thank you, George, we appreciate the time you gave us this afternoon. David, can you walk us through the patient assessment and early intervention services?

DG: I want to thank the 250 people on this call for your interest and commitment to this work.

Patient assessment and early intervention services are two of the hallmarks of the ASAM model. Again, you have the six dimensions of the criteria and I'll give you an example of a case. Think of a patient in his forties, an unemployed carpenter, a gentleman I saw whose wife was nurse and sent him in because he was drinking again, a six-pack of beer every night. He didn't have acute withdrawal high risk because he could stop drinking for a brief period of time, a week or two without relapsing immediately. He had some chronic back pain for which he was prescribed opioids, but he said he could discontinue those if he had to. He also had some history of depression, but had stopped his antidepressants. There was some history in the past of suicidality, but not currently. He was willing to go into treatment and to some AA meetings and to see a counselor. He could go day-to-day and, potentially, a week at a time without feeling that he had to relapse if his withdrawal was managed and his wife was willing to hold onto him and keep him in the house unless he relapsed and stopped treatment; then she was ready to kick him out.

According to the six dimensions, first of all, this patient doesn't have any severe or imminent medical withdrawal or psychological crisis so in the absence of any of those being severe, nothing in any of the other three dimensions applies to justify of hospital or medically managed inpatient hospitalization.

For a residential level three placement he has to meet the criteria in any one of the first three dimensions and he does on the emotional side because he has a history of depression, a history of suicidality, although not currently, and he's not on his antidepressants currently, which would take a couple of weeks to start working if he starts taking them now, but he doesn't meet the need for residential level three care on any of the remaining three dimensions.

He doesn't meet level one criteria because the mood or depression problems on dimension three probably are more uncertain and will remain so until his antidepressant kicks in; so he doesn't qualify just to go for outpatient care, come back in a week and we'll see how you're doing.

Therefore, he qualifies for level two intensive outpatient or partial hospital care and that's how we integrate across the six dimensions to get to a level of care placement.

What's the evidence for this? That was published in a series of 10 seminal papers that I edited on addiction treatment matching and, basically, what those papers and many subsequent papers show is that the evidence is good for face validity, the ASAM criteria makes sense, it seems to fit with common sense expectations, and when you do a test of the criteria with computerized software, which we now have widely available, you get good inter-rater validity and concurrent validity with other instruments.

More important is getting predictive validity. The matching is better if the patient is sent to the ASAM match, compared to a lesser match, first of all, in no-show rates; immediate engagement and global improvement over 30 days or three months time frame. Drug use is lower if the patient is matched to the right level of care. Readiness for step down to a lower level of care at some further time point. Even annual hospital utilization; one-year timeframe the hospital utilization is lower if the patient is properly matched.

This is true in multiple sub-groups of different populations, different drugs, and co-morbid psych populations.

It is not only true for undermatching; it's also true for overmatching. If you apply too much care, not only is it wasteful of the resources, but the data in two different analyses show that you can actually have worse clinical outcomes. It works in multiple systems, cultures, languages, different countries, and different time frames.

Where the new software has been utilized, in LA County and in Massachusetts, you see good patient and provider adoption and you can use it more briefly for repeated use across the time frame for utilization review.

There are a couple of different ways to use the tool; one if for screening and provisional referrals. The CONTINUUM triage tool, Co-triage, implements in 10 minutes a brief referral assessment in a systematic fashion. It uses a motivational interviewing process so we're asking the patient to spend about 10 minutes to answer a few questions to get a rough sense of the best place to start care and then we're notifying the patient of what to expect; once they get to the provisional referral they'll detail the information and discuss where to precisely start for your best chance for a good outcome. It could be at a more intensive or a less intensive level of treatment, but Co-triage is designed, in 10 minutes, to get the most likely place to successfully start the next stage of treatment.

The full CONTINUUM assessment, which is a comprehensive assessment tool, is a structured interview. It has many sections, as you can see on the left, and the navigation window allows the clinician to jump around from section to section. If the patient wants to quickly jump into their legal problems, you can do that. It also has subsections such as an alcohol and drug withdrawal assessment; things that an expert clinician learns how to do in the course of their career, but now we can structure a patient to

have the same assessment, the same depth and precision, whether it's a novice clinician assessing them or an expert clinician. All the data are stored as well.

There are some complex constructs in assessing patients for level of care; one is motivation, another is craving, and another is course or history of treatment. Each of these has to be explored in some depth. As you can imagine, patients who have addiction and are in denial can be withholding; they may not even acknowledge to themselves the whole range of their problems.

Here's the motivation or readiness question and it poses the question to the patient like this, which the counselor is prompted to ask: Do you have any concerns about pursuing treatment? You stop there and the patient might say no, I know I've got to do treatment. Okay, fine. Now we go from that open-ended question type to closed-ended questions and this is optimal questioning. We ask: Would anything possible hold you back, such as money? What about insurance? What about a schedule? What about attending groups? Patients might say I'm shy and can't talk in groups. How about having to take medicine? No, I don't like medicines. How about taking drug tests? No, I'm voluntary, you don't have to test me and I don't want to do that. How about drinking or drug-using friends? All my friends are drug-using friends; no one else wants to be friends with me.

Is this a patient who is fully participating already in treatments that are recommended, but maybe is having more craving? No. Is it someone who's willing to openly participate fully in all recommended treatments? No. He's worse than a passive response and he's resisting important components. In fact, he's rejecting or obstructing the plan with many contingencies.

The computer regards this as a 0, 1, 2, 3, 4 quantitative answer to a sophisticated question about motivation or readiness. That's one example of how we can structure a very effective assessment; even a novice clinician can do an expert interview with the assistance of this kind of a tool.

At the end of the assessment, which can take an hour once you're used to it, the level of care recommendation is provided and the clinician makes a judgment. Is this where I'm going to send the patient or am I going to disagree? The clinician actually gets to answer the reason for a final disposition, where the patient is actually being sent, if it's different from the recommended level of care and this is very important.

Number one, it reduces the urge to game the system; to try and guess how this complex algorithm is working so that you can make sure you get your bed filled. We get a variety of options, including that it could be the patient chose to go to a different level than we recommended, or that level is not available in geographic proximity or there's a mobility problem and the patient can't climb stairs to that day treatment program or the family has to be taken care of and the patient can't go inpatient or insurance won't cover it or doesn't have insurance, the wait list, etc., or the clinician disagrees with the ASAM criteria recommendation.

It's very important that we allow the clinician to use their judgment to disagree. Ultimately, this is not a research tool this is a clinical tool that has to take into account some of the gray zones.

We get this information and you can use that for a needs analysis; if you're a system planner you can use it for quality improvement if you see a lot of disagreements that don't make sense and we have a good read on how clinicians across the system are operating.

At the end of the triage, the output gives us a provisional recommendation and you'll notice this particular patient is recommended for level three, residential inpatient services. This is not specific enough because it's a triage, a quick rather than comprehensive assessment, so we don't get the decimal qualifiers. It says level three residential and opioid treatment services (OTS), which can include methadone, office-based buprenorphine, and also the antagonist treatment, extended release naltrexone or naltrexone. Here it's because of the patient's pregnancy. So you see the unbundling that George talked about where you can use both OTS and residential care.

We have these two tools and it's going to help us select the optimal level of care. One of the levels of care is sort of an early intervention stage; it's actually pre-treatment because maybe we don't have enough information to even know if we have a diagnosis of an opioid use disorder. The level 0.5, early intervention stage, is organized and addresses substance use for people who don't meet the criteria; they have some readiness to be evaluated or to learn skills for change and it may be that this patient isn't yet diagnosable with a use disorder, but is in need of prevention services.

Where would you use these early intervention services? An emergency department, a primary care setting would do this kind of expert care screening brief intervention, and impaired driving programs. There may be people in these programs that don't have an opioid or alcohol use disorder, but they need a lot of intervention; that's critical to prevention and reducing their risks. It also can be used in a variety of other settings, even work settings.

The length of service should be variable, not fixed, because individuals have different understanding, comprehension, cognitive capacities; sometimes you elicit new information and new concerns surface. There may be some regulatory settings where the length of service is mandated, like sentencing for operating under the influence of alcohol, but it's better if it's variable according to the patient's progress in the educational process.

The staffing should be individual's trained in the biopsychosocial dimensions including certified or licenses counselors, but behavioral health professionals or general health professionals in a more primary care setting could be appropriate; even primary care physicians.

Another category of service that has become extremely important because it can improve retention and longitudinal recovery effort is recovery support services. These can be provided directly throughout the SUD care continuum. They are not professional, licensed, degreed service providers; these are non-clinical services, recovery coaches, or recovery ambassadors, but they're not trained counselors. What they do is support the individual and the family throughout the recovery process and they provide assistance with alcohol and drug-free social activities, aftercare services, helping people with childcare so they can go to their counseling and AA meetings, helping them get to employment, vocational rehab

services, and educational services, and housing. They also provide peer support and recovery coaching, kind of like an AA sponsor, but integrated into the recovery treatment system so these are employed people. For that reason, their work needs to be funded because they're very effective in sustaining retention in treatment and relapse prevention and getting people to and from self-help and support groups.

I'll stop there and hand it back to John.

JO: Terrific, David, I really appreciate it. We have another polling question and it's pretty straightforward. Is your state currently using the ASAM assessment criteria for Medicaid reimbursement? You have four options: yes, we're using the ASAM criteria standardized assessment tool; no, we're using a brief or summary assessment tool that is ASAM informed; no, we're using a home grown assessment that's not related to ASAM; or, just not sure. Let's take a few moments to answer the polling question.

It looks like we're leveling out. There's a distribution between respondents that are using the ASAM standardized tool or some that are using a more home grown tool or a brief ASAM informed tool. There's a bunch of you that aren't sure. Thank you for those responses.

David, there's a number of questions that have come in and, I think, some of these are more clinical in nature and some of these are more operational, so we may have to pass on the operational. There is one question that's related to withdrawal management; I'm not sure if you're open to trying to answer it, but let's throw it out there: Can you discuss the impact of medication assisted treatment (MAT), especially subutex and naltrexone in relationship to withdrawal management?

DG: I'm happy to talk about that and if George wants to as well. In MAT, for which the more modern term is medication in addiction treatment, but we can talk about that another time, the medications include all the FDA approved agents: naltrexone, extended release naltrexone, buprenorphine, and methadone. All of these are approved and important in helping patients stabilize and make use of the psychosocial treatments. ASAM unbundles these from the levels of care and calls for them to be used at any level of care; and for all of them to be available. In withdrawal management we prepare the patient to use a medicine like extended release naltrexone because you need to completely withdraw the patient before they can start a blocking agent like extended release naltrexone.

It's different with suboxone, subutex, and all the buprenorphine preparations, and also methadone, because the patient does not have to undergo withdrawal. For methadone they don't have to undergo withdrawal at all; they can start immediately on methadone and, therefore, no withdrawal management is necessary.

For buprenorphine, the patient needs to come in at least 24 hours into mild withdrawal so that when they go on the partial agonist, buprenorphine, which doesn't produce a full agonist or opioid effect it doesn't throw the patient into relative withdrawal. That's just, literally, waiting a day or it could be as little as 12 hours before you start the patient; as soon as they have some early withdrawal signs or symptoms. You don't need withdrawal management if you're going to start the patient on

buprenorphine or methadone, but you do need it if you're going to start the patient on a naltrexone formulation.

JO: That's very helpful. A couple of questions are around the interface between SUD and, I'm assuming, mental health when folks are talking about co-occurring disorders, but it may be able to be applied more broadly to other co-morphic conditions, but are there specific considerations when you are using the assessment that clinicians need to make when individuals are presenting with co-occurring mental health and SUDs? I think one of your examples included that, but if you could elaborate, David, on that it would be terrific.

DG: Dimension three, emotional, behavioral, and cognitive conditions and complications, requires a pretty detailed assessment of whether the patient has had a psychiatric illness and whether they have been treated and have adequate resources for those needs. It also requires a psychological symptom inventory: mood, anxiety, thought disorder, cognitive problems, behavioral AXIS-2 problems, suicidality; it's so important that the ASAM CONTINUUM assessment has a rigorously structured sequence throughout all of these areas. A lot of programs worry that they shouldn't really assess suicidality and they'll actually divert a patient if the patient says sometimes I just wish I didn't wake up in the morning; they'll say we'll have to have you wait for an ambulance to take you to the crisis unit over at the hospital ER to assess you for those problems. That could be the wrong answer.

Instead, ASAM says let's provide the right sequence of questions in the right language to assess suicidal ideations, suicidal plans, suicidal gesture history, and problems in monitoring or support in the community. Then the algorithm can take care of figuring out if the patient needs hospital level 4.0 treatment for the psychiatric problems or whether one of the other levels of care will suffice, maybe with co-occurring enhanced care, which has certain specifications, or co-occurring capable care, which has different specifications; less intensive. That's how the ASAM criteria very discreetly managed different levels of need.

JO: Do you know of a state or a place that this is occurring, but given that there are levels of care that are directly related to dual diagnosis, mental health and substance use, have you seen how either the dual diagnosis acute residential services or the enhanced acute treatment services are intertwined or incorporated into some of the ASAM levels of care?

DG: Absolutely, John. The language in ASAM is very precise, but states have evolved, sometimes, different language, although they may have very nicely matched services, they might use a different name. One thing for a state to consider doing is do a crosswalk between your levels of care and the terminology you use and how do they map to all of the different ASAM terms for levels of care including co-occurring.

A bigger, more common problem or concern at least, is that sometimes states don't have all the different levels of care and they don't fund the discreet sub-qualifiers. What you need to do is use the ASAM model precisely and as empirically derived and do the crosswalk to the levels of care that you do currently offer and then look at the discrepancies and see if there are certain areas of the state where you have a higher prevalence of patients with co-occurring needs and then you know whether it would

make sense to try to upgrade the services or the contracts for programs in those areas, or do quality improvement to add more co-occurring enhanced or co-occurring capable care.

Obviously we're all working within the real world and you don't solve all these problems instantly, but at least if you have the precise terminology and information quantitatively then you can look at the crosswalk and figure out where you want to focus your efforts at improving.

JO: Let's move on and then back to you, David, and talk a little bit about partial hospitalization and clinically managed low intensity services.

DG: Now we're going to get into the next higher levels of direct clinical care; we're no longer in withdrawal management, we've decided a patient needs more than the 0.5 screening level of care and we're not going to apply level one, outpatient, but we're going to consider partial hospitalization. Then we'll get into level three.

You can see back on this graphic that we have within level two, within this gray 2.1 intensive outpatient services, and this could be nine hours a week, three nights a week of an evening care program three hours each night and patients who are working during the daytime might be ideal for that setting.

Then we get into 2.5 and level 2.5 is partial hospital services. We'll focus on that and then I'll talk about 3.1, the clinically managed low intensity residential services.

For 2.5, and this is really just an overview, just a high level look, the basic requirements are that if the patient has any biomedical or psych problems, they are severe enough that they would distract the patient from once-week outpatient treatment; the patient would have trouble with those medical problems whether it be pain or emotional, whether it's depression or anxiety and between last week and this week the patient might have relapsed to pills because of any of those problems. If they would distract it's a reason for a patient to be in an every day treatment model. If the patient can't even make it two days in a row without safety or certainty, then that's another way to say the same thing.

There's going to be something in this level, dimensions one, two, or three and one or more of the following:

- Requires structured therapy to promote progress: that means the patient has prior readiness problems with multiple treatment failures or impulse control problems.
- The symptoms are on a trajectory of worsening, intensifying, such that if the patient doesn't have structured therapeutic services they're likely to get worse and worse and worse.
- Continued exposure in the environment to family or neighbors or friends that are non-supportive or sabotaging; you want the patient to be out of that environment, at least during the daytime and at night when everybody's sleeping it's not as critical.

You need this level, dimension one, two, or three problem - biomedical, emotional - either one of those and one of the readiness, impulsivity, or environmental problems as well.

You have those problems, so what kind of services do you need? You need a structured intensive outpatient setting with about 20 or more hours a week, so that could be half a day for five days a week

during the work week; it has to be clinically intensive programming meaning every one of those four hours a day has to be active, providing a support system, supporting both medical and behavioral health needs, as well as the substance use needs, and it has to be at least co-occurring capable (that's the lower intensity of services), which means able to provide some supervision, some assessment, and referral to expert psych services if needed, or co-occurring enhanced care where you actually have psych consultation on site.

That means the staffing needs to be interdisciplinary with cross-training in some mental health skills and have to be able to provide medical support including psychological testing, maybe, on consultation, psychiatric services on consultation, lab services, and emergency services.

In more detail, the patient will need one-to-one and group counseling treatment services for the addiction, medication management for addiction medication treatment, educational groups, occupational therapy, family therapy, and motivational enhancement. The med stuff has to be available at least by consultation within eight hours, by telephone, or if it's available in person, within two days. Emergency services have to be available within 24 hours. This doesn't mean you have to be situated next door to an emergency room, but it means that you have to have an affiliation agreement with an emergency room and transport to the emergency room so if the patient decompensates you can get them to the services reliably in a fairly short period of time. So that means direct affiliation with other levels of care has to be in place.

JO: David, before you start on this slide I just wanted to let folks know that some of you may have lost sound, but we are working to resolve that particular issue.

DG: Thanks, John. Let me move from 2.5, which is still is an outpatient, intensive outpatient service partial hospitalization, to 3.1. Again, I'm staying on the high level overview. This is going to be a little confusing because normally you'd think 3.1 is in the three zone, so it's going to be more intensive than something in the two zone, and that's actually not right.

Three simply refers to a residential setting; the patient doesn't go home at the end of the day. Two refers to the patient goes home at the end of the day, but has intensive services. On a high level, remember that 3.1 does have fewer services and less intensive services, and less specialty services than 2.5. Two point five has more hours per week of clinical services than 3.1.

If we accept the fact that 3.1 has fewer services, what is it? Just to summarize, this is a little too much shorthand, but it's what a lot of people think of as a halfway house where people are out working during the day, maybe, and they come in during the evening and have some groups and are supervised, and it's a professional setting where you have a professional counselor supervising, but it doesn't have intensive clinical services.

What are the six dimensions of need for a given patient who would meet the requirements for 3.1?

- A patient cannot have acute intoxication or withdrawal symptoms or they have to be manageable without clinical manipulation or intervention;
- The biomedical conditions have to be stable and not require any intensity;

- The emotional and cognitive conditions: the patient has to have a stable mental status, oriented and with it, and a stable psych condition; if they're on meds they have to be able to take their meds by themselves without being dispensed by a nurse;
- Readiness to change has to be partially present; there has to be an acceptance of the need for treatment, but maybe the patient needs continuous motivating services on a day-to-day basis or to be structured in a residential day-to-day setting in order to maintain that readiness;
- The patient may have some problems with their coping skills to get through week-to-week or at least day-to-day without relapsing, so they may need a structured setting and staff support to keep reminding them of the reasons they came in for treatment, the benefit of sticking with it, and holding on to the recovery process;
- The recovery environment may be unsupportive or non-contusive or sabotaging of recovery and that's why the patient needs at least evenings and weekends to be in a structured, supervised, supportive setting; the patient might be able to cope for work purposes or going to school or volunteering in a community program during the daytime, but the recovery environment where they would go home to live is disruptive to their recovery.

You can see how all of these get put together for a low-intensity program, level three; it's residential, it's clinically managed, but it's not high intensity. It's a 24-hour setting, at least five hours a week of professional treatment, so this is not a sober house where people are just living together and somebody comes in and checks in when they collect the rent and says "you're going to your meetings, right?" That's not level 3.1.

It has a clinical focus; it's very specific and in the documentation, the assessment, and the treatment planning each patient is individually assessed for their need for improving readiness, the recovery skills they need to work on, relapse prevention strategies, and efforts to build their personal responsibility so they're not just managed by the staff and protected from going back to substance use, but they learn how to take responsibility for insulating themselves even when they go outside the residence. It also includes social reintegration, so group activities within the house are professionally guided.

That staffing requires 24/7 on-site health professionals; it doesn't necessarily need on-site 24/7 nursing and certainly doesn't need medical staffing. The clinical staff have to be knowledgeable about both substance use and psych conditions that are common in substance use patients and there have to be other disciplines around to consult or call upon and the specs in the book are pretty specific about what that involves.

The physicians, nurse practitioners, and physician assistants, those medical people, aren't doing direct service provision in a halfway house or 3.1, but they are reviewing the admissions and provide consultation as needed.

The services promote organizing daily living, helping patients get back to personal responsibility for their appearance and showing up on time for appointments and job interviews and getting work and to counseling. They may get services like couples therapy outside of the treatment program, outside of the residence, and work on family reintegration outside of the facility.

The skill treatment services include managing their medications, assessing that they're compliant and adhering to the meds, and psychoeducation going on right in the facility. They do random urine drug screens, individualized according to a patient's given need for the patient-specific substances and level of risk, and access to support from physicians and emergency services and others.

One of the interesting things about the most current ASAM edition is that you can have a patient who needs level 3.1 because their recovery environment is so disruptive and they can't go back home and stay stable in their recovery, but that they actually need a lot more clinical services than 3.1 provides. So you could, instead of using 3.7 or 3.5 for such a patient, the software might recommend a combination of 2.5 plus 3.1 concurrently; partial hospitalization and low-intensity, clinically managed services.

It's important to realize there's some flexibility in the ASAM model for the different service combinations.

What are some of the summary points that are important to take away from this overview and also to drive looking into the details of the book because the book is the bible; that is the reference for all these intricate specifications and decision rules?

The first thing is that SUD treatment has to be provided across a broad, flexible continuum of care. It's a disease that has, first of all, many substances, it affects many different regions of the brain, for some people it's disrupting their mood, their anxiety, others their cognition, and others their character. The continuum of services has to meet those different needs.

Number two, people in the throes of addiction change over time so there are temporal changes that have to be monitored on an ongoing basis and different levels of services are needed at different times; a flexible continuum based on patient needs.

The difference between clinical and patient needs is that the psychological symptoms and the cognitive and medical needs are clearly clinical needs, but sometimes a patient has a family situation that requires them to be available at home; that's a patient need. It's not a clinical problem, but you still have to take it into account in considering what level of care will work for this patient.

That's one important takeaway. The next is: What's the ultimate objective of these things? As Dr. Kolodner pointed out, withdrawal management or detox, as it used to be called, is not treatment in and of itself; it's really preparation of the brain and the body chemistry to maximize the likelihood of making it into and sticking with psychosocial rehab because that's really treatment and we have to fund the connection into treatment. If we're just funding detox, we're really not addressing this disease and certainly not this epidemic.

The next is that when we make a determination of what level of care the patient needs, we've got to consider all six biopsychosocial dimensions. All of these are discreet; they're overlapping, but they're really separate considerations and sometimes people get confused about the dimension five - relapse and continued use potential.

Don't all those things cause relapse? Yes, they do, but relapse in dimension five really means the immediate impulsivity or craving, driving, reinforcement driving risk, so it's really separate and all of them have to be considered independently and then combined in an integrated fashion.

Finally, as I just told you in the combination of 2.5 and 3.1, there are times the patient may need to combine different levels of care like the unbundling of medication in addiction treatment with the level one or two or three or four services.

I'll stop there.

JO: You're probably not going to stop because there are some questions for you. Let me ask you a couple of questions, David. One is, I think, a general question and it's probably back to nomenclature and back to the future in terms of some of this nomenclature, but there's some confusion about even the term partial hospitalization and, especially, if those services aren't necessarily provided in an overnight inpatient setting. Can you shed any light on the history of the partial hospitalization nomenclature?

DG: That's such an obvious question and yet I've never heard anybody ask it, so good job for you whoever asked that question. It's called partial hospitalization yet it's not in a hospital. Actually, in the mental health world they started these programs out in-hospitals, so it's a historical origin. I think a better way to think of it today is that even in a community setting not part of a general hospital or a psych hospital, a partial hospital program actually has a lot of hospital-like services and the patients who need that need those medical, nursing, and consultative services. That's why it's called partial hospitalization.

JO: Another question around MAT and the interface with withdrawal management: Does MAT occur in some or all of the residential withdrawal management levels?

DG: Yes. I'll offer to George to answer this, too, but yes. You can stabilize a patient in their withdrawal and manage them to induction onto extended release naltrexone in level one, level two, level three, or level four, withdrawal management. George, did I say that correctly?

JO: George had to drop off a little while ago, David.

DG: I think George would say yes.

JO: I know this is probably not a short answer, David, but I think some folks are still trying to figure out how to fit the – kind of 50,000-foot level – what's the difference between levels 3.5 and 3.7?

DG: Level 3.7 has more medical and psych services available on site. It doesn't have to be in a hospital setting, but it has a lot more availability so that active medical monitoring of the patient is happening, it's scheduled, it's in the facility and patients' medical and/or psych needs can be actively managed day-to-day. It's changing doses and adding new therapies so if you look in the book at the difference between them you'll see some concrete differences.

Level 3.5 really involved from the old therapeutic community model. It wasn't nearly as heavy on the medical and acute clinical needs.

JO: One last question before we close out the webinar. Do you have any information around the key allied health professionals that would be part of an inpatient level of care?

DG: The book actually details the differences for each level of care on the point system and it details where allied health professionals, another name for counselors, are more primary as the service delivery personnel versus where social workers, psychologists, nurses, and physicians are more necessary. The book is fairly prescriptive in its specifications for staff of different levels.

JO: One last question that just came in and I think it's the perfect question. Does ASAM level 4.0 need to be provided in an inpatient hospital setting?

DG: The answer to that, technically, is no, but it's going to have to provide all of the services, almost all of the services, that you would find in a hospital setting. You could set up, and there are examples that are a little bit more like psych hospitals, where you don't have an emergency room, there's no surgery going on, and you don't have a pharmacy, so it's not a hospital, but you still have nurses and doctors in every day, you have doctors doing rounds, you have the ability to bring in consultants, and nighttime management of all the medications and dosing, and ability to have an on-call doctor come in if necessary in the nighttime. It can be out of a general hospital setting, technically.

JO: We are at our time, David, thank you very much. I know this was a lot of information in a short amount of time that you had to condense. Thank you all for joining us this afternoon's very well attended webinar. If you need to get hold of the speakers, here's their contact information. Last, but not least, please remember to complete the evaluation form that follows this presentation because feedback is important for future presentations.

[end of tape]