Medicaid Innovation Accelerator Program (IAP)

Introduction to the American Society of Addiction Medicine Criteria for Clinical and Program Standards

National Dissemination Webinar Series
April 19, 2017
3:30pm - 5:00pm EDT
Logistics

- Please mute your line & do not put the line on hold
- Use the chat box on your screen to ask a question or leave comment
  - Note: chat box will not be seen if you are in “full screen” mode
  - Please also exit out of “full screen” mode to participate in polling questions
- When spreadsheets are shared “full screen” mode is recommended
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Disclaimer

• The comments made on this webinar are offered only for general informational and educational purposes. Any comments, advice or material presented by speakers during this webinar are for general information and do not reflect endorsement by CMS.
Welcome and Overview

- **Tyler Sadwith**
- Medicaid Innovation Accelerator Program SUD Lead, Health Insurance Specialist, Disabled and Elderly Health Programs Group, CMS
Purpose & Learning Objectives

- Improve our understanding of the recovery-oriented model of care for Substance Use Disorders (SUD)

- Discuss how the American Society of Addiction Medicine (ASAM) Criteria supports the SUD continuum of care

- Improve our understanding of service specifications within each ASAM Criteria defined level of care
Agenda

• Introduction to ASAM Criteria
• Withdrawal Management Levels of Care
  – Discussion Break
• Patient Assessment & Early Intervention Services
  – Discussion Break
• Partial Hospitalization & Clinically Managed Low Intensity Residential Services
  – Discussion Break
• Wrap Up & Resources
• George Kolodner, MD
• Chief Clinical Officer
  – Kolmac Outpatient Recovery Centers
• Clinical Professor of Psychiatry
  – Georgetown University and University of Maryland Schools of Medicine
• David Gastfriend, MD
• Scientific Advisor
  – Treatment Research Institute
• Chief Architect, CONTINUUM – The ASAM Criteria Decision Engine
  – American Society of Addiction Medicine
• Vice President
  – Washington Circle Group
Moderator

- John O’Brien, MA
- Senior Consultant
  - Technical Assistance Collaborative
Introduction to ASAM Criteria

John O’Bien, MA
Senior Consultant
Technical Assistance Collaborative
Re-designing SUD Services

• Supporting access to quality SUD services:
  – Introduce a comprehensive continuum of care based on industry standards
  – Enhance clinical practices and promote clinical guidelines and decision-making tools for serving youth and adults with SUD
  – Enhancing provider competencies to deliver SUD services with fidelity to industry standard models, such as the American Society for Addiction Medicine (ASAM) Criteria
  – Encouraging states to develop a strategy to ensure providers meet industry standards
Developing an Industry Standard

1980s: 40-50 criteria sets differing on assessment, placement, length of stay

1990: Development of Cleveland Circle Criteria & National Association of Addiction Treatment Providers’ (NAATP) Patient Placement Criteria

1991: NAATP & ASAM collaborate to create Patient Placement Criteria (PPC) for the Treatment of Psychoactive SUDs

1996: ASAM PPC-2

2001: ASAM PPC-2R

2013: ASAM Treatment Criteria for Addictive, Substance-Related & Co-Occurring Conditions

2013 ASAM Criteria references updates from DSM-5, includes a new definition for ‘addiction’, moves away from PPC to considering levels of care across a continuum
ASAM Guiding Principles

Assessment. Move from one-dimensional to a multidimensional assessment.

Treatment Approach. Shift from program driven to clinically driven & outcomes-driven; focus on outcomes; interdisciplinary team approach.

Terms of Treatment. Move away from using “treatment failure” as an admission prerequisite; clarify “medical necessity”; engage with “informed consent.”

Length of Service. Move from fixed length to variable length depending on client needs.

Continuum. Move from limited levels of care to a broad, flexible continuum of care.

Population. Identify adult- and adolescent-specific needs.

Goals & Roles. Clarify treatment goals and the physician’s role.
Introduction to the ASAM Criteria

- SUD benefits should be designed to support the care continuum
  - The ASAM Criteria offers a model service continuum
  - Recovery supports are also necessary
ASAM: Key Service Specifications

- Settings
- Support Services
- Staff
- Therapies
- Assessment
- Documentation
Withdrawal Management
Levels of Care

George Kolodner, MD
Lead Author, Withdrawal Management Chapter, ASAM Criteria
Chief Clinical Officer, Kolmac Outpatient Recovery Centers
Need for Withdrawal Management (WM) Services

- People with SUDs have good treatment outcomes
- Problem: Not enough people with SUD enter treatment
- Onset of withdrawal symptoms presents a unique opportunity to engage individuals with SUD in the treatment system

**Withdrawal Management (WM) Levels of Care**

1. Ambulatory WM w/o Extended On-Site Monitoring
2. Ambulatory WM W/ Extended On-Site Monitoring
3. Residential / Inpatient Services
   - 3.2 Clinically Managed Residential WM
4. Medically Managed Intensive Inpatient WM
Defining Treatment Terms

• Clinically Managed:
  – Appropriate for individuals with emotional, behavioral cognitive, readiness to change, relapse, recovery environment concerns
  – Services are directed by non-physician addiction specialists

• Medically Managed:
  – Appropriate for individuals requiring daily medical care and 24-hour nursing
  – Diagnostic and treatment services are directly provided and/or managed by an appropriately trained and licensed physician
Level of Care Decisions

• Two major guidelines:

1. Conserve scarce resources by using lowest intensity level of care in which effective treatment can be delivered

2. There is evidence of poorer treatment outcome if level of care intensity is either too high or too low
Primary Goal of Withdrawal Management Services

• **Goal:** Maximize the likelihood of continuing into the psychosocial rehabilitation of addiction

• **Challenge:** Premature termination of treatment is a significant problem

• **Facilitator:** The likelihood of continuing is much greater if psychosocial rehabilitation services are initiated *simultaneously* with WM services
  – Delay increases the likelihood of treatment drop-out
Identifying the Appropriate Level of Care: Residential/Inpatient

• Level 3.2-WM: Clinically Managed Residential WM
  – Ex. Social setting WM facility

• Level 3.7-WM: Medically Monitored Inpatient WM
  – Ex. Free standing WM facility, within specialty unit of an acute care general/psychiatric hospital, addiction rehab facility

• Level 4-WM: Medically Managed Intensive Inpatient WM
  – Ex. Acute care general/psychiatric hospital

Higher intensity residential and inpatient levels of WM may not be the most appropriate level of care...
Identifying the Appropriate Level of Care: Ambulatory Withdrawal Management

- Level 1-WM: Ambulatory WM Without Extended On-Site Management
  - Ex. Physician’s office, home healthcare agency
- Level 2-WM: Ambulatory WM With Extended On-Site Management
  - Ex. Partial hospitalization facility

Reasons for Preferring Outpatient Levels of Care:

- More accessible
- Simultaneous provision of psychosocial services is more feasible
- Continuity of care is more easily preserved as patients are “stepped down” to less intensive levels of care
Using Multidimensional Assessment to Determine WM Level of Care

- **Step 1:** Determine patient’s narrow Risk Rating for Dimension 1, Withdrawal Potential
- **Step 2:** Determine patient’s final Risk Rating by using assessment of Dimensions 2 to 6 to adjust narrow rating
- **Step 3:** Use matrix associated with the specific substance to match patient’s final Risk Rating with appropriate Level of Care and Setting

- **Risk Range**

  - 0: None/Minimal
  - 1: Mild
  - 2: Moderate
  - 3: Significant
  - 4: Severe
# Example of WM Assessment & Matching: Opioids

## Step 1: Dimension 1 Assessment

| Assessment: Patient has nausea, diarrhea, body aches, is anxious, restless and irritable | Determination: Risk rating 2, moderate risk |

## Step 2: Adjust Risk Rating Based on Multidimensional Assessment

| Assessment: Patient had debilitating symptoms during previous withdrawal, now has low level of commitment to treatment w/ questionable cooperation | Determination: Risk rating increased to 3, significant risk |

## Step 3: Match Final Risk Rating w/ Level of Care & Setting

### Two possible levels:

- **2-WM:** Ambulatory WM w/ extended on-site monitoring
- **3.7-WM:** Medically monitored inpatient WM
# Example of WM Assessment & Matching: Alcohol

## Step 1: Dimension 1 Assessment

| Assessment: Patient has moderate anxiety, sweating, insomnia, mild tremor | Determination: Risk rating 2, moderate risk |

## Step 2: Adjust Risk Rating Based on Multidimensional Assessment

| Assessment: Patient had a seizure during previous withdrawal, and now has moderately intensive depression | Determination: Risk rating increased to 3, significant risk |

## Step 3: Match Final Risk Rating w/ Level of Care & Setting

<table>
<thead>
<tr>
<th>Two possible levels:</th>
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<tbody>
<tr>
<td>2-WM: Ambulatory WM w/ extended on-site monitoring</td>
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</table>
Polling Question (1/2)

• Which level(s) of withdrawal management is(are) your state currently covering? Select all that apply.
  – Ambulatory w/o monitoring
  – Ambulatory w/ monitoring
  – Clinic. Manag. Residential
  – Med. Monitored IP
  – Med. Manag. IP
  – Not sure
Discussion & Questions (1/3)
Patient Assessment & Early Intervention Services

David R Gastfriend, MD DFASAM
Chief Architect, CONTINUUM
– The ASAM Criteria Decision Engine
American Society of Addiction Medicine
Vice President, Washington Circle Group
# Patient Assessment

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<tr>
<td>4: Medically Managed</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3: Residential</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2: Intensive Outpatient</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>1: Outpatient</td>
<td>+</td>
<td>+</td>
<td>-</td>
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**Level 2**

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The ASAM Criteria

Medicaid Innovation Accelerator Program
Evidence for ASAM Matching

Validity

- Face validity, inter-rater validity and concurrent validity

Predictive Validity

- ASAM matching: superior in...
  - no-show rates, global improvement, drug use, step-down, hospital utilization
- Overall and with heroin, cocaine, comorbid populations
- For undermatching and overmatching
- In multiple systems, reimbursement systems
  (i.e. block grant, Medicaid, Veterans Health Administration)
- In multiple cultures/languages (i.e. Massachusetts, New York City, Belgium, Norway)
- At multiple time frames: immediate, 30-day, 90-day, 1year

Feasibility

- Good patient and provider adoption
- Streamlined for repeated use across the CONTINUUM
Johnathan Wesley
Birth Date: 06/17/1980  Gender: Male
Created By: gastfriend@gmail.com

"Thank you for doing this screening with me today. I'd like to spend about 10 minutes with you now, asking you just a few questions to get a rough sense of the best place to start your care. When you arrive there, they will conduct a more detailed assessment and discuss with you whether you should start treatment there or at a place that offers a more intensive or less intensive level of treatment. Is that OK?"
Example Patient Assessment w/ CONTINUUM (2/3)
Example Patient Assessment w/ CONTINUUM (3/3)

Johnathan Wesley
Birth Date: 06/17/1980  Gender: Male  Religion: Other  Ethnicity: Caucasian
Created By: gastfriend@gmail.com

Category of final disposition (i.e., where the patient is actually being sent to treatment):

Level 3.7 - Medically Monitored Intensive Inpatient Treatment

Reason for final disposition (i.e., where the patient is actually being sent different from Recommended):

Clinician disagrees with ASAM Criteria recommendation

- Not applicable (patient agrees) or No Answer
- Final disposition is, or is expected to be, same as recommended by ASAM Criteria
- Different treatment selected due to patient choice
- Recommended program is unavailable in geographic region
- Lack of physical access (e.g., transportation, mobility)
- Conflict with job/family responsibilities
- Patient lacks insurance
- Patient has insurance but insurance will not approve recommended treatment
- Program available but lacks opening or wait list too long
- Program available but rejects patient due to patient characteristic(s), e.g., attitude, behavior, clin
- Court or other mandated treatment is different or blocks PPC-2R recommendation
- Patient rejects any treatment at this time
- Patient eloped

Clinician disagrees with ASAM Criteria recommendation
- Not known

NOTE: This provisional record is an individual provider assessment (including FEi Systems) assessment from the use of this individual provider assessment (including FEi Systems) assessment tool, which may be available in all levels and modalities of care.

Comments:

This is a Demo Site do not enter any actual PHI.
Example Patient Assessment - Triage

Patient: L-3Prg Gastfriend
Interviewer: gastfriend@gmail.com

Admission Date: 12/4/2016 3:21 PM
Assessment Begun: 12/4/2016 3:21 PM
Assessment Ended: 12/4/2016 3:26 PM

20) Would ambulation/mobility problems impede attending No treatment?

21) Will daily routine keep patient occupied most days AND No free from problematic alcohol or drug(s)?

Comments:

FINAL SCORING & PROVISIONAL RECOMMENDATION

This patient has met the provisional requirements for Level 3 - Residential/Inpatient Services, Opioid Treatment Services (Pregnancy).

QUALIFIERS - SUBLEVELS OF CARE

This patient also shows signs of Withdrawal Management.

Note:

1. L-0.5, L-1, L-2 and L-4 in this Triage Tool are fully specified, whereas L-3 has specifications but can also be selected as a default, when none of the other LOCs are specified. This is to ensure adequate services for the initial evaluation site, where additional detail will become known in the full CONTINUUM(TM) assessment.

2. L-OTS is not one LOC but includes: OTP (Methadone Maintenance Program), OBOT (Office-Based Buprenorphine Treatment) and XRNTX (Extended-Release Naltrexone). IN PREGNANCY: Patient should be sent to either OTP, or if unavailable, OBOT. Otherwise, the choice between OTP, OBOT & XR-NTX should be by patient choice. L-OTS can be combined with any other LOC; therefore, if L-OTS is recommended in addition to L-3 or L-4, the patient should proceed to a L-3 or L-4 site for full evaluation.

3. If L-4 is recommended, consider ambulance transport, e.g., if patient is frankly psychotic, acutely suicidal, or acutely medically ill.
Level 0.5: Early Intervention Services

Description

• **Organized services that address risk factors related to substance use**
• Appropriate for individuals who do not meet diagnostic criteria for an SUD – confirmed by diagnostic and multidimensional assessments
  – Individuals expressing readiness to change, needing skills for change, and/or having living environment challenges
• Consistent with National Institute on Drug Abuse’s “indicated prevention” and public health descriptions of “secondary prevention”

Services and Setting

• Emergency department, primary care: Screening, brief intervention, referral to treatment (SBIRT)
• Impaired driving programs: educational information mandated for driving under the influence or while intoxicated
• Community, Criminal Justice, School, Work Settings: one-on-one counseling, motivational interventions, educational programs in community settings
Level 0.5: Early Intervention Services Cont’d

Length of Service

- **Varies based on multiple factors:**
  - Individual’s ability to understand information provided and engage in behavior change
  - Surfacing of new concerns requiring treatment at more intense level of care
  - Regulatory mandated length of service

Staffing

- Trained personnel knowledgeable about biopsychosocial dimensions of substance use
- Can include certified/licensed addiction counselors, generalist health care professionals
- Emergency and primary physicians generally administer SBIRT
- Addiction specialists as resources for clinical teams
Recovery Support Services

• Recovery support services:
  – Can be provided throughout the SUD care continuum
  – Are non-clinical services that support individuals and families throughout the recovery process
  – Are an integral part of a recovery-oriented approach

• Example services include, but aren’t limited to:
  • Alcohol and drug free social activities
  • Aftercare services
  • Case management services
  • Child care
  • Employment and education services
  • Housing supports
  • Individual services coordination
  • Information and referral
  • Peer supports
  • Recovery coaching
  • Relapse prevention
  • Self help and support groups
  • Transportation to and from treatment
Polling Question (2/2)

• Is your state currently using the ASAM assessment criteria for Medicaid reimbursement? Select one option.
  – Yes, ASAM standardized tool
  – No, brief ASAM-informed tool
  – No, non-ASAM, homegrown tool
  – Not sure
Partial Hospitalization & Clinically Managed Low Intensity Services

David Gastfriend, MD
Chief Architect, CONTINUUM – The ASAM Criteria Decision Engine
American Society of Addiction Medicine
Vice President, Washington Circle Group
ASAM Levels of Care

- **Covered**: Level 0.5, withdrawal management levels and patient assessment
- **Next focus**: Levels 2.5 and 3.1
**Adult Admission Criteria for Level 2.5**

*This webinar only presents a high-level overview of admissions criteria*

**Basic Requirements**

- If any biomedical or emotional, psychological or cognitive conditions, these are severe enough to distract from treatment or require medical monitoring/management
- If any emotional, behavioral or cognitive conditions, these prevent stability over a 48-hour period or risk endangerment

**And 1 or more of the following:**

- Requires structured therapy to promote progress (e.g., previous treatment failures or impulse control issues)
- SUD symptoms are intensifying or there is a high likelihood of relapse w/o structured therapeutic services
- Continued exposure to non-supportive living/working environment hinders recovery
Level 2.5: Partial Hospitalization Services

Description

- Structured intensive outpatient settings (e.g., partial hospitalization programs) with ~20 or more hours of clinically intensive programming each week provide a support system for all medical and behavioral health needs
- Co-occurring capable vs. co-occurring enhanced

Staffing

- Interdisciplinary teams with cross-training in mental health
- Qualified practitioners who can provide medical, psychological, psychiatric, lab, toxicology, and emergency services
Level 2.5: Partial Hospitalization Services
Cont’d

Services

• Skilled treatment services including:
  – 1:1 and group counseling, medication management, educational groups, occupational therapy, family therapy, motivational enhancement

• Consultation/referral access:
  – Medical, psychological, psychiatric, lab, toxicology within 8 hours via telephone or 48 hours in-person

• Emergency services w/in 24 hours via telephone 7 days/week

• Direct affiliation with other levels of care
# Adult Admission Criteria for Level 3.1

*This webinar only presents a high-level overview of admissions criteria*

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td>Acute Intoxication or WD Potential</td>
<td>• No symptoms or symptoms manageable in 3.1</td>
</tr>
<tr>
<td>Biomedical Conditions</td>
<td>• Stable or not severe enough to require inpatient treatment</td>
</tr>
<tr>
<td>Emot’l, Behav’l, &amp; Cognitive Conditions</td>
<td>• Stable mental status AND stable psychiatric condition OR requires residential setting to succeed in SUD treatment</td>
</tr>
<tr>
<td>Readiness to Change</td>
<td>• Acknowledges need for treatment but may require additional motivating services or a structured setting to be successful</td>
</tr>
<tr>
<td>Relapse, Continued Use Potential</td>
<td>• Individual requires coping skills, requires a structured setting to manage SUD, or staff support to maintain engagement</td>
</tr>
<tr>
<td>Recovery Environment</td>
<td>• Can cope outside 24-hour facility for work/school/community activities but overall environment not conducive to recovery</td>
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</table>
Level 3.1: Clinically Managed Low-Intensity Services

Description

• 24-hour treatment settings providing structure and supports with at least 5 hours/week of low-intensity professional treatment services
• Clinical focus on improving readiness to change, recovery skills, relapse prevention, coping, personal responsibility & social reintegration

Staffing

• 24/7 onsite allied health professionals (counselors/group living workers)
• Clinical staff knowledgeable about biopsychosocial dimensions of SUD and psychiatric conditions
• Interdisciplinary team of trained, credentialed medical (e.g., nursing), addiction, & mental health professionals
• Physicians, nurse practitioners and physicians assistants are not involved in direct service provision but review admissions & consult
Level 3.1: Clinically Managed Low-Intensity Services Cont’d

Services

• Promoting organization of daily living tasks:
  – Personal responsibility, appearance, punctuality; counseling and clinical monitoring to support work/school/family integration

• Skilled treatment services including:
  – Medication management/adherence, individual/group/family therapy, motivational enhancement, psychoeducation

• Random urine drug screens per treatment plan

• 24/7 access to telephone or in-person physician and emergency services

• Ability to arrange for additional necessary services

• Direct affiliation with other levels of care

Level 2.5 may be combined with Level 3.1 in some cases
Webinar Summary: Key Take Away Points

- SUD treatment should be provided across a broad, flexible continuum of services with treatment decisions made based on clinical and patient needs.

- The goal of withdrawal management is to maximize the likelihood of continuing into the psychosocial rehabilitation of addiction.

- Level of care determinations are related to patient needs across six biopsychosocial domains that must be assessed.

- It may be appropriate to combine some levels of care depending on patient needs.
Discussion & Questions (3/3)
Speaker Contact Information

• David Gastfriend
  – Treatment Research Institute
  – gastfriend@gmail.com

• George Kolodner
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  – gkolodner@kolmac.com

• John O’Brien
  – Technical Assistance Collaborative
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Thank You!

Thank you for joining us for this National Dissemination Webinar!

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