

# Fundamentals of American Society of Addiction Medicine (ASAM): Navigating Levels of Care

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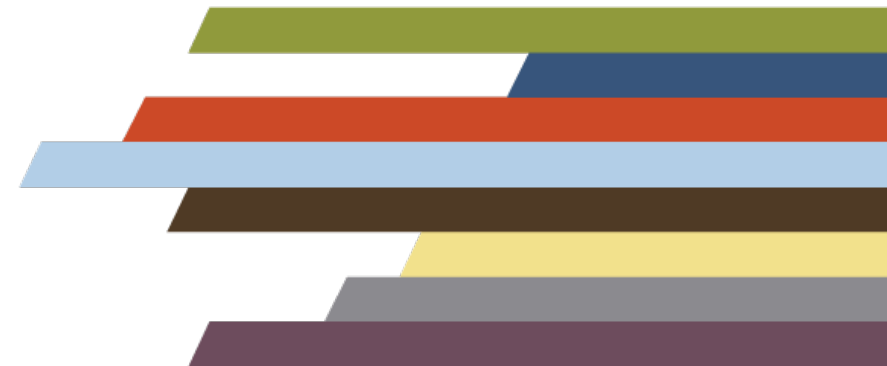


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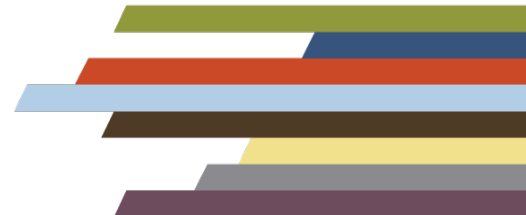


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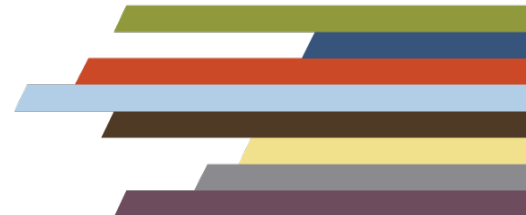
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# Overview of this Webinar

- ASAM Guiding Principles
- Understanding Medical Necessity
- Review of ASAM Continuum of Care
- Medication Assisted Treatment Options
- ASAM 6-Dimensional Assessment
- ASAM Continued Service, Transfer, Discharge Criteria
- COD Considerations
- Other Consideration Recommending Level of Care



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# ASAM Guiding Principles

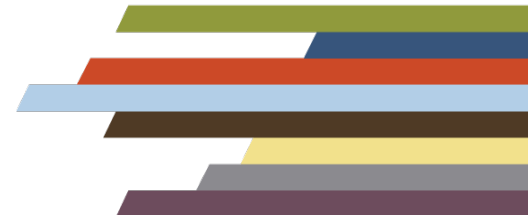
- One dimensional to multidimensional assessment
- Clinically driven and outcome-driven treatment
- Variable length of service based on person centered needs
- Broad and flexible continuum of care
- Adolescent specific needs
- Moving away from using “treatment failure”



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# ASAM Guiding Principles Continued

- Interdisciplinary, team approach to care
- Clarifying the role of the physician
- Focusing on treatment outcomes
- Informed Consent
- Medical Necessity (definition on next slide)

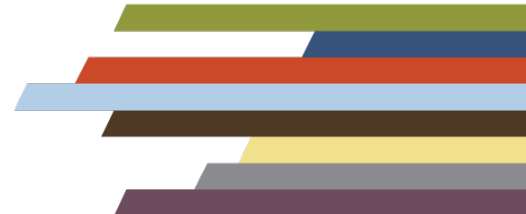


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# ASAM Continuum of Care

## Informed Consent

- “Proposed modalities”
- “The risks and benefits”
- “Appropriate alternative treatment”
- “Risks of treatment versus no treatment”

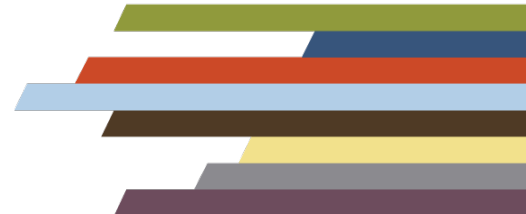


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# Medical Necessity Definition from ASAM

Pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. -It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in D-1; acuity of physical health need (as in D-2); or D-3 psychiatric issues (such as imminent suicidality). Rather, “medical necessity” encompasses all 6 dimensions so that a more holistic concept would be “Clinically-Necessity”, “necessity of care”, or “clinical appropriateness.”



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# ASAM Continuum of Care

- New information regarding:
  - Older adults
  - Parents with children
  - Those working in safety sensitive occupations
  - Criminal justice settings

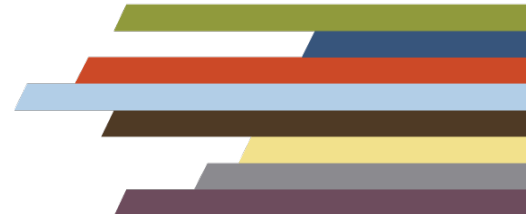


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# ASAM Continuum of Care

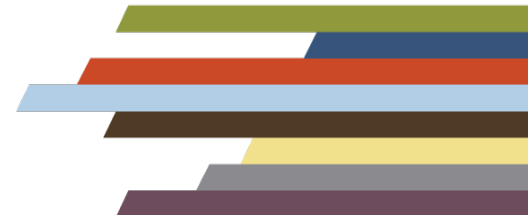
- Level 0.5 Early Intervention
- Level 1 Outpatient
- Level 2.1 Intensive Outpatient
- Level 2.5 Partial Hospitalization



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# ASAM Levels of Care

- Level 3.1 Clinically Managed Low-Intensity Residential
- Level 3.3 Clinically Managed Population-Specific High Intensity Residential (adult only)
- Level 3.5 Clinically Managed High-Intensity Residential (adult)
- Level 3.5 Clinically Managed Medium-Intensity Residential (adolescent)

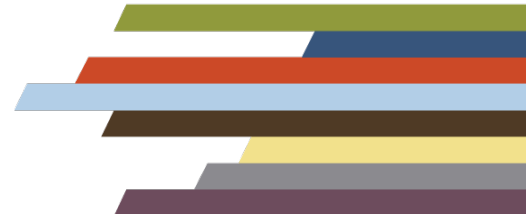


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# ASAM Levels of Care

- Level 3.7 Medically Monitored Intensive Inpatient (adult)
- Level 3.7 Medically Monitored High-Intensity Inpatient (adolescent)
- Level 4 Medically Managed Intensive Inpatient
- Opioid Treatment Services
  - Opioid-Based Opioid Treatment (OBOT)

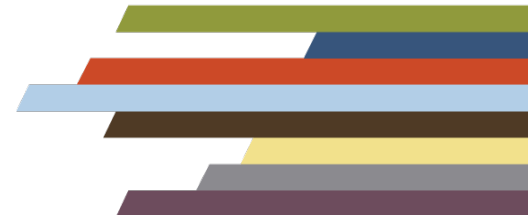


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# ASAM Withdrawal Management Level of Care

- Level 1-WM: Ambulatory Withdrawal Mgmt. without Extended On-site Monitoring
- Level 2-WM: Ambulatory Withdrawal Mgmt. with Extended On-site Monitoring
- Level 3.2-WM: Clinically managed Residential Withdrawal Management
- Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management
- Level 4-WM: Medically Managed Intensive Inpatient Withdrawal Management

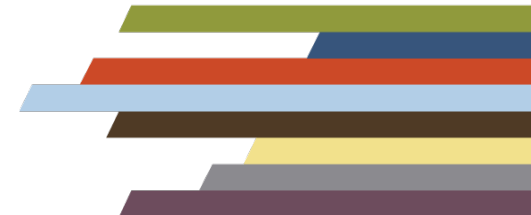


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# Medication Assisted Treatment (MAT)

- Myths, Stereotypes and Stigmas
- FDA Approved Medication related to OUD Treatment
- Effectiveness of Medication related treatment
- Psychosocial Treatment is Critical
- OUD Treatment Models

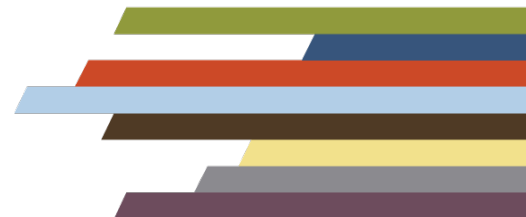


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# Medication Assisted Treatment (MAT)

## Myths Stereotypes and Stigmas

- Patients are still addicted
- People are still getting high when on MAT
- People are seeking buprenorphine to get a high
- MAT is simply a substitute for illicit use of an opioid
- Medication alone is sufficient for treatment

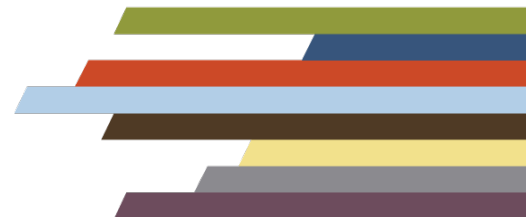
NIDA Blending Initiative, Opioid Management TOT (2007)



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# Medication Assisted Treatment (MAT)

## FDA Approved Medication related to OUD Treatment

- Methadone (Agonist) (approved 1964, 1974 Narcotic Treatment Act)
- Naltrexone (Antagonist) (Approved 1984)
- Buprenorphine & Buprenorphine Naloxone: (Partial Agonist) (Approved 2002)

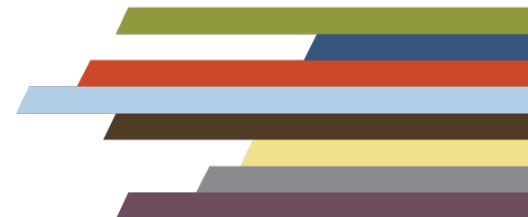


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# Medication Assisted Treatment (MAT)

- Agonist: Morphine-like effect (heroin, methadone)
- Partial Agonist (Buprenorphine & Bupe Naloxone)
- Antagonist: (naltrexone, naloxone)

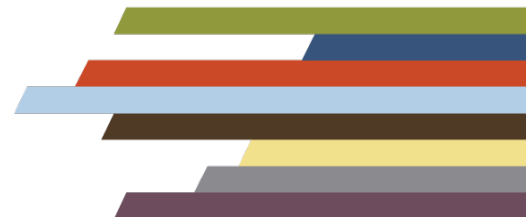


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# Medication Assisted Treatment (MAT)

## Effectiveness of Medication related treatment

- **Partial Opioid Agonist**
  - Has effects of **typical opioid agonists at lower** doses
  - Produces a **ceiling effect at higher** doses
  - Binds to opioid receptors and is **long-acting**
- **Slow to dissociate from receptors** so effects last even if one daily dose is missed.
- **FDA approved** for use with opioid dependent persons aged **16** and older

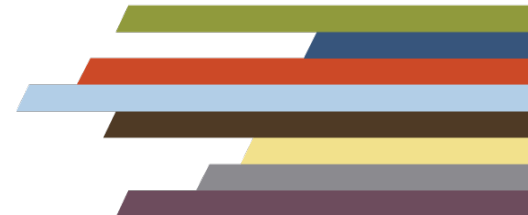


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# Medication Assisted Treatment (MAT)

Effectiveness of Medication related treatment Continued:

Clinical trials with opioid dependent adults have established the effectiveness of buprenorphine for the treatment of heroin addiction.

Effectiveness of buprenorphine has been compared to:

- **Placebo** (Johnson et al., 1995; Kakko et al., 2003; Ling et al., 1998)
- **Methadone** (Fischer et al., 1999; Johnson, Jaffee, & Fudula, 1992; Ling et al., 1996; Schottenfield et al., 1997; Strain et al., 1994)
- **Methadone and LAAM (levo-alpha-acetyl-methadol)** (Johnson et al., 2000)

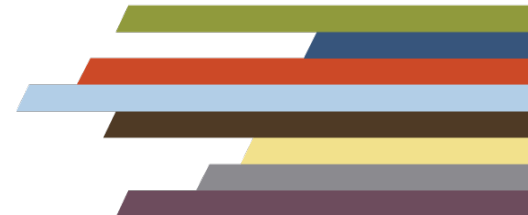


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# Medication Assisted Treatment (MAT)

## Effectiveness of Medication related treatment

- Buprenorphine is as effective as **moderate doses of methadone** (Fischer et al., 1999; Johnson, Jaffee, & Fudula, 1992; Ling et al., 1996; Schottenfield et al., 1997; Strain et al., 1994).
- Buprenorphine is as effective as **moderate doses of LAAM** (Johnson et al., 2000).
- Buprenorphine's partial agonist effects make it **mildly reinforcing**, encouraging medication compliance (Ling et al., 1998).
- After a year of buprenorphine plus counseling, **75%** of patients retained in treatment compared to **0%** in a placebo-plus-counseling condition (Kakko et al., 2003).

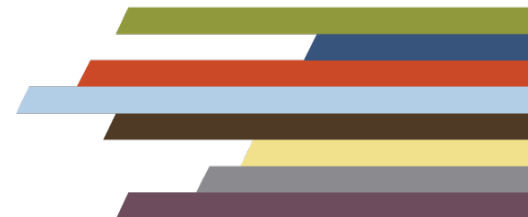


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# Medication Assisted Treatment (MAT)

- Psychosocial Coordinated Treatment is Critical
  - Appropriate medication management in combination with psychosocial approaches is most effective
  - Utilizing Evidence Based Practices is important
  - Multidimensional Team Approach
  - One Integrated Treatment Plan
  - Utilization of ASAM throughout the Continuum of Care

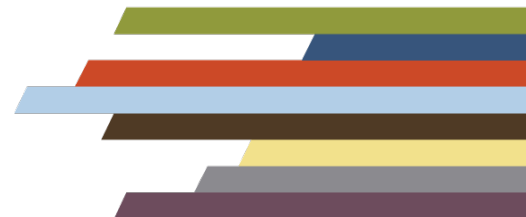


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# Medication Assisted Treatment (MAT)

## OUD Treatment Models

### Clinical Services within each of the 3 Models:

- Traditional Methadone Clinic Model now Opioid Treatment Services
- Buprenorphine & Buprenorphine Naloxone
- Naltrexone

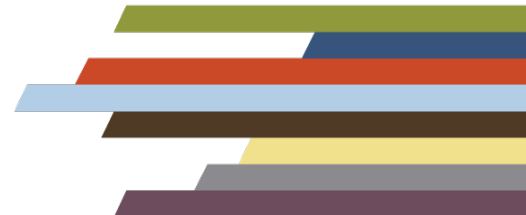


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# ASAM Six Dimensional Assessment

Start on page 43

- This next section will go through the Six Dimensions and questions to be administered within each Dimension.

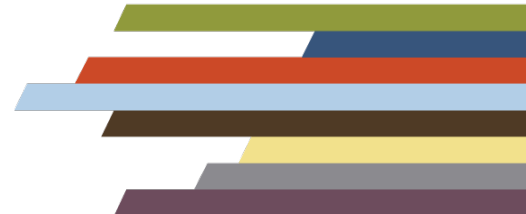


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# Dimension 1: Acute Intoxication and/or Withdrawal Potential

- What risk is associated with the patient's current level of acute intoxication?
- Are intoxication management services needed?
- Is there significant risk of severe withdrawal symptoms, seizures or medical complications?
- Are there current signs of withdrawal?
- Standardized withdrawal scale score?
- Vital signs?
- Does the patient have supports to assist in ambulatory withdrawal management?

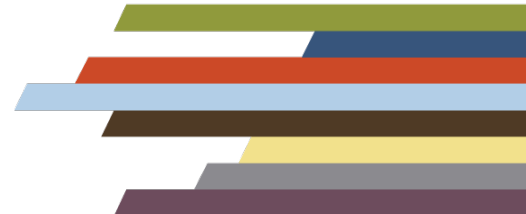


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# Dimension 2: Biomedical Conditions and Complications

- Are there current physical illnesses, other withdrawal that need to be addressed?
- Are there chronic conditions that need stabilization or ongoing disease management?
- Is there a communicable disease present?
- Is the patient pregnant, what is her pregnancy history?

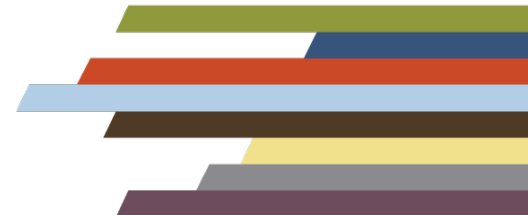


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# Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications

- Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed?
- Are there chronic conditions that affect treatment such as bipolar or anxiety?
- Do any emotional, behavioral, or cognitive signs or symptoms appear to be an expected part of the addictive disorder?

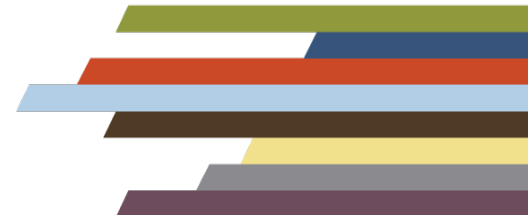


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## Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications Continued:

- Are they severe enough to warrant specific mental health treatment, even if symptoms are caused by substance use?
- Is the patient able to manage the activities of daily living?
- Can the client cope with any emotional, behavioral or cognitive problems?

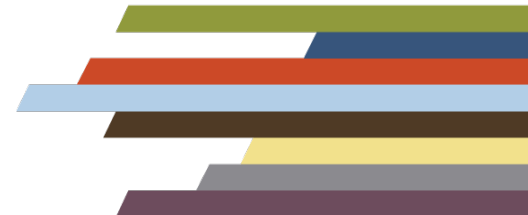


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# Dimension 3 Risk Domains/Subdomain

- Dangerousness/Lethality
- Interference with Addiction Recovery Efforts
- Social Functioning
- Ability for Self-Care
- Course of Illness

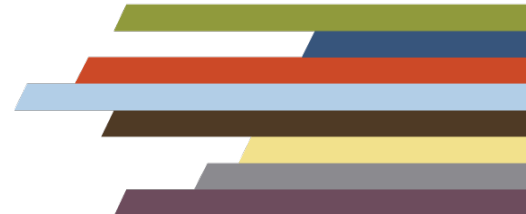


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# Dimension 4 Readiness to Change

- How aware is the patient of the relationship between their alcohol, tobacco, or other drug use or behaviors involved in the pathological pursuit of reward or relief and his or her negative life consequences?
- How ready, willing, or able does the patient feel to make changes?
- Do any emotional, behavioral, or cognitive signs or symptoms appear to be an expected part of the addictive disorder?

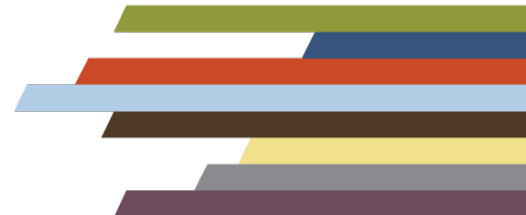


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# Dimension 5 Relapse, Continued Use or Continued Problem Potential

- Is the patient in immediate danger of continued severe mental health distress and/or alcohol, tobacco and/or drug use?
- Does the patient have any recognition or understanding of, or skills in coping with his or her addictive, co-occurring, or mental disorder?
- Have addiction and/or psychotropic medications assisted in recovery before?
- What are the person's skills in coping with protracted withdrawal, cravings, or impulses?



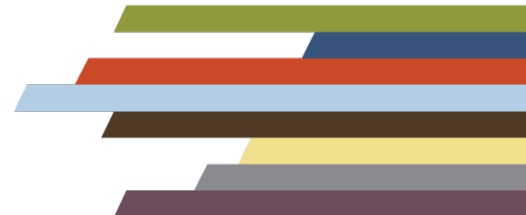
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## Dimension 5 Relapse, Continued Use or Continued Problem Potential, Continued

- How well can the patient cope with negative effects, peer pressure, and stress without recurrence of addictive thinking and behavior?
- How severe are the problems and further distress that may continue or reappear if the patient is not successfully engaged in treatment?
- How aware is the patient of relapse triggers and skills to control addiction impulses or impulses to harm self or others?



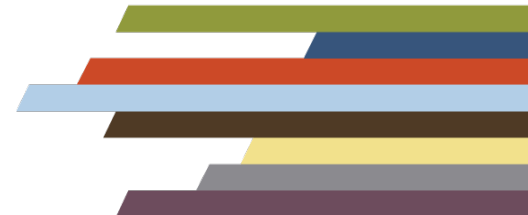
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# Dimension 6 Recovery / Living Environment

- Do any family members, significant others, living situations, or school work situations pose a threat to the patient's safety or engagement in treatment?
- Does the individual have supportive friendships, financial resources, or educational or vocational resources that can increase the likelihood of successful recovery?

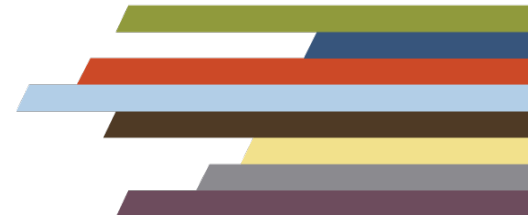


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# Dimension 6 Recovery / Living Environment, Continued

- Are there legal, vocational, regulatory (e.g professional licensure), social service agency, or criminal justice mandates that may enhance the person's motivation for engagement in treatment if indicated?
- Are there transportation, childcare, housing, or employment issues that need to be clarified and addressed?

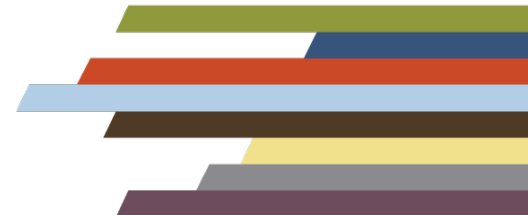


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# Principles of Assessing Risk

- Risk is multidimensional and biopsychosocial
- Risk relates to the patient's history (life time)
- Risk is expressed in current status (last 30 days)
- Risk involves a degree of change from baseline or premorbid functioning (normal expression or pathological expression)

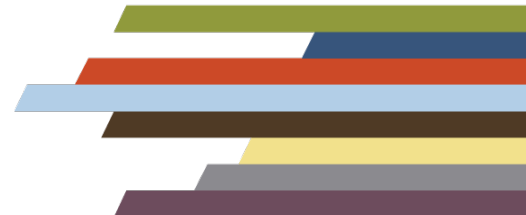


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# Establishing a Risk Rating System: Page 56-57

## Overview of Dimensional Risk Rating and 0-4 Point Scale:

- 0: Low Risk
- 1: Mild Risk
- 2: Moderate Risk
- 3: Serious Risk
- 4: Utmost Risk

## Overall Risk Rating:

Range of Low, Moderate, High

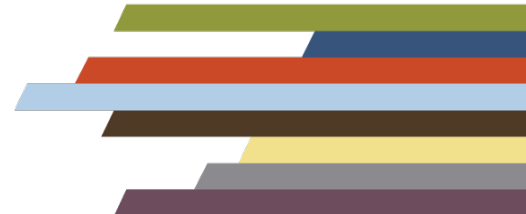


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# Severity Specifics

## 0 - Low Risk

- Non-issue or very low risk issue
- Presents no current risk
- Chronic issues mostly or entirely stabilized

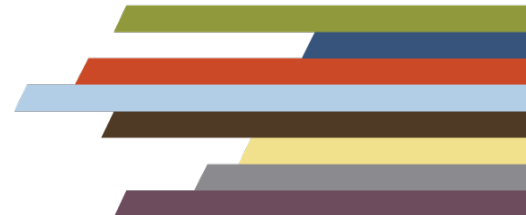


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# Severity Specifics

## 1 – Mild Risk

- Indicates mildly difficult issues
- Minor signs and symptoms
- Issues typically resolved in short period

## 2 – Moderate Risk

- Moderate difficulty in functioning
- Somewhat persistent chronic issues
- Relevant skills, or support systems may be present

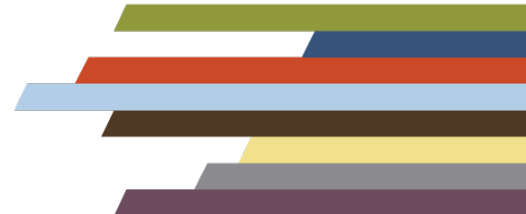


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# Severity Specifics

## 3 – Serious Risk

- Difficulty coping within given dimension.
- Near imminent danger

## 4 - Utmost of Severity

- Critical impairments in coping and functioning
- Signs and symptoms, indicating “imminent danger”

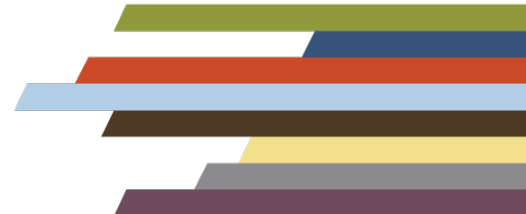


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# Matching Multidimensional Severity

Step 1: Risk of Imminent danger (rule out)

Step 2: Determine risk rating in each dimension

Step 3: Identify appropriate types of services

Step 4: Development of initial treatment plan

Step 5: Ongoing Utilization Management  
throughout the continuum of care

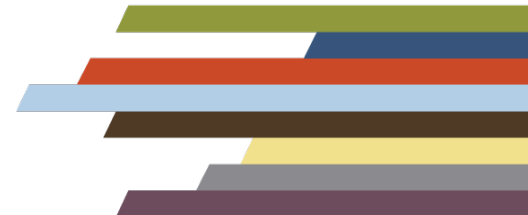


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# ASAM Continued Service Criteria

- Client is making progress but hasn't achieved goals yet so continuing at the present level of care is indicated.
- Client is not making progress towards goals but has the capacity to resolve problems. Client is actively working toward goal so continuing at the present level of care is indicated.
- New problems have been identified that are appropriately treated at this level of care so continued service is indicated.



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# ASAM Discharge & Transfer Criteria

- Client has achieved treatment plan goals, resolving problems that justified admission so transferring client to a less restrictive level of care is indicated.
- Client has been unable to resolve problems that justified admission despite amendments to the treatment plan. Treatment at another level of care is therefore indicated:
- Client demonstrated lack of capacity to resolve problems due to diagnostic or COD issues. Treatment at another level of care is therefore indicated.
- Client's problems have intensified or has new problems that can only be treated at a higher level of care.



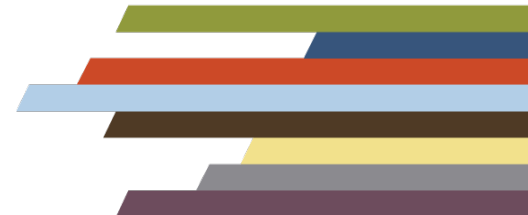
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# Co-Occurring Considerations

- Interdisciplinary staff
- COD screening tools
- Comprehensive assessment that includes COD domains
- Differential diagnosis
- Integrated treatment planning
- Integrated progress note documentation
- Evidenced based COD interventions
- Continuity of care
- Stage wise assessment, treatment planning and ongoing documentation

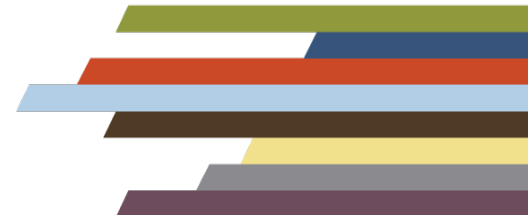


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# Other factors to determine the most Appropriate Level of Care

- Screening Tools
- Comprehensive Bio-psychosocial/spiritual Assessment
- DSM 5 Differential Diagnosis (Severity)
- ASAM 6-Dimensional Assessment (Risk Rating) (Already Covered)
- Matrix for Adult Matching (Risk Rating) pg. 73 \* Matrix for Adolescent Matching (Risk Rating) pg. 90
- Crosswalk of the ASAM Admission Criteria pg. 175-178 (Already Covered)
- Admission Criteria by Level of Care, starting on pg. 179, Level 0.5 Early Intervention
- Recommendations

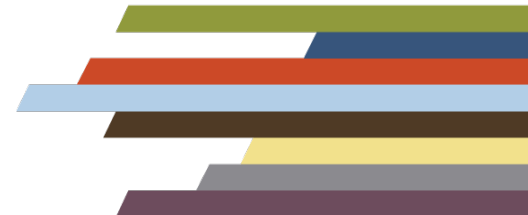


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# Admission Criteria by Level of Care

- The Admission Criteria section focuses in more detail by Dimension what Criteria is considered related to placement of care.
- There is separate Admission Criteria for each level of care

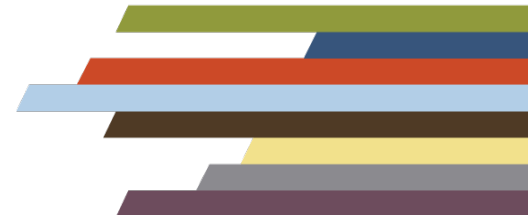


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# The End

Thank you for participating today

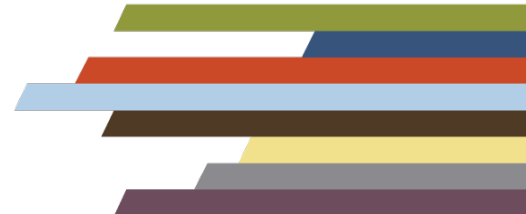
Questions/Feedback Appreciated



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# Reference

The ASAM Criteria, Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition, 2013.



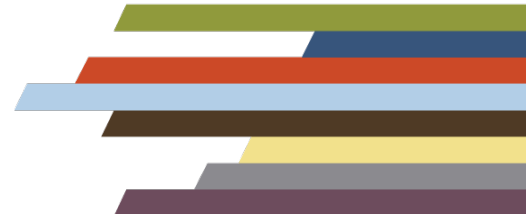
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# Fundamentals of American Society of Addiction Medicine (ASAM): Navigating Levels of Care Webinar

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