

ASAM APPLICATION FAQ

July 6, 2018

Note: The Q & A addressed in this FAQ applies specifically to application/use of the ASAM in Pennsylvania and not the transition to ASAM in general. These questions were generated through the listening sessions, acquired through the 2-day skill building trainings, or received directly by DDAP through the ASAM email account. Medical Assistance/HealthChoices questions will be answered by Department of Human Services and posted or linked on the DDAP website at a later time.

A) GENERAL

1. Why can't the Admission Criteria Decision Rules be summarized in a location other than the book?

- a. *The ASAM Criteria, 3rd Edition* is not meant to simply be a check list for admission criteria, rather it is a clinical guide for the provision of client centered services. For this reason, this resource should be used in its entirety not only for admission determinations, but for service/treatment planning, continued stay determination, etc. As the field becomes more familiar with the ASAM principles, use of this resource will become more second-nature.
- b. To assist with the transition in using *The ASAM Criteria* in determining decisions about admission, DDAP has created two documents: the "ASAM Crosswalk with PA's System of Care" and "Guidance for Application of ASAM in PA's SUD System of Care". These resources which are found on the DDAP website:

[http://www.ddap.pa.gov/Professionals/Pages/For Treatment Providers.aspx](http://www.ddap.pa.gov/Professionals/Pages/For_Treatment_Providers.aspx) provide summary information which can be used in conjunction with the entire ASAM text.

2. How much of the ASAM Criteria can be released to agencies per 255.5?

- a. Compliance with 255.5 does not change with the transition to ASAM.

3. In Adolescent ASAM Criteria, we were instructed to recommend the highest LOC, always. Is the Adult ASAM Criteria going to mandate the same? And where do we find the bed space?

- a. While the current transition to ASAM appears to focus on Adult services because of the Pennsylvania Client Placement Criteria (PCPC) was specific to the adult population, the current 2-day, in person ASAM Skill Building Training and *The ASAM Criteria, 3rd Edition* pertains to both the adult and adolescent population.
- b. Please see page 111 of *The ASAM Criteria, 3rd Edition* regarding "Exceptions to the ASAM Admission Criteria" which will more fully address the question. The bottom line is, sound clinical judgement should be used at all times. When a level of care is not available due to capacity issues and the higher level of care is not available for the same reason, interim and/or support services should be offered and it should be indicated in the case note/WITS why the recommended level of care was not provided.

4. How is a provider to resolve SIP = State Intermediate Punishment program which mandates 60 days inpatient?

- a. While ASAM indicates a person-centered approach that is individually determined, those persons in the criminal justice system remain accountable to comply with criminal justice sanctions. (See *The ASAM Criteria*, p. 300)

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B) ASSESSMENT / CONTINUED STAY / RECORD KEEPING

- 1. Would having a standard assessment tool that follows the ASAM Criteria be helpful with the roll out?**
 - a. PA WITS, the new prevention and treatment data system will have a required, standard assessment tool (The TAP). Implementation of WITS is scheduled for July 1, 2018 as well.
- 2. Will collateral information from friends, family, etc. be enough to qualify a client for a higher a level of care or intensive services even if client is not admitting to that level of severity? How will this play out practically?**
 - a. Good clinical practice is driven by obtaining well-rounded, valid information about an individual; however, good clinical decision making should never be driven by a single, outside source of information. Collateral information will supplement that which is given by the individual, but will not serve as a substitution for that information. Collateral information can be used in the therapeutic process, rather than drive level of care determination. While collateral information should not be sought out without a properly signed consent, there are times when collateral information is offered to the clinician unsolicited, without consent.
- 3. If a client is assessed for a specific LOC, such as a 3.5, but is only willing to participate in a Level 1 or 2.1 service. Do we meet them where they are at and put them in a Level 1 or 2.1 despite not being stable enough?**
 - a. An assessor/clinician should follow the policies and procedures outlined by their agency for referring or admitting individuals who are best served at a different level of care. Person-centered care does not mean that sound clinical judgement is eradicated. A clinician must make such decisions based on judgement and policy, then document why the client did not receive the recommended level of care, i.e., “the client refused a higher level of care, but was willing and able to participate in xx level of care”; or, “the client refused to enter residential services despite being the recommendation for such based-on meeting xyz dimensions for this LOC. Therefore, the client was advised of the dangers and potential consequence and no referral was made.”
- 4. If a provider is contracted with both a/an SCA(s) and a BH-MCO, should I use the form in WITS or the paper ASAM Summary Sheet?**
 - a. Currently, only those clients/services paid for by the SCA are required to be entered into WITS. IF ANY amount of SCA funds are utilized to pay for services for an individual (\$1 from the SCA and the rest paid by Medicaid), the client data must be entered into WITS. Because some providers may be contracted with a BH-MCO and not an SCA, the paper form is available since such contracted service/providers are not required to be entered into the system.
- 5. “Staffed by appropriately credentialed and/or licensed treatment professionals” ---- What is considered an “appropriate credential? CADC?**
 - a. Please see “Guidance for Application of ASAM in PA’s SUD System of Care”, page 3, paragraph 3. Those staffing requirements currently identified in PA’s licensing standards, along with the Minimal Education and Training Requirements (METs) outlined by DDAP for positions/roles, and those requirements established for certification by PCB remain intact.

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- b. If any changes to the qualifications or competencies for any level of care are made moving forward, DDAP will work with appropriate stakeholder groups to establish such changes and will communicate them accordingly.
- 6. How often do treatment plans have to be signed off on the ASAM update? (If we move to more individualized, stage specific plans [as discussed in training] will each weekly update require sign off by all members of the team, including physician?)**
 - a. PA Licensing Regulations provide a minimum standard. While the regulation remains in effect, programs should have a policy and procedure in place for conducting variable lengths of stay and how this will be reflected in the updates/notes. Ideally, if treatment plans are to be utilized as a person-centered roadmap for the delivery of services, reference to and use of the treatment plan, both by the clinician(s) and the individual in treatment should occur every time the person is seen.
- 7. Can we integrate the DAP note and Treatment Plan? Eliminate treatment plan updates, and just reflect the updates in our DAP notes?**
 - a. The transition to the ASAM does not eliminate the regulatory requirement to do service/treatment planning, case notations, etc.
- 8. Develop an ASAM Criteria Spread Sheet/Check List AND an on-line form similar to Adolescent ASAM or PCPC.**
 - a. The PA WITS provides an ASAM “check list”/summary sheet. There is also similar document available on the DDAP website.
- 9. This level of Assessment, with collaboration with others, will take more than 2 hours to complete.**
 - a. Historically, level of care assessment/“intake” has been done through the completion of the biopsychosocial or an assessment tool which is then used to inform the application of the “placement tool”; therefore, the only change will be getting accustomed to the ASAM.
 - b. Otherwise, assessment is (and should have always been) an ongoing process. As the therapeutic relationship is built and an individual continues to “do life”, additional information and input may occur. Collateral information in collaboration with others may occur at intake, but will most likely take place in conferring with the extended members of the treatment team (including family members, probation officers, etc.)
- 10. Through ASAM Criteria, will case managers be the ones to develop treatment plans?**
 - a. As is the case now, treatment plans are a clinical activity and should be developed between the individual and counselor/therapist.
- 11. For an individual who is using 2 substances & only wants to stop one illegal substance & continues to use one illegal substance but gets individual goals to stop what drug they choose, testing positive for an illegal substance – ASAM says it is successful completion. How do I explain this to probation?**
 - a. The clinical/therapeutic process should work toward motivating an individual toward change. While engaged in the process, the clinician should assist the individual in recognizing his/her goals, including those related to the criminal justice system. If an individual completes his/her stated goals in treatment, but these do not include abstinence from the use of illegal substances, this would be indicated in the clinical notes. Case consultation and clinical

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supervision should always be utilized when a clinician is in doubt about the status of or type of discharge an individual should receive.

12. What should be done regarding level of care placement while waiting for ASAM trainings to be completed?

- a. Similar as was done when new staff were not trained in the PCPC, supervisory staff should continue to review PCPC/ASAM decisions of staff in the interim of receiving appropriate level of care placement training, as noted in the DDAP Treatment Manual, Sections 9.05 & 10.05 “Requirements of Case Management Supervision.”
- b. The Level of Care Placement Tool for which the supervisor is trained, the ASAM or the PCPC, should be the criteria used in directing, reviewing and approving assessments for supervisees who have not yet been trained. The ASAM is expected to be in full use by all staff by December 31, 2018.

13. How should we integrate use of medical marijuana for treatment of opioid use disorder with ASAM Criteria?

- a. Providers should have policies regarding the use of all medications within the facility or program.
- b. A Medical Practitioner certified within the Medical Marijuana Program makes the determination of the appropriateness for an individual. Use of Medical Marijuana should be noted in the clinical assessment.

Note: medical marijuana is not a first line treatment for the treatment of OUD.

DIMENSIONS / LEVEL OF CARE

1. Dimension 6 uses the terminology “Environment is Dangerous”. Dangerous is different for everyone. How is it defined?

- a. “Dangerous” is more fully expounded upon in each of the levels of care in Dimension 6 where this terminology is used. Refer to the full ASAM text.

2. If a level of care is not available, we bump up a level of care. If someone needs Level 4 and there is a 6 month wait list, how do we serve this client?

- a. How does one serve such a client now? The most appropriately available services or interim services should be made available to serve an individual. See page 111, The ASAM Criteria, 2013.

3. If a program is 3B only and the individual needs more time in a 3.5 LOC, will the person require a transfer or will they be permitted to continue care where they are?

- a. Time spent in any level of care should be clinically driven by an individual’s dimensional needs and the identified most appropriate level of care to address those needs. It should never be identified by the type of service and or program. See sections of the ASAM text that address Treatment/Service planning, pages 105 – 126 and Continued Stay and Discharge Planning, pages 299 – 306.

4. At 3.5 LOC, how will it be determined if the care needed is 3B (Short Term) or 3C (Long-term)?

- a. Please refer to the “Guidance for Application of ASAM in PA’s SUD System of Care”.

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5. **Level 0.5 or DUI Intervention is not covered by insurance. Because the shift is to use evidenced based criteria for funding, will this level of care be covered by insurance?**
 - a. Depending on the payer, .5/intervention services may be presently covered by insurance, i.e., for SBIRT services.
 - b. Intervention services are also permissible services to be paid by the Single County Authority (SCA as determined and defined by their internal policies and procedures.
 - c. Future inclusion of types of intervention services, including DUI Interventions are yet to be determined.
6. **Will there be new models or definitions for levels of care based upon the hours and staffing described in ASAM?**
 - a. The assessment and determination of redefining how services are delivered, including defined hours and type and credentialing of staffing will be determined as the transition process continues. Until further notice, service description/hours and staffing requirements will remain.
7. **What do we do about insulin dependent diabetes or seizures that previously immediately qualified them for 4A? Is the goal to try to authorize lower level if medical conditions are stable? How do we define stable with chronic conditions? We could get push back from providers?**
 - a. The level of care should be determined by the medical needs/stability of the individual and the program/facility's capability to appropriately address or monitor the chronic condition.
8. **With the hour requirements NOT changing, where do we put clients who need more intense, and/or more hours per week than currently offered at a given LOC? (Example: Currently IOP Program is 7 hours weekly, new criteria is 9 hrs.)**
 - a. Please note the hours historically applied to IOP using the PCPC was "treatment session at least 3x/week for at least 5 hours, but less than 10")
 - b. Ideally, if the payer is willing to modify/intensify the LOC and pay for additional hours within the parameters or as described by ASAM, and the provider is willing and able to provide it, there is technically no issue.
 - c. If the provider is unwilling or unable to provide the intensified hours of IOP than currently established for program-driven care despite the funders willingness to pay for the services, the assessor/program should consider referring the individual to a program that can best meet the individual's needs.
 - d. If the individual requires a more intense service than can be met at the IOP level of care, they may be better served in PHP or residential services.
9. **If a bed is not available in Level 4 (Medically Managed Intensive Inpatient Services) should an individual be referred to a Level 3 service?**
 - a. Level 4 services as described in The ASAM Criteria, 2013, pages 280 -290, are for individuals needing acute care inpatient setting/primary medical and nursing care. If an individual meets the admission criteria for this level of care, their medical issues would preclude them from participating in a lower level of care until which time their medical issues have been stabilized.
10. **Why is family not addressed at in Dimension 6 Risk Rating?**

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- a. An overview of Dimension 6 is provided in The ASAM text on pages 52 – 53 and in the level of care dimensional criteria throughout the book, where family is indeed addressed. It would be included in the Risk Rating information on page 65, “Lack of positive support system”, i.e., if a family member were actively using in a manner that would put that individual in question at significant risk, that would apply to lack of positive social support. On the other hand, if a using parent lives in California and the individual being assessed lives in PA, the imminent risk or immediate danger is most likely low or non-existent.

11. If a client is assessed for a specific LOC, such as a 3.5, but is only willing to participate in a Level 1 or 2.1 service. Do we meet them where they are at and put them in a Level 1 or 2.1 despite not being stable enough?

- a. An assessor/clinician should follow the policies and procedures outlined by their agency for referring or admitting individuals who are best served at a different level of care. Person-centered care does not mean that sound clinical judgement is eradicated. A clinician must make such decisions based on judgement and policy, then document why the client did not receive the recommended level of care, i.e., “the client refused a higher level of care, but was willing and able to participate in xx level of care”; or, “the client refused to enter residential services despite being the recommendation for such based-on meeting xyz dimensions for this LOC. Therefore, the client was advised of the dangers and potential consequence and no referral was made.”

C) MEDICATION ASSISTED TREATMENT

1. Page 290: The book mentions that Buprenorphine can be prescribed while receiving services in Levels 2, 3, and 4. What about Methadone or Vivitrol?

- a. The reference at the bottom of page 290 in the ASAM text is specifically in reference to OTP/NTP, which is why it specifically addressed methadone and buprenorphine. Otherwise, FDA approved MATs issued by a waived prescribing physician can be used across the continuum of care.

2. Currently with Methadone Maintenance, clients are using Fentanyl which provides a high that breaks through “blocking dose”. Clients develop a dependence and experience withdrawal. Since we are an Opiate Treatment Service, funders will not provide inpatient treatment as the clients technically are already getting treatment. How will this be addressed?

- a. MAT alone is not treatment/a level of care. While NTPs are required to provide a minimum amount of counseling hours, such programs are outpatient. An individual may require a higher level of care than this (1.0), and such a referral should occur. See “Guidance for Application of ASAM in PA’s SUD System of Care”, page 25. As was the case in the past and should continue, if funders are unwilling to pay for a medically necessary level of care, the grievance and appeal process should be utilized by both the facility and the client.

3. Does use of the ASAM force individuals to use MAT?

- a. No, individuals should be recommended the type and level of care that is medically warranted. Not everyone is a candidate for MAT or desires MAT. But, everyone should have an informed

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and accurate review of the treatment options available to them, regardless of an assessor's/treatment provider's/payer's potential bias. Similarly, no one should be precluded from participating in a level of care because they are on a MAT. In most cases, individuals are not prohibited from participating in treatment because they use an inhaler for asthma, or takes medication for high blood pressure based on the use of medication alone.

4. What criteria will be used for admission/level of care determination into Methadone Maintenance Treatment?

- a. See pages 290 – 306 in The ASAM Criteria, 2013 text. The criteria for OTP is presented as a Level 1 service (outpatient) with particular criteria for maintenance treatment noted on pages 296 – 298 of The ASAM Criteria, 2013. Since other medications in addition to methadone are approved by the FDA and may be available to an individual, assessors/clinicians should be well-versed on available medications and be able to discuss these options with an individual, so that an informed choice about medications along with behavioral therapies can be determined.
- b. Various sources of information have been published to date regarding use of MAT. For example, See the joint July 11, 2014 Information Bulletin for additional information:
- c. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf> or The National Practice Guidelines for The Use of Medications in the Treatment of Addictions Involving Opioid Use:
- d. <https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24>

5. How will MAT be provided across the continuum, (in residential and other levels of care) when many providers currently do not accept patients on MAT?

- a. It is accurate that a large portion of providers are licensed as “drug-free” facilities and may not prescribe MAT. However, just as this does not preclude such providers from accepting someone on blood pressure medication or an inhaler for asthma, this does not and should not preclude them from admitting an individual who is on medication for their SUD. To do so would be discriminatory. In fact, there are currently providers across the continuum who do treat individuals who are also on an MAT. This includes residential providers who, in coordination with an NTP, will admit individuals on methadone maintenance until which time their needs at this higher level of care have been addressed and they can resume services at a lesser intensity. While such programs may currently be limited, over the course of the ongoing implementation process of ASAM DDAP will be encouraging and expecting providers to establish policy and procedures to make this more widely available. Many of the current federal funding streams have made the availability of MAT across the continuum a requirement and have prohibited the use of funds to providers who exclude individuals who are on a MAT.

6. We are an outpatient facility, the majority of our patients are receiving medication maintenance via Buprenorphine but we also have patients that are just attending outpatient counseling. Should all of our patients be assessed for Level 1? Or should our

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counseling only patients be Level 1 and the Buprenorphine patients be assessed for OTS? Additionally, we are treating a handful of patients with Vivitrol, my understating is that these individuals would fall under Level 1. Is that correct?

- a. The easiest way to distinguish this is to think about medication that is used for any other medical condition. For example, you could have several individuals who are diabetic in your outpatient treatment program. One may be taking oral medication to treat his condition, another may be on insulin, another may not be taking any medication and be controlling symptoms by diet and exercise ---BUT, they're ALL in outpatient counseling as long as they meet the 6 dimensional admission criteria for outpatient LOC. If an individual is needing medication, but meets the criteria for a higher level of care, including residential services, such a referral should be made.

If an individual with an SUD is needing NTP services, i.e., methadone maintenance (or buprenorphine) via a licensed narcotic treatment program, they would likely receive the outpatient services at that facility, UNLESS, the intensity of the OP counseling needed by that individual was more than the NTP could provide. Medication Assisted Treatment/OTS is a support to the individual's medical condition (SUD), while they are receiving behavioral, clinical, therapeutic counseling.

D) CO-OCCURRING

1. **Are we going to be mandated to be licensed co-occurring capable or enhanced and what are the regulations (staffing, training, etc.) if we need to do so?**
 - a. The Department of Drug and Alcohol Programs has no mandate for a provider to become co-occurring capable or enhanced.

E) SPECIAL POPULATIONS (Criminal Justice, LGBTQ, Women)

1. **How will the criminal justice system adapt to this new "individualized" program modality?**
 - a. How SUD Treatment services are being determined and delivered are currently in transition; this means that the criminal justice system is in transition as well. DDAP/DHS will continue to message these changes to partners in the criminal justice field with the intent to drive consistency regardless of a referral source. Additionally, SCAs and providers should be meeting with their criminal justice partners to discuss the ASAM transition.
2. **Why aren't veterans being considered a special population?**
 - a. Veterans were not addressed as a "special population" in the PCPC. However, veterans are addressed as a "priority population" in DDAP's Treatment Manual.

F) TRAINING

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- 1. There is a July 1st implementation date; will more concrete guidance follow? For all parts of the system?**
 - a. DDAP has been providing guidance to the field on an ongoing base through postings on its website: Timeline, FAQs, Updates, “Guidance for Application of ASAM in PA’s SUD System of Care” and the ASAM Crosswalk. As the transition continues to be implemented (over time) additional resources and information will be forthcoming.
- 2. Do clinicians have to take other trainings (Screening, Assessment, Case Mgmt. Overview, Addictions 101) to do the ASAM independently?**
 - a. Training requirements for those agencies who contract with SCAs for case management services as outlined in the DDAP Treatment Manual remain in effect.
- 3. How do I find out about ASAM Criteria trainings in my area?**
 - a. The DDAP website’s ASAM Criteria page links directly to the events listings page on the Train for Change website. Each scheduled event should include registration information. http://www.ddap.pa.gov/Professionals/Pages/For_Treatment_Providers.aspx. If you are an SCA contracted provider and unable to find available training, please reach out to your SCA and/or email RA-DAASAM@pa.gov to communicate your training needs.
- 4. What is DDAP’s ongoing training and education plan relative to The ASAM Criteria? Who will train my new staff?**
 - a. There are evolving and complex needs during a change process as large as the shift to The ASAM Criteria and DDAP will continue to do its part to guide our providers to the most pragmatic training solutions. However, DDAP classroom training requisites are but one component to an implementation requiring a strategic and comprehensive approach. Each agency can ensure clinical efficiency and fidelity to The ASAM Criteria through ongoing staff support groups, clinical team meetings, supervision, communicating with your SCA/BHMCO, and routinely checking the ASAM Criteria page on the DDAP website for updates and guidance. DDAP will support your ongoing internal training initiatives by being available to address your questions or concerns via our ASAM Criteria resource account at RA-DAASAM@pa.gov.

G) FUNDING

- 1. Will more funding be available for education and development of new levels of care?**
 - a. While The ASAM Criteria may use different names or references than what we have been used to in referencing the PCPC, all current levels of care will remain intact moving forward. Please refer to the “ASAM Crosswalk with PA’s System of Care” found on the DDAP website at: http://www.ddap.pa.gov/Professionals/Pages/For_Treatment_Providers.aspx/ There may be infrequently utilized or available levels of care, such as those described in 3.3. As such programs become more available, DDAP will do its best to inform assessors, clinicians of where

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these services exist.

2. **Are all the managed care organizations trained and expected use of the ASAM criteria to conduct admission/continued stay/discharge reviews?**
 - a. BH-MCO staff have been engaged in training and will be required to utilize The ASAM Criteria.
3. **Are the commercial carriers going to be forced to follow the new ASAM Criteria?**
 - a. DDAP has no authority over commercial insurance carriers to require them to utilize the ASAM Criteria. However, DDAP has been working closely with the PA Department of Insurance to inform 3rd party payers of the move to this evidence based practice and will continue to do so.

H) MISCELLANEOUS

1. **Is it possible to get a resource list of specific levels of care facilities per county?**
 - a. This question is best posed to the local SCA or the BH-MCO as services are contracted at the local level as is. Refer to www.ddap.pa.gov.
2. **Outpatient treatment for Medicare clients is extremely limited. How can we change this and make sure outpatient is available for Medicare clients?**
 - a. Aside from the transition to ASAM, SUD treatment limitations for Medicare patients may exist in several areas, but most commonly in two: availability of specialized services for aging Pennsylvanians; and, Medicare benefit coverage for payment of the services. While specialized services may be more challenging to locate, there are facilities that are equipped to address the unique needs of this population. Assessors/clinicians must be familiar with their provider network and the services provided by each and make appropriate referrals accordingly.
 - b. Contact should always be made with the Single County Authority (SCA) in which county the Medicare recipient resides. Depending on the contacts and funding availability of that county, resources may be available for funding assistance to individuals where Medicare does not cover for a needed level or type of service.
 - b. Medicare is a federal program.