SANTA CLARA COUNTY
Behavioral Health Services

ASAM in the DMC-ODS Waiver

How Do You Apply QI/QA to ASAM

APRIL 27TH, 2017

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AGENDA
OPERATIONALIZING ASAM

To start: 3 concepts in ASAM that aren't necessarily found in more traditional SU tx, and then:

1) Engagement
   - OP 4in 30 metric
2) Continuum of Care
   - SCC COC algorithm
3) ASAM specific data
   - ALOC
   - UCLA spread sheet
   - Interval Assessment Policy
4) UM – authorizations
   - ASAM imminent danger language
5) What you need to do ASAM as a system
   - Clinicians
   - Quality Improvement Staff

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ASAM SIX DIMENSIONS

1) Acute Intoxication and/or Withdrawal potential
2) BioMedical Conditions and Complications
3) Emotional/Behavioral/or Cognitive conditions and complications
4) Readiness to Change
5) Relapse, Continued Use or Continued Problem Potential
6) Recovery Environment

EBP: Treatment Matching

ASAM

SIX DIMENSION MULTI DIMENSIONAL ASSESSMENT

The 3 H's:

History

Here and Now

How worried are you

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ASAM

SIX DIMENSION MULTI DIMENSIONAL ASSESSMENT

ENGAGEMENT

Getting people into SU treatment where they will actively participate at whatever level of intensity they have been placed is the most important thing.

FIT approach
Treatment matching
Outcome Gold Standard: **length of time in the Continuum of Care**

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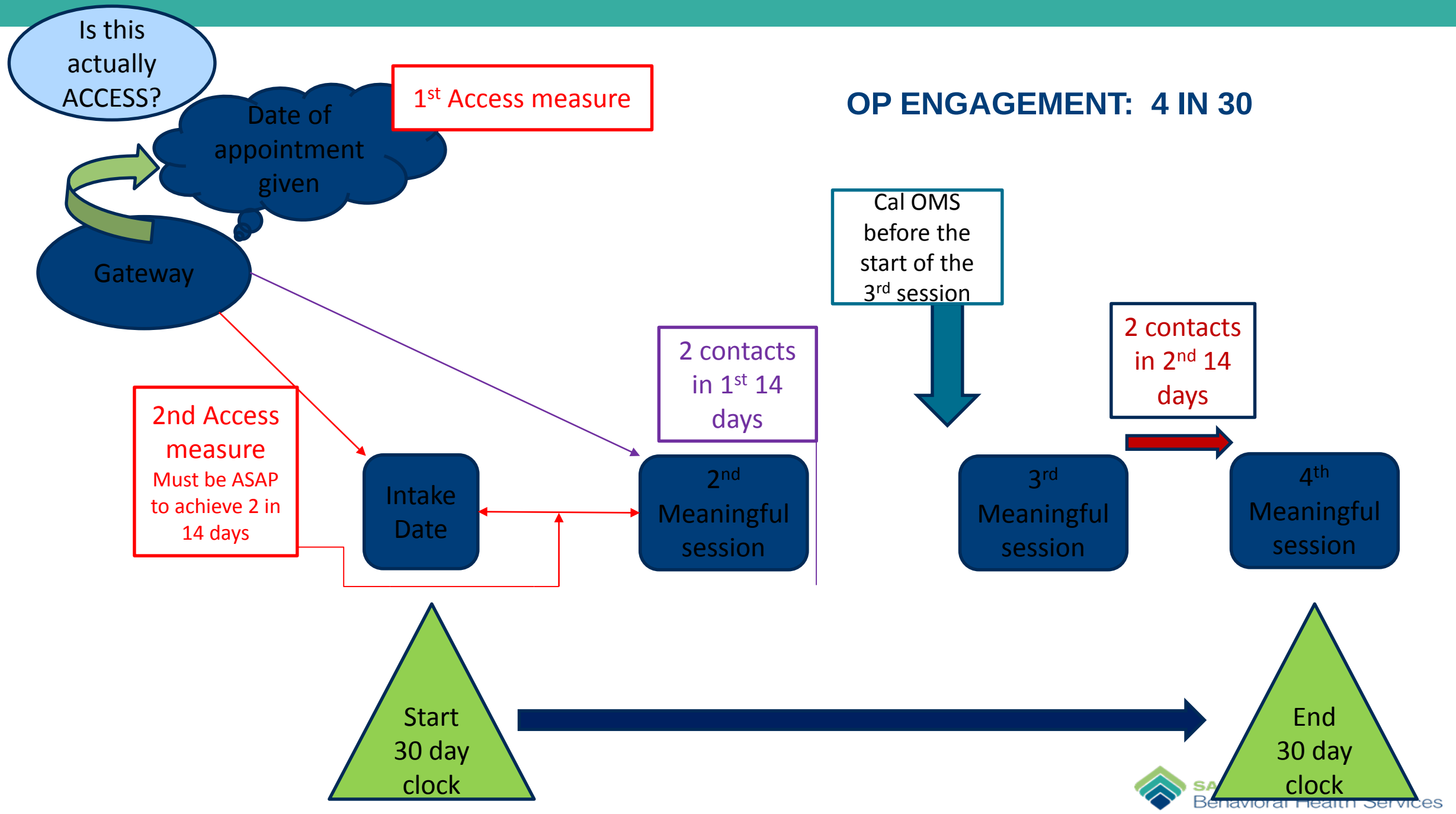
OP ENGAGEMENT: 4 IN 30



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CONTINUUM OF CARE – DATA AND ANALYSIS

Instructions (SCC "algorithm")
Creating an episode of care (pg. 1)

Purpose: To create an episode of care using currently available EHR data

Definitions:

An episode of care is defined as all treatment provided without a break (see definition below), following an initial admission (the index admission) until a discharge from the terminal modality. Each episode of care:

- begins with an admission (following a screening and assessment)
- may involve more than 1 admission
- may involve admissions to several different tx modalities during a single episode
- may begin at any point in the continuum (any modality) such as detox, residential or outpatient. First admissions to IOP rarely occur – check to see that it is a true admission
- involves only those AMT clients who have had admissions within the current fiscal year

CONTINUUM OF CARE – DATA AND ANALYSIS

Instructions

Creating an episode of care – cont'd (pg. 2)

The criteria for selecting admissions for an episode of care are:

Admission must be 'true admissions' - Same day admissions – discharges should not be counted

- When using FY files, select a date range that includes admissions from previous quarter. (Note: Episodes frequently cross fiscal years.)
  - For any fiscal year, use both open admissions and new admissions for the fiscal year. Open admissions are those admissions that occurred in the previously fiscal year, and are still open in the new fiscal year.
- Note: the same logic applies to calendar year calculations
- For admissions to be considered part of a single episode of care, the principle of temporal continuity should be applied. This means that there is no break in treatment I.e the next admission has occurred within 30 days. (Note: Do not rely on CalOMS ADM – 2 Admission Transaction type as this is not used in a consistent fashion in the system of care. A value of 1 denotes an initial admission and 2 denotes a transfer or change in service. Providers are not using this appropriately and ADM 2 has a lot of missing data).

CONTINUUM OF CARE – DATA AND ANALYSIS

Instructions

Creating an episode of care – cont'd (pg. 3)

- Temporal continuity is defined as an admission to a different modality within 30 days of discharge. So, if a client is discharged from detoxification services on 1/1/2016 and is admitted to residential on 1/10/2016, include this admission.
- Also included are 'negative' 15 days between residential discharge and an outpatient admission. A client may be admitted to an outpatient program before being discharged from a residential program to ensure a warm handoff.
- On occasion, an admission could be delayed for some reason. So, it is possible that some number of admissions within a single episode of care occur after the 30 day period. Each case should be reviewed to make a determination as to whether it should be included in a particular episode or care, or whether it should be counted as a separate episode. In these cases:
  - Check to see whether there is Gateway screen between the last discharge and the new admission
  - Check the discharge status to see if 1, 3 or 5 were checked. All involve referrals to additional services. Again, this is not fool-proof as providers do not use the status designations consistently.

UTILIZATION IN ASAM
-YOU HAVE TO COLLECT ASAM DATA-

ALOC

Assessment and Level of Care Authorization

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ASAM DATA COLLECTION – UCLA WAIVER EVALUATION PROJECT

Date of Screening or Assessment (MM/DD/YYYY)	Client Identification Number (CIN)	Client First Name	Client Last Name	Client Date of Birth (MM/DD/YYYY)	Type of Screen / Assessment	Indicated Level of Care/WM	Additional Indicated Level of Care/WM, if any	Additional Indicated Level of Care/WM, if any	Actual LOC/WM decision	Additional Actual Level of Care/WM placement decision, if any	If Actual LOC/WM was not among those Indicated, Reason for Difference	If "other" reason, please explain	If referral is being made but admission is expected to be DELAYED, reason.	If "other" reason, please explain
9/8/201612345678A		John	Doe	1/1/1996	Brief Initial Screen	Residential, exact ASAM level unspecified	Withdrawal Mgmt, exact ASAM level unspecified		Withdrawal Mgmt, Residential, exact ASAM level unspecified	Withdrawal Mgmt, Residential, exact ASAM level unspecified	Not applicable - no difference			
9/9/201612345678A		John	Doe	1/1/1996	Initial Assessment	3-WM Clinically managed residential withdrawal management	3.1 Clinically Managed Low-Intensity Residential		3-WM Clinically managed residential withdrawal management	3-WM Clinically managed residential withdrawal management	Not applicable - no difference			

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ASAM LOC Fidelity – regular intervals in ALL treatment situations

Clinical guidelines for frequency of re-assessing 6 dimensions - Based on ASAM criteria

ASAM fidelity:

In addition to assessing across dimensions to determine the required level of care, fidelity to ASAM criteria includes the spirit of how programs and systems of care operate. Describing services as having fixed length of stay is one of the main issues with fidelity to the spirit of ASAM criteria. Length of stay should be determined by tracking severity, function, and progress, rather than be predetermined (*ASAM Criteria, 2013, p.21*).

Assessing progress through the levels of service:

Patient's progress through treatment in all six dimensions "should be formally assessed at regular intervals relevant to the patient's severity of illness and level of function, and the intensity of service and level of care" (*ASAM Criteria, 2013, p.110*).

In ASAM criteria, "formal assessment of progress in all 6 dimensions" and "review/reassessment of treatment plan" are used somewhat interchangeably (p. 110). Both are important to assessing the progress in treatment, determining the appropriate level of care, and identifying any new problems that may require more or less intensive level of care.

For the purpose of this document, *re-assessment* is defined as review of all 6 dimensions at regular intervals and therefore will be called *review*.

Frequency of the review of 6 dimensions:

Below are the clinical guidelines for regular intervals for each level of care:

Outpatient Programs (OP; all except Medication Assisted Treatment) – review should be done about every 6 sessions:

- Level 1 OP - If 1 session a week, review about every 6 weeks; if 2-3 sessions a week, review every 2-3 weeks, etc.
- Level 2.1 IOP – if patient attends 3 times a week, review in 2 weeks; if daily attendance – review weekly
- Level 2.5 Partial Hospitalization – if patient attends daily, review weekly.

Residential levels – once a week, or more often if the person is quite unstable.

Documentation of the review:

The review of 6 dimensions at regular intervals should be documented using A-LOC form and included in patient's medical record. Treatment plan should be updated as a result of the review when needed.

UTILIZATION IN ASAM

CONSIDERATIONS

Waiver – Residential Authorization

- Actually using ASAM for placement AND on-going Tx
- Least Restrictive LOC
  - No “fail first”
  - SU Tx is most effective in the environment were SU occurs
- Stabilization vs. Cure
  - Residential is *STABILIZATION* – not cure
- Recovery Residence
  - THU/SLE – adjunctive support to OP tx – DIM 6 issues

UM (authorizations) - Imminent Danger Residential Criteria

Level of Care Placement Criteria
Based on The ASAM Criteria

What are the differentiating criteria for residential levels as compared to outpatient levels? (page 175, Tab 4. Adult Crosswalk)

3.1

- Danger in environment

3.3

- Cognitive deficits and related dangerous consequences of use (consider SU impact on cognitive functions)
- Danger in environment

3.5

- Functional deficits in mental health, such as inability to control impulses
- Difficulty with or marked opposition to treatment with dangerous consequences
- No recognition of skills needed to prevent continued use, with imminent dangerous consequences
- Danger in environment.

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Imminent Danger Residential Criteria

What is danger in environment? **Dim 6 criteria for 3.1 level**, P 230-231.

Patient is able to cope, for limited periods of time, outside of the 24-hour structure in order to pursue clinical, vocational, educational, and community activities. **AND**

Environment characterized by a moderately high risk of initiation of physical, sexual or emotional abuse, or substance use so endemic that the patient is assessed as being unable to achieve or maintain recovery at a less intensive level of care. **OR**

High-risk social contacts that jeopardize recovery, or lack of social contacts, isolation and withdrawal. Social network with friends who are regular users making recovery goals unachievable. **OR**

Living in environment infested with drugs making recovery goals unachievable. **OR**

School, work or living environment makes recovery unlikely, and the patient has insufficient resources and skills to maintain adequate level of functioning outside 24-hour supportive environment. **OR**

In danger for victimization.

With the exception of the first bullet, same as above applies for levels 3.3 and 3.5, plus take into account functional and cognitive limitations, and risk of victimization or neglect when assessing person's ability to cope in their current environment (see p. 243 for level 3.3 and p. 259 for level 3.5 for more details on Dim 6 specifications).

Imminent Danger Residential Criteria

Examples of environment-related issues that can be appropriately addressed at level 3.1 (p.222-224):

- Living situation toxic to recovery: substance exposure, substance-infested environment, culture of substance-involved and antisocial behaviors
- Chaotic home situation
- Drug using family or significant others
- Lack of daily structured activity, such as school or work
- Patient's functional deficits include greater than average susceptibility to peer or other influence

QM IN ASAM

- Assessment Gates – “intake”
- “interval” Assessments
- Movement in the COC
- ASAM “Golden Thread”
  - Current ASAM assessment
  - Treatment Plan - Dimensions
  - Progress notes – Dimensions
  - *Clinical Performance Measures – Chart Audit*

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QM IN ASAM

What Doing the ASAM Really Means

- Clinicians learn the ASAM – 6 DIM first and foremost
- Clinicians learn the ASAM LOC per the Waiver STCs –
- Clinicians assess using 6 DIMs
- Clinicians Tx Plan using ASAM
- Clinicians perform “interval” ASAM assessments and update Tx plan and treatment interventions
- Clinicians Document using ASAM
- Clinicians Present Cases using ASAM model

QM IN ASAM

What Doing the ASAM Really Means

- QM learns the ASAM – 6 DIM first and foremost
- QM learns the ASAM LOC per the Waiver STCs
- QM audits use of 6 DIMs
- QM audits use of ASAM in Tx Planning
- QM monitors *variance* in system, provider, client LOS
- QM monitors frequency of "interval" ASAM assessments – matches to admission and discharge dates (keep track of this data)
- QM monitors COC utilization/frequency
- QM authorizes Residential services according to ASAM Criteria/Imminent Danger consideration (keep track of this data) – ALOC style Document
- QM ***teaches*** the "Spirit of ASAM" through on-going interactions with clinical provider system (see What Doing the ASAM Really Means)

Clinical Performance Measures – Get ASAM into the Chart Audit

1st Problem Statement identifies areas of impairment or distress of substance use
1st Problem Statement is correctly matched with the appropriate ASAM dimension
The Stage of Change is correctly matched with appropriate Problem Statement
Goal(s) directly relate to the Problem Statement & matches the Stage of Change
Action Steps are strength-based
Action Steps are stated in measurable terms (S.M.A.R.T.)
Action Steps help achieve the Goal (s)
2nd Problem Statement identifies areas of impairment or distress of substance use
2nd Problem Statement is correctly matched with the appropriate ASAM dimension
The Stage of Change is correctly matched with appropriate Problem Statement
Goal(s) directly relate to the Problem Statement & matches the Stage of Change
Action Steps are strength-based
Action Steps are stated in measurable terms (S.M.A.R.T.)
Action Steps help achieve the Goal (s)
3rd Problem Statement identifies areas of impairment or distress of substance use
3rd Problem Statement is correctly matched with the appropriate ASAM dimension
The Stage of Change is correctly matched with appropriate Problem Statement
Goal(s) directly relate to the Problem Statement & matches the Stage of Change
Action Steps are strength-based
Action Steps are stated in measurable terms (S.M.A.R.T.)
Action Steps help achieve the Goal (s)

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Comments & Questions

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