SUD Technical Assistance Webinar Series

VIRGINIA MEDICAID: 26—ASAM CRITERIA ASSESSMENT DIMENSIONS 5 & 6
PAUL BRASLER, LCSW, CAIP
MARCH 29 & 31, 2022

Department of Medical Assistance Services
Welcome & Meeting Information

- WebEx participants are muted
- Please use the Q & A feature or the Chat feature if you have a question

- The focus of today’s presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions

- We do not offer CEUs for this webinar series
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The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,997,093 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.
The ASAM dimensions are designed to guide the assessment process and ensure that each client receives the most appropriate, individualized treatment. A clear understanding of these treatment assessment dimensions is critical for providers, Managed Care Organizations and other professionals in order to operationalize this content in practice with Medicaid members who have a substance use disorder.

PLEASE NOTE that the goal of this training is to help raise providers' awareness and understanding around implementing ASAM Treatment Assessment dimensions. This training is not designed as a substitute for official ASAM training, nor is this to serve as a substitute for any ASAM training that is required by any local, state, or federal regulatory agency or certifying organization. This training is not sponsored or endorsed by ASAM.
Naloxone Resources

- Get trained now on naloxone distribution
  - REVIVE! Online training provided by DBHDS every Wednesday
  - [https://getnaloxonenow.org/](https://getnaloxonenow.org/)
    - Register and enter your zip code to access free online training
- Medicaid provides naloxone to members at no cost and without prior authorization!
- Call your pharmacy before you go to pick it up!
- Getting naloxone via mail
  - Contact the Chris Atwood Foundation
  - [https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422](https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422)
    - Available only to Virginia residents, intramuscular administration
SUPPORT Act Grant Website -
https://www.dmas.virginia.gov/#/artssupport
Hamilton Relay Transcriber (CC)

- The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.

- We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.

- The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.
Pre-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

If you haven’t already, before the start of today’s webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey. [https://redcap.vcu.edu/surveys/?s=C8HERT9N3P](https://redcap.vcu.edu/surveys/?s=C8HERT9N3P)

- Your name and contact information will not be linked to your survey responses.
- Your decision to complete the survey is completely voluntary.
- When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
- You are able to complete one pre and post survey per each webinar topic you attend.
- Your completion of the pre-webinar survey will enter you into a drawing to win a $50 Amazon gift card as well as participation in the post-webinar survey will enter you into another $50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!
Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.
First Things First…

- Even the best assessment policy, process, tools or forms cannot replace an empathetic, trained provider.
- Prior to even thinking about doing an assessment, we need to agree:
  - People are worthy of help, have the right to self-determination, and should be treated with respect and dignity.
  - Our role is to walk with our clients; not live their lives for them, and to respect their choices, even when those choices are things we disagree about.
  - No one sets out to become addicted to substances or behaviors.
  - Recovery is possible and is defined by the client.
We want to use “Person-Centered language”

- Not “Addict,” but Person who uses drugs or Person with a substance use/behavioral disorder
- Not “Addiction,” but Substance Use Disorder (SUD)
- Not “Abuse,” but Use
- Not “Clean,” but In Recovery or Testing Negative
- Not “Dirty,” but Testing Positive
- Not “Relapse,” but Return to Use

At the same time, out of habit, I may inadvertently use some of these older words/terminology—and some of the sources I quote use older terms

Be cognizant that some people may describe themselves as “alcoholics,” “junkies,” etc., or may refer to “clean time” as how long they have been in recovery (and we need to respect this)
Why ASAM (American Society of Addiction Medicine) Criteria?

“The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions has its roots in the mid-1980s and was designed to help clinicians, payers, and regulators use and fund levels of care in a person-centered and individualized treatment manner. To increase access to care and improve the cost-effectiveness of addiction treatment, the ASAM Criteria represents a shift from [italics in original]:

(con’t)
Why ASAM (American Society of Addiction Medicine) Criteria?

- One-dimensional to multidimensional assessment—from treatment based solely on diagnosis to treatment that addresses multiple needs
- Program-driven to clinically and outcome-driven treatment—from placement in a program often with fixed lengths of stay to person-centered, recovery-oriented, individualized treatment response to specific needs and progress and outcomes in treatment
- Fixed length of service to a variable length of service, based on patient needs and outcomes; and
- A limited number of discrete levels of care to a broad and flexible continuum of care in a chronic disease management system of care” (Herron & Brennan, 2020, p. 172)
## ASAM Criteria Levels of Care

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Description (Herron &amp; Brennan, 2020, pgs. 174 – 175)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0</td>
<td>Medically managed intensive inpatient. 24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3; counseling available to engage patient in treatment</td>
</tr>
<tr>
<td>3.7</td>
<td>Medically monitored intensive inpatient. 24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3; 16 hours per day for counselor availability</td>
</tr>
<tr>
<td>3.5</td>
<td>Clinically managed high-intensity residential treatment. 24-hour care with trained counselors to stabilize multi-dimensional imminent danger and prepare for outpatient treatment; able to tolerate and use a full active milieu or therapeutic community</td>
</tr>
<tr>
<td>3.3</td>
<td>Clinically managed-population-specific high-intensity residential. 24-hour care with trained counselors to stabilize multi-dimensional imminent danger; less intense milieu and group treatment for those with cognitive or other impairments unable to use a full active milieu or therapeutic community</td>
</tr>
<tr>
<td>3.1</td>
<td>Clinically managed low-intensity residential. 24-hour structure with available trained personnel with emphasis on re-entry to the community; at least 5 hours of clinical service per week</td>
</tr>
<tr>
<td>2.5</td>
<td>Partial Hospitalization. 20 hours of service or more per week in a structured program for multi-dimensional instability not requiring 24-hour care</td>
</tr>
<tr>
<td>2.1</td>
<td>Intensive Outpatient. 9 hours of service or more per week (adults); 6 hours or more per week (adolescents) in a structured program to treat multi-dimensional instability</td>
</tr>
<tr>
<td>1.0</td>
<td>Outpatient Services. Less than 9 hours or service per week (adults); &lt;6 hours per week (adolescents) for recovery or motivational enhancement therapies/strategies</td>
</tr>
</tbody>
</table>
ASAM Criteria Assessment Dimensions

- ASAM exists to provide best-practices guidance for SUD providers in all treatment settings
  - This includes guidance on how to conduct a comprehensive assessment for all clients receiving SUD treatment

There is not a specific ASAM Assessment form or template

- Instead ASAM outlines six criteria dimensions that should be a part of every SUD assessment to ensure that the client’s needs are identified and met
<table>
<thead>
<tr>
<th>Assessment Dimensions</th>
<th>Assessment &amp; Treatment Planning Focus</th>
</tr>
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<tbody>
<tr>
<td>1. Acute intoxication and/or withdrawal potential</td>
<td>Assessment for intoxication or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued addiction services</td>
</tr>
<tr>
<td>2. Biomedical conditions and complications</td>
<td>Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services</td>
</tr>
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</tr>
<tr>
<td>3. Emotional, behavioral, or cognitive conditions and complications</td>
<td>Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services</td>
</tr>
<tr>
<td>4. Readiness to change</td>
<td>Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change</td>
</tr>
</tbody>
</table>
### ASAM Criteria Assessment Dimensions
(Herron & Brennan, 2015, p. 174)

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<th>Assessment Dimensions</th>
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<td><strong>5. Relapse, continued use, or continued problem potential</strong></td>
<td>Assess readiness for relapse prevention services and teach where appropriate. Identify previous periods of sobriety or wellness and what worked to achieve this. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies</td>
</tr>
<tr>
<td><strong>6. Recovery environment</strong></td>
<td>Assess need for specific individualized family or significant others, housing, financial, vocational, educational, legal, transportation, childcare services. Identify any supports and assets in any or all of the areas</td>
</tr>
</tbody>
</table>
Comprehensive assessment of the patient is critical for treatment planning.

However, completion of all assessments should not delay or preclude initiating pharmacotherapy for opioid use disorder.

If not completed before initiating treatment, assessments should be completed soon thereafter.

ASAM Assessment Recommendations (ASAM, 2020, p. 26)
Assessment Criteria
Dimension 5
RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL
Assessment Criteria Dimension 5

- Assess readiness for relapse prevention services and teach where appropriate
- Identify previous periods of sobriety or wellness and what worked to achieve this
- If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies
“High rates of relapse have led many researchers to conceptualize addiction as a ‘chronic relapsing illness’ and understand relapse prevention [RP] as an iterative process of change rather than as a full inoculation against relapse”

(Herron & Brennan, 2020, p. 402)
A goal of SUD treatment is to anticipate relapses, and develop ways to both avoid them AND deal with them if they happen.

Expect relapses to happen, and do not judge the client for this and reframe them as opportunities for continued growth in treatment.

Be sure to re-assess the client following a relapse to determine if they require prompt medical attention.
Questions About Relapse

1. What are some reasons to stop using substances, or to change/decrease your use?

2. When you think about not using substances (or changing what you use or how much you use), what do you think will be your biggest challenges?

3. If you stopped using, or decreased your use, in the past; what worked for you? How could you do this again?

4. How have you weighed the benefits and challenges of continuing to use versus stopping/decreasing your use?

5. What are some things that have triggered your use in the past or that could trigger you to return (or continue) to use?
Lapse, Relapse, Prolapse & More
(Herron & Brennan, 2020, p. 402)

- **Lapse**: The initial episode of use of a substance after a period of abstinence

- **Relapse**: Continued use after the lapse

- **Prolapse**: A behavior that is consistent with getting back on track in the direction of positive behavior change

- **Abstinence Violation Effect**: Self-blame and loss of perceived control that individuals often experience after the violation of self-imposed rules
“Recovery in the context of SUD refers to a long-term process in which there is change not only in the use of substances but also in personal and social aspects of a person’s life. The road to recovery remains anything but linear and smooth, and the outcome anything but predictable. Domains of change during the recovery process can include physical, psychological, spiritual, behavioral, interpersonal, sociocultural, familial, and/or financial”

(Herron & Brennan, 2020, p. 403)
Determinates of Relapse

**Self-Efficacy:** A person’s belief in their ability to achieve a goal

“The person’s belief in their ability to control use of a substance is a reliable predictor of lapses immediately after treatment and over long-term outcomes” (Herron & Brennan, 2020, p. 403)

**Outcome Expectancies**

“Individuals who developed an addiction typically have developed a set of expectancies that anticipate positive outcomes from engaging in the behavior, serving as a source of motivation to engage in it” (Herron & Brennan, p. 403)

**Motivation**

“May relate to the relapse process in two distinct ways: The motivation for positive behavior change and the motivation to engage in the problematic behavior” (p. 403)
Determinates of Relapse

- **Coping**
  - “The most critical predictor of relapse is the individual’s ability to utilize adequate coping strategies in dealing with high-risk situations. What predicts sustained sobriety is the individual’s capacity for dealing with life’s challenges, particularly with coping strategies that exclude avoidance” (Herron & Brennan, p. 404)

- **Negative Emotional States**
  - “Practitioners should incorporate strategies to decrease and manage negative emotional states such as anxiety, anger, boredom, depression, loneliness, or guilt and shame. It is not the emotional state that determines if a relapse occurs but the use of coping strategies to manage the state” (p. 404)

- **Interpersonal Determinants**: Social network size and quality
Relapse Prevention Interventions
(Herron & Brennan, 2020, 404 – 406)

1. Help individuals understand relapse as a process and event and learn to identify the warning signs
   - Attitudinal, emotional, cognitive, and behavioral changes may occur much longer before resuming substance use
   - Warning signs include reducing contact with others
   - Relapses can be seen as links in a chain (reviewing and monitoring these can be good strategy)

2. Help individuals identify their high-risk situations and develop effective cognitive and behavioral coping
   - “A person heading for a relapse usually makes several mini-decisions over time, each of which brings them closer to creating a high-risk situation or giving in to the decision to use a substance. These choices are called ‘apparently irrelevant decisions,’ and they need to be identified and addressed”
Relapse Prevention Interventions
(Herron & Brennan, 2020, 404 – 406)

3. Help individuals enhance their communication skills and interpersonal relationships and develop a recovery social network
   ▶ Involving family members and social supports in the treatment process generally enhances the individual’s recovery efforts
   ▶ Engaging in peer or mutual support groups is also helpful

4. Help individuals reduce, identify, and manage negative emotional states
   ▶ “Helping people become aware of their moods and emotions or feelings, understand the connection between thoughts and emotions, and changing how they think can help them manage these without resorting to substance use”
   ▶ Encourage individuals to change behaviors relative to an emotional state (e.g., exercise when depressed)
Relapse Prevention Interventions
(Herron & Brennan, 2020, 404 – 406)

5. Help individuals identify and manage cravings and cues that precede cravings
   - Practitioners can provide psychoeducation on cues and how they trigger cravings
   - “Cognitive interventions include changing thoughts about the craving, challenging euphoric recall, talking oneself through the craving, thinking beyond the high about the negative consequences of using, using 12-step slogans, and delaying the decision to use”

6. Help individuals identify and challenge cognitive distortions
   - Also called “stinking thinking”
   - Help clients identify their stinking thinking and use counter-thoughts to challenge those errors (e.g., “I’ll die if I don’t use”)

Relapse Prevention Interventions
(Herron & Brennan, 2020, 404 – 406)

7. Help individuals work toward a more balanced lifestyle
   “A person’s lifestyle can be assessed by evaluating patterns of daily activities, sources of stress, daily hassles and uplifts, the balance between ‘wants’ (i.e., activities engaged in for pleasure or self-fulfillment) and ‘should’ (i.e., external demands), health, exercise and relaxation patterns, interpersonal activities, and religious beliefs”

8. Consider the use of medications in combination with psychosocial treatments
Relapse Prevention Interventions
(Herron & Brennan, 2020, 404 – 406)

9. Facilitate the transition between levels of care for individuals completing residential or hospital-based inpatient treatment programs or structured partial hospital or intensive outpatient programs
   - “Interventions used to enhance treatment entry and adherence that also lower the risk of relapse include providing a single session of motivational therapy before discharge from residential or intensive treatment, using telephone or [social media] reminders of initial treatment appointments, and providing reinforcers for appropriate participation in treatment activities”

10. Incorporate strategies to improve adherence to treatment and medications
    - (e.g., motivational interviewing)
Clients can be helped to think about their triggers:

**HALT** (hungry, angry, lonely, tired)

**RIID** (restless, irritable, isolated, discontent)

**BAAD** (bored, anxious, angry, depressed)

- Environmental cues can include sights, smells, sounds, tastes, locations, etc.
- “People, Places and Things”
Assessment Criteria
Dimension 6
RECOVERY ENVIRONMENT
Assessment Criteria Dimension 6

- Assess need for specific individualized family or significant others, housing, financial, vocational, educational, legal, transportation, childcare services

- Identify any supports and assets in any or all of the areas
A coordinated approach to the delivery of health, substance use disorder, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals.

(CSAT, 2000, p. xiii)
Why is Care Coordination So Important in SUD Treatment (CSAT, 2000, p. xiii)

1. Retention in treatment is associated with better outcomes, and a principal goal of care coordination is to keep clients engaged in treatment and moving toward recovery.

2. Treatment may be more likely to succeed when a client’s other problems are addressed concurrently with substance use.

3. Comprehensive SUD treatment often requires that clients move to different levels of care or systems; case coordination facilitates such movement.
The primary goal of care coordination is to help clients connect with services and resources that enhance their recovery.

CC starts by understanding the client’s Recovery Capital.
Personal Recovery Capital:
The client’s physical health, emotional supports and things that support recovery (housing, income, insurance, food, safety)

Family/Social Recovery Capital: The resources and support available to the client from their family and friends (emotional, financial, help with childcare, transportation)

Community Recovery Capital: Resources available in the client’s community (healthcare, childcare, transportation, housing, etc.)
Some Care Coordination Needs

- Medical appointments
- Medical treatment
- Obtaining health insurance
- Dental care
- Transportation
- Childcare
- Job search
- Housing
- Enrolling in job training
- Legal aid

- Meeting legal system obligations (coordinate with probation/parole)
- Financial assistance
- Obtaining food vouchers
- Access food pantries
- Clothing
- Adult education needs
- Enrolling children in school
- Immigration needs
- Additional mental health needs
Assessing for Dimension Criteria 6

1. Who does the client live with, or who do they have responsibility for?

2. What are the strengths and needs of each person living with the client/part of client’s responsibilities?

3. What can our agency provide?

4. What services are available in your community and how do we help client access the services?
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References


