Understanding the ASAM Criteria in Action from Assessment to Treatment Planning ASAM-B

LA County Dept. of Public Health
Substance Abuse Prevention & Control

Disclaimer & Disclosure

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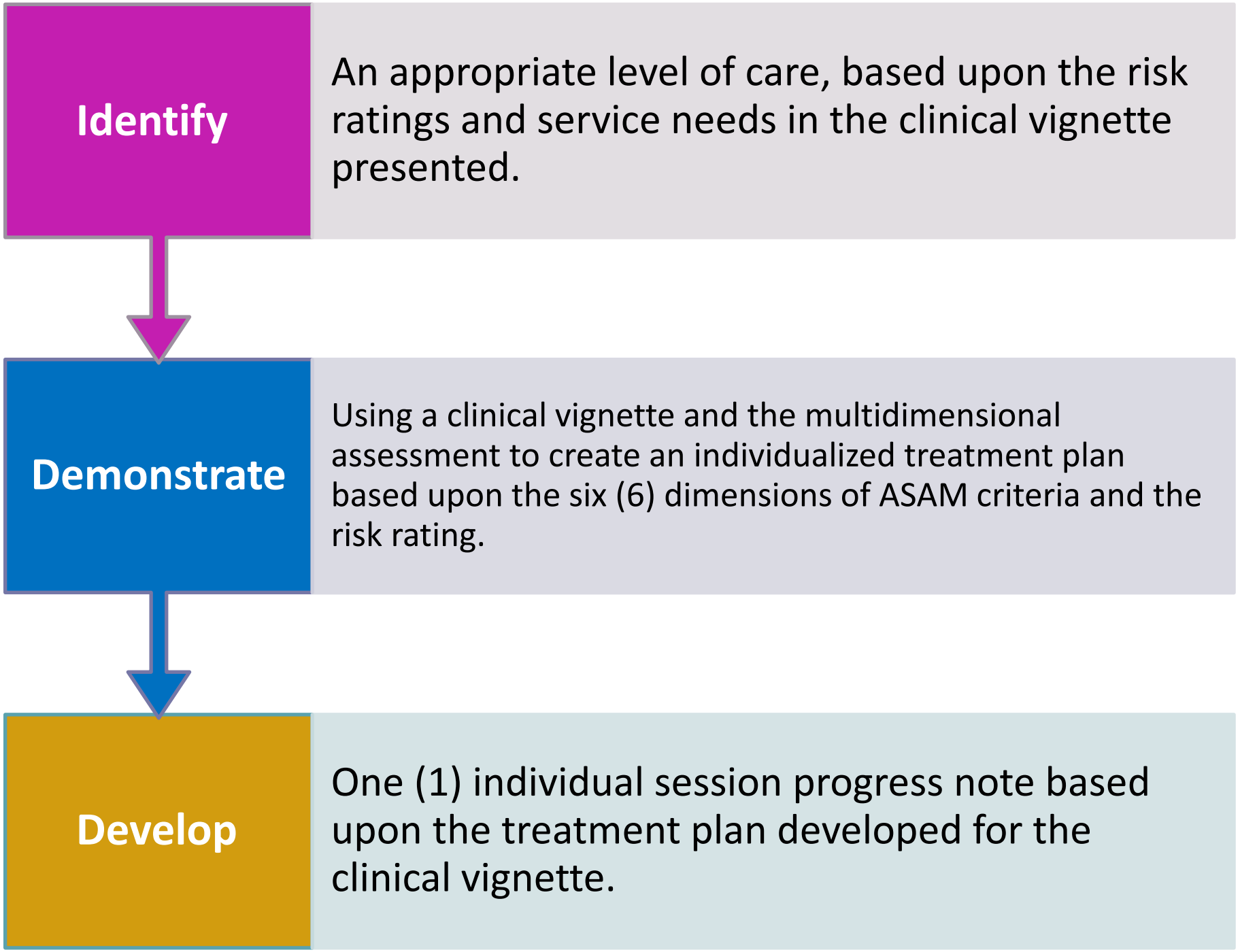
Disclosure-

There is no commercial support for this activity

Learning Objectives: at the end of the presentation attendees will be able to



Steps to Providing [Drug Medi-Cal (DMC) Billable] SUD Services

"All providers must be trained in the ASAM criteria PRIOR to providing services"

- Per Department of Healthcare Services (DHCS)-State Guidelines

May provide non-DMC services as a registered SUD (i.e. to non-SAPC pts) without this training

Take ASAM-A Training

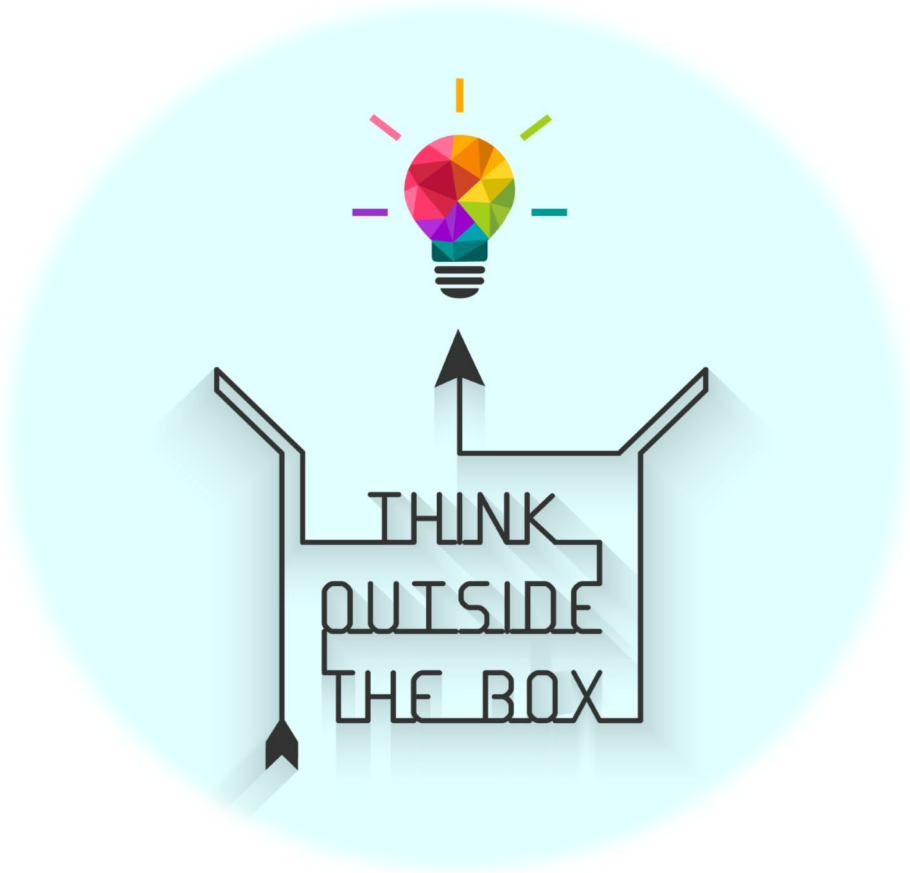
Take ASAM-B Training

You are Here!

1. Conduct ASAM CO-Triage Screener or ASAM Screener for Youth & Young Adults
2. Continuum Assessment
3. Conduct SUD Tx

SAPC Provider Manual Version 9.0 pg. 186

Why the ASAM Criteria Continues to be Used



- Treatment is **person-centered** and **collaborative**
- Services that are directly related to **specific**, **unique** to a patient's multidimensional assessment
- Services are designed to meet a patient's **specific needs** and **preferences**

"Sized" to match patient's problems and needs aka Clinically Driven Outcomes

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The ASAM Criteria

The ASAM Criteria is a standardized and organized way to deliver comprehensive and biopsychosocial substance use disorder (SUD) treatment services through a multidimensional assessment

The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd Edition.

Assessment of Dimensional Risk Ratings

Assessing Risk for Each Dimension

0 Non-issues, or very low-risk issue. No current risk-any chronic issues likely to be mostly or entirely resolved.

1 Mild difficulty, signs, or symptoms. Any chronic issues likely to resolve soon

2 Moderate difficulty in functioning with some persistent chronic issues

3 Serious issues or difficulty with coping. High risk or near imminent danger.

4 Utmost severity. Critical impairments/symptoms indicating imminent danger.

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What Guides Placement Priorities?

- The highest severity problem, with specific attention to Dimensions 1, 2, and 3 should guide the patient's entry point into the treatment continuum.
- Stabilization and/or Resolution of any acute problem(s) provides an opportunity to shift the patient down to a less intensive level of care.

Assessing "Immediate Needs" and "Imminent Danger "

Includes (3) three components:

1) The strong probability that certain behaviors will occur (i.e., continued alcohol or drug use, etc.)

2) That such behaviors will present a significant risk of serious adverse consequences to individual and/or others (i.e., driving while intoxicated, neglect of child, etc.)

3) The likelihood these events will occur in the very near future (within *hours or days*, **not** weeks or months).

The ASAM Criteria, 2013, p. 56

Risk Rating	Dimension 1	Dimension 2	Dimension 3	Dimension 4	Dimension 5	Dimension 6
0	Fully functioning, "no signs of intoxication or withdrawal present".	Fully functioning, no biomedical symptoms or signs are present. Biomedical conditions are stable.	Good impulse control and coping skills in subdomains (dangerousness/lethality, interference with recovery efforts, social functioning, self-care ability, course of illness).	Patient shows willingness and commitment to both SUD and mental health (MH) treatment. Patient is proactive and responsible.	Low relapse potential. Good coping skills.	"The patient has a supportive environment or is able to cope with poor supports."
1	Mild to moderate intoxication interferes with daily functioning but does not pose a danger to self or others. Minimal risk of severe withdrawal.	Biomedical signs/symptoms are mild to moderate that may interfere with daily functioning.	There is a suspected or diagnosed EBC condition that requires intervention but does not significantly interfere with treatment. Relationships are being impaired but not endangered by substance use.	Patient shows willingness and commitment to both SUD and MH treatment but feels ambivalent with the need for change.	Minimal relapse risk. Relapse prevention skills and self-management skills are fair.	Patient is able to cope even with passive support or limited support from loved ones.
2	Intoxication may be severe but responds to support; not posing a danger to self or others. "Moderate risk of severe withdrawal".	Biomedical conditions may interfere with recovery and mental health treatment. Neglecting serious biomedical conditions. Presence of acute but non-life-threatening medical symptoms and signs. Shows some "difficulty tolerating and coping with physical problems."	Persistent EBC condition, with symptoms that distract from recovery efforts, but are not an immediate threat to safety and do not prevent independent functioning.	Patient is reluctant to enter treatment. Aware of negative consequences of substance use but has "low readiness to change and is passively involved in treatment. May be inconsistent with treatment and self-help group attendance.	Patient is capable of self-management with prompting but has "impaired recognition and understanding of" relapse.	Patient is able to cope with clinical structure even thought their environment is not supportive of SUD recovery.

Adapted from Mee-Lee, D., Shulman, G. D., Fishman, M. J., Gasfriend, D. R., & Miller, M. M. (Eds.). (2013). *The ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions* (3rd ed.). Carson City, NV: American Society of Addiction Medicine. pp.74-89.

Risk Rating	Dimension 1	Dimension 2	Dimension 3	Dimension 4	Dimension 5	Dimension 6
3	"Severe signs/symptoms of intoxication indicates… an imminent danger to self or others". Risk of severe but manageable withdrawal; or withdrawal is worsening.	"Poor ability to tolerate and cope with physical problems." Poor health condition. Neglecting serious medical problems but health is still stable.	Severe EBC symptoms, but sufficient control that does not require involuntary confinement. Impulses to harm self or others, but not dangerous in a 24-hr setting.	Patient does not follow through treatment consistently and has limited insight to need for treatment. Not aware of the need to change.	Limited understanding on relapse and has poor coping skills. Limited relapse coping skills.	Patient struggles with coping even with clinical structure due to unsupportive recovery environment.
4	"Incapacitated, with severe signs and symptoms. Severe withdrawal presents danger, as of seizures. Continued use poses an imminent threat to life (e.g., liver failure, GI bleed, or fetal death)."	Presence of serious medical problems. "Patient is incapacitated." Requires medical stabilization and medication management in a hospital setting.	Severe EBC symptomatology; requires involuntary confinement. Exhibits severe and acute life-threatening symptoms (e.g., dangerous or impulsive behavior or cognitive functioning) posing imminent danger to self and others.	Inability to follow through treatment recommendations and see the connection between substance use and negative consequences. Blaming others for their SUD and unwilling to explore change. Requires immediate action if patient shows imminent risk to harm self/others due to SUD or MH conditions.	No relapse prevention skills to reduce relapse. Repeated treatment has little effect on improving the patient's functioning. Requires immediate action if patient shows imminent risk to harm self/others due to SUD or MH conditions.	Patient's surrounding environment is hostile and not supportive of SUD recovery. Patient struggles to cope with the environment. Requires immediate action if the environment is posting imminent threat to patient's wellbeing and safety.

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SNAP During Assessment to Care Planning

County of Los Angeles Public Health

Strengths

- Characteristics of patients or elements of their lives used in the past and present to cope with difficult situations
- EX: Supportive family & friends, hope, connected with identified values and beliefs

Needs

- What the patient needs in order to participate in treatment goals (needs may also be identified by the provider)
- EX: Get into stable housing, assessment for MAT, learn coping skills

Abilities

- What the patient is capable of
- EX: Resiliency, finding resources, asking for help

Preferences

- Refers to what the patients wants in terms of practical aspects of treatment
- EX: Inpatient vs. Outpatient Treatment, Treatment conducted in primary language

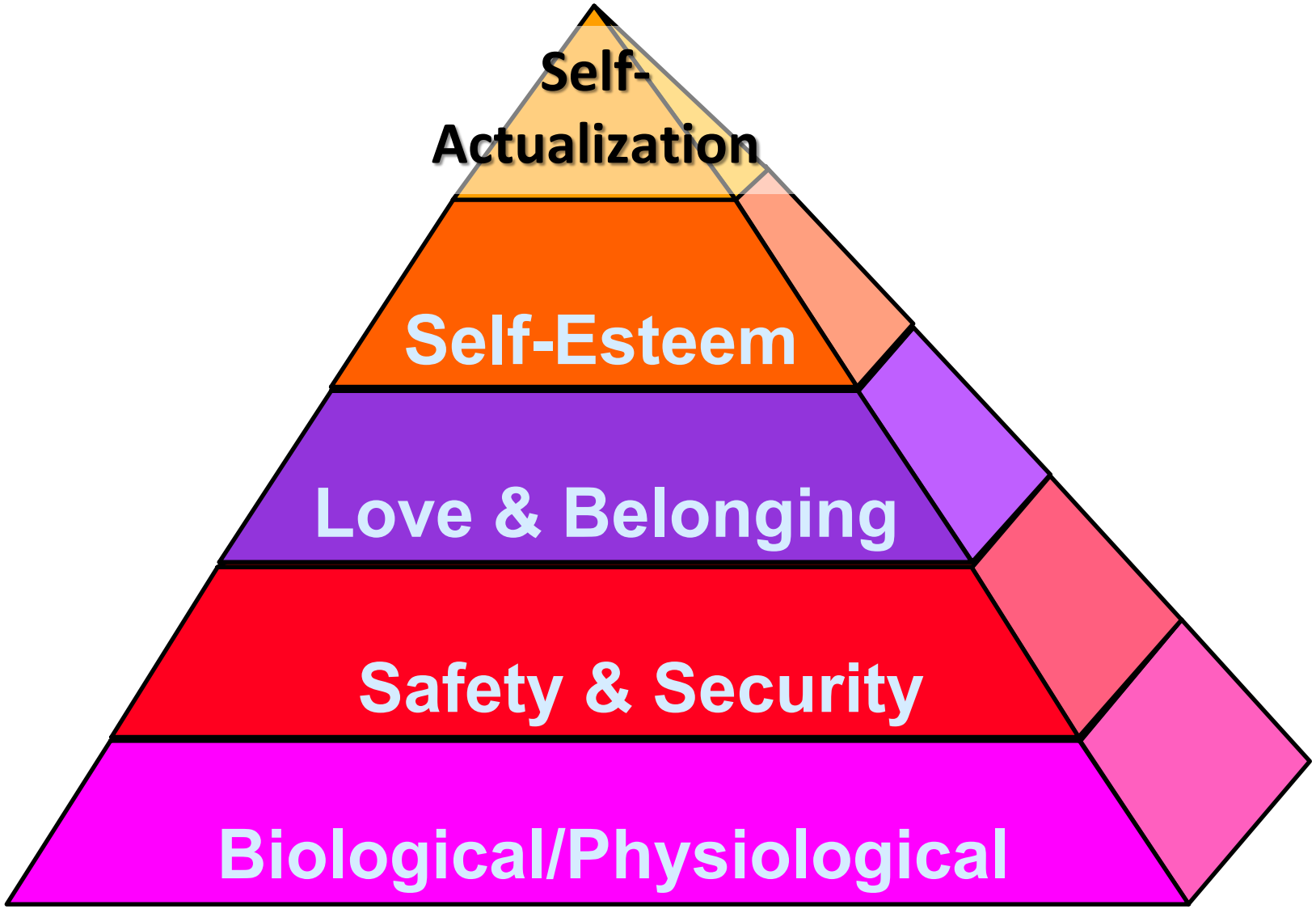
Case Vignette- Andrea

- 27-year-old African American female with opioid use disorder, severe.
- She has been using prescribed opioids for medical complications following a surgical procedure a few years ago. When her physician refused to refill her prescription for misusing the prescription, she smoked heroin, then started to inject heroin shortly after.
- Prior to the surgery, Andrea was living independently, working for a local tech start-up after receiving her BA in business.
- Andrea lost her job, then her apartment, and moved in with her sister.
- Andrea reported some depressive symptoms due to substance use and unemployment. She is not sure about receiving psychological services.
- Andrea stated that she has anemia, and she has stopped taking iron pills.
- Andrea has just completed LOC 3.2 withdrawal management with no prior SUD treatment history.

What are Andrea's Strengths/Needs/Abilities/Preferences (SNAP)?

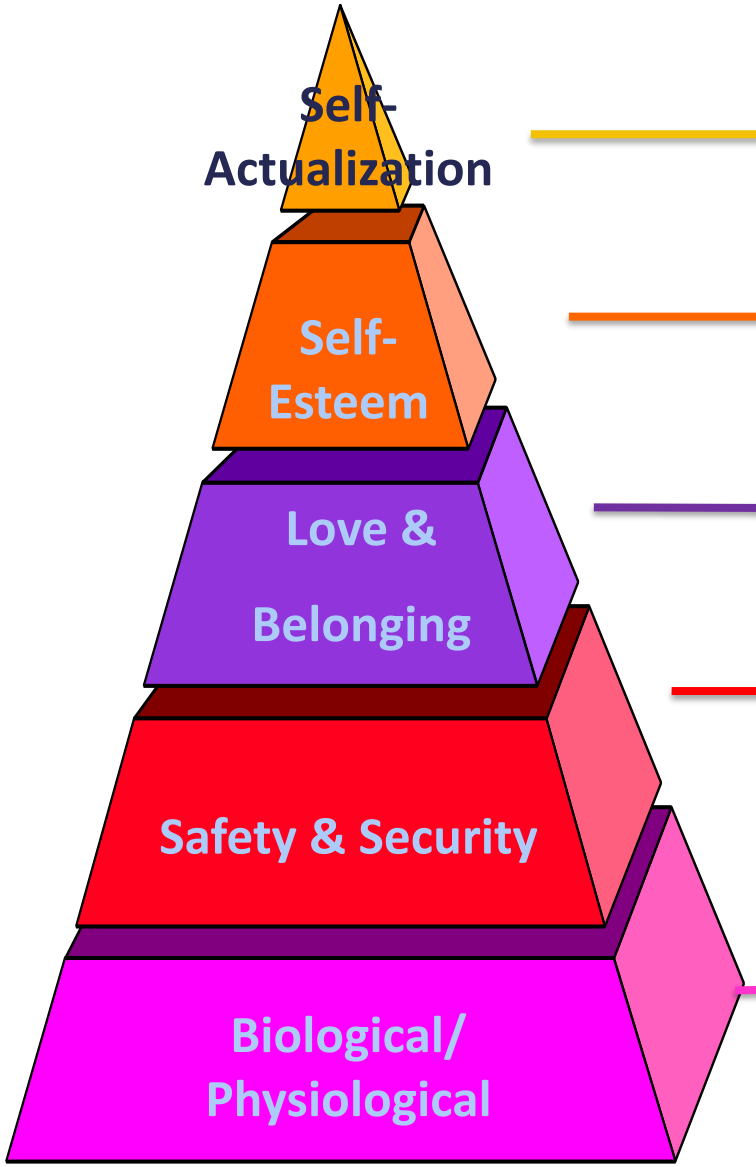
Considering Patient Needs

Hierarchy of Needs-Simplified Version



Slide Credit: UCLA Integrate Substance Abuse Programs

Relationship Between ASAM Dimensions & Hierarchy of Needs



ASAM Dimension 4 – Readiness to Change

ASAM Dimension 3 – Emotional/ Cognitive Conditions

ASAM Dimension 6 – Recovery/ Living Environment

ASAM Dimension 2 – Biomedical Conditions
ASAM Dimension 3 – Emotional/ Cognitive Conditions
ASAM Dimension 5 – Relapse/ Continued Use

ASAM Dimension 6 – Recovery/ Living Environment
ASAM Dimension 1 – Acute Intoxication/Withdrawal
ASAM Dimension 2 – Biomedical Conditions
ASAM Dimension 3 – Emotional/ Cognitive Conditions

Slide Credit: UCLA Integrate Substance Abuse Programs

Cultural Factors

Assessing for Cultural Implications on Assessment & Care Planning

- Individualistic vs. collectivistic culture
- Family and/or Community involvement
- Direct or indirect communication
- View of authority
- Beliefs about treatment
- Does culture change the focus of the goals?
  - Type of referrals (language, gender, ethnicity)
  - Who to involve in care planning

Improving Cross-Cultural Communication

- Slow down
- Use plain, non-jargon language
- Use the "teach-back" method. Ask the patient, in a nonthreatening way, to explain or show what they have been told.
  - Avoid the "do you understand?" question.
- Create a shame-free environment that encourages questions and participation.

For more information check out SAMHSA Tip 59 A Treatment Improvement Protocol- "Improving Cultural Competence"

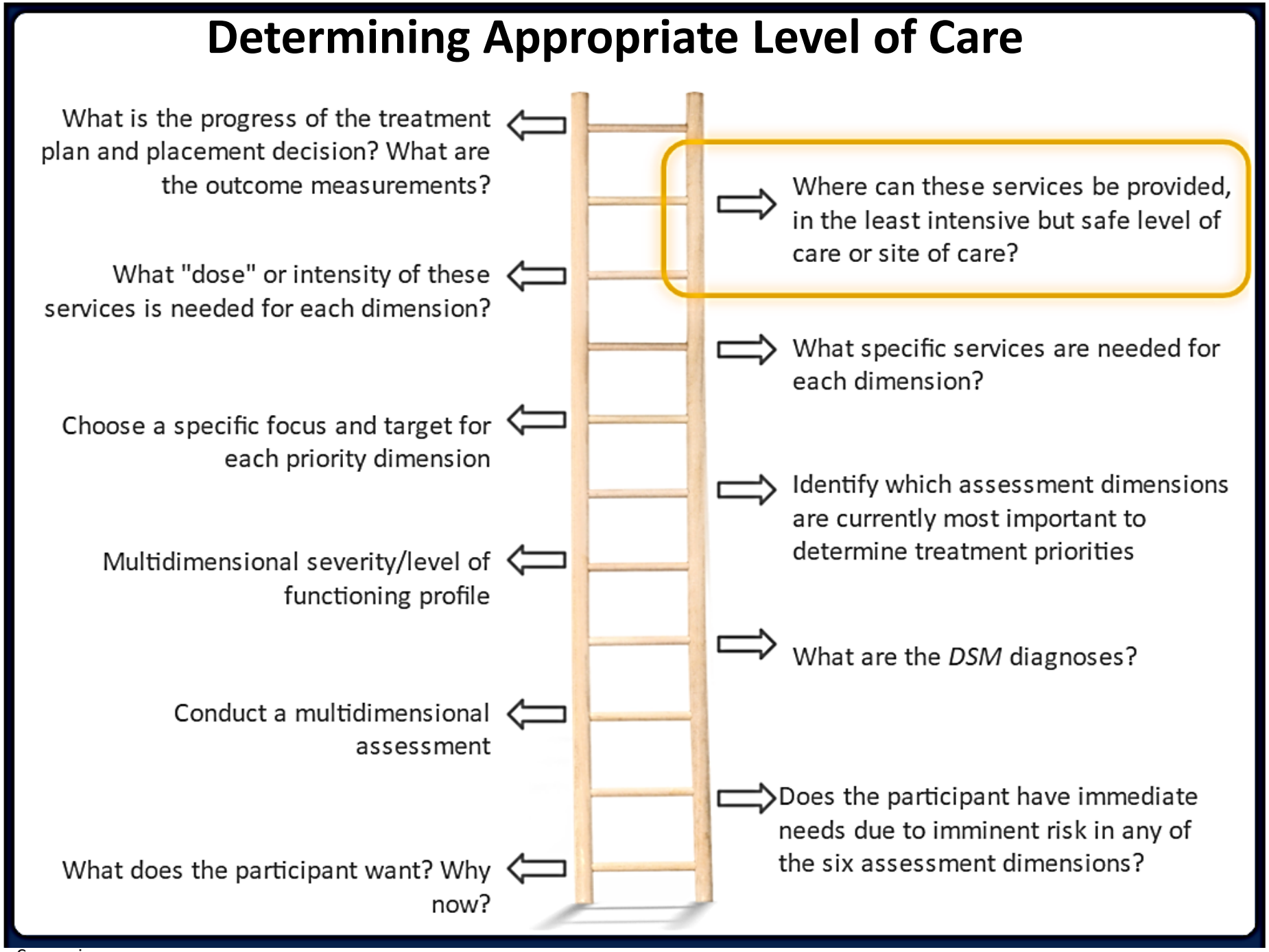
Additional Cultural Considerations

- Cultural issues- including the use of the patient's preferred language, play a role in creating a sense of safety and promote accurate understanding of the patient's situation and options
- Identify and incorporate a patient’s culturally-related strengths and resources
- Engage in self-education about specific cultural norms and treatment considerations
- These issues must be addressed sensitively at the *outset* and *throughout* the treatment process
- We need to keep own biases in check our because how we think about the patient will influence our writing and speaking of them

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3641707/

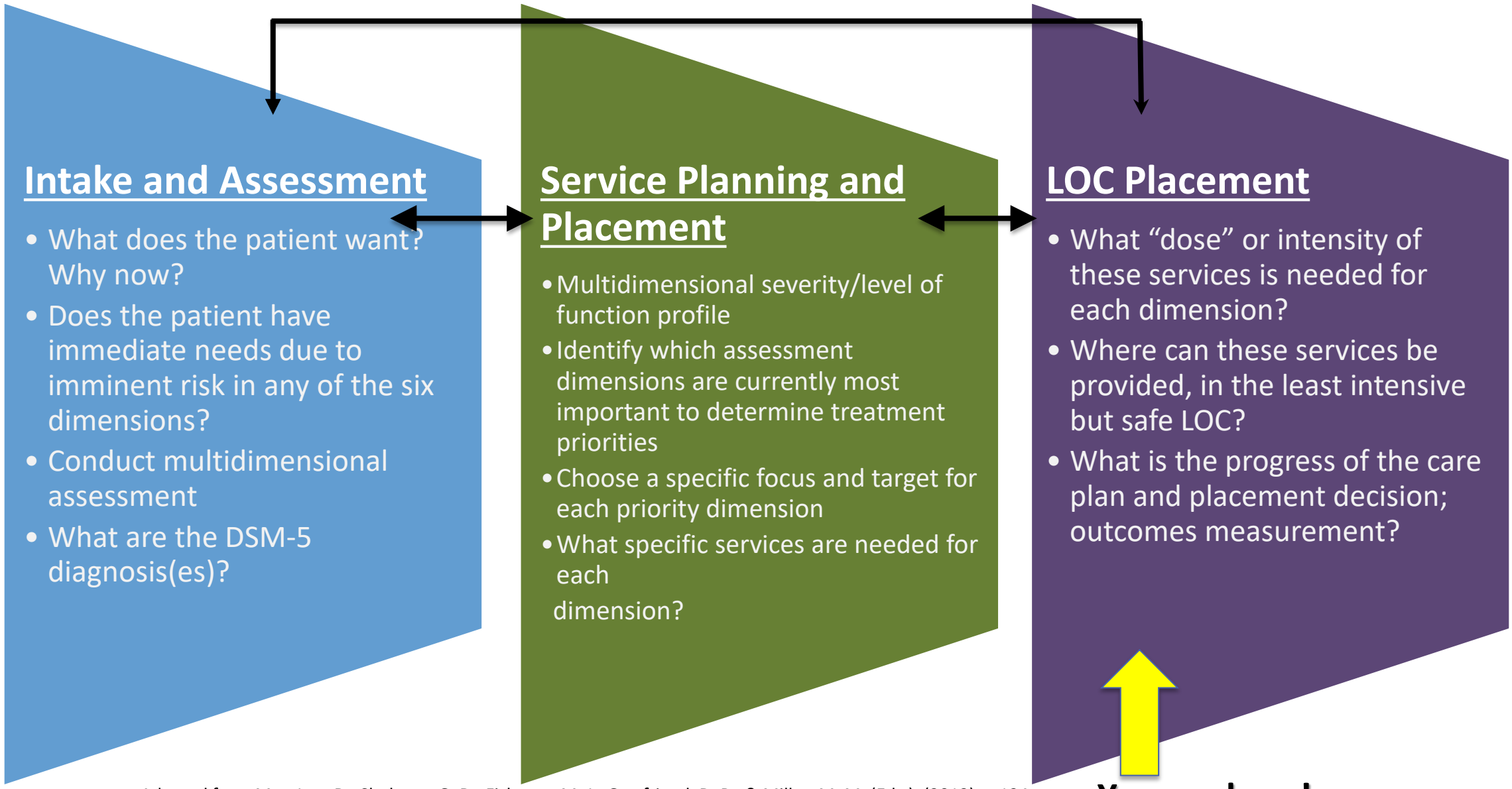
Levels of Care (LOC) Placement

Determining Appropriate Level of Care



Slide credit: The Change Companies

Level of Care (LOC) Placement Decision Tree



Adapted from Mee-Lee, D., Shulman, G. D., Fishman, M. J., Gastfriend, D. R., & Miller, M. M. (Eds.). (2013) p. 124.

Title of ASAM LOC & Provider-Outpatient

ASAM	Title	Description	Provider
0.5	Early Intervention	Screening, Brief Intervention, and Referral to Treatment (SBIRT). **For youth and young adults under the age of 21*	DHCS Certified Outpatient Facilities
1	Outpatient Services	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies	DHCS Certified Outpatient Facilities
2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability	DHCS Certified Intensive Outpatient Facilities
*2.5**	*Partial Hospitalization Services*	*20 or more hours of service/week for multidimensional instability not requiring 24-hour care*	*DHCS Certified Intensive Outpatient Facilities (NOT provided by SAPC Provider Network under DMC-ODS)*

Title of ASAM LOC & Provider-Residential

ASAM	Title	Description	Provider
3.1	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.	DHCS Licensed and DHCS/ASAM designated Residential Providers
3.3	Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.	DHCS Licensed and DHCS/ASAM designated Residential Providers
3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate/use full milieu or therapeutic community	DHCS Licensed and DHCS/ASAM designated Residential Providers

Title of ASAM LOC & Provider

ASAM	Title	Description	Provider
*3.7**	*Medically Monitored Intensive Inpatient Services*	*24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counselor availability*	*Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric hospitals*
*4**	*Medically Managed Intensive Inpatient Services*	*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*	*Recovery Hospitals, Hospital; Free Standing Psychiatric hospitals*
OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder	DHCS Licensed OTP Maintenance Providers, licensed prescriber

Levels of Withdrawal Management

Withdrawal Management	Level	Description
Ambulatory Withdrawal Management without Extended On-Site Monitoring	1-WM	***Mild*** withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery
Ambulatory Withdrawal Management with Extended On-Site Monitoring	2-WM	***Moderate*** withdrawal with all day withdrawal management support and supervision; at night, has supportive family or living situation; likely to complete withdrawal management
Clinically Managed Residential Withdrawal Management	3-WM (3.2WM & 3.7WM)	***Moderate-Severe*** withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery
Medically Managed Intensive Inpatient Withdrawal Management	4-WM	***Severe,*** unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability

LOC Determination

Key Placement Considerations

Level 1

What the patient WANTS

What the patient NEEDS

What RESOURCES are available

Level 2

- Providing patient-centered services, what patient wants isn't always what they need – balance is required

- Current needs may differ from needs just a few hours into the future
- Assessors have the ability to use clinical judgment to ***override*** ASAM CONTINUUM recommendations

- Health systems have fixed resources – need to balance needs with resources

END RESULT:
Balanced Placement Decision

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What are the LOC considerations?

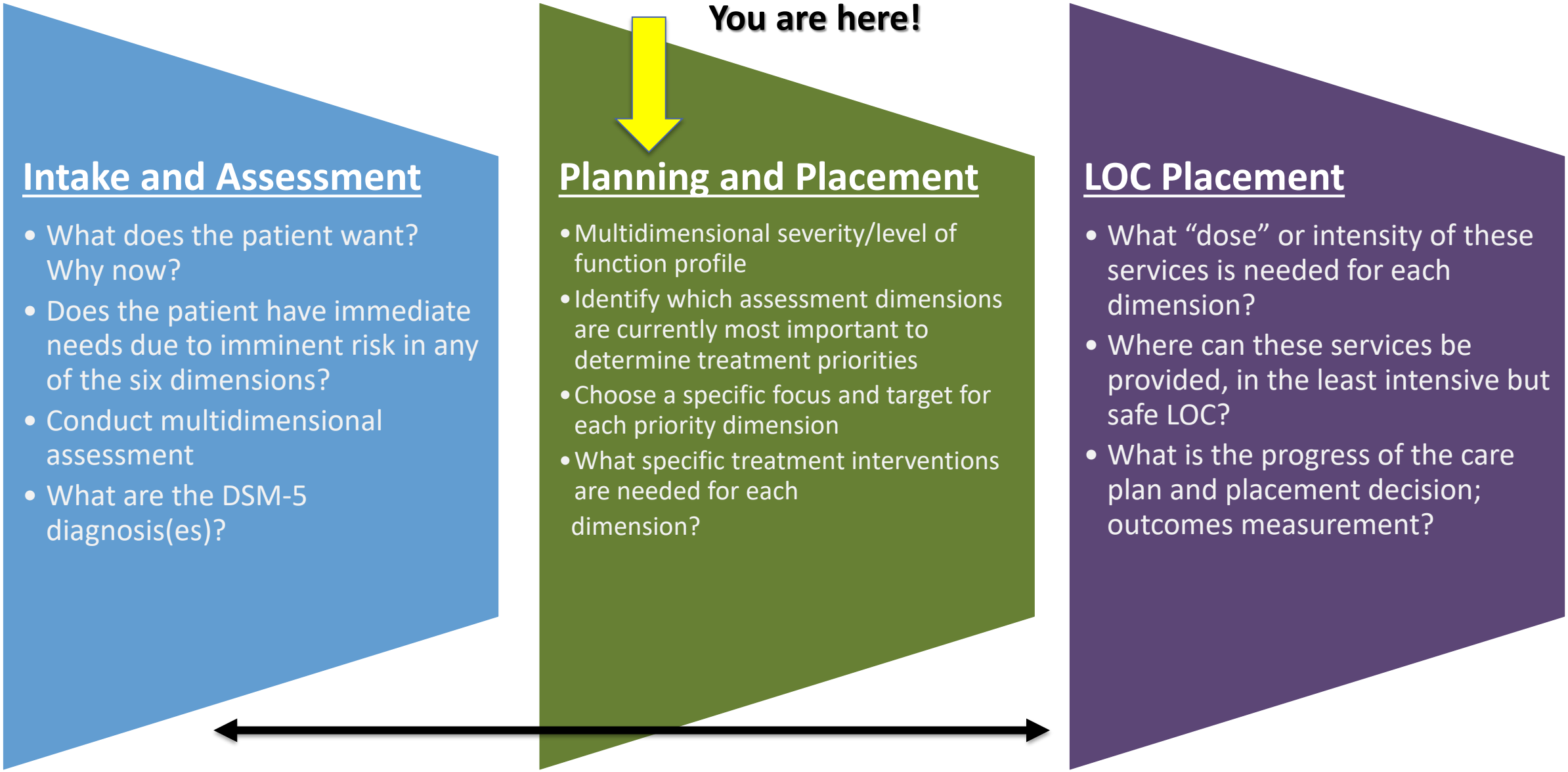
From ASAM Criteria to Developing a Plan of Care (Treatment Planning)

Assessment Dimensions	Assessment and Care Planning Focus
1.Acute Intoxication and/ or Withdrawal Potential	**Assess for intoxication and/or withdrawal management.**
	Care Planning Focus: Withdrawal management
2.Biomedical Conditions and Complications	**Assess and treat co-occurring physical health conditions or complications.**
	Care Planning Focus: Physical Health Services
3.Emotional, Behavioral or Cognitive Conditions and Complications	**Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications.**
	Care Planning Focus: Mental Health Services

Adapted from UCLA-ISAP ASAM-A presentation 2015-2021

Assessment Dimensions	Assessment and Care Planning Focus
4. Readiness to Change	**Assess stage of readiness to change.**
	Care Planning Focus: If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies.
5. Relapse, Continued Use, or Continued Problem Potential	**Assess readiness for relapse prevention interventions and teach where appropriate.**
	Care Planning Focus: Use motivational strategies to raise awareness of consequences
6. Recovery Environment	**Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services**
	Care Planning Focus: Utilizing existing support systems while identifying additional support needs

LOC Placement Decision Tree



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Problem List & Treatment

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- Access
- Engagement
- Assessment
- ***Care Planning/ Problem List***
- Treatment

CalMHSA LMS (2022). CalAIM Training: Module 1 CalAIM overview.

Chat Question

What problems (for the Problem List) can you identify from the vignette on the next slide?

Identify the problems & the ASAM Dimension

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Identify problems for each of the six (6) dimensions.

The ASAM Criteria and Problem List

County of Los Angeles Public Health

Date Problem Added	Problem Statement	Dimension	Identified By	Practitioner	Practitioner's Title
11/01/2024	**Opioid use disorder, severe**	1	Staff	John Smith	LCSW
11/16/2024	**Reported by patient: Anemia**	2	Staff	Jane Doe	Certified SUD Counselor
11/15/2024	**Dysthymic disorder**	3	Staff	John Smith	LCSW
11/16/2024	**Doubts with substance use and mental health treatment**	4	Staff	Jane Doe	Certified SUD Counselor
12/01/2024	**Z60.9 Problems related to social environment, unspecified**	5	Staff	Jane Doe	Certified SUD Counselor
01/08/2025	**Z59.811 Housing instability, housed, with risk of homelessness**	6	Staff	Jane Doe	Certified SUD Counselor

After gathering the list of problems, what are the next steps?

Care Planning: Dimension 1

Dimension 1: Acute Intoxication and/or Withdrawal Potential

Opioid use disorder, severe

- Intoxication level
- Withdrawal symptoms
  - Imminent threat to life
- MAT needs
- Identifying use patterns
- Harm reduction
  - Reducing substance use
  - Using clean syringe (if applicable)
  - Fentanyl test strips
- Imminent danger to self/others (substance related)

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Care Planning: Dimension 2

Dimension 2: Biomedical Conditions and Complications

Reported by patient: Anemia

- Physical exam
- Medical history
- Medications
- Imminent medical risks
- Management of biomedical conditions
- Coping mechanisms for biomedical conditions

"You are perfectly sound."

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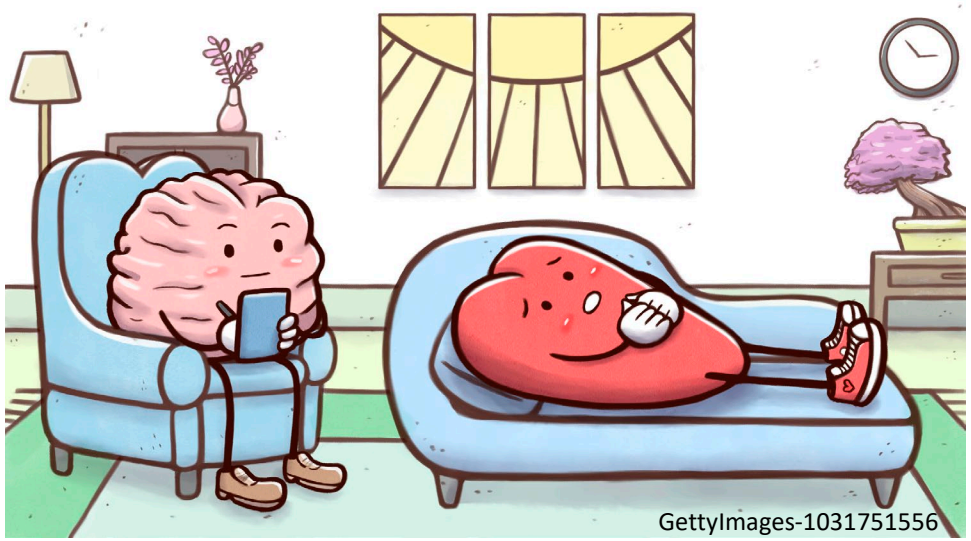
Care Planning: Dimension 3

Dimension 3: Emotional, Behavioral, or Cognitive (EBC) Conditions and Complications

Dysthymic Disorder

- Mental health screening
- Mental health treatment (referral)
- Medication needs
- Mental health symptom
- Mental health maintenance
- Imminent risk
- Interaction with SUD and Mental Health treatment
- Interactions with other ASAM dimensions



Care Planning: Dimension 4

Dimension 4: Readiness to Change

Doubts with substance use and mental health treatment

- Level of commitment
- Willingness to receive treatment
- Readiness of making changes
- Motivational Interviewing
- Attendance
- Insight to treatment needs
- Ability of following through treatment recommendations

Care Planning: Dimension 5

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

Z60.9 Problems related to social environment, unspecified

- Coping skills
- Relapse prevention skills
- Self-management skills
- Insight into relapse pattern
- Treatment history

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Care Planning: Dimension 6

Dimension 6: Recovery/Living Environment

Z59.811 Housing instability, housed, with risk of homelessness

- Imminent risk or threat in living environment
- Service linkages (physical needs and social needs)
- Social support (family, friendships)
- Peer support group
- Sponsorship
- Neighborhood


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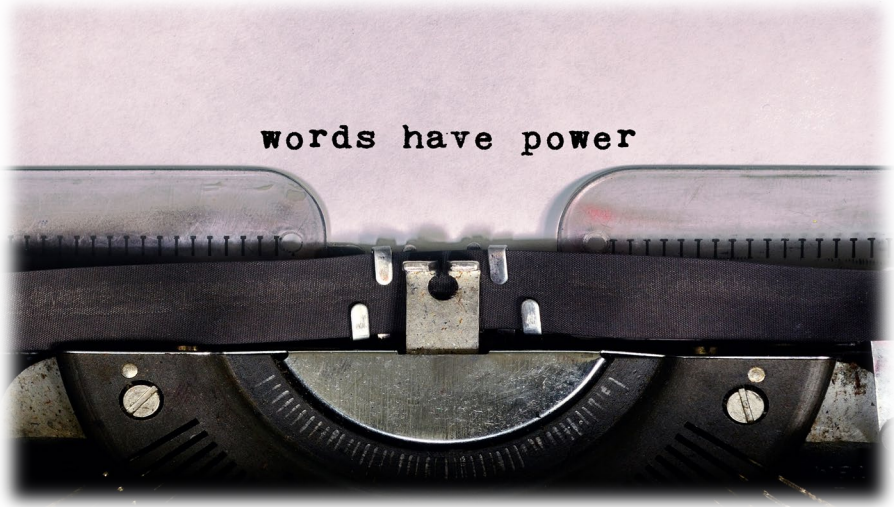
Guidance for Care Planning . . .

- All **problems** identified are included regardless of available agency services
- Include all **problems** whether deferred or addressed immediately
- Each dimension should be reviewed
- A referral to outside resources is a valid approach to addressing a problem, but should NOT be the first step



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Motivational Interviewing

- Motivational Interviewing (MI) is a patient-centered style of communication that engages individuals and facilitates intrinsic motivation for change.

- ***Collaboration*** between patient and provider
- ***Ambivalence*** about substance use is typical AND a primary obstacle to behavior change.
- Direct argument and confrontation tends to result in defensiveness and in patients "digging in," negatively impacting behavior change.
- Creating ***discrepancy*** between a patient's goals/values and their current behavior can be an effective way to address ambivalence.
- Being ***empathic*** and ***supportive***, while actively guiding will provide the best conditions for patient to change

Documentation Considerations

Focusing on Patient-Centered Care

- Patient-First Treatment, Goals & Language
- Utilizing language of hope, positives & patient strengths
- **How a person identifies themselves is up to them, but we can still use person centered/person first language to validate their experience and reduce stigma.**
  https://www.recoveryanswers.org/addiction-ary/

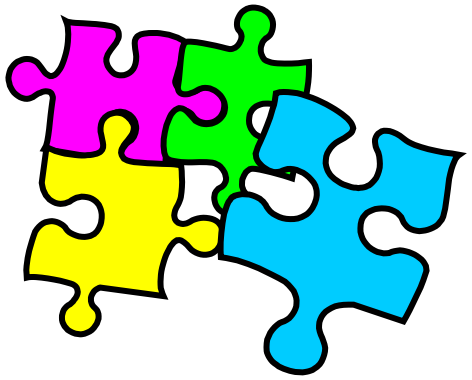
Instead of:	Use:
He/she/they is/are an addict	Has a substance use disorder… Is using substances….
Defining the person by their diagnosis/struggles/distress	They are experiencing…
Using condescending, intimidating, or clinical language	Language that conveys accuracy, respect, objectivity
Sensationalizing a substance use disorder (i.e., “uses dope…”)	Language that supports wellness and recovery and not perpetuating stigma
Resistant	Loss of Motivation, breakdown in communication, need to re-establish collaboration with patient

Take a few minutes to rewrite the statements on the next slide.

Re-write with Patient-First Language

Problematic Language in Care Planning Documentation

1) Patient says bad things about themselves
2) Patient is in denial.
3) Heroin Abuser
4) Patient is promiscuous
5) Patient is resistant to treatment and doesn't want help
6) Patient is on probation because they are a drug addict



Thoughts on These Sentences?

Changing Language - Examples

1. **Patient has low self-esteem.**

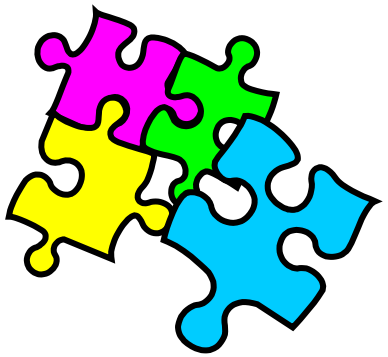
   Patient engages in negative self-statements daily; such as “I’m a horrible person when I take pills”

2. **Patient is in denial.**

   Patient reports two DWIs in past year but states that alcohol use is “not a problem” and they “only drink socially”

3. **“Heroin Abuser”**

   Patient experiences tolerance, withdrawal, loss of control, and negative life consequences due to their five (5) year history of opioid use.



How do we change the language?

Changing Language – Examples Cont'd

4. **"Patient is promiscuous"**

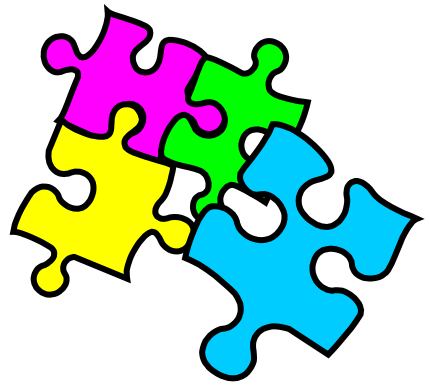
   Patient participates in unprotected sex four (4)times a week and reports that is due to methamphetamine use

5. **"Patient is resistant to treatment and doesn't want help"**

   In past 12 months, patient has left AMA three (3) treatment programs prior to completion

6. **"Patient is on probation because they are an addict"**

   Patient has legal consequences because of their alcohol use-related behavior



How do we change the language?

Initial Problem List
&
Development Note

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S.M.A.R.T. Goals

Specific	• Exactly what is trying to be accomplished • Who, what, when, where, why
Measurable	• How will the patient and counselor evaluate progress toward the goal. • “Show your work”
Achievable	• Ensuring the actions, behaviors, outcomes are possible based on the patient, situation, setting and external factors. • Achievable does not mean easy, goals should be challenging
Relevant	• Is the goal related to what the person wants for treatment, related to the ASAM, related to the SUD, what has been discussed in sessions
Time-Bound	• Goals should have a target date to when they should be completed • Time-bound also refers to the frequency of the behaviors, dates and deadlines to accomplish.

Examples of SMART Goals

1. Patient will refrain from using all illicit substances as evidenced by negative UA test results in the next 30 days.

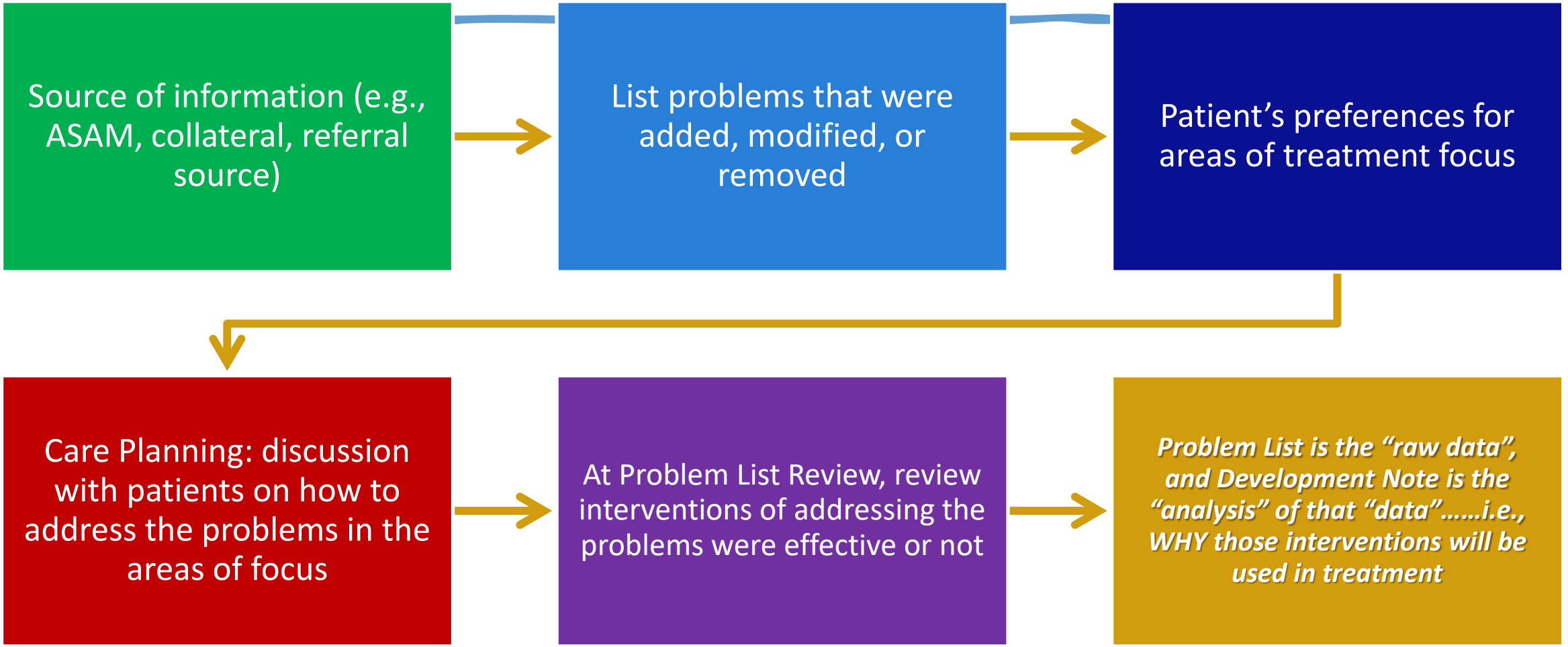
2. Patient will develop a relapse prevention plan with 4 identified triggers and 6 coping skills that can help address cravings in the next 30 days.

3. Patient will be attending in-person AA meetings 3x/week to build healthy social support as evidenced by attendance log in the next 30 days.

4. Patient will identify 5 connections between substance use symptoms and depressive symptoms as evidenced by completing a co-occurring disorder handout in the next 30 days.

5. Patient will construct, revise, and complete resume during weekly meetings with employment specialist in the next 45 days.

Items Included in the Problem List - Treatment Plan Development Note



This note should support evidence this was a collaborative process

Case Vignette- Andrea

- 27-year-old African American female with opioid use disorder, severe.
- She has been using prescribed opioids for medical complications following a surgical procedure a few years ago. When her physician refused to refill her prescription for misusing the prescription, she smoked heroin, then started to inject heroin shortly after.
- Prior to the surgery, Andrea was living independently, working for a local tech start-up after receiving her BA in business.
- Andrea lost her job, then her apartment, and moved in with her sister.
- Andrea reported some depressive symptoms due to substance use and unemployment. She is not sure about receiving psychological services.
- Andrea stated that she has anemia and she has stopped taking iron pills.
- Andrea has just completed LOC 3.2 withdrawal management with no prior SUD treatment history.

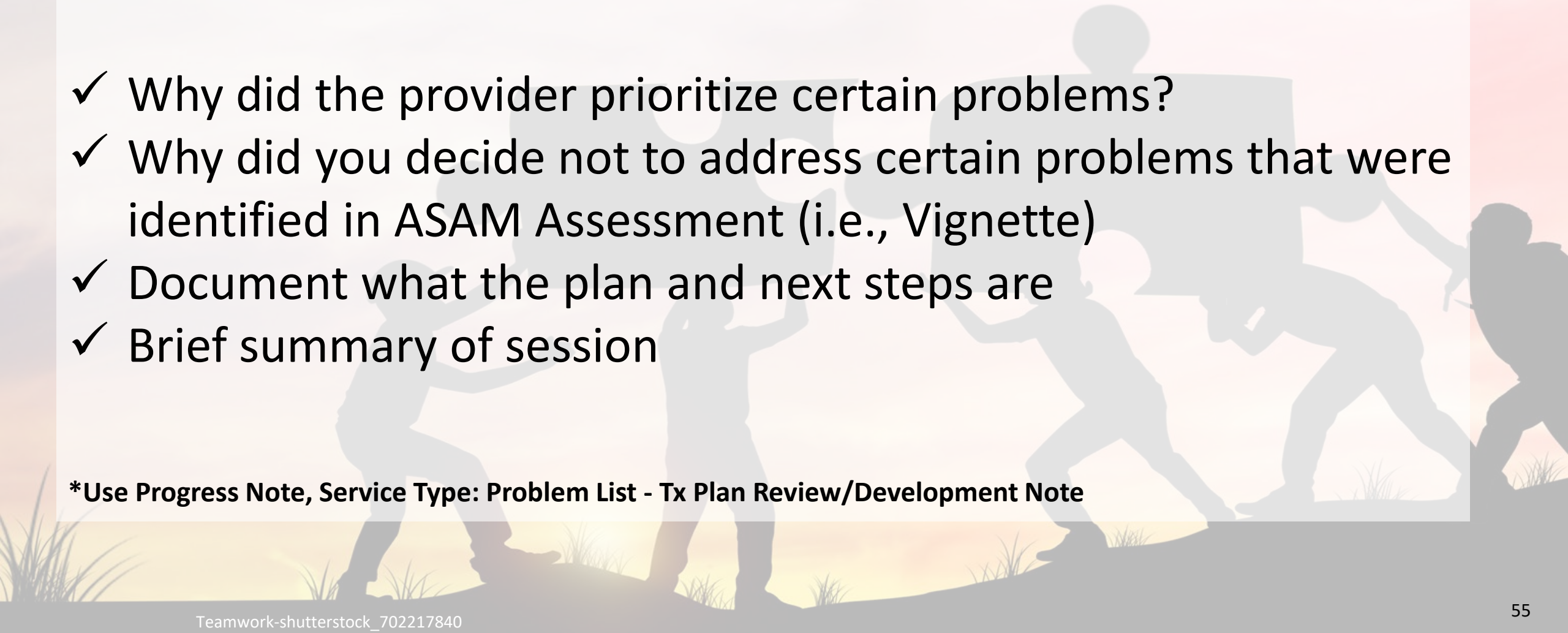
Take a few minutes to practice writing an initial problem list development note (fill in any information from what was previously discussed in this training)

Documenting Initial Problem List Development in a Note*

What to include:

- ✓ Why did the provider prioritize certain problems?
- ✓ Why did you decide not to address certain problems that were identified in ASAM Assessment (i.e., Vignette)
- ✓ Document what the plan and next steps are
- ✓ Brief summary of session

***Use Progress Note, Service Type: Problem List - Tx Plan Review/Development Note**



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Poll Question

What are the 4 R's when it comes to SUD treatment in Los Angeles County?

(Hint it relates to Balanced Placement Decisions)

a. Right services, Right choice, Right setting, and Right timing.
b. Right choice, Right services, Right duration, and Right clinic.
c. Right services, Right time, Right setting, and Right duration.
d. Right choice, Right time, Right medication, and Right duration.

Poll Answer

RIGHT SERVICES

RIGHT TIME

RIGHT SETTING

RIGHT DURATION

Next Steps

- ✓ *"Making the Most of the ASAM CONTINUUM Assessment Tool"*
- ✓ *Developing a Plan of Care for Substance Use Providers: CalAIM Requirements and Best Practices"*
- ✓ *"Clinical Documentation for Substance Use Treatment Providers" CalAIM Requirements and Best Practices"*

- ❖ *ASAM released 4th Edition, but the State of California is still using the 3rd Edition.*

Go forth, conduct ASAM Continuums, Care Planning sessions with patients and *Save Lives*…..

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Summary

1. Today we reviewed and identified Levels Of Care (LOC) based on Risk Ratings within the context of clinical vignette

2. While using that same vignette we demonstrated how to utilize the multidimensional assessment to create an individualized plan of care based on the six (6) dimensions of the ASAM Criteria.

3. You developed an individual plan of care development note from a vignette.

References and Resources

- Center for Integrated Behavioral Health Solutions www.cibhs.org
- Mee-Lee, David. (Eds.) (2013) *The ASAM criteria :treatment for addictive, substance-related, and co-occurring conditions* Chevy Chase, MD. : American Society of Addiction Medicine
- SAPC Treatment Provider Manual**– Version 9.0** http://publichealth.lacounty.gov/sapc/bulletins/START-ODS/24-08/SAPC-IN24-08-Provider-Manual-9.0-Att-II-10-04-2024.pdf
- Stallvik, M, Gastfriend, D. R., & Nordahl, H. M. (2015). Matching patients with substance use disorder to optimal level of care with the ASAM Criteria software. *Journal of Substance Use, 20,* 389-398. DOI:10.3109/14659891.2014.934305
- The Change Companies: www.changecompanies.net
- UCLA ISAP Pacific Southwest Addiction Technology Transfer Center www.psattc.org