# ASAM Criteria 4th Edition: Implication for SAPC Treatment Provider Agencies

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**11/13/24**

**None of the planners or presenters for this activity have disclosed relevant financial relationships with ineligible companies.**

There is no commercial support for today's activity

Ineligible companies are companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

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No financial conflicts of interests

Brian is the President of the American Society of Addiction Medicine, so comments on topics involving ASAM may be biased towards ASAM

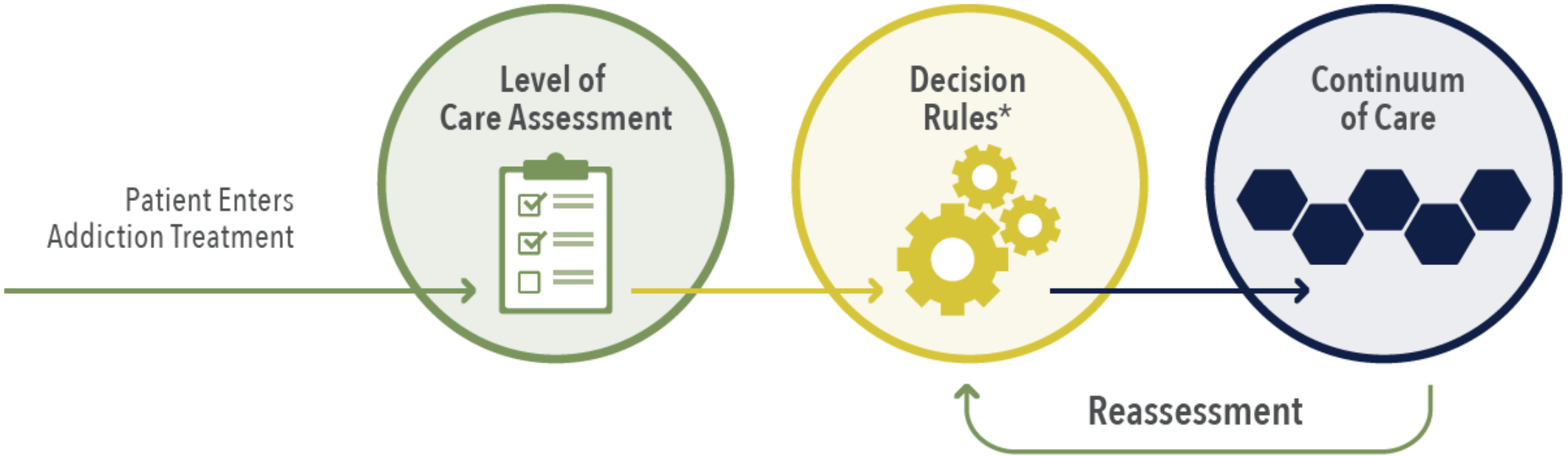
# The ASAM Criteria

- The criteria provide a consistent way to:
  - assess patients' biopsychosocial circumstances to identify the appropriate level of care
  - develop comprehensive, individualized, and patient-centered treatment plans
  - define the services that should be available at each level of care
- Promote individualized and holistic treatment planning
- Guide clinicians and care managers in making objective decisions about patient admission, continuing care, and movement along the continuum of care.

# Principles of *The ASAM Criteria*

- Admission into treatment is based on patient needs, not arbitrary prerequisites
- Multidimensional assessment addresses the broad biological, psychological, social, and cultural factors that contribute to addiction and recovery
- Treatment plans are individualized based on patient needs and preferences
- Care is interdisciplinary, evidence-based, patient-centered, and delivered from a place of empathy
- Co-occurring conditions are an expectation, not an exception
- Patients move along the continuum of care based on their progress, not predetermined lengths of stay
- Informed consent and shared decision-making accompany treatment decisions

# Core Components of The ASAM Criteria




* Decision rules include the Dimensional Admission Criteria and the transition and continued service criteria.

## Goals of the Fourth Edition

- Update the standards to reflect the current state of science and practice
- Further promote a chronic care model that supports seamless movement along the care continuum
- Improve clarity and simplify where possible to support more effective implementation

# Access to Addiction Medications

- Dimension 1 updated to include “Addiction Medication Needs”
- All medically managed levels of care able to initiate all FDA-approved medications for SUD
- All patients should have a physical exam within a reasonable time that assesses addiction medication needs
- All clinically managed levels of care able to support continuation of any FDA-approved medication

# NEW METHODOLOGY

# ASAM Criteria 4th Edition Development Process

17 Writing Committees

Structured Evidence Review

Review 3rd Edition standards

Draft standards and decision rules

Voting Panel rating and reconciliation

Public comment period and reconciliation

**Board and Council Review and Approval**

**Narrative Chapter Field Reviews**

# Stakeholder Outreach

Nearly 3000 comments addressed

274 unique organizations & individuals for targeted outreach

- 61 Directors of Single State Agencies + NASADAD
- 52 State Medicaid Directors + NAMD
- 51 Allied Organizations
- 37 ASAM State Chapter Presidents
- 23 Payers
- 21 Organizations representing diverse clinical experts
- 18 Federal Agencies
- 7 Patients, People in Recovery, PWUD Organizations
- 4 Justice Involved Agencies

**Public Comment Period #1**
**Initial Thoughts on 3rd Ed**

| 35 Organizations | 224 Commenters | 1504 Comments |
|---|---|---|

**Public Comment Period #2**
**Proposed Major Changes**

| 55 Organizations | 135 Commenters | 461 Comments |
|---|---|---|

**Public Comment Period #3**
**Proposed Standards and Decision Rules**

| 51 Organizations | 102 Commenters | 906 Comments |
|---|---|---|

7 Payers, 4 Policy Makers, 12 Treatment Programs, 31 Providers and More!

>87k recipients of non-targeted email outreach


Governance and Oversight
Board of Directors
Approved Major Changes
Quality Improvement Council
Approved Decision Rules & Standards
ASAM Criteria Strategy Steering Committee
Approved Decision Rules & Standards
Editorial Team
Voting Panel
18 Writing Committees

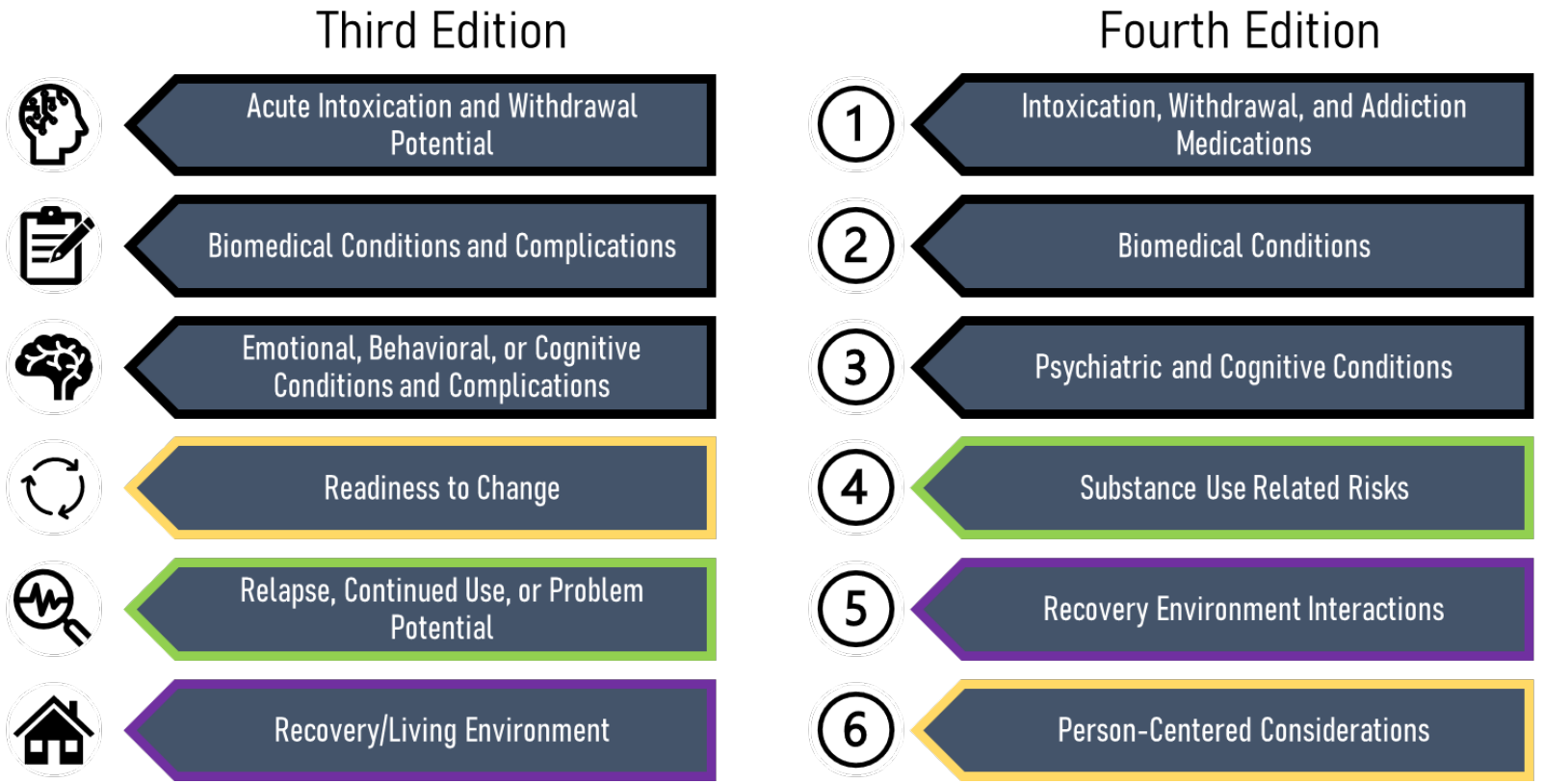
# ASSESSMENT STANDARDS

# ASAM Criteria Assessment

- The 4th Edition describes separate standards for:
  - The ASAM Criteria **Level of Care Assessment** that is used to determine the recommended level of care
  - The ASAM Criteria **Treatment Planning Assessment**
  - Both assessments are multidimensional and consider the patient's full biological, psychological, and sociocultural context

# Reordering the dimensions

- Since readiness to change does not independently contribute to initial treatment recommendations the dimensions will be adjusted
- Readiness considered across all dimensions.
- New Dimension 6 focuses on patient preferences, barriers to care, and need for motivational enhancement




# Assessment Dimensions

# Subdimensions

**Dimension 1 – Intoxication, Withdrawal, and Addiction Medications**

- Intoxication and associated risks
- Withdrawal and associated risks
- Addiction medication needs

**Dimension 2 – Biomedical Conditions**

- Physical health concerns
- Pregnancy-related concerns
- Sleep problems

**Dimension 3 – Psychiatric and Cognitive Conditions**

- Active psychiatric concerns
- Persistent Disability
- Cognitive Functioning
- Trauma exposure and related needs
- Psychiatric and cognitive history

**Dimension 4 – Substance Use Related Risks**

- Likelihood of risky substance use
- Likelihood of risky SUD-related behaviors

**Dimension 5 – Recovery Environment Interactions**

- Ability to function in current environment
- Safety in current environment
- Support in current environment
- Cultural perceptions of substance use

**Dimension 6 – Person-Centered Considerations**

- Patient preferences
- Barriers to care
- Need for motivational enhancement

# Dimension 1

- Intoxication, Withdrawal, and Addiction Medications
  - Intoxication and Associated Risks
  - Withdrawal and Associated Risks
  - Addiction Medication Needs

## Medical Management

- Medications (and related education)
- Nursing care
- Medical monitoring/follow ups

## Clinical Services and Supports

- Motivational interventions
- Treatment plan/medication adherence
- Behavioral interventions
- Psychoeducation
- Overdose prevention

# Dimension 2

- Biomedical Conditions
  - Physical health concerns
  - Pregnancy-related concerns
  - Sleep problems

## Medical Management

- Medications (and related education)
- Monitoring/follow ups
- Anticipated duration of medically managed care

## Referrals for External Care

- Care coordination
- Patient navigation

## Clinical Services and Supports

- Goals related to physical health
- Treatment plan/medication adherence
- Psychosocial services
- Motivational interventions

# Dimension 3

- Psychiatric and Cognitive Conditions
  - Active psychiatric symptoms
  - Persistent disability
  - Cognitive functioning
  - Trauma-related needs
  - Psychiatric and cognitive history

## Medical Management

- Medications (and related education)
- Monitoring/follow ups
- Anticipated duration of medically managed care

## Referrals for External Care

- Care coordination

## Clinical Services and Supports

- Goals related to mental and cognitive health
- Treatment plan/medication adherence
- Psychosocial services
- Integrated treatment plans
- Motivational interventions


# Dimension 4

- Substance use-related risks
  - Likelihood of engaging in risky substance use
  - Likelihood of engaging in risky SUD-related behaviors

## Clinical Services and Supports

- Individual goals
- Building skills and insight
- External factors that influence recovery
- Adherence to treatment plan
- Motivational interventions

## Harm Reduction Strategies

## Recovery Support Services

- Peer support


# Dimension 5

- Recovery Environment Interactions
  - Ability to function effectively in current environment
  - Safety in current environment
  - Support in current environment
  - Cultural perceptions of substance use and addiction

## Clinical Services and Supports

- Establishing safe living environment
- Insight
- Skills of daily living
- Building a support network
- Motivational interventions
- Family/support system interventions
- Case management

## Recovery Support Services

- Peer support
- Educational services (eg, job training, financial literacy, parenting skills)
- Social services navigation


# Dimension 6

- Person-Centered Considerations
  - Barriers to care
  - Patient preferences
  - Need for motivational enhancement

## Clinical Services and Supports

- Motivational interventions
- Coordination with external agencies (eg, criminal justice, child protective services)

## Recovery Support Services

- Services addressing SDOH
- Social services navigation
- Peer support

# CONTINUUM OF CARE

# *The ASAM Criteria* Continuum of Care for Adult Addiction Treatment

| | | | | |
|---|---|---|---|---|
| **Level 4: Inpatient** | | | | 4 Medically Managed Inpatient<br>4 Psych |
| **Level 3: Residential** | | 3.1 Clinically Managed Low-Intensity Residential | 3.5 Clinically Managed High-Intensity Residential<br>3.5 COE | 3.7 Medically Managed Residential<br>3.7 BIO<br>3.7 COE |
| **Level 2: IOP/HIOP** | | 2.1 Intensive Outpatient (IOP) | 2.5 High-Intensity Outpatient (HIOP)<br>2.5 COE | 2.7 Medically Managed Intensive Outpatient<br>2.7 COE |
| **Level 1: Outpatient** | 1.0 Long-Term Remission Monitoring | | 1.5 Outpatient Therapy<br>1.5 COE | 1.7 Medically Managed Outpatient<br>1.7 COE |
| **Recovery Residence** | RR Recovery Residence | | | |

# Notable Level of Care changes

Removing Level 0.5. Early intervention and prevention are addressed in a new chapter.

Removing Level 3.3. Reflecting that cognitive deficits should be addressed in all levels of care.

Level 3.2 WM services integrated into Level 3.5.

Recovery support service expectations at each level of care.

Expectation that all levels of care be co-occurring capable at minimum.

Adding harm reduction as a component of individualized care.

# Continuity Along the Continuum

Prevent sharp drop-offs in clinical care

Structured services 7 days per week in Level 3.1 and 3.5

Aligning clinical service standards.

# Access to Addiction Medications

- Dimension 1 updated to include "Addiction Medication Needs" to support delivery of the standard of care for SUD treatment
- All medically managed levels of care able to initiate all FDA-approved medications for SUD
- All patients should have a physical exam within a reasonable time that assesses addiction medication needs
- All clinically managed levels of care able to support continuation of any FDA-approved medication

# Expansion of Level 1

- Level 1.0 – Long-Term Remission Monitoring
  - Recovery management checkups
  - Rapid reengagement in care when needed
- Level 1.5 – Outpatient Therapy
  - Less than 9 hours per week of psychosocial services
- Level 1.7 – Medically Managed Outpatient
  - Encompasses Level 1-WM from 3rd edition
  - Incorporates low threshold medication initiation
  - Able to provide psychosocial services equivalent to Level 1.5

# Updated Continuum of Care

- Reframing early intervention and prevention
  - Includes chapter but no longer uses Level 0.5 nomenclature
- Treatment of cognitive impairments
  - Eliminates third edition Level 3.3
  - Includes chapter addressing treatment of individuals with cognitive impairments across the continuum
- Updating Level 3.7 to reflect residential care

# Supporting Comprehensive Care

- Integrating withdrawal management and biomedical care in the continuum of care
  - Level 1.7: Medically Managed Outpatient Treatment
  - Level 2.7: Medically Managed Intensive Outpatient Treatment
  - Level 3.7: Medically Managed Residential
    - Level 3.7 BIO has advanced biomedical capabilities including intravenous (IV) fluids and medications, as well as advanced wound care
  - Level 4: Medically Managed Inpatient

# Integrating Co-Occurring Capability

- All programs should be co-occurring capable at minimum
  - Program services designed with expectation that most patients have co-occurring conditions
  - Ability to manage mild to moderate acuity, instability, and/or functional impairment.
  - At least one staff member qualified to assess and triage mental health conditions
  - Integrated treatment plans
  - Coordination with external mental health providers as needed
  - Program content that addresses co-occurring conditions

# Recovery Services

- Recovery service expectations at each LOC
- Dimensional Admission Criteria consider the need for recovery residence support
- Algorithm may recommend an outpatient level of care plus a recovery residence
- New chapter on Integrating Recovery Support Services (Chapter 15)

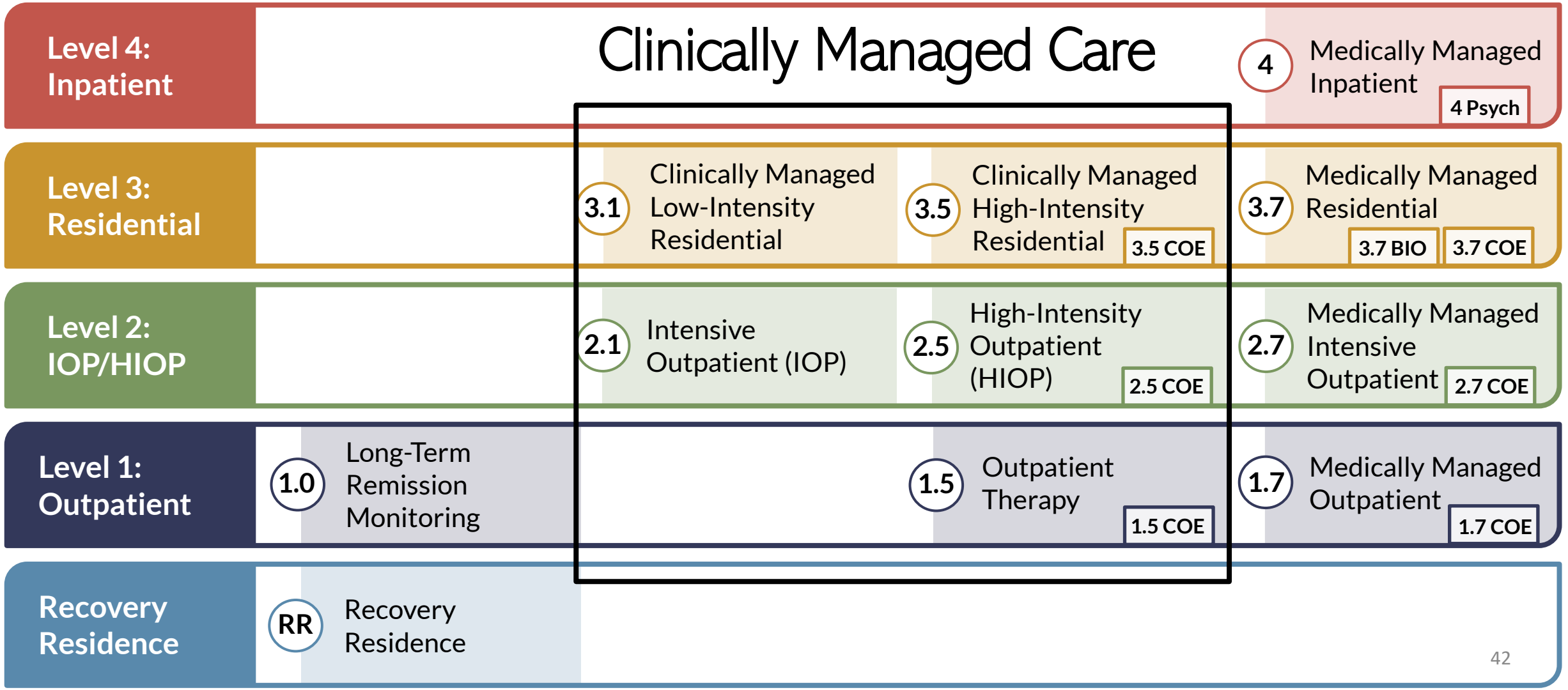
# Continuity Along the Continuum

- Prevent sharp drop-offs in clinical care
- Structured services 7 days per week in Level 3.1 and 3.5
- Aligning clinical service standards
  - Aligning 2.1 and 3.1: 9-19 hours of clinical services per week
  - Aligning 2.5 and 3.5: 20 plus hours of clinical services per week

# Chronic Care Model

- Integration of long-term remission monitoring (Level 1.0)
- Emphasis on recovery services (RSS)
  - Assessment of RSS needs
  - RSS service standards for each level of care
- Encouraging formal affiliations across levels of care to support seamless transitions

# *The ASAM Criteria* Continuum of Care for Adult Addiction Treatment



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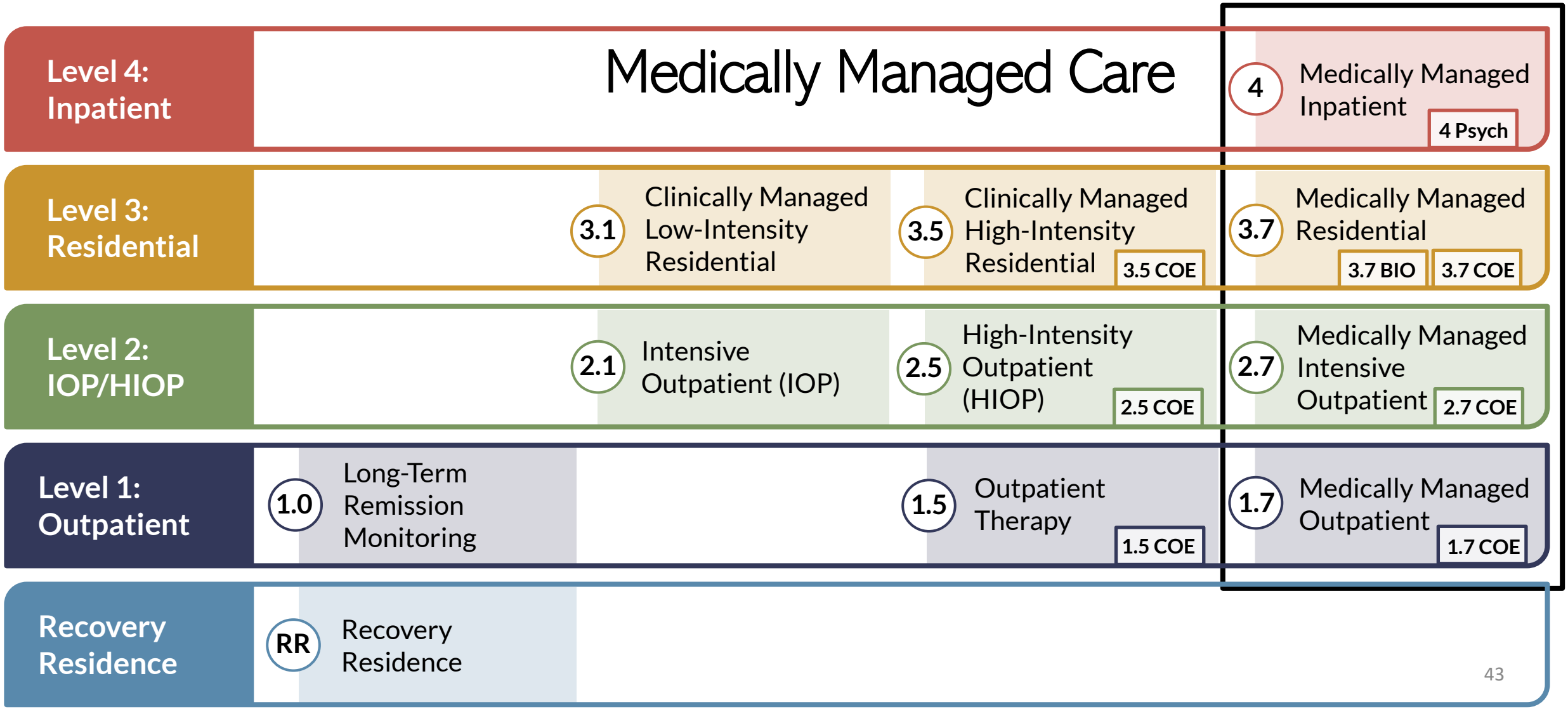

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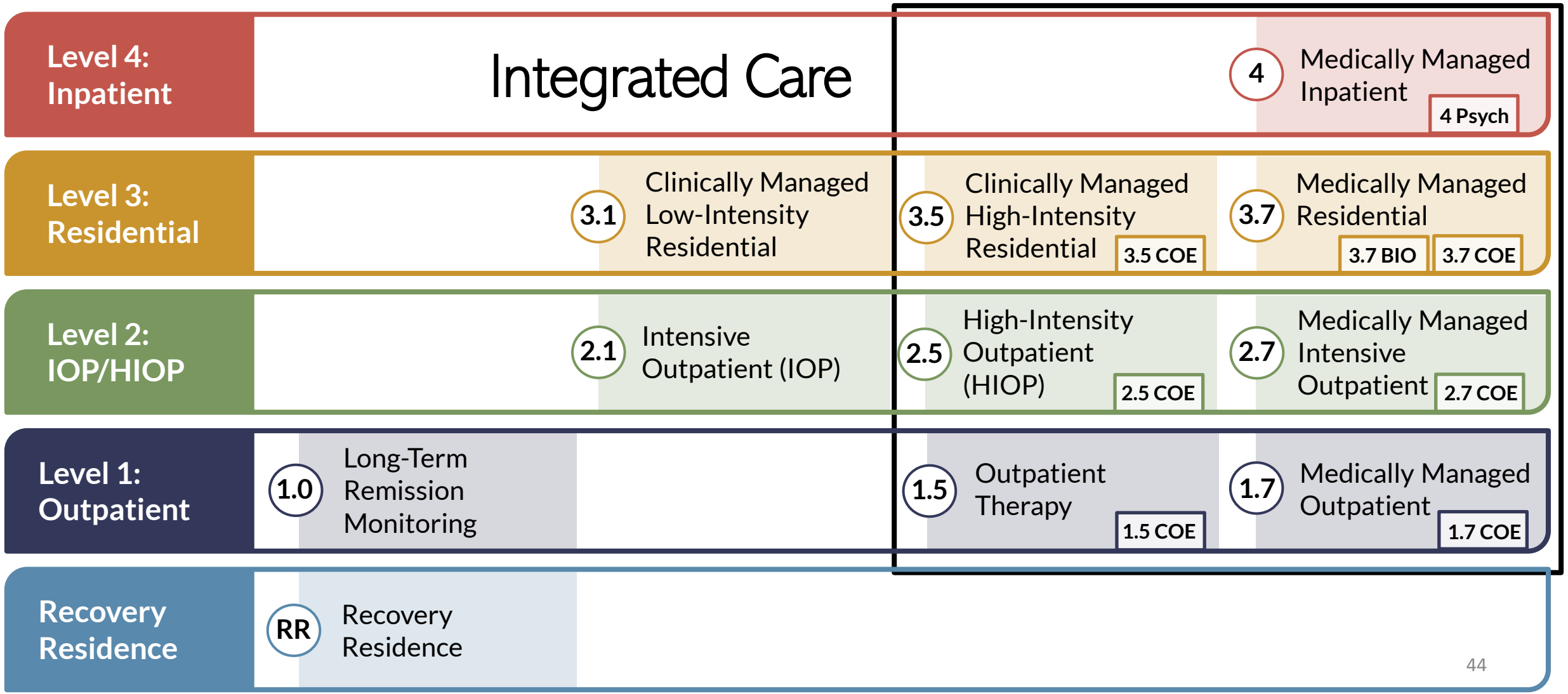
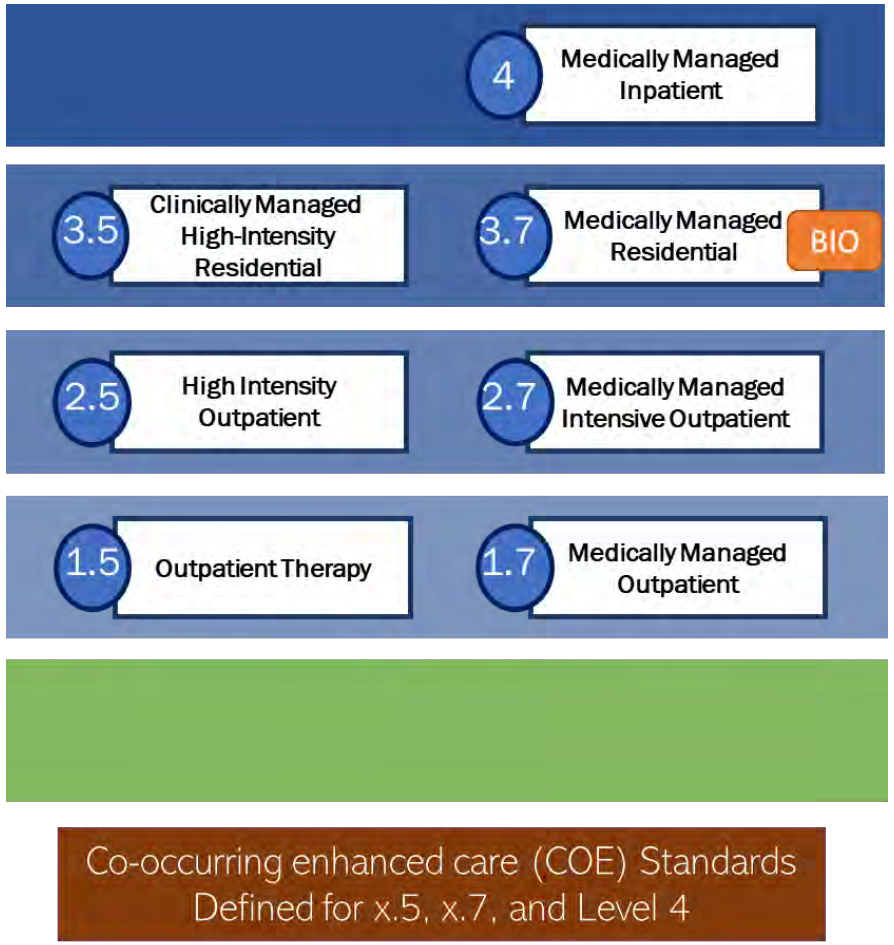


## Integration of Care

- Withdrawal management and biomedical services integrated into the main continuum
- All programs expected to be co-occurring capable

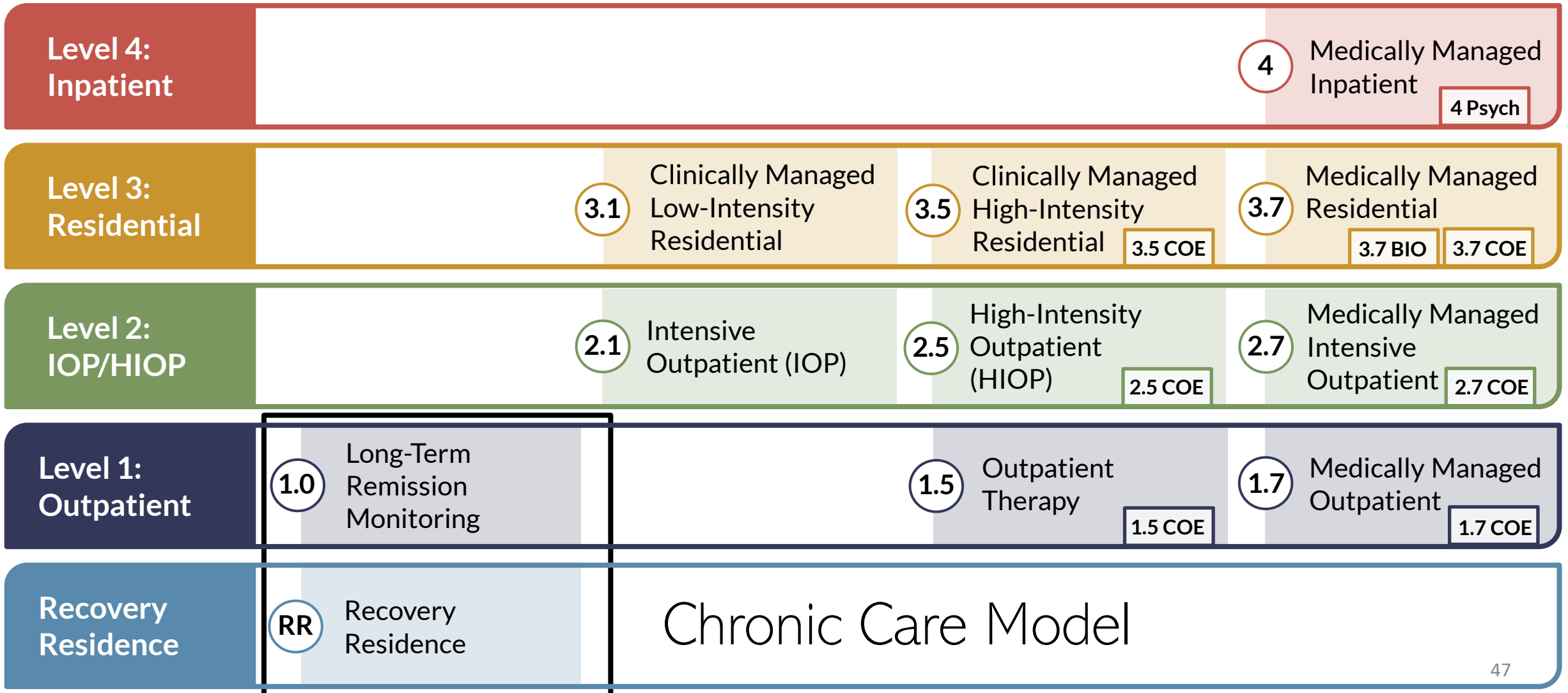


# Integrating Co-occurring Capability

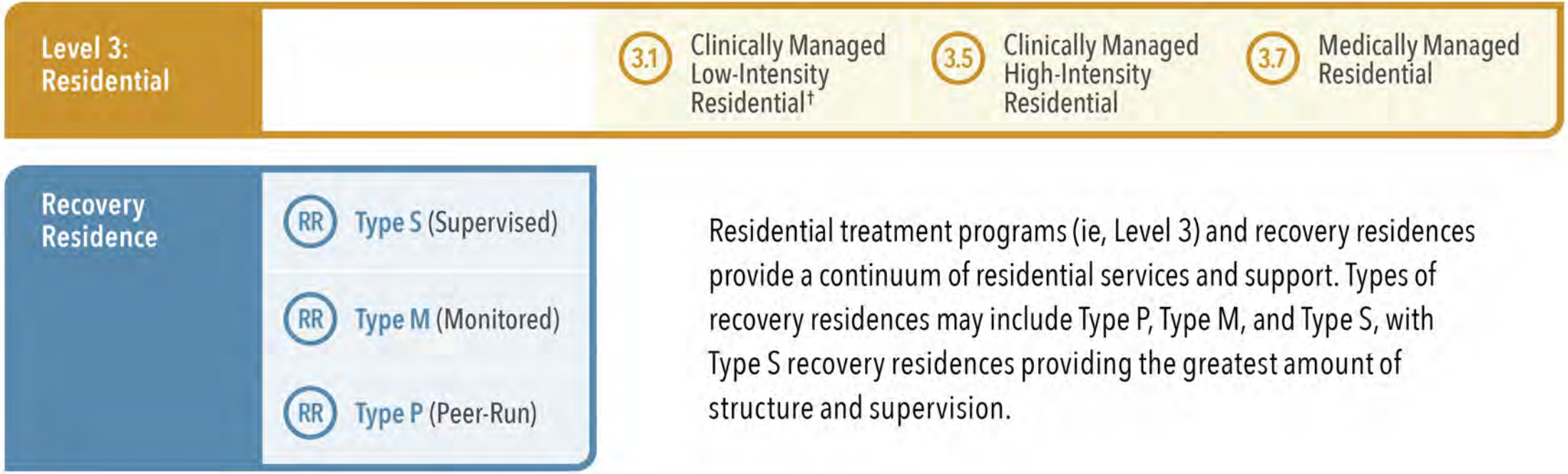
All programs should be co-occurring capable at minimum

- Program services designed with expectation that most patients have co-occurring conditions
- Ability to manage mild to moderate acuity, instability, and/or functional impairment.
- At least one staff member qualified to assess and triage mental health conditions
- Integrated treatment plans
- Coordination with external mental health providers as needed
- Program content that addresses co-occurring conditions

# *The ASAM Criteria* Continuum of Care for Adult Addiction Treatment



## Residential Treatment and Recovery Residence Continuum of Care*




Residential treatment programs (ie, Level 3) and recovery residences provide a continuum of residential services and support. Types of recovery residences may include Type P, Type M, and Type S, with Type S recovery residences providing the greatest amount of structure and supervision.

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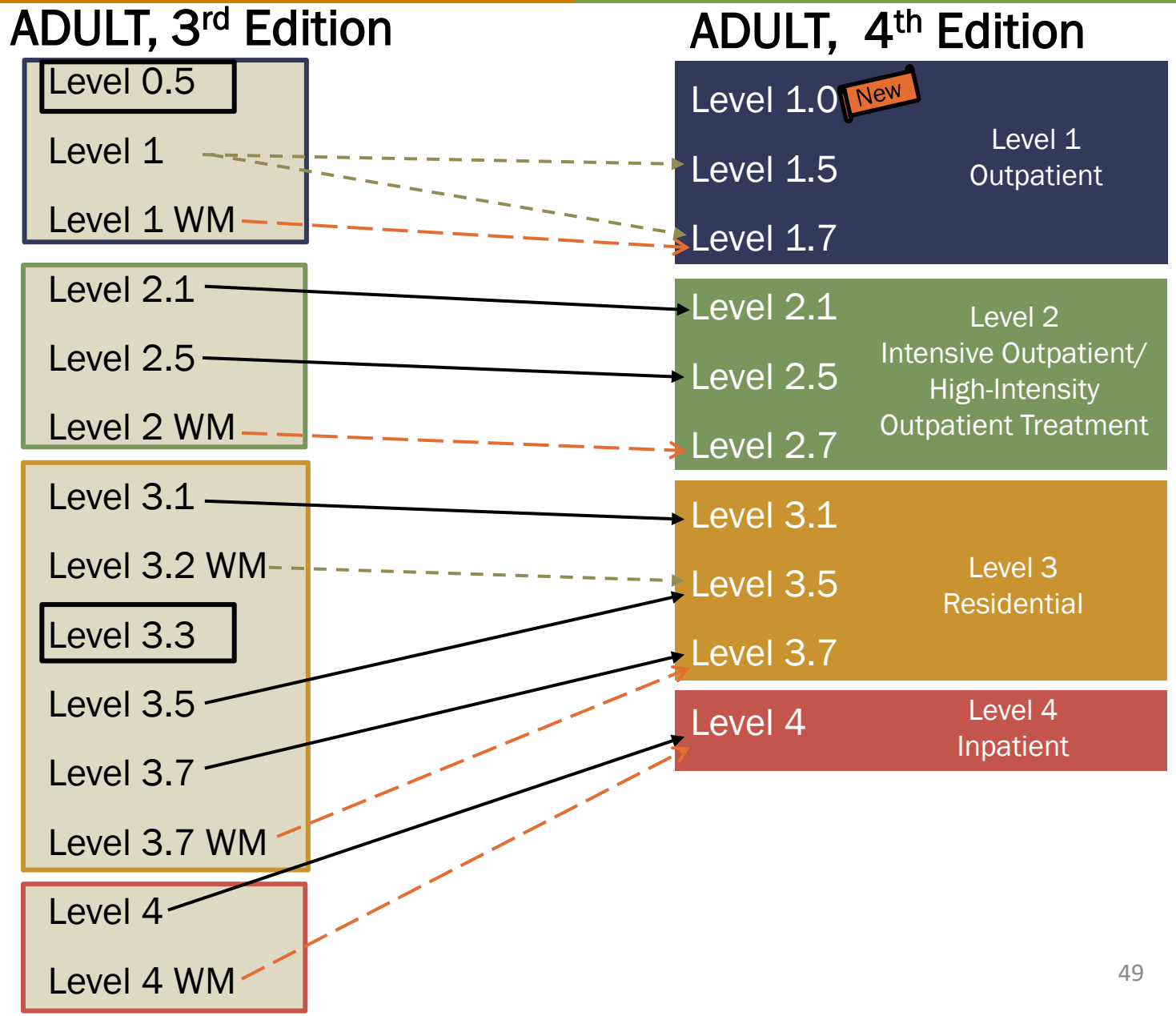
* Developed in coordination with the National Alliance for Recovery Residences (NARR).

† NARR Type C (Clinical) programs are equivalent to *The ASAM Criteria* Level 3.1 that applies the social model.

# Changes to The ASAM Criteria Continuum of Care – Adult




Key

- Services discussed in new chapters
- Elements incorporated into other level(s)
- Incorporated into a new level care
- Revised and updated level of care

# Service Characteristic Standards

# Service Characteristic Standards

# Clinically Managed Outpatient

| | 1.0<br>Long-term Remission Monitoring | 1.5<br>Outpatient Therapy | 2.1<br>Intensive Outpatient Treatment | 2.5<br>High-intensity Outpatient Treatment |
|---|---|---|---|---|
| **Medical Director** | Not typical | Not typical | Not typical | Yes |
| **Nursing** | Not typical | Not typical | Not typical | Variable† |
| **Program Director** | Variable‡ | Yes | Yes | Yes |
| **Allied Health Staff** | Variable | Variable | Typically available | Typically available |
| **Physical exam** | Verify a physical exam in the last year or refer | Within 1 month of treatment initiation | Within 14 days of admission § | Within 7 days of admission |
| **Nursing Assessment** | Not typical | Not typical | Not typical | Not typical |
| **Clinical Services** | Recovery and remission management services | Direct psychosocial services | Direct psychosocial services<br>Therapeutic milieu | Direct psychosocial services<br>Therapeutic milieu |
| **Clinical Service Hours** | Quarterly services at minimum | <9 h/wk | 9-19 h/wk | ≥20 h/wk |
| **Recovery Support Services (RSS)** | Recovery management checkups and other RSS* | Yes* | Yes* | Yes* |

* Directly or through formally affiliated provider

# Residential Levels Overview

| | 3.1 | 3.5 |
|---|---|---|
| | **Clinically Managed Low-intensity Residential Treatment** | **Clinically Managed High-intensity Residential Treatment** |
| **Supervision** | Patients may leave independently during the day with appropriate accountability checks | 24-h supervision |
| **Medical Director** | Not typical | Yes |
| **Physicians and Advanced Practice Providers** | Not typical | Available to review admission decisions. |
| **Nursing** | Not typical | Variable[†] |
| **Program Director** | Yes | Yes |
| **Allied Health Staff** | On-site and alert 24 h/d | On-site and alert 24 h/d |
| **Physical Exam** | Within 14 days of admission[‡] | Within 72 hours of admission |
| **Nursing Assessment** | Not typical | Not typical |
| **Clinical Services** | • Direct psychosocial services<br>• Therapeutic milieu | • Direct psychosocial services<br>• High-intensity therapeutic milieu |
| **Hours of Clinical Services** | 9-19 h/wk, available 7 d/wk | ≥20 h/wk, available 7 d/wk |
| **Recovery Support Services** | Yes* | Yes* |

* Directly or through formally affiliated provider

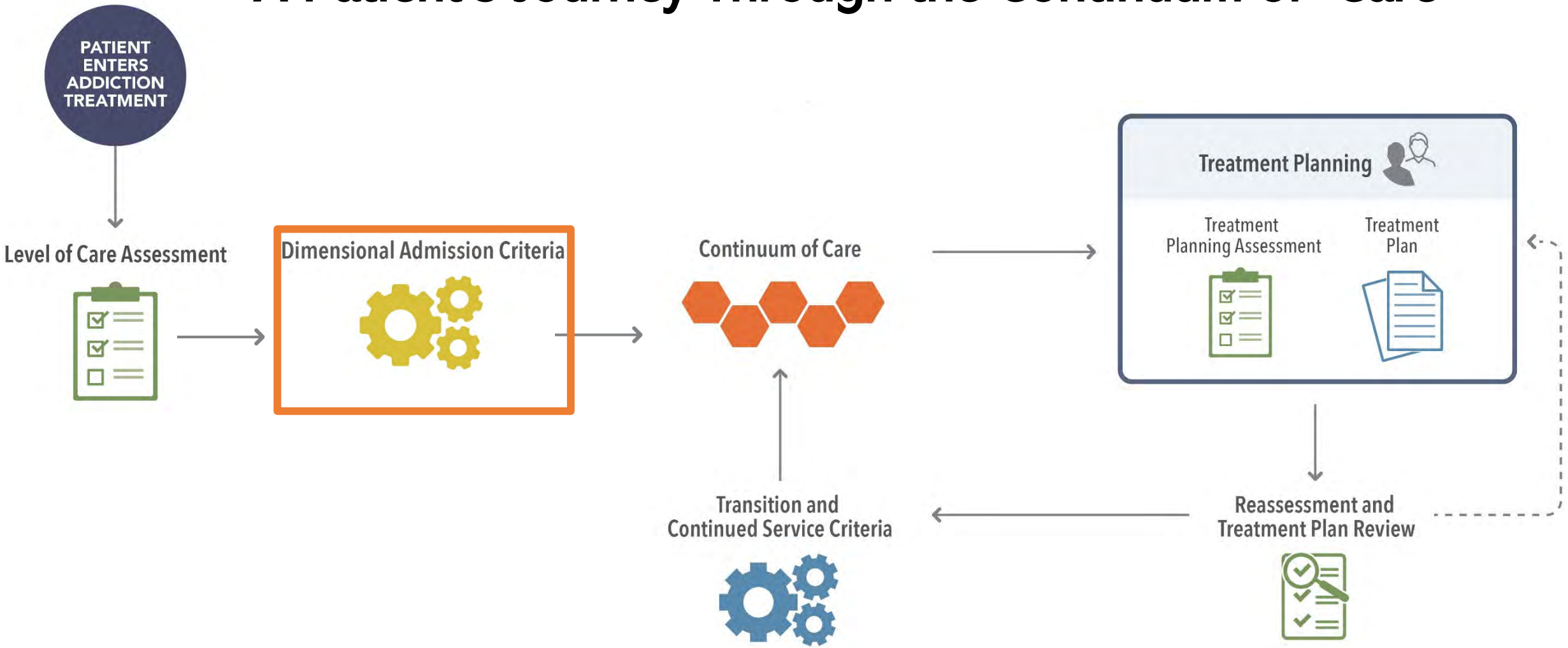
# Medically Managed Overview

| | 1.7 | 2.7 | 3.7 | 4 |
|---|---|---|---|---|
| | **Medically Managed Outpatient Treatment** | **Medically Managed Intensive Outpatient** | **Medically Managed Residential Treatment** | **Medically Managed Inpatient Treatment** |
| **Supervision** | N/A | N/A | 24-h supervision | 24-h supervision |
| **Medical Director** | Yesǂ | Yes | Yes | Yes |
| **Physicians and Advanced Practice Providers** | Available by appointment | Available on-site or via telehealth during program hours | Available on-site or via telehealth 24/7 | Typically available on-site 24/7 |
| **Nursing** | Variable | Yes | Available 24/7 | Available 24/7 |
| **Program Director** | Not typical | Yes | Yes | Variable |
| **Allied Health Staff** | Variable | Typically available | Typically available | Typically available |
| **Physical Exam** | Typically at initial assessment | Within 24-48 hours of initial assessment | Within 24 hours of admission | Within 24 hours of admission |
| **Nursing Assessment** | Variable | At admission | At Admission | At Admission |
| **Clinical Services** | • Direct withdrawal management and biomedical services<br>• Management of common psychiatric disorders<br>• Psychosocial services* | • Direct withdrawal management and biomedical services, with extended nurse monitoring<br>• Management of common psychiatric disorders<br>• Psychosocial services* | • Direct withdrawal management and biomedical services<br>• Management of common psychiatric disorders<br>• Psychosocial services (direct or through formal affiliation) | • Direct withdrawal management and biomedical services (ICU available)<br>• Psychiatric services<br>• Psychosocial services (direct or through formal affiliation) |
| **Clinical Service Hours** | <9 h/wk | ≥20 h/wk | ≥20 h/wk | Variable |
| **Recovery Services** | Yes* | Yes* | Yes* | Yes* |

ǂ may be the responsible physician in an independent practice; * Directly or through formally affiliated provider

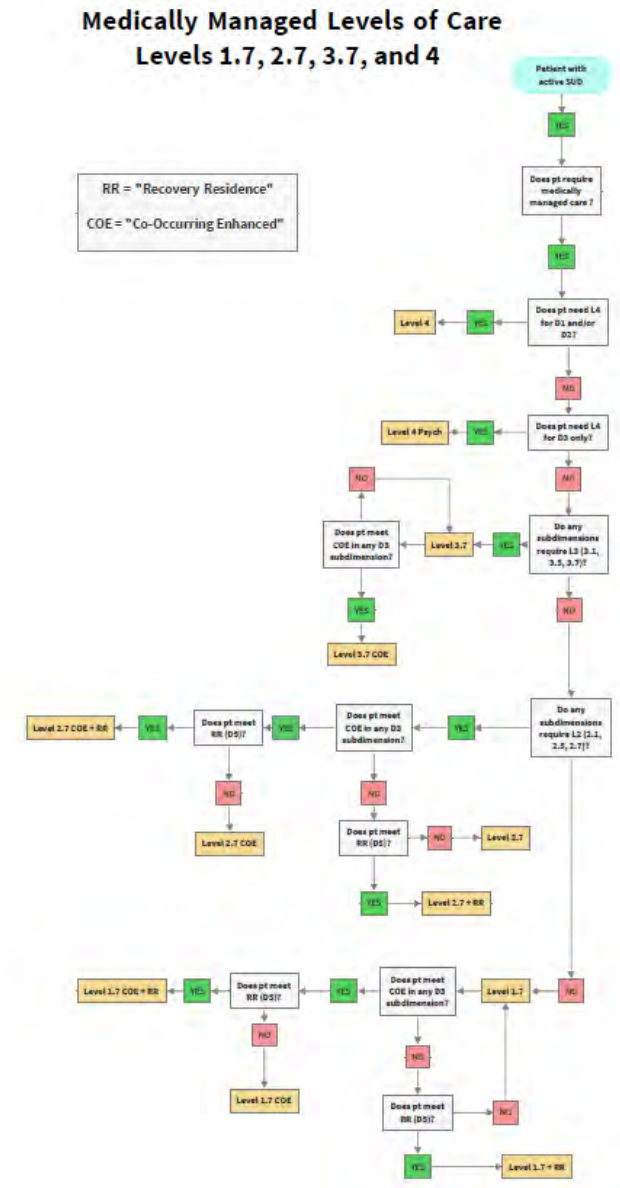
# Dimensional Admission Criteria

# A Patient's Journey Through the Continuum of Care

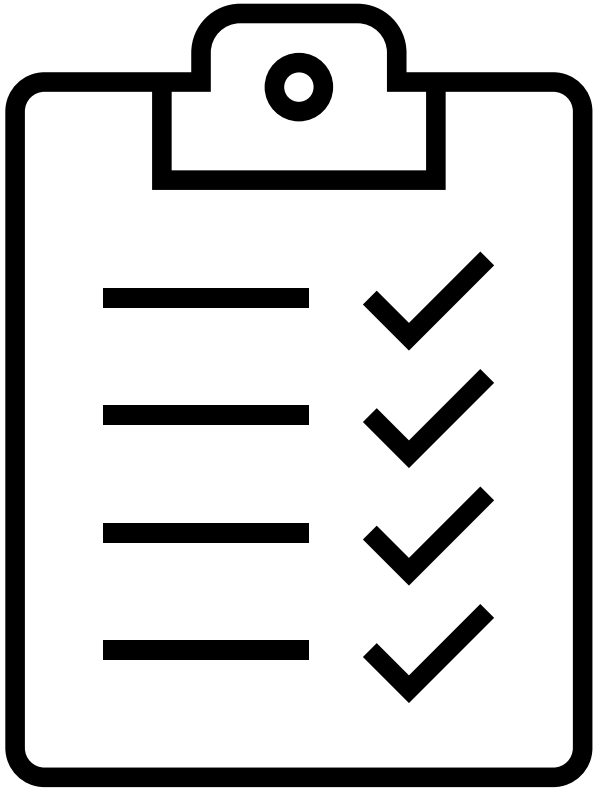


# Dimensional Admission Criteria

- Applicable to patients with SUD
- Recommend the least restrictive or intensive level of care where the patient can be safely and effectively treated
- Algorithm-first development
- Dimensional Admission Criteria tied to risk ratings



# Dimensional Admission Criteria



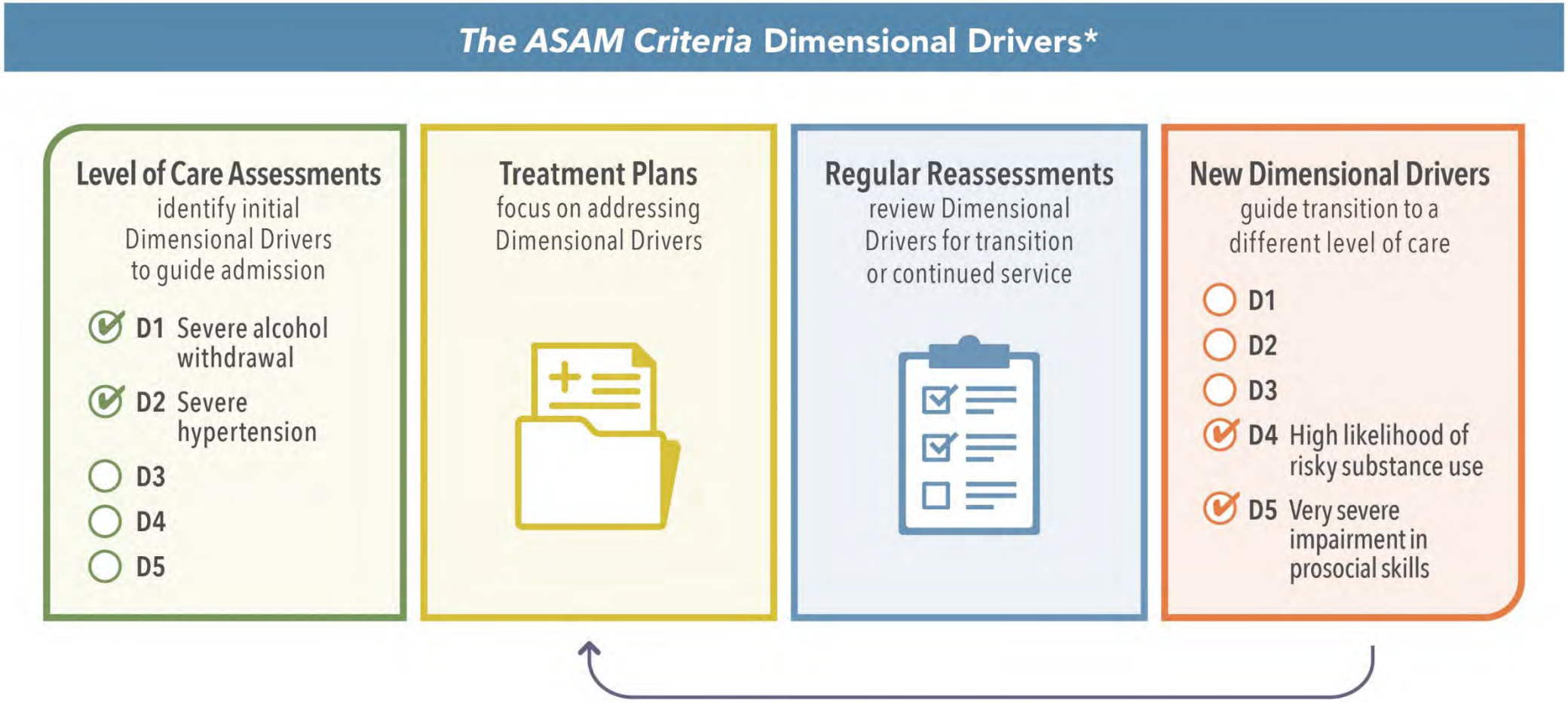
- Risk ratings in each subdimension are the foundation of the Dimensional admission criteria. For example:
  - Dimension 4 – Substance-Use Related Risks
  - Subdimension: Likelihood of engaging in risky substance use
    - Risk rating E = Minimum Level 3.5
      - The patient has a high likelihood of engaging in substance use with significant risk of serious harm or destabilizing loss.

        AND
      - The patient requires 24-hour clinical support and supervision to prevent substance use while developing recovery-sustaining skills.

# Dimensional Admission Criteria

- Clinicians assign a risk rating for each subdimension based on the associated clinical descriptions
- Level of care determination algorithm is used to identify recommended level of care

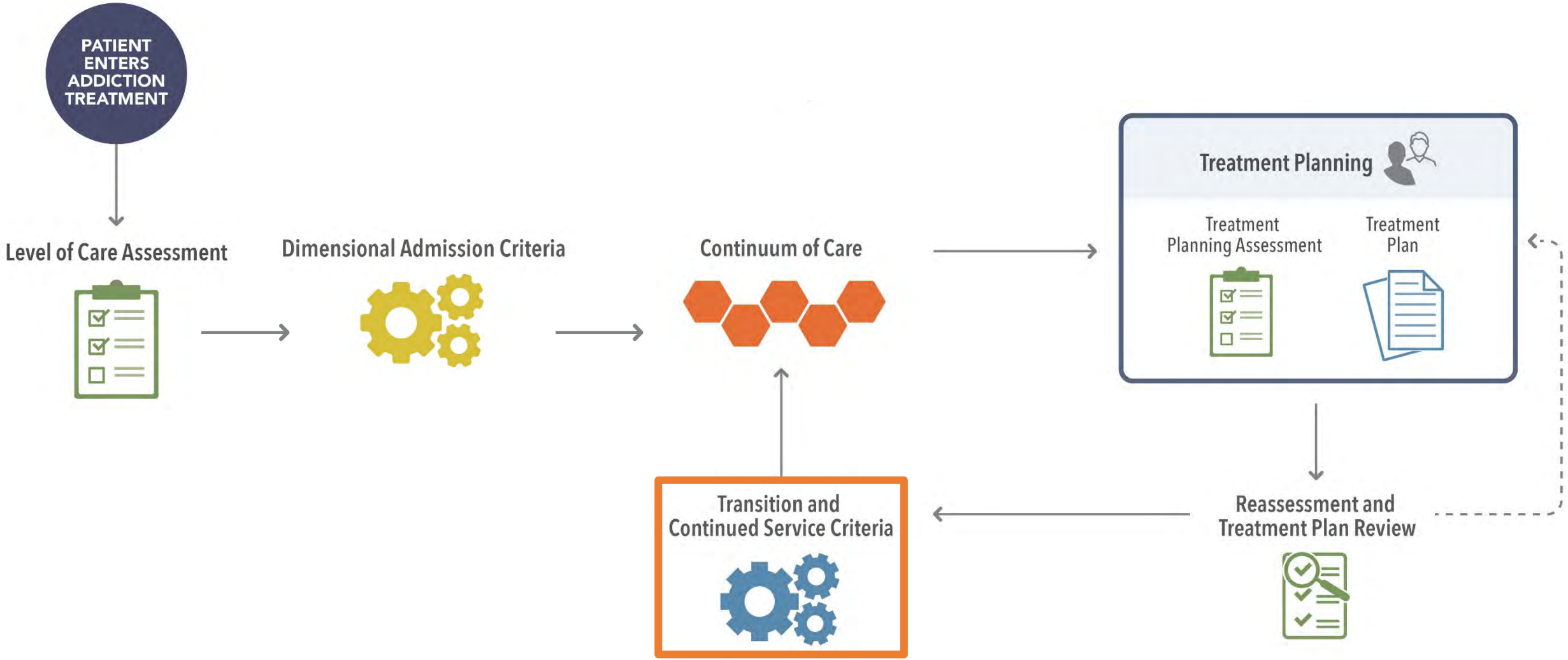
| Subdimensions | Risk Rating |
|---|---|
| ***Dimension 1: Intoxication, Withdrawal, and Addiction Medications*** | |
| Intoxication and Associated Risks | ANY = Any Level of Care |
| Withdrawal and Associated Risks | 1 = minimum Level 1.7 |
| Addiction Medication Needs | A = Minimum 1.7 |
| ***Dimension 2: Biomedical Conditions*** | |
| Physical Health Concerns | 0 = No specific needs |
| Pregnancy-related Concerns | 1 = minimum Level 1.7 |
| ***Dimension 3: Psychiatric and Cognitive Conditions*** | |
| Active Psychiatric Symptoms | 2A = minimum Level 2.5 COE |
| Persistent Disability | 0 = No specific needs |
| ***Dimension 4: Substance Use-related Risks*** | |
| Likelihood of Engaging in Risky Substance Use | D = minimum Level 3.1 |
| Likelihood of Engaging in Risky SUD-related Behaviors | 0 = No specific needs |
| ***Dimension 5: Recovery Environment Interactions*** | |
| Ability to Function Effectively in Current Environment | B = minimum Level 2.5 |
| Safety in Current Environment | A = minimum Recovery Residence |
| Support in Current Environment | A = minimum Recovery Residence |



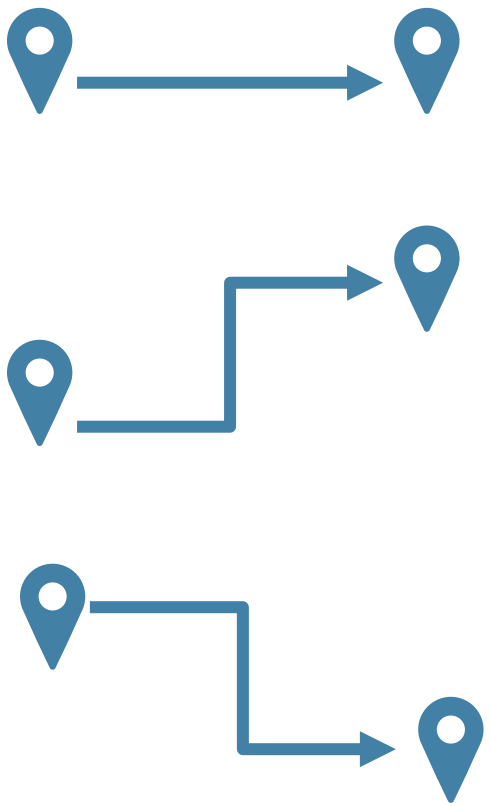

* The Dimensional Drivers presented in this figure are illustrative; Dimensional Drivers should be individualized to each patient.

***Dimensional Drivers*** are the concerns that drive the recommendation for a specific level of care for an individual. They are concerns that cannot be safely and effectively managed in a less intensive level of care.

# A Patient's Journey Through the Continuum of Care



# Transition and Continued Service Criteria



- Criteria for continued service at the current level of care
  - Patient shows progress or progress is expected imminently based on factors such as increased engagement or adjustments to the treatment plan
- Criteria for transition to a more intensive level of care
  - Patient has failed to improve in a reasonable timeframe
  - Patient has worsened or new issues have emerged that meet criteria for a more intensive level of care
- Criteria for transition to a less intensive level of care
  - Dimensional drivers have stabilized such that the patient no longer meets the Dimensional Admission Criteria
  - Patient can be safely and effectively treated in a less intensive level of care

# Level of Care Assessment

**Patient Entering Addiction Treatment**

**Level of Care Assessment**

Dimensions 1-5

**Dimensional Admission Criteria**

LOC recommendation

Dimension 6

LOC placement

**Continuum of Care**

- Level of care recommendations are made based on assessment of Dimensions 1 -5
- Dimension 6 involves a shared decision-making process to determine where the patient is able and willing to engage in treatment

# Treatment Planning Assessment

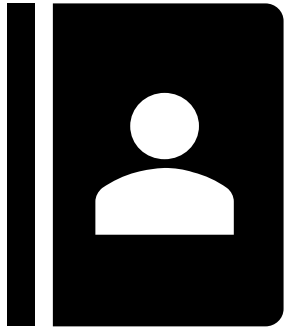
**Patient admitted to treatment**

**Continuum of Care**
Level of care placement

**Transition and Continued Service Criteria**

**Treatment Planning Assessment**

**Treatment Plan**



**Reassessment and Treatment Plan Review**

# DEVELOPING A PLAN OF CARE
also known as
# TREATMENT PLANNING

# Treatment Planning


- Occurs soon after admission
  - May be delayed if the patient is too acutely ill to participate
- Collaborative process between clinicians and patients
  - May include family and support systems
- Focused on Dimensional drivers and patient priorities

# Treatment Planning Principles

- Individualized
- Patient centered
- Unconditional positive regard
- Meet patients where they are
  - Build upon patient strengths
  - Respect autonomy and values
  - Get patient buy in

# Multidisciplinary Process

Treatment planning should be led by patient's primary clinician

Dimensions 1 or 2 concerns that require medical care should be led by a medical professional

Dimension 3 concerns that require psychiatric services should be led by a mental health professional

# Building Therapeutic Alliance

- Personal bond made up of reciprocal positive feelings
- Agreement on treatment goals
- Agreement on objectives and action steps
- Trauma-sensitive and culturally humble approach
  - Treatment plans informed by patient's trauma history and cultural identities
  - Consider related vulnerabilities

Cultural humility: A process of entering a relationship with another person with the intention of honoring their beliefs, customs, and values. It entails an ongoing self-exploration and self-critique combined with a willingness to learn from others.

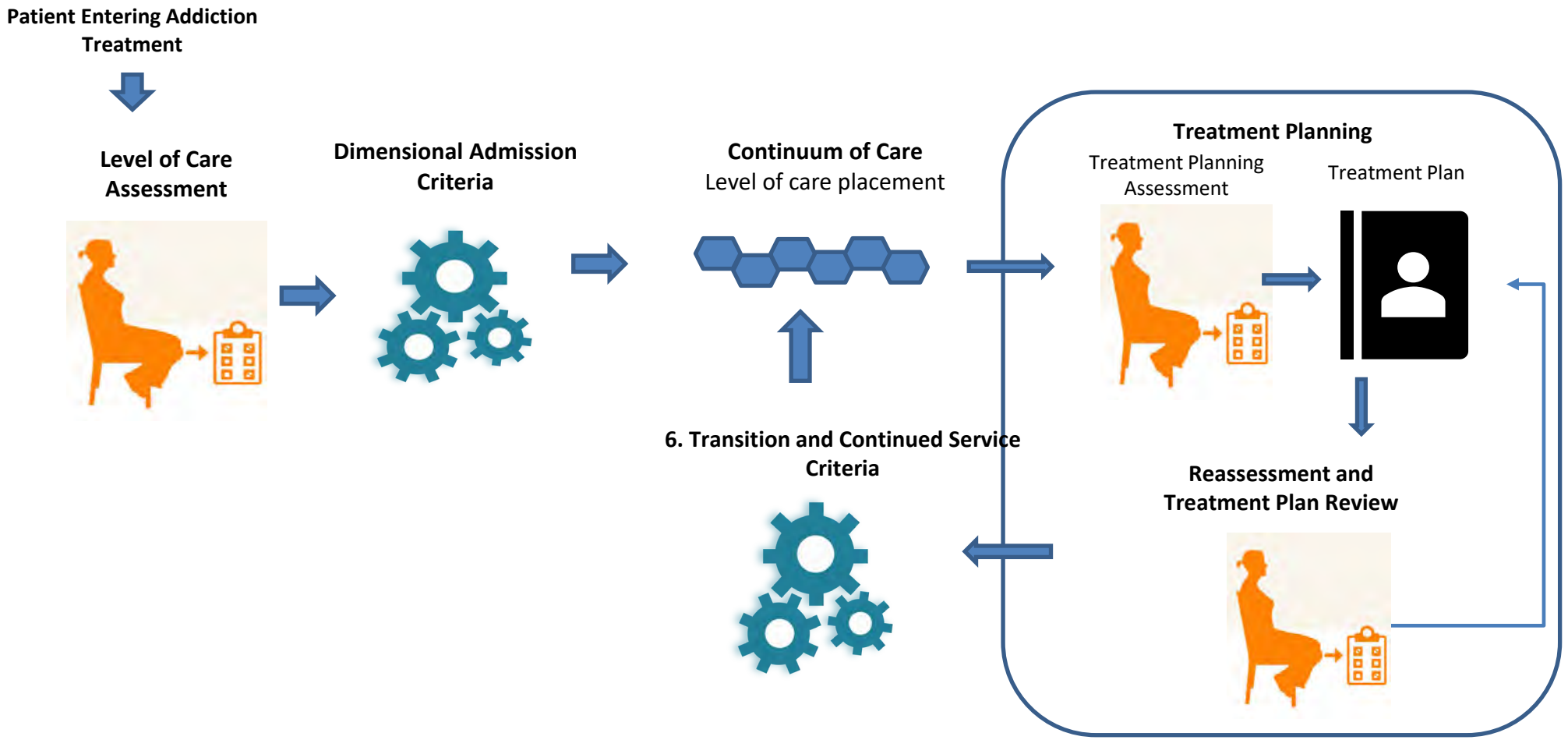
# Treatment Planning Process

- Identify the problems in each Dimension/subdimension
  - Determine which are Dimensional Drivers
- Work with the patient to develop **goals, objectives, and action steps** that:
  - Address the Dimensional Drivers
  - Reflect the patient's priorities in their own words
  - Are meaningful to them
  - Objectives can realistically be addressed at the given level of care

# Treatment Planning Process

- Integrates motivational interviewing to expand patient insight
- When identifying goals, objectives and action items, consider
  - Patient strengths
  - Need for motivational and harm reduction strategies
  - Availability of services and anticipated wait times
  - Care coordination needs
  - Past successes and challenges

# A Patient's Journey Through the Continuum of Care



# Treatment Planning

- Clinicians works with patients to:
  - Identify any problems in each subdimension
    - Determine which are Dimensional Drivers
  - Develop goals, objectives, and action steps that:
    - Address the Dimensional Drivers
    - Reflect additional patient priorities
    - Are expressed in the patient's priorities own words
    - Can realistically be addressed at the given level of care

# Reassessment and Treatment Plan Review

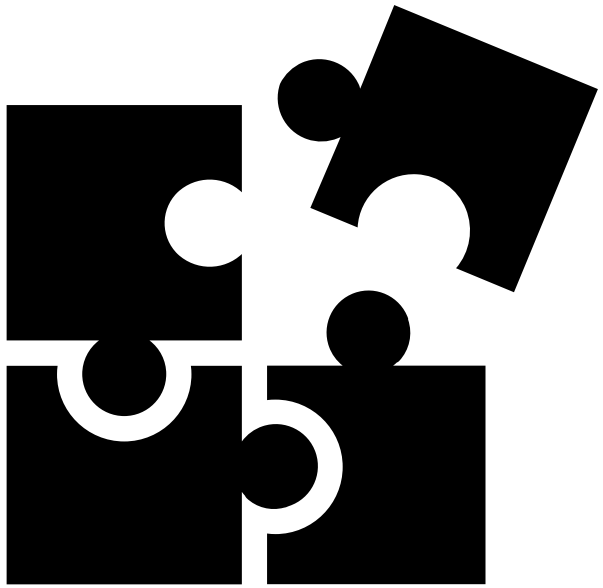
- Treatment planning is a continuous process
  - Which strategies are working? Which are not?
  - Does new information indicate need for different strategies?
- Determine when the patient should transition to more or less intensive level of care
- Adjust goals, objectives, and/or action items based on patient response to care

# Plans of Care

- How will success be measured
- Contingency plans in case instability arises
- Safety planning
- Transition planning (beginning at admission)
  - Continuity of care
  - Dimension 5 or 6 concerns that may impact transition to a less intensive level

# Care Coordination

- The treatment plan should be well coordinated with external providers
  - shared understanding of treatment plan goals
  - incorporate relevant services
    - Appointment reminders
    - Relevant psychoeducation
    - Motivational interventions
    - Adherence monitoring



# Other Changes

# New Content

- Treatment Planning (Chapter 9)
- Telehealth and Other Health Technologies (Chapter 13)
- Integrating Recovery Support Services (Chapter 15)
- Integrating Trauma-Sensitive Practices, Culturally Humble Care, and Social Determinants of Health (Chapter 16)
- Addressing Pain (Chapter 18)
- Addressing Cognitive Impairment (Chapter 19)

# New Chapter on Treatment Planning

- Identify any problems in each subdimension
  - Determine which are Dimensional Drivers
- Clinicians works with patients to develop goals, objectives, and action steps that:
  - Address the Dimensional Drivers
  - Reflect additional patient priorities
  - Are expressed in the patient's priorities own words
  - Can realistically be addressed at the given level of care

# Reassessment and Treatment Plan Review

- Treatment planning is a continuous process
  - Which strategies are working? Which are not?
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# Additional Volumes

- Adolescent and Transition Age Youth
- Correctional Settings and Reentry
- Behavioral Addictions

# Implementation Tools

- Updating implementation tools
  - Training courses
  - ASAM Criteria software
  - Level of Care Certification program with CARF
  - ASAM Criteria Interview Assessment guide
- Developing new implementation tools
  - Standard medical necessity and continued service forms
  - Treatment planning template


asamcriteria.org

# Questions?

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Interested in more? Come to:

- ASAM Annual Meeting (Denver in April 2025!) http://www.asam.org
- CSAM Annual Meeting (San Diego Aug 2025!) http://csam-asam.org
- AAAP Annual Meeting (Naples, FL Nov 2024!) http://www.aaap.org

# Discussions/Questions

**“The opposite of addiction is not sobriety; the opposite of addiction is connection.”**

*- Johann Hari*

# References for Further Study

Training and consolation on The ASAM Criteria is available through the following designated training organizations:

ASAM American Society of Addiction Medicine

https://elearning.asam.org/asam-criteria-education

Hazelden Betty Ford Foundation

https://discover.hazeldenbettyford.org/

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