**ASAM Training Q&A Session:**

**Friday, 11/17/17**

**ASAM RELATED QUESTIONS**

1. **How will providers document when/if use of ASAM Criteria occurred?**

The Intake/Screening form has been revised to include the ASAM Dimensions, Risk Ratings, and Level of Care Recommendations. Two new forms have been created (a “Risk Rating Checklist” and a “Summary of Multidimensional Assessment/Level of Care Recommendation” form) to help organize assessment information received from the ASI/YAI and other forms currently used (such as the Health Screening Questionnaire, High Risk Assessment, etc.) These forms are currently being piloted and will be refined based on provider input. It is anticipated that the final version of these forms will be released by February 2018. Additionally in the near future, risk ratings for each ASAM Dimension and Level of Care information will be required data entry fields in SanWITS.

1. **Will all programs be using the Continuum application? Will ASAM software be provided and if so, what are the costs associated?**

No, currently San Diego County is not planning to purchase the Continuum software.

1. **How will implementation of ASAM criteria be audited/supervised/controlled for quality/effectiveness?**

Monitoring the use of ASAM Criteria will take place at both the program and County level. Programs will be expected to monitor staff use of the ASAM Criteria via individual supervision, treatment teams, peer-chart-reviews, etc. County QM staff will conduct periodic chart reviews and monitor SanWITS reports for ASAM data entry.

1. **Community is very important in recovery. Will clients in different levels of care be able to participate in structured activities together?**

All services should be based on client needs and his or her individualized treatment plan. Depending on this (and the type of structured activity) clients in different levels of care may be able to participate in activities together.

1. **Do you recommend transitioning to DSM 5 Diagnosis criteria once ASAM Criteria is implemented?**

Currently, all SUD providers are encouraged to use DSM-5 criteria.

1. **What are some commonly used outcomes that align with/support ASAM Criteria?**

DHCS (Department of Health Care Services) has contracted with UCLA’s (University of California, Los Angeles) Integrated Substance Abuse Programs to conduct an evaluation to measure and monitor outcomes of the DMC-ODS. In addition to data from other sources (e.g., CalOMS, Drug Medi-Cal Billing claims, etc.), a tool will be created by UCLA to collect outcome data on each client’s ASAM determination at intake, at specified intervals, at discharge and at transitions between levels of care.

1. **Is the ASAM Criteria going to be implemented within schools?**

All County of San Diego contracted SUD programs will be expected to utilize ASAM criteria.

1. **How are you going to utilize this measure with the forensic population coming from a custody setting when it hasn’t been normed for said population?**

ASAM Criteria is not considered a “measure” or “tool,” like the ASI or other validated measures for assessments. Rather, the ASAM Criteria is a way to organize assessment data that is collected in a variety of ways into a comprehensive conceptualization of the client’s needs, and to make level of care determinations based on this information. Therefore, it is suitable for all populations.

1. **Does staff have to be licensed to complete ASAM assessments and intakes? Do you have to have licensed or licensed eligible staff to assess according to ASAM Criteria?**

Under the STCs (Standard Terms and Conditions) of the DMC-ODS (Drug Medi-Cal Organized Delivery System), medical necessity determinations (initial and on-going) must be performed through a “face-to-face review” by a medical director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA - which includes Nurse Practitioners, Physician Assistants, Registered Nurses, Licensed Psychologists, LCSW, LPCC, LMFTs, and licensed-eligible practitioners working under the supervision of licensed clinicians). Since the STCs define medical necessity as having both a DSM SUD diagnosis AND meeting the ASAM Criteria definition of medical necessity for a specific level(s) of care, licensed staff are an integral part of completing the intake and assessment process, according to ASAM Criteria.

It is important to note that the DHCS Information Notice 16-044 clarified the definition of “Face-to-Face Review” to be at a minimum between the certified counselor who has completed the assessment for the client and the Medical Director, licensed physician, or LPHA. Therefore, certified counselors may conduct intakes and assessments according to ASAM Criteria, but must have a face-to-face review with licensed staff, and this interaction must also be documented in the client’s chart.

1. **How will you ensure AOD counselors have adequate clinical skill to apply ASAM criteria?**

The County will continue to make ASAM training available to all programs to increase the skill level of AOD counselors and LPHAs regarding ASAM Criteria. Programs are expected to be active participants in their staff development around skill building utilizing ASAM criteria by sharing case presentations in individual supervision and treatment team meetings utilizing the criteria for discussion and justification of level of care recommendations. In addition, all registered and certified AOD counselors must receive proper supervision. Programs must have written policies and procedures in place to address how supervision will be provided as well as how quality of services will be monitored.

1. **Will there be consultation available with ASAM?**

County SUD QM is hoping to provide monthly consultation meetings for program managers and clinical supervisors in the near future.

1. **Is the expectation that all recipients of Drug Medi-Cal services in San Diego County will have an assessment based on ASAM Criteria, or will some clients receive some other type of assessment?**

It is the expectation that regardless of the assessment tools (e.g., ASI, YAI, etc.) utilized all recipients of DMC services will have their assessment information reviewed according to ASAM Criteria, and that level of care determinations will be made based on this criteria and the client’s specific individualized needs.

**OTHER QUESTIONS REGARDING DMC-ODS IMPLAMENTATION**

1. **As a provider network, we are concerned that the clients we serve often do not do well in treatment when on Methadone. Few clients complete treatment. What advice do you have for us?**

Research has shown that for the treatment of addiction, a combination of medications and behavioral counseling is more successful than either intervention alone. For this reason, MAT (medication-assisted treatment) is a part of a comprehensive, biopsychosocial approach to the treatment of SUDs that includes psychosocial interventions such as counseling, behavioral therapies, case management, and care coordination. As such, MAT is an evidence-based treatment to facilitate recovery and is a best practice for individuals for whom it is clinically appropriate.

There are currently several FDA-approved medications for the treatment of various types of addiction in adults, including Methadone, which is approved to treat Opioid Use Disorder. Concerns about a client’s presentation in treatment while on Methadone should be discussed directly with the prescriber as part of care coordination, as this feedback is important in relation to dosing and possible adjustments to dosing.

Also, if there are any specific areas within your program where you would like to see an improvement (such as improved program retentions of specific populations) then this might be an opportunity for a quality improvement project aimed at improving retention rates.

1. **What services will AOD Counselors be able to provide under the DMC-ODS? Are RADTs considered qualified for Drug Medi-Cal billing?**

Registered and Certified AOD Counselors will be able to provide intake, assessment and treatment planning (with LPHA review/co-signature), counseling, collateral, crisis intervention, case management, recovery services, and monitoring of withdrawal management services (with education). All registered and certified AOD counselors must receive proper supervision and programs must have written policies and procedures in place to address how supervision will be provided as well as how quality of services will be monitored.

1. **Will the intake paperwork be modified?**

The Intake/Screening form has been revised to include the ASAM Dimensions, Risk Ratings, and Level of Care Recommendations. Additionally, two new forms have been created (i.e., a “Risk Rating Checklist” and a “Summary of Multidimensional Assessment/Level of Care Recommendation”) to help organize assessment information received from the ASI/YAI and other forms currently used, such as the Health Screening Questionnaire, High Risk Assessment, etc. These forms are currently being piloted and will be refined based on provider input. It is anticipated that the final versions of these forms will be released by February 2018.

1. **Will outcomes change in contracts?**

Yes, contracts and Statements of Work are being revised to address all DMC-ODS requirements.

1. **Do you foresee Title 22 regulation guidelines changing due to DMC being implemented in residential and detox programs for adults and adolescents?**

Currently, Title 22 only allows residential SUD services to pregnant and postpartum women when provided in facilities with 16 beds or less to be billable to DMC. Under the DMC-ODS, residential services are billable to DMC for all clients who meet medical necessity criteria for this level of care, and there are no facility size limitations.

1. **What are the timelines for residential?**

While DHCS has outlined timelines for Drug Medi-Cal reimbursement for residential days, lengths of stay will also be based on medical necessity and treatment needs, in accordance with ASAM criteria and individualized treatment plans.  Drug Medi-Cal stay limits, as per the DMC-ODS Standard Terms and Conditions (STCs) are as follows:

* Adolescents: up to 30 days in one continuous period. Maximum of two non-continuous 30-day stays in any one-year period. One extension of up to 30 days beyond the maximum length of stay may be authorized for one continuous length of stay in a one-year period.
* Adults: up to 90 days in one continuous period. Maximum of two non-continuous stays in any one-year period. One extension of up to 30 days beyond the maximum length of stay of 90 days may be authorized for on continuous length of stay in a one-year period.
* Perinatal Clients may receive a longer length of stay based on medical necessity (up to the length of the pregnancy and 60 days after the pregnancy ends).
* Criminal Justice population: may receive extended lengths of stay if assessed for need (e.g. up to 6 months residential; 3 months FFP with a one-time 30-day extension if found to be medically necessary and if longer lengths are needed, other county identified funds can be used).

1. **Will bed-holds be allowed for residential? If so, for how long? Will authorization be required when they return? How will bed-holds impact the number of times a client can be in residential care? How do bed holds impact DMC billing?**

All residential processes, including bed hold policies, are currently being discussed and will be decided with input from ADSPA. Bed holds will not impact the number of times a client can be in residential care. However, bed holds will impact DMC billing as a direct service must be provided to the client to bill DMC, so bed hold days will not be billable to DMC.

1. **In residential programs (adolescent and adult) what will be the DMC guidelines for progress notes? How will progress notes impact billing?**

The format of progress notes for residential programs is currently being discussed and will be decided with input from ADSPA. Progress notes will have to meet certain standards (e.g., content, timelines for completion, etc.) in order to be billable to DMC. Services claimed that do not have corresponding progress notes meeting these standards will be subject to recoupment.

1. **For adult withdrawal management, will a treatment plan need to be developed in a certain timeline? Will a medical director need to sign-off to meet medical necessity? How long will DMC authorize for individuals to stay in a 24 hour facility to withdrawal?**

Yes, services for withdrawal management will need to be documented on a treatment plan and treatment plans will need to be completed within specified timelines, which are currently being discussed and will be decided with input from ADSPA. Under the DMC-ODS, the medical director or LPHA must sign the treatment plan in order to meet medical necessity. Length of stay for withdrawal management in a 24-hour facility is based on the client’s medical necessity.

1. **We are using the ICD-10 diagnosis of Opiate Intoxication when we get a client on methadone. Where does this fit on the ASAM dimensions and how would you rate the risk?**

Methadone is an FDA approved medication for treatment of an Opioid Use Disorder. Assigning a diagnosis based upon someone taking a medication is not appropriate, as many other factors need to be considered during a diagnostic assessment. Information regarding the use of a medication alone does not determine a risk rating or an ASAM level of care. When there are concerns about a client’s presentation in treatment (e.g., client appears drowsy in group or has difficulty paying attention), it is the expectation that programs will coordinate care with the prescriber as this feedback may impact dosage levels.

1. **Will providers have access to an EHR and does the County foresee this going live 7/1/18?**

The County of San Diego is in meetings with FEi, the vendor for SanWITS, and we are moving forward with use of SanWITs as the EHR for the SUD System of Care. It is anticipated that many elements (e.g., assessments, ASAM Criteria information, progress notes, etc.) will be in place by 7/1/18.

1. **Under the DMC-ODS, will treatment plans need to include both frequency and duration? If so, how does this fit with re-assessment/clinically driven care?**

Title 22 currently requires documentation of the frequency of services and target dates for the accomplishment of action steps and goals.  Under the DMC-ODS, treatment plans will continue to require identification of both frequency and duration of services/interventions, in alignment with both re-assessment and clinically driven care. The treatment plan can be updated and the frequency and duration of services/interventions adjusted based on the client’s current needs. All required elements in a treatment plan (i.e., frequency, duration, target dates, action steps, etc.) need to be individualized and specific to the client and not be “cookie-cutter” (i.e., where each client has the same goals, action steps, frequency, etc.) Treatment planning is a continuous process, including the identification of the frequency and duration of the service, and should be client-centered, individually focused, and based on medical necessity.

1. **Will there be a requirement for pre-authorization for adult withdrawal management and adolescent group homes?**

Pre-authorization is required for residential services. This would include adult withdrawal management in a residential setting as well as adolescent group homes. Pre-authorization is not required for outpatient withdrawal management or other outpatient services.

1. **Will children staying in residential care with their moms be charged room and board or will there be a separate funding source for children?**

No, children are not charged room and board. In instances when a mother receives support, such as CalFresh or “food stamps”, then the extra funds received for each child/children would go to the program for food costs. Similarly, if support is received through other government resources, such as CalWORKs that pays for daycare, then the program may collect that payment.

1. **What will case management and recovery services look like? How will they be billed?**

Case management services are defined as a service to assist with client access to needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Case Management focuses on coordination of care with SUD providers, primary care, mental health providers, and the criminal justice system, if needed. Case Management services may be provided by a LPHA or a certified AOD counselor, and may be provided face-to-face, by telephone, or by telehealth with the client and may be provided anywhere in the community.

Recovery services include outpatient counseling (e.g., individual or group) to stabilize the client and then reassess if the client needs further care. This includes recovery coaching, peer-to-peer services and relapse prevention, linkages to life skills, employment services, job training and education services, linkages to self-help and support, and linkages to housing assistance, transportation, case management and individualized service coordination. Recovery services are provided as medically necessary to a client after completing their SUD treatment, and may be utilized when a client is triggered, has relapsed, or to prevent relapse. They may be provided face-to-face, by telephone, or by telehealth with the client and may be provided anywhere in the community. These services will be billed through SanWITs and claimed to the appropriate designation (i.e. “Case Management” or “Recovery Services”).

1. **Regarding youth, sometimes they’re referred to treatment because they’ve gotten in trouble and parents make them come. However, they may not meet criteria for a DSM-5 SUD diagnosis. Through the DMC-ODS, can we bill for services for this type of client?**

Youth are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Eligibility for EPSDT broadens the definition of medical necessity for youth to include individuals who are deemed “at-risk” for a SUD. Therefore, if the youth does not meet the criteria for a DSM-5 SUD diagnosis, but is determined to be “at-risk” (based on reports of experimental or early-phase substance use, associated biopsychosocial risk factors, etc.) services may be billable. The “at-risk” determination would need to be made by an LPHA (or a registered/certified counselor with signature approval from an LPHA), and would be eligible for short-term intervention outpatient services.

1. **Will our discharge codes in CalOMS change to match client-centered language?**

DHCS is planning changes to CalOMS; however, the exact nature of the changes is unknown at this time. The County will continue to work with DHCS to obtain information to share as it becomes available.

1. **Will QSR Reports change to match client centered outcomes?**

QSR reports will be revised to align with any contract/SOW changes resulting from the DMC-ODS implementation.

1. **If a client reaches the maximum number of times per year to receive residential care (paid by Drug Medi-Cal), will there be other funding sources available to help provide treatment services?**

The system of care is changing from being program focused (i.e. “this is a six month program”) to being client focused (i.e. “a client transitions between levels of care based on their need”), and all services must be justified by the client’s medical necessity for them based on their specific individualized needs. Therefore, if a client has reached their maximum allowable DMC residential stays per year, and residential services are medically necessary, then additional funding may be available on a case-by-case basis.

1. **With the DMC-ODS implementation, how will the County address mandated clients? How is the County going to communicate with Drug Court/Probation regarding ASAM criteria if there is a discrepancy between justice system requirements and the client’s needs?**

Currently, the County has a workgroup with Justice Partners to develop specific forms and processes in line with ASAM Criteria that meets the needs of justice clients and their partners. Plans for Justice Partners to be ASAM trained are in process and policies are being developed.

1. **What is the projected design of transition between levels of care?**

The goal will be to have seamless transitions between levels of care to assure clients have their individualized needs met without disruption to services. This will include addition of Case Manager positions to SUD programs, standards for referral of clients, Memorandum of Understanding (MOU) agreements with managed care plans that serve DMC-ODS clients, and education to the greater community partners (i.e. hospitals, Crisis Houses, etc.) about referral resources to maximize client placement into the right service at the right time. Standards for care coordination and continuity of care will be implemented and providers will be expected to adhere to them as a way of reaching better clinical outcomes for all SUD clients.