ASAM LISTENING SESSIONS – NOTES

11/02/2022 RESIDENTIAL (RES)

Requesting clarification about if the assessment done in OP will be able to be used for the RES admission
Request to design a continuum where information is shared across LOC
Request for more information on the STC requirement of an "independent review process" - who will review and when?
When Oregon moves to ASAM, clarify the expectations for: site reviews, hours of services delivered, credentials, etc. so we know what has to change
When a program assigns a LOC but the IND is not attending, how will HSD respond (not hold the program accountable)
Requesting clarification on the ASAM Certification Manual
Several providers requested clarification on how Oregon will approach the site reviews when ASAM is out of the grace period and what tools will be used to measure compliance
What types of credentials are qualified to complete the ASAM assessment
Is there a brief version of *The ASAM CONTINUUM* assessment for re-auths and transfers between LOC?
Will HSD write OAR so that they do not jeopardize accreditation with CARF, JCo.
Will HSD revise OAR to reduce the amount of documentation required at the time of entry? It is difficult for the IND, time consuming for the program and not conducive to the therapeutic relationship.
Rural program is overwhelmed, and leaders are working all shifts and positions. Wondering the point of this if there are not enough staff to run the program.

11/02/2022 OUTPATIENT (OP)

Concern about ASAM trying to move from guidelines to requirements can be hurtful if it is no longer a conceptual framework. Eliminate ASAM or offer providers ability to choose between ASAM and other models
Concern about ASAM Criteria applying to white, affluent persons who are not receiving Medicaid benefits
Concern about ASAM Criteria 4th Edition pushing IND into RES, having too high a dose of tx hours and being too deterministic (this is related to a CCO's UM practices)

Need a shared language - this is vitally important. These (above) concerns are not about HSD, but ASAM 4th Ed. How effective is it if you have to override it?
Pay for the Train the Trainers to maintain fidelity and consistency across the State and whenever new staff onboard
There is an access issue. Reduce other paperwork at intake to offset the longer ASAM assessment and not increase the waitlists
Coordination between LOC. Can the OP assessment be sent to the detox?
We don't see the move to using the ASAM assessment as being detrimental.
UM: CCO denying claims for IOP when there are no residential beds, or the IND is not willing to engage in RES.
OHA needs to be more directive with the CCOs to get consistency and network adequacy
Demo'd the software: good outputs, length is concerning.
Request for HSD to see what data *The ASAM CONTINUUM* can feed into MOTS so there is less repetition and so that what is currently built into assessments is not lost and needing to be recreated
MOTS is a burden. The amount and frequency of reporting, and number of errors is so high that there are staff dedicated to only doing MOTS. IND don't always know the answers to the MOTS questions
Request for HSD to build a cross walk of all the required documents for all the different types of programs. Identify what is needed in addition to The ASAM assessment. Note what is no longer needed (covered by ASAM)
Consider the LSCMI criminogenic risk screen tools
Consider integration to reduce the number of times the same person is asked the same questions in different forms
So important to consider the impact of the tools on the therapist and IND. Decrease burden and increase efficiency. Needs to be meaningful and done with intention.
Request direction on how to be in compliance with the AOR when the ASAM can be done over several sessions
Which credentials can complete The ASAM assessment

11/03/2022 WITHDRAWAL MANAGEMENT (WM)

Concern expressed about a requirement to use a full ASAM assessment during residential withdrawal management. Currently doing DIM 1 and an H&P.

Consequences of completing a full ASAM at this LOC would include: slow, dangerous for some patients, need to hire more staff to get the other DIM's assessed and that is not feasible.
Completing a full ASAM implies that every individual intends to continue in care and many do not.
completing a full ASAM is wasteful when the referring provider sends one and the next LOC provider is required to do one at entry
if programs were required to complete a full ASAM and someone left ASA prior to it being completed, but having had a few bed days, would the program be paid for the bed days used?
Does The ASAM CONTINUUM software integrate with my program's EHR?
There is an opportunity to re-envision and write WM rules to reflect that it is really a medical intervention, not BH counseling/treatment
the majority of what our counselors do all week is ASAM assessments because the stay is so brief.
assessments and a LOC inform a treatment plan. What is the meaningful use of the information being collected and how do we want staff interacting with the patients in the brief time they are stable and awake?
Focus of the BH staff should be on getting the patients to the next right place, spending time on ASAM is a waste at this LOC.
ASAM is costly because of staff
Need to focus on Medical Necessity. ASAM is a barrier. Need to connect with services and support transition. Envision it like being in the hospital and having social workers help with next steps.
CONCERN: several residential programs require the ASAM from the WM in order to put an individual on a waitlist.
CCOs in several Counties have required ASAM at the time of transition from WM
ASAM's CONTINUUM assessment does not meet CARF's standards for an ASAM assessment. REQUEST: consider an OAR that allows the use of the CARF ASAM assessment when a program is accredited.
Similar concerns expressed about programs accredited by the Joint Commission -
Ensure OARs reflect that WM is a medical stabilization intervention and involves motivational strategies, not counseling
We have an abbreviated ASAM we use for LOC 3.7, approved by our Compliance Specialist.

ASAM Co-Triage - is this mostly for call centers? Can it be used as an abbreviated ASAM in WM?
ISSRs gave providers 14 days to get the assessment completed while individuals engaged in services. But now, providers don't get reimbursed for services until the assessment and service plan are done (upfront). Pre-engagement and Outreach teams work mostly with the IND who won't engage in a long intake process. we need another way to do this. we lose a lot - 30-40% of IND after the first 3-4 sessions. if we assess those who are engaged, we will focus our resources on those IND.
Physical Health is low barrier/ early engagement. There is a parity issue here.
Prioritize what we can do when IND are awake.
provide specific training on LOC 3.7WM for the Staff
Current EHR pulls data from the assessment into the MOTS and Service plans - can The ASAM CONTINUUM software do this?
Will the ASAM be a MH assessment? Co-occurring?
REQUEST: that HSD push back on ASAM to create an assessment for WM that is between the Co-Triage and the CONTINUUM full assessment, something low barrier.

11/07/2022 CULTURALLY SPECIFIC OUTPATIENT

Request for OHA to work with ASAM so that ASAM offers an assessment tool in Spanish
The Change Companies trainings available through OHA DUII are lacking in cultural considerations. Make available trainings on ASAM that have cultural considerations.
We are a small program and cannot afford software.
ASAM is not culturally specific or trauma informed. Are there suggestions about how to do what we do and use ASAM?
What are the ASAM Waiver options for a Tribe?
How do we adapt the ASAM assessment tool so that it is culturally responsive and useful?
Some individuals who need residential are in their 50's and 60's and faith-based programs are not really where we want to send them, but they don't read or write English, and some are also not able to read or write fully in their native

language. How do we get them into SUD RES that is culturally specific and has language/ translation that is not limited to Spanish? This is a serious gap.
Same as above for individuals speaking Spanish, there is only one SUD RES program in the State for Spanish speaking individuals.
Please talk more and consider the special challenges for the culturally specific programs (timeline)
our program uses its own version of ASAM assessment, and we are co-occurring. The amount of paperwork for co-occurring services is overwhelming and if we don't adjust our MH assessment it will result in compliance and efficiency issues.
Be flexible in the implementation. Consider the differences in resources, speed and complexity
Access to MH services is difficult, with long waitlists at most programs. We need to find a better way to integrate MH with SUDS so that individuals who need MH services and/ or medications can access those, as the barriers often impeed the ability to progress in SUD services.
Can we use ASAM for co-occurring?
Will ASAM work with MOTS reporting?
Current assessment is translated by the counselor during the interview and the ASAM assessment will take longer, and we will need time to understand how to properly translate it.
Our program does not have a written assessment form, it is an interview with a thorough written summary.
Does OHA plan to train providers on ASAM 4th Edition after it is released?

11/09/2022 CULTURALLY SPECIFIC RESIDENTIAL

Most staff in our program speak and write little English, with Spanish being the primary language. Many individuals are Native American, and Spanish is a second language.
There are over 500 Tribal languages
The ASAM assessment does not consider culture. Our assessment asks about: when they came to the US, where they were born, the

legal status (which needs to be done in a very sensitive manner), gang affiliation, etc.
In a workforce shortage we are developing staff internally, helping Treatment Assistants become Peers and CADCs.
Barrier: MHACBO tests are very difficult for Spanish speakers, and it is intimidating, so some don't even want to try. Same for the QMHA/P tests which are only in English. MHACBO made one exception, but this process is intimidating.
The Spanish and Tribal cultures are relational and having a tool that is very institutionalized is a barrier.
There is mistrust of the mainstream, and this tool is mainstream.
Several Senior staff, one a program director, are Tribal members and/ or speak Spanish as a primary language
It is going to take creativity to use this too. Our staff and clients are relational, and we need to get to know each other to get the information
This is probably one of the most intimidating and needlessly long tools I've ever used.
Think about the history of when there was a form everyone was going to have to use, and it eventually failed.
We will still have to do all the other screening tools, that are currently built into our assessment, to comply with CARF [and the CCOs]
We still have to do an interpretive summary, as the automated one is not sufficient for CARF and is not sufficient as a computer cannot account for all the barriers and variables that will weigh into a LOC placement and treatment plan and doesn't replace a clinician's judgement.
The evidence-base for this tool is not with the Spanish-speaking or Tribal communities
Years ago, OHA paid ASAM to train program leaders on the Continuum and then each program built their own assessment tool. Our program made the ASAM assessment culturally specific.

Our staff don't have the capability of typing into the fillable fields.
Neither OHA nor CARF have ever made a recommendation about changing something in the structure of our ASAM assessment tool.
The ASAM assessment does not collect military history, an in-depth trauma history, and only has a few questions for suicidality. CARF requires all these and an evidence-based SI screening tool, the GAD-7 and PHQ-9.
The ASAM assessment overly promotes residential services and residential, if a bed is available, is not always an option for individuals. It doesn't consider barriers and recommendations.
Nothing is adding up – what ASAM does, what CARF is requiring, what we are currently doing, it is frustrating but the fact that ASAM is not that culturally sensitive is the most pressing issue right now.
ASAM is not listening. They are saying it includes everything and does everything.

11/14/2022 OTP

How will ASAM reporting work with MOTS? With the transition from MOTS to ROADS how will the timelines and coordination work?
How to ensure that what is already reported in MOTS so we don't have to create something new.
Do not want to lose sight of accreditation standards that have to be considered in assessments.
There are a lot of regulatory expectations at treatment entry that place a high bar around information gathering and verification and medical assessment that ASAM assessment to get in front of that is concerning.
Concern: ACEs. The ASAM assessment is not customizable, it is not flexible. The ASAM medical component will not meet what current organizational requirement.
That ASAM assessment gets inserted into existing rules and is an additional step.
Does not feel compatible with co-occurring disorders. Rulemaking needs to be careful and thoughtful

Not to double and triple work - retention is paramount right now.
Have added in gambling and trauma into assessment and our assessment is robust compared to ASAM. Will be developing other workflows to ensure compliance with CCC contracts.
Concerned about length of time it will take to complete the assessment and impact on client. Want assessments to be shorter not longer.
Rules currently read at time of entry for assessment and need flexibility as assessment is a process and can take time to collect.
How do you bill for an assessment if you are doing it over time?
Will the ROADS conversion happen before the end of the ASAM implementation?
Concern about organizations will have to change the way they are reporting for the implementation of ROADS and that is an IT issue - the ASAM will be an additional change at this time.
Concern about going backwards to paper forms and uploading into chart.
This is a expensive option moving forward.
Need to consider the mismatch between ASAM recommended LOC and patient accepted LOC. Additionally, utilizing that as justification to not fun care through CCO.
The gap between LOC and availability.
How will ASAM implement within current EHRs? Already have an assessment built in that takes information right into treatment planning that is really helpful for clinicians.

11/16/2022 CCO

Danger looking at this is just one part of the system- need to look at this overall totality of administrative burden for CMHP's and CCO providers.
Current rules are not backed by federal standards- layers have been added but nothing taking away.
Workforce capacity - staffing levels are low and administrative burden impacts staffing levels
Take a hard look at the Nineteen OARS - not just for ASAM but everything as the work is all encompassing of what providers are dealing with.
From CCO perspective is this a federal requirement?
How does this apply to pharmacist review? Are the trainings required?

Recommendation not to apply to pharmacists ASAM requirements. Trainings do not seem applicable to pharmacist.
If determined that pharmacist need to be involved, then specific listening sessions for pharmacist be held to determine what trainings need to be provided. Would need to consider within delegated oversight how to apply that correctly.
What specific courses/trainings across the board will be required?
If considering trainings for pharmacist that trainings be relevant and or depending on the expectation and would be an approved CE for the pharmacy profession.
Have there been identified issues with the medication side of SUD? If so, utilizing those concerns for development of trainings for pharmacist. Is it a service gap or deficiency in providing the medications to patients for SUD? Focused intervention vs. broad training requirement.
Will the requirement be that providers have certification for each level of care? Concern that it will increase barriers - limiting access.
SUD providers need more flexibility between staffing levels for traditional outpatient and IOP.
Makes sense for residential level of care to have different certifications based on level of care because of the requirements for residential. Medical detox vs non-medical detox makes sense.
Does not make sense for outpatient services to have different certifications based on level of care.
If for residential services, there are different certifications need to support those level ahead of time. Example is critical resource like childcare.
To have level of care certification for residential CCO's would need access to a accessible system to show which programs are certified at what levels of care. Would need to also include culturally specific services etc.
Meeting the requirements is difficult across the state as the behavioral health workforce is already challenged - rural and frontier communities' difficulties are exacerbated.
Paying different levels of care different rates could result in pay inequities for rural/frontier areas.
Providers currently struggle to have their documentation meet evidence-based criteria and being more stringent will be harder on providers.
Recommendation for early adopters with different stakeholders to see how the trainings work etc.

11/29/2022 CMHP

Clients prefer someone to be fully present – do not like tools. Person centered conversation.
Will OHA be negotiating with ASAM to reduce the length of the assessment to be conducted in a shorter period of time?
Concerned CMHP's and SUD providers were not giving the opportunity to provide feedback regarding the CONTINUUM tool prior to being chosen by OHA.
Impact on co-occurring disorders and meeting the multiple needs of those individuals without conducting double assessments.
Requirements for CBHC's go beyond even what is required in OAR's – there are a lot of metrics and screening tools. Do not see the way to embed all of the requirements of ASAM CONTINUUM tool without significant administrative burden on top of everything else that has been required the last few years.
Concern that this change will impact the organizations' ability to maintain staffing levels and in turn meet client service needs.
ASAM was developed before P2P methamphetamine and fentanyl situation – designed more as a managed care tool. Concerned that tool will not provide the information needed to achieve better care. Needs to be value added.
Concern about workforce crisis and that administrative burden is listed as one of the reasons individuals leave the field.
Most programs are already using a ASAM 1 pager tool, and this assessment looks very different and in a different order. Would require retraining of all our staff on how they are doing their clinical interviews with clients.
CBHC are struggling on how to implement this process as already conducting a comprehensive assessment.
Shift in approach to services due to less mandated clients (Measure 110). Engagement is more difficult.
Rules are applied uniformly not based on clinical judgement. Example: determine when a full ASAM vs a mini ASAM may be appropriate.
Is it rule that we have to use the ASAM CONTINUUM tool? Can a different approach be determined on how to meet the SUD Waiver requirements?
Interested in seeing the ASAM Compliance tool to prepare for future site reviews etc.

12/01/2022 PERSONS WITH LIVED EXPERIENCE

Limited familiarity with ASAM tool – communication about levels of care for service determination has been limited
Concern about availability and access for residential services when individuals are ready to change.
Lack of placements creates a cycle of stabilizing individuals and needed to re-stabilize
Services based on the what the individual is seeking
Measure 110 impact on availability of drugs within the community
Request for one-pager describing Levels of Care – provided
Need a network that provides information about availability of beds etc.
Request for training opportunities for ASAM