Slide 1 - Introduction
- Committee Members and audience are welcomed to the meeting.

- Doug Day takes over as facilitator. Today’s discussion will build on our last meeting February 28th and move forward with the other ASAM Residential levels of care. On 2/28 we discussed ASAM level of care LOC 3.1 and began to review LOC 3.5. The meeting today will focus on the rest of those levels of care. We will not specifically focus on withdrawal management in today’s meeting, although some withdrawal management information is included because of the treatment duration for adolescents. The slides in today’s discussion are essentially the same those used on February 28th.

Slide 9 - Milestone Objectives For Today’s Discussion
- State: Our focus today is on the SUD waiver Milestone 3 which requires the use of the nationally-recognized program standards and asks us to examining state policy rules and manuals and determine any needed changes to support compliance with ASAM standards.

Slide 12 - Substance Use Disorder (SUD) Residential Treatment Program Level Set
- State: Note that residential treatment is not housing. ASAM criteria itself is not state-specific, so we need to take this info and provide guidance on operationalizing the ASAM criteria. We have included in the last three slides of this presentation links to other states for reference. Considerations for adolescents are marked in orange.

Slide 30 - How Does This Discussion Relate to the SUD 1115 Waiver?
- State: This ties back to slide 9 and waiver milestone 3. We’re required to review policies regarding SUD residential treatment and we will propose changes necessary to align with ASAM standards.

Slide 31 - Summarizing February 28th Discussion
- State: LOC 3.1 is interesting because of the intersection of housing and treatment. We discussed one of the major differences between 3.1 and recovery housing is that 3.1 provides a treatment setting and clients are there for clinical and treatment purposes. Recovery housing is not intended to offer treatment. It offers only housing and is governed by lease and tenant landlord arrangements.

- State: On 2/28 we also discussed medication access. We have a number of members on the team who represent Opioid Treatment Programs (OTPs) while others do medication-assisted treatment in combination with other community partners like FQHCs and independently practicing physicians.

- State: On 2/28 members talked often about staffing needs and challenges, especially with regard to the charts listing the practitioner types. We also discussed the use of allied health professionals, peers, and the clinical monitoring and supervision of those paraprofessionals.
• State: we also discussed specific considerations and differences mentioned in the ASAM criteria between treatment for adults compared to adolescents.

Slide 32 - Today’s Meeting Goals

State: Goals today are to continue discussion from 2/28 and finish up LOC 3.5. Then talk about 3.3 and 3.7 and compare where there are differences between current practice and ASAM standards and why that is the case. The most beneficial part of these meetings is the active participation and contribution from the committee members. We appreciate your input and insights.

Slide 33 - Adult (high-intensity) and Adolescent (medium-intensity) Clinically Managed Residential Level of Care 3.5 Co-occurring Enhanced (pg. 252)

• State: Our discussion on 2/28 ended at level 3.5, co-occurring enhanced. LOC 3.5 co-occurring enhanced programs are designed to stabilize the patient’s mental health problems and psychiatric symptoms. Goals of the therapy apply to both the patient’s substance use disorder and co-occurring mental disorder and there’s attention given to medication education and management.

• State: These are programs for patients able to tolerate and benefit from a planned program. Other patients, especially, those with severe and chronic mental illness, may not be able to benefit from a 3.5 level of care. Once stabilized, patients with severe and chronic mental illness may require planning for integration into intensive case management, pain management, and/or psychotherapy.

Slide 34 & 35 - Adult (high-intensity) and Adolescent (medium-intensity) Clinically Managed Residential Level of Care 3.5 Co-occurring Enhanced (pg. 253)

• State: Because this is a co-occurring level, clinicians need to review the patient’s psychiatric history and mental status. A comprehensive psych history and exam and psychodiagnostics assessment are performed within a reasonable time as determined by the patient’s needs. There are ongoing re-assessments of the patient’s mental status with frequency determined by the urgency of the patient’s psych symptoms. Follow through with mental health treatment using psychotropic medications is also needed in here.

• State: ASAM notes that certain patients may need the kinds of assessment and treatment services described here for co-occurring enhanced but at a reduced-level of frequency and comprehensiveness to match the greater stability of their MH systems. So we expect that as patients get better they may still need co-occurring enhanced level, but as they become more stable they can transition down to the co-occurring capable level.

Floor was opened for comments from members re: LOC 3.5

• SAC: Is 3.5 and 3.5 co-occurring enhanced the same thing or separate?
  o State: ASAM groups them both as 3.5 but separates with a higher tier for individuals who have different mental health needs and then go into co-occurring enhanced who may have higher significant psychiatric co-occurring conditions along with their substance use disorder.

• SAC: Will they be a different billable rate?
  o State: Today’s discussion is not about payment rates. We are focusing on understanding the medical, clinical, staffing aspects.
• SAC: Understood, but higher tiers into 3.5 could be more costly than traditional 3.5.
  o State: we are focused first on understanding the nuances. Rate setting will come later.

• State: Any other insights/comments?
  o SAC: My comment is on the next slide that talks about adolescent-specific considerations. I just want to point out that we also need to be focusing on adolescence educational and vocational aspects of at this level of care 3.5.

Slide 37 - Adolescent Clinically Managed Medium-Intensity ASAM Residential Level of Care 3.5 (pgs. 247, 248)

• State: ASAM has set treatment criteria specific to the needs of adolescents. They are not “little adults”. They’re growing and changing and need interventions like modeling prosocial patterns of behavior and adaptive patterns of emotional responsiveness. Treatment of adolescents also includes elements of helping them gain skills that lead to maturity.

Slide 38 - Adolescent Clinically Managed ASAM Residential Level of Care 3.5 (pg. 249)

State: This slide shows how ASAM can be very specific in mentioning support systems and availability of emergency consultation with a physician by telephone or in-person. The slide also mentions the requirement for appropriate medical procedures such as lab and detox testing, appropriate medical and psychiatric treatment through consultation referral to off-site concurrent treatment services, or transfer to another level of care. It also mentions the need for providers at this level to have a direct affiliation with other levels of care. OhioMHAS has broadly included this requirement in SUD residential certification standards.

Slide 39 - Adolescent Clinically Managed ASAM Residential Level of Care 3.5 Withdrawal Management program (pg. 250)

• State: This slide discusses clinical and treatment based specifications for staff. The educational needs of adolescents is not as clear here as it might be although it is mentioned in one of the later slides. This level of care requires emphasis on supervision, and determination of appropriate level of care and ongoing and appropriate monitoring and treatment of signs and symptoms of intoxication and withdrawal.

State: We would like to discuss the Federal Substance Abuse Prevention and Treatment (SAPT) block grant with funds allocated by OhioMHAS to the women’s treatment set aside. Recipients are required as a condition of that funding to accept any woman who is pregnant, parenting, or of childbearing age. Can any members from agencies participating in this program discuss their programming and treatment specific to the needs of adolescents and young adults.

  o SAC: We have a women’s set aside grant. We don’t see many adolescents because they are better treated in an adolescent-focused program like New Directions. We do see young ladies who are pregnant and parenting. This touches on earlier comments about traditional 3.5 vs. co-occurring enhanced capable. There are a lot of traditional 3.5 programs in Ohio because of the subsets of credentialing where some clinicians are restricted to chemical dependency versus others that are licensed to provide mental health services. We’re looking for those staff -
licensed to provide both SUD and MH services. What makes it more difficult to have a co-occurring enhanced or a co-occurring capable program is the required staff and the stability of the patients. So professional scope of practice is important.

- SAC: Of special concern is the administration of medications in a co-occurring enhanced or capable program. We have questions about how that works. Are we still relying on self-administration of medications or are we beginning to consider requiring nursing? Adding nursing means adding costs. From clinical perspective, this is something we have to pay close attention to. Also, there are references to physicians. I think that ASAM may focus on physicians for political reasons, but there are very capable nurse practitioners as well, so we should consider that in our policy.

- SAC: In looking at the adolescents, I did note on page 252 of the manual, it does mention educational services, which is important. I was surprised that the ASAM guide doesn’t have references to family. I realize that many times when dealing with adolescents with substance use disorders, there’s disruption within the family unit and youth may not have parents that are actively involved. But this should be assessed. How are we going to incorporate that sense of connection to the family as part of the treatment milieu?

• State: We appreciate your comment. ASAM doesn’t define ages – so we should discuss transition age youth and young adults and multi-systemic involvements, including traditional and non-traditional family units.

Slide 41 - Adult Clinically Managed Population-Specific High-Intensity Residential Level of Care 3.3 (pg. 236)

• State: Switch into 3.3 LOC. This is that unique level in the adult population with specific high intensity of service needs sometimes referred to as cognitively impairment. This level also has physicians, physician extenders and allied health professionals like counseling aides and group living workers, on-site 24 hours a day or as required by licensing regulations. There are some differences between these standards and our state regulatory standards, e.g. one or more clinicians with competence in treating SUD are available on-site or by telephone 24 hours a day.

• State: This level also requires clinical staff knowledgeable about the biologic and psychosocial dimensions of SUD and MH who are able to identify the signs and symptoms of acute psych conditions, including psychiatric decompensation. Staff must have specialized training.

Slide 42 - Adult Clinically Managed Population-Specific High-Intensity Residential Level of Care 3.3 (pgs. 236, 237, 238)

• State: Biomedical enhanced services are delivered by credentialed medical staff, physicians, APRNs, and physician assistants able to assess and treat co-occurring biomedical disorders and monitor patient’s administration of medications. This also fits with a comment made earlier re: self-administration vs. professional administration of medications.

• State: ASAM notes that the treatment plan includes case management conducted by on-site staff, so ASAM is pretty specific on this one. It also mentions coordination of related addiction treatment, health care, MH, and social, vocational or housing services provided concurrently.
• SAC: Is cognitive impairment specific to just psychiatric impairment or does it also include learning disabilities?
  o State: ASAM mentions individuals who suffer from chronic brain syndrome, or older adults with age and substance-related cognitive limitations, or an individuals who have experienced a traumatic brain injury, or someone with a developmental disability. Seems that a DD might be considered a learning disability.

• SAC: This would warrant staff with some specialty in working with that population, correct?
  o State: Yes. Treating an older adult is not the same as treating a younger person who may have traumatic brain injury.
  o Director Criss: The topic of Ohioans with developmental disabilities or intellectual disabilities or TBI comes up often related to both substance use disorders and mental health conditions. It's important to keep in mind across the life span. It's also important to understand the need for specialized training of BH practitioners to meet the unique needs of certain populations. We need to make sure that it's part of our ongoing plans.

Slide 44 - Adult Clinically Managed Population-Specific High-Intensity Residential Level of Care 3.3 Co-Occurring Enhanced (pgs. 236, 237)

• State: This level moves into the realm of co-occurring enhanced, co-occurring capable services which are similar to earlier slides. However, one difference is that these are general criteria, but they are meant to be individualized to tailor the general criteria to the individual's specific needs. Requirements are repeated for staffing of psychiatrists, mental health professionals and nursing staff with co-occurring enhanced, addiction treatment professionals. Here the focus is on sufficient cross training of SUD and MH to understand the signs and symptoms of mental disorder.

Slide 45 - Adult Clinically Managed Population-Specific High-Intensity Residential Level of Care 3.3 Co-Occurring Enhanced (pg. 238)

• State: Co-occurring enhanced programs offer clinical activities designed to stabilize mental health problems and psych symptoms. Goals of the therapy are to apply to both the substance use disorder and co-occurring mental disorders. Again, attention is given to medication education and management. Other patients especially those with severe chronic mental illness, may not be able to benefit from such a program. Once stabilized, such patients will require planning for an integration into intensive case management, medication management, and/or psychotherapy.

Slide 46 - Adult Clinically Managed Population-Specific High-Intensity Residential Level of Care 3.3 Co-Occurring Enhanced (pg. 238)

• State: There's heavy emphasis on taking a psych history and mental status exam, and psychodiagnostics assessment. This section notes that once the patient reaches a stable period and they can benefit from a reduced level of care and could be moved down to co-occurring capable.

Slide 47 - Adult Clinically Managed Population-Specific High-Intensity Residential Level of Care 3.3 Co-Occurring Enhanced (pg. 239)
• State: This slide includes a focus on the importance of clinical records that address and document both the mental health problems and the relationship between that, and the substance use or addictive disorder and their current level of functioning.

• SAC: Your comment about different specializations is important but there are shades of gray about when residential support is needed. Some people need only residential recovery housing while others need intensive treatment in residential settings like detox levels of care. There are lots of different specializations that all need differently trained clinical staff with different level of expertise. Its little contrived to put them in neat little packages to say this is 3.3 vs. 3.5. That implies that 3.5 is more intensive than 3.3. I think ASAM is trying to convey that there are differences between different populations, and a staff member who does well with adult males may not do well with adolescent females or people with DD. I would encourage policies that value flexibility and allow programs and providers to pivot based on community and population needs. I suggest that that we think carefully about what the capacity is for these specialties in the different parts of the State. I don’t think we have enough residential beds so having flexibility to surge from one geographic area to another would be helpful.

Slide 48 - Adult Clinically Managed Population-Specific High-Intensity Residential Level of Care 3.3 Co-Occurring Enhanced

• SAC: Agree with previous comment. We’ve gone through this slide with every LOC. The question is who and what should be the minimum requirements for staff at each of these levels of care? Is someone going to identify this?
  o State: We did talk about this slide in our 2/28 meeting going through LOC 3.1. SAC members pointed out there are licensed independents, individuals with the clinical supervision, physicians and certain levels of nursing.

• SAC: We discussed that the functions and scope of practice is as important as the actual professional nomenclature. Someone also mentioned a need for vocational specialists. We tried to focus on specialized training and experience in working with certain subpopulations, e.g. older adults versus adolescents versus licensure and nomenclature.

• SAC: Agree we need flexibility in staffing and the mix of staffing to population being served and that they need to match the different acuities and service populations. I’m just hoping we won’t conclude that Ohio will adopt a set of requirements for minimum staffing required at each of these LOCs until we can identify more about minimum staffing patterns.
  o State: The challenge is how to describe staffing in a flexible way, e.g. “individuals who are able to independently diagnose chemical dependency conditions” versus “an LICDC”. As you know any proposed OAC changes will undergo public review and input. We intend to seek input from this group before we would propose OAC changes. It may be good for a future meeting to have a dedicated discussion about practitioners. We may also need input from professional licensing boards.

• State: The ASAM criteria (published in 2013) is several years old, so some points reflect that. There is a difference between the list of practitioners on this chart versus the variety of practitioners working in the field. This comprehensive table actually omits some practitioner types currently practicing and highlights others that may have been more prominent. This and other areas of practice in the ASAM standards provide important principles but they also require context and focus on the unique needs of the population being treated.
• State: In the past ASAM has issued revised guidance in 10-year cycles. He speculated that the new certification partnership between ASAM and CARF may motivate a new set of standards being issued.

• SAC: I am concerned that the state policy needs to change as the ASAM requirements change to avoid having more than one standard.
  o State: Agreed, that is one of the aspects of rules and good government. It’s a fair point.

• SAC: It is important to maintain standards for the role of supervision especially with paraprofessionals. We have agreed on a common understanding of scopes of practice associated with certain licenses and credentials. Scope of practice has two parts: general licensure and each individual’s scope of practice based on competencies and experience. It’s the functional piece that is so important in trying to get at nuances of co-occurring capable and co-occurring enhanced and the capabilities within the special populations.

• State: Do any committee members involved in recovery housing have impressions on this topic?
  o SAC: Level 3 recovery housing and 3.1 are so close. Housing is different than the clinical treatment in 3.1. Recovery housing providers report that residents who are admitted from treatment settings say that a lot of their treatment has been with CDCAs, and not as much licensed counselors. We do see a difference from that perspective, so part of this to keep in mind is how we can ensure that housing stays housing and clinical stays clinical.

Slide 49 - Adult and Adolescent Medically Monitored High-Intensity Residential Level of Care 3.7

• State: LOC 3.7 is where adult and adolescent come back together as a medically monitored high-intensity residential level of care. We pointed out in the conversation a few months ago that 3.1, 3.3, and 3.5 are heavy on the clinical and 3.7 is much more medically focused, one step before inpatient hospitalization.

Slide 52 - Adult and Adolescent Medically Monitored High-Intensity Inpatient Services Residential Level of Care 3.7 (pgs. 267, 268)

• State: Looking at LOC 3.7 you see this interdisciplinary staff – physicians, nurses, addiction counselors, and BH specialists, who are able to assess and treat the patient and to obtain and interpret information regarding the patient's psychiatric and substance or addictive disorder. And clinical staff knowledgeable about the biological and psychosocial dimensions of addiction and other BH disorders with specialized training and behavioral health management techniques and evidence-based practices. Able to provide 24-hour professionally directed evaluation care and treatment services, and with specific inclusion of administration of prescribed medications.

Slide 53 - Adult and Adolescent Medically Monitored High-Intensity Inpatient Services Residential Level of Care 3.7 (pgs. 267, 268) (Continued)

• State: Programs are staffed by a licensed physician to oversee the treatment process to assure the quality of care. Physicians perform physical exams of all patients admitted. Many states (not Ohio) require that the physician serving as medical director for a 3.7 treatment program must be a certified addiction medicine physician or addiction psychiatrist. For adolescents, physicians should
have specialty training and/or experience in addiction medicine or addiction psychiatry, and if treating adolescents, experience with adolescent medicine.

- State: Patients at this LOC receive addiction pharmacotherapy integrated with psychosocial therapies. Prescribers are required and they should be knowledgeable about addiction treatment.

**Slide 54 - Adult and Adolescent Medically Monitored High-Intensity Inpatient Services Residential Level of Care 3.7 (pgs. 268, 270, 271)**

- State: The idea is for prescribers to have much experience or certification in treating addiction. There are a variety of certification bodies: American Board of Addiction Medicine, American Board of Neurology, and ASAM. I think it's the function, the experience, and training that you bring that is important.

- State: The treatment plan at LOC 3.7 reflects case management conducted by onsite staff so it's expected to be done within the agency. This calls for practitioners that can do the case management.

**Slide 56 - Adult and Adolescent Medically Monitored High-Intensity Inpatient Services Residential Level of Care 3.7 Co-occurring Enhanced (pgs. 267, 271)**

- State: Moving into the co-occurring enhanced level of care which is a little more specific with the psychiatrist assessing the patient within 4 hours of admission by phone or within 24 hours in-person.

- State: A RN or licensed MH clinician conducts a BH-focused assessment at time of admission. If not done by a RN, a separate nursing assessment must be done. RN is responsible for monitoring the patient’s progress and administering or monitoring the patient’s self-administration of psychotropic medications.

**Slide 57 - Adult and Adolescent Medically Monitored High-Intensity Inpatient Services Residential Level of Care 3.7 Co-occurring Enhanced (pgs. 268, 269)**

- State: Co-occurring enhanced programs are staffed by addiction psychiatrists and appropriately credential BH professionals who can assess and treat co-occurring psychiatric disorders and have specialized training. Ideally staffed by a certified addiction specialist physician along with a general psychiatrist, or by a physician certified as an addiction psychiatrist with a focus on co-occurring needs.

**Slide 58 - Adult and Adolescent Medically Monitored High-Intensity Inpatient Services Residential Level of Care 3.7 Co-occurring Enhanced (pgs. 269, 270)**

- State: Offer planned clinical activities, BH needs and psychiatric symptoms, promote stabilization and goal of therapy apply to both SUD and co-occurring MH disorder. Inclusion of medication education management, motivational engagement strategies and other evidence-based practices.

**Slide 59 - Adult and Adolescent Medically Monitored High-Intensity Inpatient Services Residential Level of Care 3.7 Co-occurring Enhanced (pg. 271)**
• State: Review of the patient’s recent psych history of mental status exam, if necessary, done by a psychiatrist. Psych assessment performed within 24 hours of admission. If the patient reaches a level of stability they can move to a reduced level and frequency of care or to a co-occurring capable program.

**Slide 61 - Adolescent Medically Monitored High-Intensity Inpatient Services Residential Level of Care 3.7 (pgs. 265, 268)**

• State: Focus here on the adolescent specifics for treatment at 3.7. Orient adolescents and structure daily life according to other organizing principles than “getting high” and “being high.” Initial abstinence through “confinement” in a level 3.7 program provides adolescents who have addiction syndromes with a reintroduction to their own patterns of emotional and cognitive experience without a constant cloud of intoxication.

• State: Staff should be knowledgeable about adolescent development and experienced in engaging and working with adolescents. Experience in adolescent medicine is ideal, this is a medically monitored level of care.

• State: When a 3.7 program provides withdrawal management services to adolescents, it must provide (in addition to the staff and therapies listed above) a physician (or physician extenders) routinely available by telephone 24 hours a day.

**Slide 62 - Adolescent Medically Monitored High-Intensity Inpatient Services Residential Level of Care 3.7 (pg. 267)**

• State: 3.7 programs provide physician monitoring and nursing care and observation available as needed based on clinical judgment, so it needs to be a medical practitioner providing clinical judgment. Physician(or extenders) are available to assess within 24 hours of admission and thereafter as necessary, and the statement is here again about nurse practitioners or physician extenders. Medical specialty consultation, psychological, laboratory, and toxicology services are available through console or referral. And direct affiliation with other levels of care.

**Slide 63 - Adolescent Medically Monitored High-Intensity Inpatient Services Residential Level of Care 3.7 (pg. 270)**

• State: As we discussed earlier ASAM criteria (in other levels of care) are light on the educational piece but here it actually is stated.
  o SAC: Agreed. About the Confinement issue…. There are some programs for adolescents that are locked or secured. So maybe confinement is too strong, but there are both “secure settings” where it’s locked from the outside in, and then there are “locked settings,” where they are locked both ways.

• State: This level also requires an interdisciplinary team providing the daily clinical services, frequent nurse monitoring of the adolescent’s progress and withdrawal management and medication administration is available if needed.

**Slide 64 - Adolescent Medically Monitored High-Intensity Inpatient Services Residential Level of Care 3.7 (pg. 271)**
• State: Assessment and treatment planning, and an initial withdrawal assessment within 24 hours of admission, or earlier if warranted. Daily nursing withdrawal monitoring assessments.

• State: Daily availability of medical evaluation with continuous on-call coverage. This recognizes that youth coming in may not be as truthful upfront about the substances they have been using. So they may start exhibiting signs of withdrawal after they've been admitted.

**Slide 66 - Application to Adult Special Populations (pgs. 307 - 356)**

State: This is the end of the 3.1, 3.3, 3.5, and 3.7 slides, but ASAM also has some special populations sections. Sections on older adults, parents or prospective parents receiving addiction treatment concurrently with their children, persons in safety-sensitive occupations (e.g. first responders, and practitioners working in criminal justice settings)

**Slide 67 - Stakeholder Public Forum on SUD 1115 Waiver – (Editor’s Note: Public forum has been Scheduled for July 16 at 10 am. Registration [here](#).**

  o Director Criss: I appreciate today's discussion and comments about the need to have a deeper discussion around staffing. Other things that stood out were the need to recognize needs of specific populations while recognizing the imperative of individualized care. We don’t want communities and programs to struggle with workforce. I appreciated the comments re: the age of the ASAM guide and that contemporary practice and opportunities may give us a more expansive view. I’m also thinking about the impact of our recent experience with using telehealth to deliver behavioral health treatment.

  o State: The purpose of this exercise is for us to seek input and advice from members of our Advisory Committee. We appreciate your input and we’re trying to catalog it to have it available to us to refer to when we begin looking at our existing Administrative Code rules for any needed changes or updates.

• State: We have completed our review of all SUD residential levels of care except for withdrawal management residential levels of care, LOC 3.2 and 3.7.

• Director Criss: Thanks to everyone for hanging in with us in these conversations. Doug, we appreciate the facilitation and the input from a lot of folks. It is important to have meaningful input from this group. If you have any other input outside of this discussion, please share those comments with us. We appreciate your time and your insights and look forward to continuing this discussion. We will talk to you next month.