

Tips to Get Your Clinical Authorization Approved By The IME

Provider Training

New Jersey State Division of Mental Health and Addiction Services (DMHAS)

The Division of Medical Assistance and Health Services (DMAHS)

and

Rutgers University Behavioral Health Care
IME Utilization Management Unit

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What are we going to cover?

1. Managed Utilization Review (UR)
2. What are the ASAM Guiding Principles
3. Levels of Care
4. Dimensional Criteria
5. Withdrawal Management Instruments
6. Extension of Care Requests For Clinical Authorization
7. The Risk Rating Matrix
8. Practice Cases
9. Questions



Part 1

Managed Utilization Review

Fundamental Purpose in Utilization Management (UM)

- Prevent the delivery of **unnecessary and inappropriate** care to consumers.
- Need to establishing both **necessity for care** and **appropriateness of care** requests as well.
- When both clinical necessity for treatment and the appropriateness of the treatment request are established, an authorization (or *certification* for care - the more correct term) for the treatment requested is issued by UM staff.

Goals for today's training are to:

1. **Share** with providers core concepts of UM and UR that enables providers to understand the thinking of UR staff when the provider requests a PA for treatment- “being on the same UR page”.
2. **Enhance providers' awareness** of what data/information UR staff is looking for to justify the provider request for treatment.
3. **Increase** efficiency and speed of PA approval procedure.
4. **Avoid denials** of PA requests.

Criteria for: Clinical Necessity for Treatment

CLINICAL NECESSITY: establishing the **NEED** for treatment requested.

- “**Why** Is treatment necessary **NOW?**” UR staff require data to establish that a problem exists which **may** require a solution/treatment **NOW**.
- **Requires** presence of **DSM-5 number and diagnostic criteria** in NJSAMS for both substance use disorders (SUD) and/or mental health disorders to establish that a behavioral problem(s) exists. **Dx defines a problem.**
- When diagnosis is established, the problem is established and treatment at an appropriate LOC **may be** necessary. But does the problem need intervention **NOW?**
- **DSM-5** diagnostic criteria must be linked to **impairments of functioning (end of LOCI-3)** by the patient resulting from the symptoms reported. **Impairments = need now.**
- Providers, on behalf of their patient, submit clinical information to establish clinical necessity (**need**) for their treatment request.

Appropriateness of Treatment Requested Based on Severity of Illness Presented

- In NJSAMS provider establishes Medical/Clinical Necessity with :
 1. **DSM 5** Dx # and Dx criteria
 2. **LOCI-3** (ASAM) with comments addressing patient's clinical SUD and MH symptoms in all six (6) ASAM Dimensions.
 3. **Impairments of Functioning** at end of LOCI-3. See next slide
- **Severity of the Illness**– based on consumer's symptoms that impair function:
 1. **Intensity** of symptom (amount of substance (s) and/or MH symptoms -1-10)
 2. **frequency** (# Xs daily, weekly, monthly) of symptom (s)
 3. **duration** (# weeks, months, years) of symptom (s)
- **UM Goal** = Match **Severity of Illness (SI) *presented*** with LOC plus other services that define the **Intensity of Services (IS) *requested***.
- **SI = IS**

Impairments of Functioning

- **UR staff asks** “what impairments are present NOW?”

Examples:

- **Family-** alcohol dependence impairs ability to parent children effectively. Spouse is divorcing client due to alc.
- **Work** – work attendance is impaired due to opioid dependency and termination is pending.
- **Community-** benzodiazepine dependency, alcohol and cannabis abuse impair client’s ability to be law abiding. Engages in petty theft to support addiction- family strife.
- **School** – severe cannabis and opioid dependence impair motivation to attend training classes for work – job at risk.
- **Self Care** – opioid dependence and alcohol abuse impair client’s ability to attend to ADLs. Hygiene and health care are compromised.

Requesting Pre-Authorization (PA) and Re-Authorization

- Authorization for treatment issued when provider establishes both Clinical Necessity and the Appropriateness of the Tx in NJSAMS via DSM5, LOCI-3, Impairments of Functioning.
- **Provider PA request includes:**
 1. **Consumer name**
 2. **Consumer ID** either State NJSAMS # or Medicaid #)
 3. **Provider ID** (either NJ State **or** Medicaid *site* ID)
 4. **Services code(s)** = HCPC for LOC - IOP, PC, OTP OP & routine OP plus CPT code(s), Detox, STR, LTR, HWH.
 5. **Number of Units** for @ Service code
 6. **Start date (admission date)** for @ Service Code

PA Issued to Provider

PA issued by the IME will contain:

1. **PA number** (State or Medicaid #)
2. **Consumer name**
3. **Consumer ID**
4. **Provider ID** (NJ State or Medicaid **site** ID)
5. Services code(s) = **HCPC** for LOC - IOP, PC, OTP OP & routine OP plus CPT code(s), Detox, STR, LTR, HWH.
6. **Number of Units** for @ Service code approved
7. **Start/End date** for @ Service code approved

Provider notified of PA issued:

1. **State** managed initiative funded Tx- In NJSAMS Pre-Authorization Module
2. **Medicaid** funded Tx -In NJSAMS “Medicaid Prior Authorization” screen.

Denials of Authorization

- **Rare event!**
- If no resolution after initial discussion (s) between UR and provider and PA denied then:
- **IME Denial of PA** is negotiated within the IME –
Two(2) within-IME URs available.
- 1. **UM Supervisor** or a licensed representative –if denied may elect 2nd within-IME UR
- 2. **IME Medical Director** or representative – usually a doctor to doctor UR.
- If still not resolved - provider may request a formal **Appeal** within DMHAS for state funded services or a **Fair Hearing** for Medicaid funded services within the Office of Administrative Law.

Requesting Re-Authorization Extensions/Continuing Care

- **Re-Authorization** requested by the provider before the End date of the previous PA or before units approved on previous PA are consumed prior to End date of previous PA.
- **Amount of time** before the End date of the previous PA for provider to request a Re-Auth will be specified in the UM limits that are being developed by DMHAS now.

Reasons for Denial of a Pre-Authorization Request or Extension of Care Request

(Will require a Comment box for each reason.)

A. Pre-Authorization Request Denial Reasons:

1. DSM 5 diagnostic symptom criteria not presented or not presented clearly. See Comment Box.
2. DSM 5 symptom criteria and/or LOCI 3 information not linked with impairments of functioning. See Comment Box.
3. Impairments of function not presented or not presented clearly. See Comment Box.
4. LOCI 3 ASAM dimensions are not complete. See Comment B
5. Use the 6 ASAM assessment dimensions to assess problems that justify admission to care. See Comment Box.
6. Client is reported with mental health symptoms which may change status to co-occurring. Clarify co-occurring status of client. See Comment Box.

Reasons for Denial of a Pre-Authorization Request or Extension of Care Request (cont.)

7. Provide additional information that was requested by phone or email, or as described in the Comment Box.
8. See Comment Box for explanation of this authorization denial.

Reasons for Denial of a Pre-Authorization Request or Extension of Care Request (cont.)

1. Extension of Care Request Denial Reasons: Provide additional information that was requested by phone or email, or as described in the Comment Box.
2. LOCI 3 ASAM dimensions are not complete. See Comment Box
3. Despite amendments to the treatment plan and past extension requests, client shows inability to resolve problem(s) that justify continuation in the present LOC. See Comment Box.
4. Client demonstrates lack of capacity to resolve his/her problem(s) at the current LOC. See Comment Box.
5. Discharge from the current level of care is indicated. See Comment Box.
6. If circumstances related to current reported crisis are related to client willful defiance or non-compliance with the treatment plan, provide client's explanation. See Comment Box.
- 7.. Modification of the current treatment plan based on client clinical needs appears in order. See Comment Box.

Reasons for Denial of a Pre-Authorization or Extension of Care Request (cont.)

8. Medical/Psychiatric symptoms reported may require a higher LOC and client should be evaluated by Medical/Psychiatric staff. See Comment Box.
9. Use ASAM Risk Rating Criteria language to justify LOC extension request in the ASAM Dimensions presented in the Comment Box.
10. Low risk ratings do not justify approval for extended care at this level of care. See Comment Box.
11. Licensed Supervisor must list credentials on LOCI.
12. Counselor and Licensed Supervisor must type in their names and list their credentials on LOCI.
13. The Extension Request LOCI is blank. The LOCI was not updated. See Comment Box.
14. The information provided in the ASAM Dimensions is repetitive or incomplete. Use ASAM language and risk ratings. See Comment Box.
15. Client is reported with mental health symptoms which may change status to co-occurring. Clarify co-occurring status of client. See Comment Box.
16. OTHER - See Comment Box

Authorization (PA) Tracking

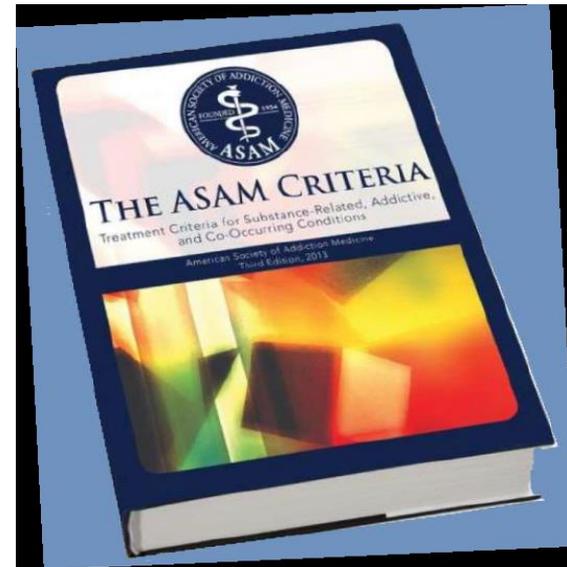
- Those providers who wish to have a copy of a set of procedures for tracking PA authorizations and when requests for Extensions of Care (for State funded services) or for Continuing Care (for Medicaid funded services) contact the IME Network Manager Ms. Laila Hull at:
 - lh495@ubhc.rutgers.edu

PART 2

ASAM Guiding Principles

ASAM –American Society of Addiction Medicine

David Mee-Lee, M.D.-Chief Editor, The ASAM Criteria 2013



Dr. Mee-Lee, “As patients receive treatment in the least intensive yet safe setting, they can test recovery skills in situations as close to ‘real world’ conditions as possible, and minimize reentry problems.”

The Role and Current Status of Patient Placement Criteria In the Treatment of Substance Use Disorders Treatment Improvement Protocol (TIP) Series 13

Lee Gartner David Mee-lee, M.D. Consensus Panel Co-Chairs U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Public Health Service Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment Rockwall II, 5600 Fishers Lane Rockville, MD 20857

KEEP IT SIMPLE

ASSESSMENT SHOULD CULMINATE IN A PLACEMENT THAT IS

LEAST INTENSIVE/RESTRICTIVE BUT SAFE

FIRST AND THEN INTENSIFIED AS CLINICALLY INDICATED

Moving from *fixed length* of service to *variable length* of service

Moving from program-driven to clinically driven and outcomes-driven treatment

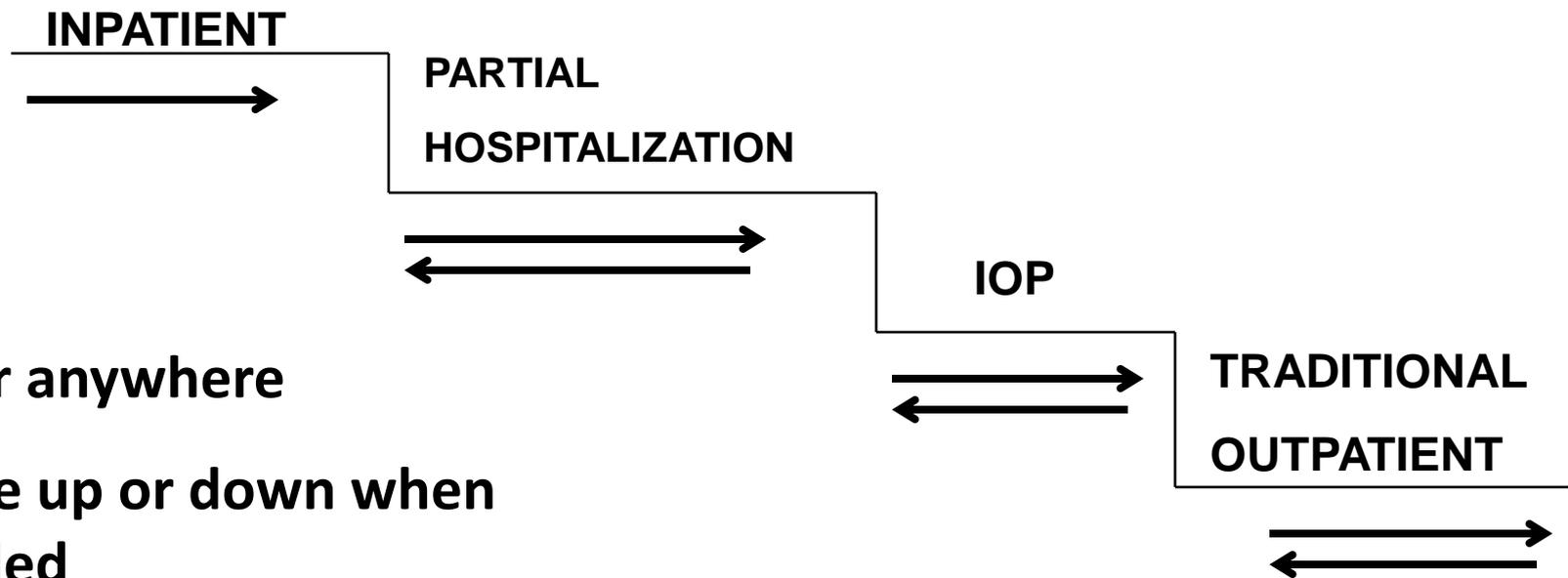
Rather than focusing on “**placement**” in a program, often with a fixed length of stay, *The ASAM Criteria* supports individualized, person-centered treatment that is responsive to specific needs and the patient’s progress in treatment.

- ❖ Outcomes research in addiction treatment has not provided a scientific basis for determining precise lengths of stay or intensity of treatment for optimum results.
- ❖ Thus, addiction treatment professionals recognize that length of stay and intensity of treatment must be individualized, based on the severity and level of function of the patient’s illness, as well as based on their response to treatment, progress, and outcomes.
- ❖ At the same time, research does show a positive correlation between longer treatment in the continuum of care and better outcomes. While length of service is still presented as variable, based on patients’ complex needs and outcomes in the current edition, both sides of this discussion (fixed versus variable lengths) are raised within these criteria in order to increase awareness of length of stay issues.

Moving from a limited number of discrete levels of care to a broad and flexible continuum of care

- ❖ Treatment is delivered across a continuum of services that reflect the varying severity of illnesses treated and the intensity of services required.
- ❖ Referral to a specific level of care must be based on a careful assessment of the patient with an alcohol, tobacco and/or other substance use disorder; and/or a gambling disorder.
- ❖ A primary goal underlying the criteria presented here is for the patient to be placed in the most appropriate level of care. For both clinical and financial resource reasons, the preferable level of care is that which is the least intensive while still meeting treatment objectives and providing safety and security for the patient.
- ❖ Moreover, while the levels of care are presented as discrete ranks, in reality they represent benchmarks or points along a continuum of treatment services that could be harnessed in a variety of ways, depending on a patient's needs and responses.
- ❖ A patient may begin at a required initial level and move to a more (step up) or less (step down) intensive level of care, depending on his or her individual needs.

Continuum of Care



Enter anywhere

Move up or down when needed

Use as many (or as few) levels as appropriate

Fidelity To The Model

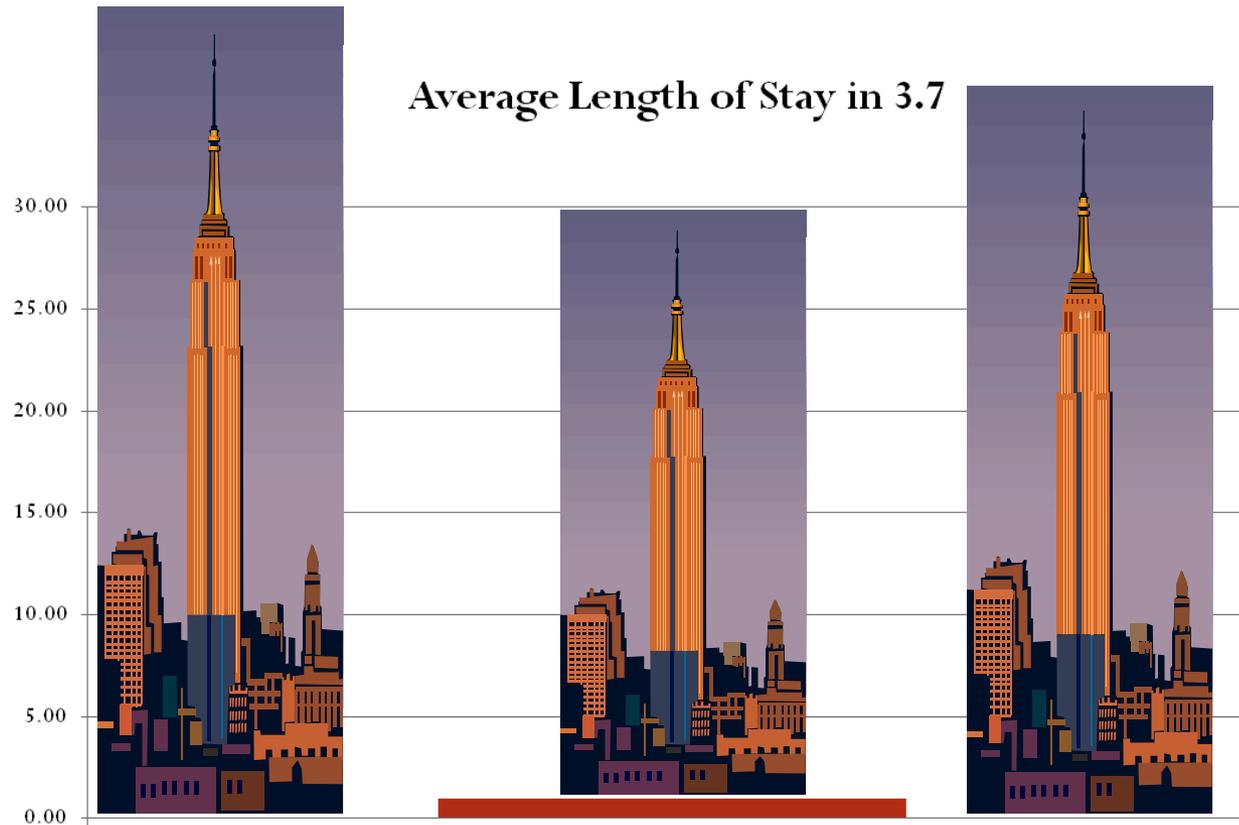
F. Fidelity to the Spirit and Content of *The ASAM Criteria* (*The ASAM Criteria* 2013, pp 21-22)

Issues often persist in today's "real world" of treatment, indicating that clinicians and programs still struggle with understanding the full intent of ASAM's criteria. These ongoing issues include:

- Some programs still describe their services as a fixed length of stay program, as evidenced by description of the program as a "Thirty Day Inpatient Program" or "24 session IOP." Or if the program claims no fixed length of stay, check what clients say if you ask: "How long do you have to be here?" An answer involving fixed numbers of sessions or weeks reveals regression to a program-driven model.

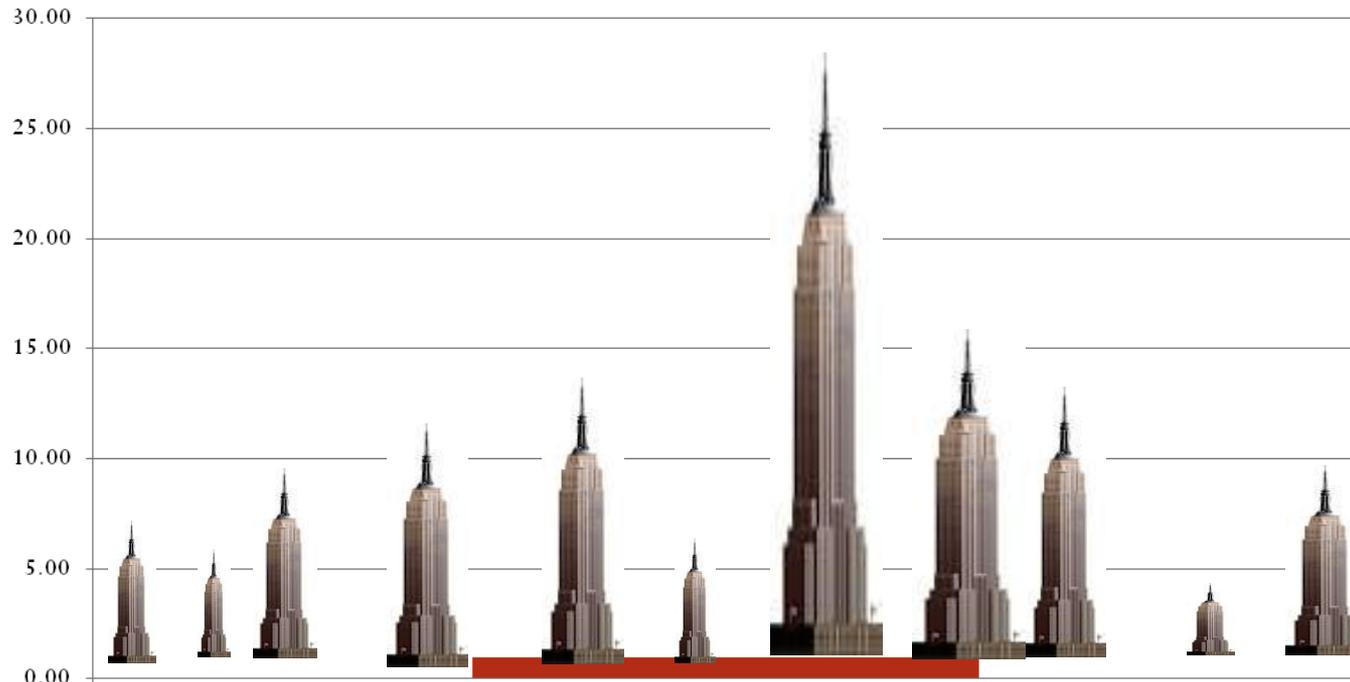
Such programs also may reveal their length of stay rigidity through the language used. Wording like "extended residential" may refer to a fixed program, since length of stay should be decided by tracking severity, function and progress, not by a predetermined decision that the patient needs a certain extended length of stay in a residential setting. Likewise, "graduating" and "completing a program" also reveals a focus on a fixed plan and program, rather than on functional improvement as the determinant of level of care and ongoing chronic-disease management (with certain episodes of care being offered with increased intensity for a relatively brief span of time) being what is needed for most patients with a substance-related or co-occurring disorder.

“Program Driven” Length of Stay



“Clinically Driven” Length of Stay Issues

Average Length of Stay in 3.7



Part 3

The ASAM Levels of Care

New Jersey DMHAS Licensed Levels of Care

- ❖ **Early Intervention 0.5 (Prevention)** Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder
- ❖ **Outpatient Services 1.0 (Standard/Traditional Outpatient)** Less than 9 hours of service/week (adults) for recovery or motivational enhancement therapies/ strategies
- ❖ **Intensive Outpatient 2.1 (IOP)** 9 or more hours of service/week; to treat multidimensional instability
- ❖ **Partial Hospitalization 2.5 (PHP)** 20 or more hours of service/week for multidimensional instability not requiring 24 hour care
- ❖ **Clinically-Managed Low-Intensity Residential 3.1 (Halfway House)** 24 hour structure with available trained personnel; at least 5 hours of clinical service/week
- ❖ **Clinically-Managed High-Intensity Residential 3.5 (Long Term Residential)** 24 hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community
- ❖ **Medically-Monitored Intensive Inpatient 3.7 (Short Term Residential)** 24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability

0.5 Early Intervention

Level 0.5 is NOT a level of care or treatment but the combination of psycho-education and assessment .

Called Early Intervention for Adults and Adolescents, this level of care constitutes a service for individuals who, for a known reason, are at risk of developing substance-related problems, or a service for those for whom there is not yet sufficient information to document a diagnosable substance use disorder.

A detailed description of the services typically offered in this level of care, the care setting and how to identify what patients would benefit best from these services based on an ASAM dimensional needs assessment, begins on page 179 of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (2013)*.

New Jersey DMHAS

Non-Licensed Levels of Care

Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services

The purpose of Level 3.3 programs has always been to deliver high-intensity services and to provide them in a deliberately repetitive fashion to meet the special needs of individuals such as the elderly, the cognitively-impaired or developmentally-delayed adult.

This level serves those in whom the chronicity and intensity of the primary disease process requires a program that allows sufficient time to integrate the lessons and experiences of treatment into their daily lives.

- Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning (Dimension 3), or because of the chronicity of their illness (Dimensions 4 and 5).
- The decimal point of 3.3 was retained to indicate the slower pace, but the name change indicates that this level is for a specific population and that high intensity work still is needed but at a slower pace.

New Jersey DMHAS

Non-Licensed Levels of Care

Level 4.0: Medically Managed Intensive Inpatient Service

This is a level of treatment which requires hospitalization.

Services that involve daily medical care, where diagnostic and treatment services are directly provided and/or managed by an appropriately trained and licensed physician.

Part 4

The ASAM Dimensions: Asking the Right Questions

The ASAM Dimensions

Dimension 1: Acute Intoxication and/or Withdrawal Potential

Dimension 2: Biomedical Conditions and Complications

Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications

Dimension 4: Readiness to Change

Dimension 5: Relapse, Continued Use or Continued Problem Potential

Dimension 6: Recovery Environment

All relate to Severity of Illness that influences the intensity of service required that you will provide.

Dimension 1:

Acute intoxication and/or withdrawal potential

What risk is associated with the patient's current level of acute intoxication?

Is there significant risk of severe withdrawal symptoms or seizures, based on the patient's previous withdrawal history, amount, frequency, and recency of discontinuation or significant reduction of alcohol or other drug use?

Are there current signs of withdrawal?

Does the patient have supports to assist in ambulatory detoxification, if medically safe?

Has the patient been using multiple substances in the same drug class?

Is there a withdrawal scale score available?

In the adult ASAM Placement Criteria, detoxification services can be provided at any of five levels of care. Specific criteria, organized by drug class (alcohol, sedative-hypnotics, opioids, et al.) guide the decision as to which detoxification level is safe and efficient for a patient in withdrawal.

Dimension 2:

Bio-Medical Conditions and Complications

Are there current physical illnesses, other than withdrawal, that need to be addressed or that may complicate treatment?

Are there chronic conditions that affect treatment?

Dimension 3:

Emotional, Behavioral or Cognitive Conditions and Complications

Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create or complicate treatment?

Are there chronic conditions that affect treatment?

Do any emotional, behavioral or cognitive problems appear to be an expected part of the addictive disorder, or do they appear to be autonomous?

Even if connected to the addiction, are they severe enough to warrant specific mental health treatment?

Is the patient suicidal, and if so, what is the lethality?

Is the patient able to manage the activities of daily living?

Can he or she cope with any emotional, behavioral or cognitive problems?

If the patient has been prescribed psychotropic medications, is he or she compliant?

Dimension 4:

Readiness to Change

What is the individual's emotional and cognitive awareness of the need to change?

What is his or her level of commitment to and readiness for change?

What is or has been his or her degree of cooperation with treatment?

What is his or her awareness of the relationship of alcohol or other drug use to negative consequences?

Dimension 5:

Relapse, Continued Use, Continued Problem

Is the patient in immediate danger of continued severe mental health distress and or alcohol or drug use?

Does the patient have any recognition of, understanding of, or skills with which to cope with his or her addictive or mental disorder in order to prevent relapse, continued use or continued problems such as suicidal behavior?

How severe are the problems and further distress that may continue or reappear if the patient is not successfully engaged in treatment at this time?

How aware is the patient of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others?

Dimension 6:

Recovery Environment

Do any family members, significant others, living situations or school or work situations pose a threat to the patients safety or engagement in treatment?

Does the patient have supportive friendships, financial resources, or educational/ vocational resources that can increase the likelihood of successful treatment?

Are there legal, vocational, social service agency or criminal justice mandates that may enhance the patient's motivation for engagement in treatment?

Are there transportation, child care, housing or employment issues that need to be clarified and addressed?

Part 5

Withdrawal Management Instruments

Current ASAM Dimensions- Assessments

Dimension 1- Acute intoxication and/or withdrawal potential

Assessment for intoxication and/or **withdrawal management** withdrawal management in a variety of levels care, and preparation for continued addiction services

Level 1-WM: Ambulatory Withdrawal Management without Extended On-Site Monitoring (**Drs. office or home health agency**)

Level 2-WM: Ambulatory Withdrawal Management with Extended On-Site Monitoring (**Day hospital service**)

Level 3.2-WM: Clinically-Managed Residential Withdrawal Management (Social Detox)

Level 3.7-WM: **Medically-Monitored Inpatient Withdrawal Management**

Level 4.0-WM: Medically-Managed Intensive Inpatient Withdrawal Management

CIWA-Ar

Clinical Institute Withdrawal Assessment -revised version

- Structured Severity Assessment Scale
- Objective Scale for use by health care personnel to evaluate patients at risk for developing alcohol withdrawal syndromes, and quantify the severity of withdrawal
- “Detox language” - to relate severity of symptoms to clinical and non-clinical reviewers.
- Serves as a **Red Flag** for potential withdrawal and serves as a placement tool.

CIWA-Ar

CIWA-Ar

is a shorter form of

Clinical Institute Withdrawal
Assessment for Alcohol



by allacronyms.com



Addiction Research Foundation Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised (CIWA-Ar)

Patient: _____ **Pulse or heart rate, taken for 1 minute:** _____

Date: _____ **Time:** _____ **Blood pressure:** _____

Clinical Institute Withdrawal

Assessment for Alcohol Scale-revised (CIWA-Ar)

1. Nausea and vomiting
2. Tremor
3. Paroxysmal sweating
4. Anxiety
5. Agitation
6. Tactile disturbances
7. Visual disturbances
8. Auditory disturbances
9. Headache or fullness
10. Orientation (0-4 points)

Clinical Institute Withdrawal Assessment for Alcohol Scale-revised (CIWA-Ar)

10 item rating system for alcohol withdrawal severity max of 67 points:

- 0-no symptoms
- 1-Mild
- 4- Moderate
- 7-Severe
- BP and HR not found to correlate with severity of withdrawal
- Can be given in under 2 minutes

Sullivan,J.T. British Journal of Addiction, 1989; 84: 1353-7.

CIWA-Ar

High scores are predictive of development of seizures and delirium.

CIWA Scale - Revised Version	
Score	Severity of Alcohol Withdrawal
Less than 8 to 10	Mild
8 to 15	Moderate
15 or more	Severe

- Scale is currently being used for medication administration at many detoxification centers.
- Using the CIWA-Ar was found to reduce side effects from over-sedation costs by avoiding unnecessary use of medications

NAUSEA AND VOMITING

Ask "Do you feel sick to your stomach?

Have you vomited?" Observation:

0 no nausea and no vomiting

1 mild nausea with no vomiting

2

3

4 intermittent nausea with dry heaves

5

6

7 constant nausea, frequent dry heaves and vomiting

TREMOR

Arms extended and fingers spread apart. Observation:

0 no tremor

1 not visible, but can be felt fingertip to fingertip

2

3

4 moderate, with patient's arms extended

5

6

7 severe, even with arms not extended

PAROXYSMAL SWEATS

Observation:

0 no sweat visible

1 barely perceptible sweating, palms moist

2

3

4 beads of sweat obvious on forehead

5

6

7 drenching sweats

TACTILE DISTURBANCES

Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?"

Observation:

0 none

1 very mild itching, pins and needles, burning or numbness

2 mild itching, pins and needles, burning or numbness

3 moderate itching, pins and needles, burning or numbness

4 moderately severe hallucinations

5 severe hallucinations

6 extremely severe hallucinations

7 continuous hallucinations

AUDITORY DISTURBANCES

Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.

0 not present

1 very mild harshness or ability to frighten

2 mild harshness or ability to frighten

3 moderate harshness or ability to frighten

4 moderately severe hallucinations

5 severe hallucinations

6 extremely severe hallucinations

7 continuous hallucinations

VISUAL DISTURBANCES

Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation:

0 not present

1 very mild sensitivity

2 mild sensitivity

3 moderate sensitivity

4 moderately severe hallucinations

5 severe hallucinations

6 extremely severe hallucinations

7 continuous hallucinations

ANXIETY

Ask "Do you feel nervous?" Observation:

0 no anxiety, at ease

1 mild anxious

2

3

4 moderately anxious, or guarded, so anxiety is inferred

5

6

7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION

Observation:

0 normal activity

1 somewhat more than normal activity

2

3

4 moderately fidgety and restless

5

6

7 paces back and forth during most of the interview, or constantly thrashes about

HEADACHE, FULLNESS IN HEAD

Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

0 not present

1 very mild

2 mild

3 moderate

4 moderately severe

5 severe

6 very severe

7 extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM

Ask

"What day is this? Where are you? Who am I?"

0 oriented and can do serial additions

1 cannot do serial additions or is uncertain about date

2 disoriented for date by no more than 2 calendar days

3 disoriented for date by more than 2 calendar days

4 disoriented for place/or person

Total **CIWA-Ar** Score _____

Rater's Initials _____

Maximum Possible Score 67

Patients scoring less than 10 do not usually need additional medication for withdrawal. Rater's Initials: _____

***The CIWA score will be in NJSAMS LOCI**

C.O.W.S.



Clinical Opiate Withdrawal Scale



Clinical Opiate Withdrawal Scale

Introduction

The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician. This tool can be used in both inpatient and outpatient settings to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time. The summed score for the complete scale can be used to help clinicians determine the stage or severity of opiate withdrawal and assess the level of physical dependence on opioids. Practitioners sometimes express concern about the objectivity of the items in the COWS; however, the symptoms of opioid withdrawal have been likened to a severe influenza infection (e.g., nausea, vomiting, sweating, joint aches, agitation, tremor), and patients should not exceed the lowest score in most categories without exhibiting some observable signs or symptoms of withdrawal.

<http://www.drugabuse.gov/tutorials/medical/health-professionals>

The clinical opiate withdrawal scale (COWS) is a clinician-administered, pen and paper instrument that rates eleven common opiate withdrawal signs or symptoms. The summed score of the eleven items can be used to assess a patient's level of opiate withdrawal and to make inferences about their level of physical dependence on opioids.

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom.

Rate on just the apparent relationship to opiate withdrawal.

For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Resting Pulse

Rate: _____ beats/minute

- Measured after patient is sitting or lying for one minute
- 0 pulse rate 80 or below
- 1 pulse rate 81 - 100
- 2 pulse rate 101 - 120
- 4 pulse rate greater than 120

GI Upset: over last 1/2 hour

- 0 no GI symptoms
- 1 stomach cramps
- 2 nausea or loose stool
- 3 vomiting or diarrhea
- 5 multiple episodes of diarrhea or vomiting

Tremor *observation of outstretched hands*

- 0 no tremor
- 1 tremor can be felt, but not observed
- 2 slight tremor observable
- 4 gross tremor or muscle twitching

Sweating: over past 1/2 *hour not accounted for by room temperature or patient activity.*

- 0 no report of chills or flushing
- 1 subjective report of chills or flushing
- 2 flushed or observable moistness on face
- 3 beads of sweat on brow or face
- 4 sweat streaming off face

Restlessness *Observation during assessment*

- 0 able to sit still
- 1 reports difficulty sitting still, but is able to do so
- 3 frequent shifting or extraneous movements of legs/arms
- 5 unable to sit still for more than a few seconds

Yawning *Observation during assessment*

- 0 no yawning
- 1 yawning once or twice during assessment
- 2 yawning three or more times during assessment
- 4 yawning several times/minute

Pupil size

- 0 pupils pinned or normal size for room light
- 1 pupils possibly larger than normal for room light
- 2 pupils moderately dilated
- 5 pupils so dilated that only the rim of the iris is visible

Anxiety or Irritability

- 0 none
- 1 patient reports increasing irritability or anxiousness
- 2 patient obviously irritable or anxious
- 4 patient so irritable or anxious that participation in the assessment is difficult

Bone or Joint aches *if patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*

- 0 not present
- 1 mild diffuse discomfort
- 2 patient reports severe diffuse aching of joints/muscles
- 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort

Gooseflesh skin

- 0 skin is smooth
- 3 piloerection of skin can be felt or hairs standing up on arms
- 5 prominent piloerection

Runny nose or tearing *Not accounted for by cold -symptoms or allergies*

- 0 not present
- 1 nasal stuffiness or unusually moist eyes
- 2 nose running or tearing
- 4 nose constantly running or tears streaming down cheeks

Total Score _____

The total score is the sum of all 11 items

Initials of person completing assessment: _____

Score:

5- 12 = mild

13-24 = moderate

25-36 = moderately severe

More than 36 = severe withdrawal

This version may be copied and used clinically.

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs*, 35(2), 253–9. *Journal of Psychoactive Drugs* Volume 35 (2), April - June 2003

Part 6

Extension of Care Requests For Clinical Authorization

After Admission

After the admission criteria for a given level of care have been met, the criteria for continued service, discharge or transfer from that level of care are as follows:

Continued Stay Criteria

It is appropriate to retain the patient at the present level of care if:

A. The patient is making progress, but not yet achieved goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit patient to continue to work toward his or her treatment goals:

or

B. The patient is not yet making progress, but has capacity to resolve his or her problems. He or she is actively working toward the goals articulated in individualized treatment plan. Continued treatment at present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;

and/or

C. New problems have been identified that are appropriately treated at present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. The level of care in which the patient is receiving treatment is therefore the least intensive level at which the patient's new problems can be addressed effectively.

- **ASAM page 300**

Discharge/Transfer Criteria:

1. The patient has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the current level of care;

or

2. The patient has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated;

or

3. The patient has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated;

or

4. The patient has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care

A Good Extension Request

- Highlights what the client accomplished previously, what they are working on now and what the client Needs to work on given additional time in treatment
- Dimensions 1, 2, 3 uses very clear and detailed information that comments on **acuity and need for stabilization**
- Uses Stages of Change language in Dimension 4
- Dimension 5 should be very clear on what relapse prevention skills the client needs to learn with additional time in treatment
- Dimension 6 should include as much Recovery Environment issues as possible

Sample Dimension 1 Comments

GOOD!

Clinician Observation for Dimension 1: Client is an IV heroin user and has been using for about 30 years. Client uses about 20 bags daily. Client last used the morning before entering the program. Without detox services, client would go into withdrawal, or continue to use heroin.

BETTER!

Clinician Observation for Dimension 1 :Client reports sniffing heroin daily and uses 10-15 bags. Client reports using heroin for 3 years. Client reports current withdrawal symptoms of nausea, aches and pains, anxiety, hot and cold sweats, and trembling. Client needs continued medical stabilization from opioid detoxification. As per the medical team, client is prescribed Suboxone 4mg every 12 hours for 6 more doses. Client is not medically stable to enter into 3.7 level of care at this time, client will need 3.7D.

NOT AS GOOD!

Clinician Observation for Dimension 1 :Client is an IV opioid user. Client last used the morning before entering treatment. Without detox services, client would go into withdrawal or continue to use.

Medically-Monitored Intensive Inpatient 3.7 (Short Term Residential) Examples of Dimensions 2 and 3

Clinician Observation for Dimension 2 : client is a Type 1 Diabetic with a history of being non-compliant with his meds (stopped using his insulin pump at home because he never got it calibrated) and diet. During his first week of treatment here he had numerous significantly elevated blood sugar levels and on 9/11/15 was sent to General Hospital for evaluation secondary to a BS reading in excess of 500. He did not appear to take this situation seriously at all making statements such as "sometimes I rock over 600" and "I'm Italian, I eat pasta" followed by laughter. He has also been caught trying to hide his blood sugar readings by hitting the "re-set" button on the monitor if the reading is quite high. He is being closely monitored by the medical/nursing department as well having periodic consultations with the dietician re: proper eating habits/snacking etc. His BS levels are still not stabilized but are improving with readings currently averaging in the "200's" with the highest in the past week being 387.

Clinician Observation for Dimension 3 : Client is currently experiencing symptoms of depression and anxiety related to the recent (August 2014) death of his wife from a drug overdose. : Client was using with his wife and he woke up to find her dead. In addition to feelings of grief and loss he is also experiencing a lot of guilt and fear (as he may be facing additional legal charges. : Client has been placed in the grief and loss group to help him process his feelings, however at this time his participation is minimal and while attentive during the group he presents as angry. He has been able open up a bit in individual sessions at has become quite tearful. He does present with a constricted affect and appears "sad" and somber at times while at other times appears anxious and angry. His appetite and sleep are fair. The plan is to continue with the grief group and work with him in individual sessions about identifying and expressing his feelings in an appropriate manner.

Sample Dimension 2

Clinician Observation for Dimension 2:

Client has major knee problems. Client regularly takes Neurontin to address his chronic knee pain. Client also has Hepatitis C and he tested positive for Tuberculosis while here at the Short-Term Program. Client does not have any acute symptoms at this time for Hepatitis C nor Tuberculosis. Because the client has Tuberculosis, he will be referred to the Board of Health to have a chest x-ray evaluation completed. The client also informed the counselor that in the past, the client tested positive for Tuberculosis, but he has never caused a problem for the client. It is fair to say that the client was exposed to Tuberculosis somewhere down the line, but he has never had symptoms to his acknowledge. It is possible that these medical concerns contribute to his mental health issues. Client suffers from depression and anxiety. Client would benefit from being extended in the Short-Term Program so that his medical problems can be properly addressed.

Clinician Observation for Dimension 2:

Client reports a hernia, chronic back and hip pain due to injuries from a car accident, and allergy to bees.

What is Imminent Danger?

1. A strong probability that certain behaviors will occur (e.g., continued alcohol or drug use or non-compliance with psychiatric medications)
2. These behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in a consistent pattern of driving while intoxicated)
3. The likelihood that such adverse events will occur in the very near future

***All 3=Imminent Danger**

Requires Inpatient Treatment

Clinician Observation for Dimension 3

Risk Rating: 3 During treatment, client was diagnosed with Bipolar II Disorder (296.89). Client has been working with psychiatric team to establish a medication regimen that appropriately addresses symptoms and **stabilization** has yet to be acquired. Client has displayed symptoms of fluctuating anxiety and depression. Client was assessed for safety and is currently not a harm to herself or others. Client would benefit from continued treatment at this level of care in order to appropriately address symptoms of co-occurring disorders by utilizing provided psychiatric services to attain **stabilization**.

Dimension 3 Request for 3.7

Clinician Observation for Dimension 3 :Client has a significant history psychiatric issues which intensified in 2015 after the death of her SO. Client reports visual and auditory hallucinations, episodes of aphasia, nightmares, and worsening feelings of anxiety and depression. Client was treated on two separate occasions at the VA and later Trinitas psychiatric hospital and prescribed medications to help her with symptoms. When client was admitted into STR program, she only had one current prescription. Client would benefit from continued care at this LOC to allow her to work with psychiatrist to establish an effective medication regimen which will help her manage symptoms and allow her to transfer to lower LOC.

Clinician Observation for Dimension 3

Client has an extensive psychiatric history dating back to about 2004. He was hospitalized at that time and did have a suicide attempt. He has been diagnosed in the past with Bipolar d/c, depressive D/C, OCD, ADHD and has been on various medications in the past but has stopped taking all of them. A psychiatric evaluation is to be performed to further assess any underlying psychiatric conditions and assess the need for medication at this time. He currently expressed depressed mood, affect, and speech. Denies suicidality but does not elaborate (can neither confirm nor deny). He is preoccupied with feelings of defeat, hopelessness, and helplessness. Presents as very motivated for treatment but does appear to exhibit difficulty with his emotions, being selective in his reports of where he is at mentally and emotionally.

Clinician Observation for Dimension 3

There is history of mental health problems dating back 2009, at which time the client was diagnosed with Schizophrenia and Bipolar Disease and medications were prescribed at that particular time. According to the client, he was doing well until he decided to stop all medications on his own without consulting a professional and he had setback with auditory hallucinations. According to the client, he resumed taking his medications under the care of a professional and he began to stabilize his mental health problems once again. However, before entering treatment on 01/10/16, the client reported that he was evaluated at the county jail by two different psychiatrists' and recommendations were made for the client to discontinue all medications. Currently the client seems to be stable and he is not reporting any symptoms of schizophrenia and/or Bipolar Disease. However, it is highly recommended for the client to be evaluated by a psychiatrist at current LOC (3.7) to ensure that the client's mental health conditions are stable and to determine if medications are warranted once again to medically stabilize the client. These services could be provided at current LOC 3.7 since the client's mental health condition if not treated, could lead the client to relapse once again.

Dimension 4 Issues:

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Readiness to Change

Prochaska and DiClemente (Stages of Change)

Pre-Contemplation
Contemplation

These are “*Discovery*”
Stages of Change

Preparation

not

Action

“*Recovery*”

Maintenance

Stages of Change

Termination

✓ Relapse and Recycling

Prochaska and DiClemente's Stages of Change Model

Pre-contemplation: not yet considering the possibility of change although others are aware of a problem; active resistance to change; seldom appear for treatment without coercion; could benefit from non-threatening information to raise awareness of a possible “problem” and possibilities for change.

Contemplation: ambivalent, undecided, vacillating between whether he/she really has a “problem” or needs to change; wants to change, but this desire exists simultaneously with resistance to it; may seek professional advice to get an objective assessment; motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong resistance and defensive behaviors; many Contemplators have indefinite plans to take action in the next six months or so.

Prochaska and DiClemente's Stages of Change Model (cont.)

Preparation: takes person from decisions made in Contemplation stage to the specific steps to be taken to solve the problem in the Action stage; increasing confidence in the decision to change; certain tasks that make up the first steps on the road to Action; most people planning to take action within the very next month; making final adjustments before they begin to change their behavior.

Action: specific actions intended to bring about change; overt modification of behavior and surroundings; most busy stage of change requiring the greatest commitment of time and energy; care not to equate action with actual change; support and encouragement still very important to prevent drop out and regression in readiness to change.

Prochaska and DiClemente's Stages of Change Model (cont.)

Maintenance: sustain the changes accomplished by previous action and prevent relapse; requires different set of skills than were needed to initiate change; consolidation of gains attained; not a static stage and lasts as little as six months or up to a lifetime; learn alternative coping and problem-solving strategies; replace problem behaviors with new, healthy life-style; work through emotional triggers of relapse.

Relapse and Recycling: expectable, but not inevitable setbacks; avoid becoming stuck, discouraged, or demoralized; learn from relapse before committing to a new cycle of action; comprehensive, multidimensional assessment to explore all reasons for relapse.

Termination: this stage is the ultimate goal for all changers; person exits the cycle of change, without fear of relapse; debate over whether certain problems can be terminated or merely kept in remission through maintenance strategies.

LEVEL 3.5

CLINICALLY MANAGED HIGH-INTENSITY RESIDENTIAL TREATMENT

Clinician Observation for Dimension 4:

Client continues to attend all his assigned groups and individual counseling sessions and is currently in the Preparation stage of change. In this stage, the client has made the decision to begin to modify behaviors and experiences to overcome stressors and building confidence. Client continues to be educated on the psychosocial problems of addiction and legal problems. Client needs to work on his commitment to himself and develop plans to deal with both personal and external pressures. During this extension period, the client will work on developing the necessary skills needed to deactivate drug/alcohol cravings while postponing instant gratification. The client will work on learning how to understand how the short-term of feeling good when using drugs/alcohol, will only lead to long term adverse consequences. Above mentioned goals could be accomplished at current LOC (3.5) with intense staff supervision monitoring behavioral changes.

Clinician Observation for Dimension 4

According to the ASAM Placement Criteria (Appendix A matrix) client meets the criteria for a risk rating of 2. The client continues to show his readiness to change by gaining a better understanding of how his substance abuse issues are related to his mental health diagnosis. He is no longer in denial about having a mental health diagnosis and is now able to recognize the negative consequences of his substance abuse. The client has taken on more responsibility in the program and has shown his willingness to work hard and step up when necessary. Client also appears to be externally motivated by fear of potential consequences through the drug court.

Clinician Observation for Dimension 5

Client's relapse potential at this time in medium to high, and client needs to work on developing the skills needed to learn how to identify/recognize relapse triggers and the dangers of high risk situations; such as avoidance, defensive behavior, and excessive worrying about others instead of self. Client also needs to learn about self-help groups and how to implement self-help groups into his relapse prevention plan. Client also needs to work on developing the necessary refusal skills in order to learn how to say no to licit/illicit substances while also learning how to deal with negative peer pressure as it has been identified that the client is a people's pleaser. Client's own personal relapse prevention plan will be completed during this extension period, and this plan will be tailored to the client's recovery needs. Above treatment plan goals could be achieved at current LOC (3.5) with intense staff supervision observing/monitoring behavioral changes.

Clinician Observation for Dimension 5

According to the ASAM Placement Criteria (Appendix A matrix) client meets the criteria for a risk rating of 4a. The client is currently working on identifying root causes with his drug problem as he has been incapable of remaining sober in the past outside of a structured living environment. The client is working on identifying traps and triggers such as being around his family and friends who are still active users. The client continues to work on relapse prevention mechanisms in order to learn how to cope with addiction problems. The client continues to learn that self medication is not a way to cope with mental illness or utilizing criminal behavior as a means to deal with his issues. Although the client is able to identify root causes and is becoming more open about his addiction, he still focuses on everyone else and their stability instead of focusing on himself. The client will continue to learn new ways to cope with life stressors as well as develop an effective relapse prevention plan.

Clinician Observation for Dimension 5

Client doesn't handle crisis very well and situations may pose imminent danger of harm to self or others in the absence of close 24-hour monitoring and structured support. The aforementioned is exacerbated by the fact that client is unable to control use of drugs, and/or antisocial behaviors. Client requires sufficient positive coping skills to face the challenges of invitation to engage in drug activities by client's peers and his cravings. During the extension period client will have the opportunity to learn and practice new positive coping mechanisms to maintain the pattern of sobriety he has achieved.

Dimension 6: Recovery Environment

Pay close attention to Dimension 6; the absence of a support system is the greatest obstacle to recovery problems with primary support group:

- Problems related to social environment
- Educational problems
- Housing problem
- Economic problems
- Problems with access to health care services
- Problems related to legal system/crime
- Other psychosocial and environmental problems

Intensive Outpatient Program Level

2.1

Clinician Observation for Dimension 4 :Client's continued illicit substances use has shown that she is not ready to change her behaviors. However, Client regularly attends IOP groups and is able to admit that she has a problem that requires intensive treatment. Client was less successful while participating in LOC I. Client requires 9 hours of intensive treatment to target her belief system and irrational thinking surrounding illicit substances use/abuse.

Clinician Observation for Dimension 5 :Client is at a high risk for relapse as evidenced by her continued illicit substances use and abuse. Client was unsuccessful at a lower level of care. Client appears to be unable to maintain sobriety on her own and requires would benefit from an intensive level of care to target problem areas.

Clinician Observation for Dimension 6 :Client's recovery environment is both hazardous and helpful. Client's environment is helpful because her children offer her support and guidance. It is hazardous because client will allow individuals who are actively using into her home. Client reports being aware that these individuals are unhealthy for her to be around and that she is working on decreasing the amount of time she spends with them.

Clinician Observation for Dimension 6

Level 2.1

Janine is residing in the residence with her grandmother which is the same situation as when she was in active use. Janine's grandmother has a history of enabling through taking custody of Janine's children as well as continuing to provide for Janine financially despite her addiction, and allowing access to funds even when signs of the addiction became evident- DYFS case, request to remove children, Janine and her husband entering into legal issues related to substance use.

While Janine's grandmother is supportive, she is not engaged in any services such as Nar-Anon or family counseling to address her behaviors and role in potential relapse. Treatment providers are requesting Janine bring her grandmother into treatment to address some of the issues present in the home environment and shift more responsibility onto Janine.

Intensive Outpatient Treatment

Level 2.1

Clinician Observation for Dimension 3 :Pt shows signs of anxiety, possible other co-occurring Dx. Pt has been given referral for psych eval although has not followed up yet with any appointments.

Clinician Observation for Dimension 4 :Pt is motivated for IOP, attendance has been good. She continues to use multiple substances and is showing some resistance to increased LOC, therefore IOP is recommended at this point with continued efforts to refer pt inpatient if drug use does not decrease and abstinence maintained.

Clinician Observation for Dimension 5 :Pt continues to use heroin several times a week and also uses cocaine and benzos sporadically per uds.

Clinician Observation for Dimension 6 :Pt has little support systems for recovery, has not began to develop relationships with those who do not use. Spends a lot of time with other people who use.

Clinician Observation for Dimension 6

Level 3.1

According to the ASAM Patient Placement Criteria (Appendix 'A' Matrix), client meets the criteria for risk rating 3, as evidenced by lack of appropriate support outside of the current treatment program. The Client has no stable home environment which to return upon program completion, and is homeless. Client still needs to obtain independent housing. Client is saving/budgeting his monies to reach this goal. Lastly, the Client needs more active participation in 12 step groups, self-help meetings and substance free activities and to obtain a sponsor and home group. He still requires frequent staff interventions and encouragement in this area. Although he seems to be improving in his motivation.

Halfway House

Level 3.1

Clinician Observation for Dimension 3: Client continues to demonstrate unstable behavior within the treatment community as evidenced by multiple conflicts with staff and peers in which client exhibits inappropriate behavior. Client was not given her medication one her recent jail sanction and returned to the facility in an agitated state.

Clinician Observation for Dimension 4: The client is in the process of working towards medication stabilization and her medication was changed at her most recent appointment on 2/2/2016. Contemplative and Action stages of change. Client continues to struggle with making behavioral changes and frequently reverts to maladaptive coping mechanisms during personal relationship conflicts. Peer relationships appear to be the most challenging aspect of treatment for her. Examples of recent acting out behavior include attempts to manipulate staff, failure to complete an assigned therapeutic homework assignment and multiple peer conflicts. Client however continues to remain compliant with facility rules and regulations, participates in groups and individual sessions and has integrated in to the AA program.

Clinician Observation for Dimension 5: Client does not appear to be stabilized on her medication at this time and would therefore be vulnerable to relapse if outside of a III.I level of care.

Clinician Observation for Dimension 6: The Client will continue to require the support and monitoring provided at the 3.I level of care while she works towards achieving medication stabilization. Clients prior living environment was not supportive of sober living and will be referred to supportive housing as part of her discharge plan. Client will be reviewed for work readiness once medication stabilization can be achieved.

Clinician Observation for Dimension 6

Level 3.5

Client needs to continue working on developing a positive support system supportive of his recovery program. Client will achieve this by continuing to attend AA/NA meetings, completing Step work, and learning about sponsorship. Client also needs to continue working on developing new social skills while identifying how his negative peers contributed to his substance use disorder and involvement with the legal system.

Client needs to increase permanent housing, employment, education, and other necessary supports; and reduce barriers to social inclusion.

Upon successful completion of residential treatment, Mr. XXXXX will be transitioning to a halfway house as his outside recovery environment has been identified as not conducive towards his recovery process.

Primary counselor has submitted proper documentation for referrals to Acme and The Everything Else Treatment Programs with the objective of securing a bed for Mr. XXXXX once the client completes residential treatment.

Part 7

The Risk Rating Matrix

Risk Ratings

0) No Risk or Stable – Current risk absent. Any acute or chronic problem mostly stabilized

1) Mild - Minimal, current difficulty or impairment. Minimal or mild signs and symptoms. Any acute or chronic problems soon able to be stabilized and functioning restored with minimal difficulty.

2) Moderate - Moderate difficulty or impairment. Moderate signs and symptoms. Some difficulty coping or understanding, but able to function with clinical and other support services and assistance.

3) Significant – Serious difficulties or impairment

Substantial difficulty coping or understanding and being able to function even with clinical support. Moderately high intensity of services, skills training, or supports needed. **May be in, or near imminent danger.**

4) Severe - Severe difficulty or impairment

Serious, gross or persistent signs and symptoms to tolerate and cope with problems

Is the client in imminent danger?

High intensity of services, skills training, or supports needed

More immediate, urgent services may require inpatient or residential settings; or closely monitored case management services at a frequency greater than daily

RISK RATING – 4a

NO IMMEDIATE ACTION REQUIRED

TIP: This is the highest Risk Rating for a client to remain in a DMHAS Licensed Level of Care

Substance Use Disorders

Repeated treatment with little positive effect on the patient's functioning. He or she has no skills to cope with and interrupt addiction problems, or to prevent or limit relapse. However, the patient is not in imminent danger and able to care for self. (e.g., the patient has undergone repeated withdrawal managements but is unable to cope with continued cravings to use)

Mental Disorders

Repeated treatment have had little positive effect on the patient's functioning. He or she has no skills to cope with and interrupt mental health problems, or to prevent or limit relapse. However, the patient is not in imminent danger and able to care for self. (e.g., The patient is severely and chronically mentally ill with chronic dysfunction and inability to arrest psychotic episodes)

RISK RATING – 4b

IMMEDIATE ACTION REQUIRED

(Level 4.0)

TIP: if you use a Risk Rating of 4b your client needs to enter a Non Licensed Level of Care by DMHAS

Substance Use Disorders

The individual has no skills to arrest the addictive disorder, or to prevent relapse to substance use. His or her continued addictive behavior places the patient and/ or others in imminent danger (e.g., a patient whose continued drug use leads to impulsive, psychotic and aggressive behavior)

Mental Disorders

The patient has no skills to arrest the mental illness, or to prevent relapse to mental health problems. His or her continued psychiatric disorders places the individual and /or others in imminent danger (e.g., a patient whose depression and feelings of hopelessness cause strong impulses to slash his or her wrists, or who has paranoid delusions with command hallucinations to harm others)

Dimension 6 Risk Rating 2

Substance Use Disorders

The patient's environment is not supportive of addiction recovery, but, with clinical structure, the patient to cope most of the time.

Mental Disorders

The patient's environment is not supportive of good mental health, but, with clinical structure, the patient to cope most of the time.

(The ASAM Criteria pages 103-104)

Dimension 6 Risk Rating 4a

Substance Use Disorders

The patient's environment is not supportive, and is chronically hostile and toxic to addiction recovery or treatment progress (for example, the patient has many drug-using friends, drugs a readily available in the home environment, or there are chronic lifestyle problems but no acute conditions). The patient is unable to cope with the negative effects of this environment on his or her recovery.

Mental Disorders

The patient's environment is not supportive, and is chronically hostile and toxic to good mental health (for example, the, there is chronic parental neglect, along with caretaking and adult supervision problems, but not acute conditions). The patient is unable to cope with the negative effects of this environment on his or her recovery.

Dimension 5 Risk Rating 3

Substance Use Disorders

The patient has little recognition and understanding of substance use relapse issues, and has poor skills to cope with and interrupt addiction problems, or to avoid or limit relapse.

Mental Disorders

The patient has little recognition and understanding of mental illness relapse issues, and has poor skills to cope with and interrupt mental health problems, or to avoid or limit relapse.

(The ASAM Criteria pages 100-101)

Dimension 5 Risk Rating 4a

Substance Use Disorders

Repeated treatment episodes have had little positive effect on the patient's functioning. He or she has no skills to cope with and interrupt addiction problems, or to prevent or limit relapse (for example, the patient has undergone repeated episodes of addiction treatment, but is unable to cope with continued cravings to use.) However the patient is not in imminent danger and is able to care for self.

Mental Disorders

Repeated treatment episodes have had little positive effect on the patient's functioning. He or she has no skills to cope with and interrupt mental health problems, or to prevent or limit relapse (for example, the patient is severely and chronically mentally ill, with chronic dysfunction and inability to arrest psychotic episodes.) However the patient is not in imminent danger and is able to care for self.

Dimension 6 Risk Rating 2

Substance Use Disorders

The patient's environment is not supportive of addiction recovery, but, with clinical structure, the patient to cope most of the time.

Mental Disorders

The patient's environment is not supportive of good mental health, but, with clinical structure, the patient to cope most of the time.

(The ASAM Criteria pages 103-104)

Dimension 6 Risk Rating 4a

Substance Use Disorders

The patient's environment is not supportive, and is chronically hostile and toxic to addiction recovery or treatment progress (for example, the patient has many drug-using friends, drugs a readily available in the home environment, or there are chronic lifestyle problems but no acute conditions). The patient is unable to cope with the negative effects of this environment on his or her recovery.

Mental Disorders

The patient's environment is not supportive, and is chronically hostile and toxic to good mental health (for example, the, there is chronic parental neglect, along with caretaking and adult supervision problems, but not acute conditions). The patient is unable to cope with the negative effects of this environment on his or her recovery.

Consider Clinical Data to Include in Your PA Request

- **DSM 5** – which criteria to include
- **LOCI 3** – completed clearly all 6 Dimensions
- **Impairment of Function**- all areas applicable
- **CIWA** scores (alcohol)– 19 plus for detox- 3.7
- **COWS** scores (opioids)- mild, moderate, severe.
- **Motivational level** (Dimension 4)- E.G. Contemplation, Maintenance, etc.
- **Risk Rating** – 0, 1, 2, 3, 4, 4a, 4b for each ASAM Dimension

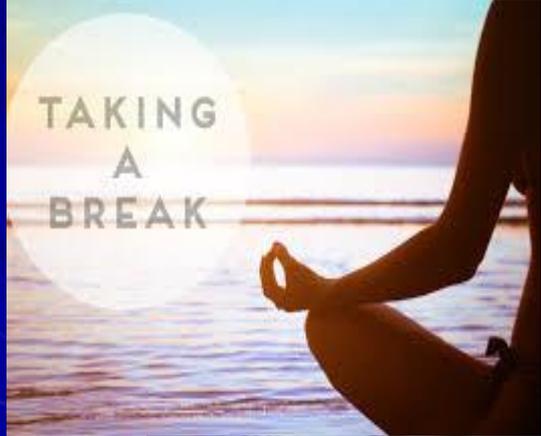
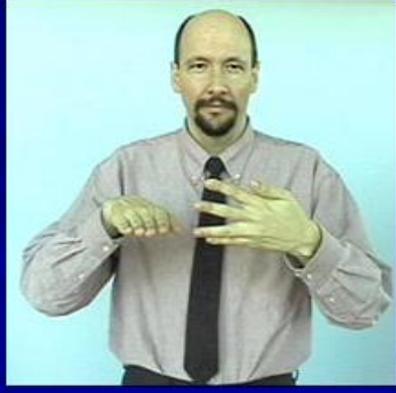


Take a Break



It's Time For A Break

American Sign Language



Take a break...



Part 8

Cases

Skill Building through Case Studies

Review of the following LOCI completed in NJSAMS

- Review for clinical appropriateness
- Review for completeness
- Review for accuracy
- Language, spelling etc.

Patient Placement / Level of Care Justification

A clinical justification provides a summary of the evidence that justifies the recommendation, (a.k.a., Patient Placement Decision).

We as clinicians are responsible for what we believe, and why we believe it.

Clinicians must be skilled at writing, clear, concise, and clinically defensible justifications for their recommendations, and persist in advocating for the services clients need.

ASAM Patient Placement Criteria for the Treatment Of Substance-Related Disorders (ASAM PPC-IIr):

- **“Making it Real, Making it Work”**
- **Terrencewalton@aol.com**

CASE ONE: GEORGE

46 YEAR OLD MALE

1. Alcohol- Reports drinking a bottle of wine over the weekend.
2. Heroin- Hasn't used in years; so long couldn't remember when; shot 3 to 4 times per day; dime bag each time.
3. Cocaine- Smoking regularly for past year—20 or more days per month; Smokes 6-7 rocks per day.
4. Cannabis- Last smoked 1 week ago; smoking less since starting crack; Previously smoked daily—about 4 dimes per day; began smoking daily as teen.
5. PCP- Reports hasn't smoked in years.

CASE ONE- GEORGE

ACUTE INTOXICATION & WITHDRAWAL POTENTIAL

1. Moderate Severity:

2. Smoked crack 20 or more days a month for at least the past year; smoked last night.
3. In addition to smoking crack, he reports drinking alcohol and smoking marijuana. He reports no withdrawal symptoms when abstinent from alcohol.
4. Client's lips were severely burned. His sister stated that when client can't get access to a lighter or match, he'll attempt to light the crack pipe using the stove. She stated that his coat caught fire recently.

CASE ONE- GEORGE

BIOMEDICAL CONDITIONS & COMPLICATIONS

1. Low Severity:

2. Client states that he fell out of a truck at age 14 and was hospitalized. He states that he was in a coma for days.
3. Client also states that he was hospitalized at age 18 for pneumonia.
4. He does not report any other prior or on-going medical issues.
5. He does not report any medical issues in the past 30 days.

CASE ONE- GEORGE

EMOTIONAL, BEHAVIOR AND COGNITIVE CONDITIONS AND COMPLICATIONS

1. High Severity:

2. Diagnosed with schizophrenia and bi-polar disorder; monthly Haldol injections for years
3. Has received SSI for over 15 years
4. Client reported compliance w/treatment; denied hallucinations and delusions.
5. Sister reports client has been talking to the TV and to himself; has a fixed belief that people change bodies and that's how his deceased father is still alive.

CASE ONE- GEORGE

READINESS TO CHANGE

1. **Moderate Severity:**
2. Verbalizes desire for treatment and considers treatment to be very important.
3. Willingness to engage in treatment and ability to follow through with treatment recommendations is also in doubt.
4. Sister indicated that client has completed detox multiple times, but has refused to enter treatment, not engaged while in treatment, and/or left treatment early.

CASE ONE- GEORGE

RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL:

1. **High Severity:**
2. Began marijuana at age 14 and alcohol at 15. He could not recall when he began smoking crack.
3. Reports history of drinking daily, 4-5 bottles of wine per day; greatly reduced in last 4 months.
4. History of smoking 4-5 dime bags of marijuana per day. Indicates THC use decreased when his crack use picked up about a year ago.
5. Reports smoking crack 20 or more days a month; 6-7 rocks per episode. Reports daily cravings for crack; no recent sustained abstinence; unable to describe strategies for achieving abstinence.

CASE ONE- GEORGE RECOVERY/LIVING ENVIRONMENT

1. **Moderate Severity:**
2. Lives with his mother and has done so all his life. No drug or alcohol users in home.
3. Client's sister accompanied him to the interview and appeared supportive and involved.
4. Reports spending most of his free times with a "friend". He stated that they used drugs together.
5. Client states that he panhandles to support his drug habit and that's how he ended up with his current charge unauthorized entry. No other criminal charges.

CASE ONE- GEORGE RECOMMENDATION

- Detoxification followed by
- Long-Term Residential

CASE TWO- NIKI

READINESS TO CHANGE

1. Does not appear to be amenable to treatment.
2. Does not feel she has a problem with alcohol or drug use.
3. Indicates that participating in treatment could interfere with her work schedule because she works 16 hour shifts as a private duty nurse.

ASSESSING READINESS TO CHANGE

- Pre-Contemplation
- Contemplation
- Preparation
- Action
- Maintenance

ASSESSING RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL

Is this person addicted?

Are they currently using?

Do they have awareness of how to get and/or stay clean?

Do they have the ability to get and/or stay clean? a)

Historical Pattern of Use and relapse

Acute Pharmacologic Responsivity

External Stimuli Responsivity (triggers & stress)

Cognitive and Behavioral Measures of Strengths and

Weaknesses (self efficacy, coping skills impulsivity)

CASE THREE: RASHAUN

RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL:

Client presents with history of drug use beginning with marijuana at age 14, alcohol (15), cocaine/crack (23), and heroin (24). Currently, he reports using all drugs “occasionally”, maybe 3-4 times a month.

He reports using a dime bag of heroin and marijuana per occasion. He could not say how much crack he smokes because it’s always given to him.

Client denies any significant cravings. He reports smoking crack because “it comes around me.”

Drug test records show consistent positives for the above referenced drugs.

CASE THREE- RASHAUN RATE RELAPSE/CONTINUING USE POTENTIAL

Dimension 5
High Severity



1. The strong probability that certain behaviors (such as continued drug use or relapse) will occur;
2. The likelihood that such behaviors will present a significant risk of serious adverse consequences to the individual and/or others; and
3. The likelihood that such adverse events will occur in the very near future

ASSESSING RECOVERY/LIVING ENVIRONMENT

- Supportive of or Toxic to Recovery (continuum)
- Structured Time versus Idle Time
- Potential for Victimization or Perpetration

CASE FOUR- MARY

RECOVERY/LIVING ENVIRONMENT

1. Does not have a supportive family
2. Has her own apartment and lives alone
3. Doesn't have any friends, because "they get you in trouble"
4. Spends most of her free time with her 8 year old goddaughter or with her cousin—who uses drug and alcohol
5. Has other associates who use drugs and alcohol; has distanced herself from them due to her court involvement
6. Works as private duty nurse full time
7. First charge— assault

ASSESSING RECOVERY/ LIVING ENVIRONMENT

1. Do family members, close associates, living situations, neighborhoods, school, or work pose a threat to client safety and/or treatment engagement?
2. Does client have supportive friendships, financial resources, daily structure; or educational, vocational or spiritual resources that can increase treatment success?
3. Are there transportation, child care, housing or employment issues that need to be clarified and addressed prior to treatment?

ASSESSING RECOVERY/ LIVING ENVIRONMENT

1. Living with active users = **High Severity**
2. Living in drug infested neighborhoods, but **not** with anyone actively using = **at least moderate severity**
3. Search for mitigating factors that lessen risk
4. **Almost nothing can lower the risk score of someone living with an active user**

BIG HINTS

High Severity in Relapse Potential with
Imminent Danger + High Severity in
Recovery Environment =
Residential Treatment

High Severity in Relapse Potential without Imminent
Danger + High Severity in Recovery Environment =
Intensive Outpatient Treatment

ONE MORE BIG HINT

**Look for Information
that lowers severity—
not just information
that raises severity**

Admission Level of Care Inventory

The case of Mr. D.

Mr. D. is a 41 y/o married white male, unemployed carpenter, referred by his wife, a nurse, who, after his recent relapse, will soon throw him out if he continues his daily 6-pack habit.

His history includes:

1. no prior withdrawal symptoms
2. major depression with suicidal ideation
3. intermittent prescriptions for opiates for low back injury
4. alcoholism in his father

He would now accept treatment, including abstinence from any opiates, restarting his antidepressant, & attending some AA meetings.

Tracy

A 16-year-old young woman is brought into the emergency room of an acute care hospital. She had gotten into an argument with her parents and ended up throwing a chair. There was some indication that she was intoxicated at the time and her parents have been concerned about her coming home late and mixing with the wrong crowd. There has been a lot of family discord and there is mutual anger and frustration between the teen and especially her father. No previous psychiatric or addiction treatment.

The parents are both present at the ER, but the police who had been called by her mother brought her. The ER physician and nurse from the psychiatric unit who came from the unit to evaluate the teen, both feel she needs to be in hospital given the animosity at home, the violent behavior and the question of intoxication.

Assess

Using the six ASAM assessment dimensions, the biopsychosocial clinical data is organized as follows:

Dimension 1, Intoxication/Withdrawal: though intoxicated at home not long before the chair-throwing incident, she is no longer intoxicated and has not been using alcohol or other drugs in large enough quantities for long enough to suggest any withdrawal danger.

Dimension 2, Biomedical Conditions/Complications: she is not on any medications, has been healthy physically and has no current complaints

Dimension 3, Emotional/Behavioral/Cognitive: complex problems with the anger, frustration and family discord; chair throwing incident this evening, but is not impulsive at present in the ER.

Dimension 4, Readiness to Change: willing to talk to therapist; blames her parents for being overbearing and not trusting her; agrees to treatment, but doesn't want to be at home at least for tonight

Dimension 5, Relapse/Continued Use/Continued Problem Potential: high likelihood that if released to go back home immediately, there would be a reoccurrence of the fighting and possibly violence again, at least with father.

Dimension 6, Recovery Environment: parents frustrated and angry too; mistrustful of patient; and want her in the hospital to cut down on the family fighting

Severity Profile: Dimension: 1 2 3 4 5 6

Severity:

Services Needed:

Site of Care:

Sandy

This 26 year old, white female wife of an army officer:

She has been snorting cocaine off and on for about four years, and for the last year, 3-4 times a week, 1-2 lines at a time. During the past 6-7 months she has begun experimenting with crack, which she says she likes but is afraid she will lose control. She drinks 2-3 drinks at a time, 2-3 times a week, with occasional drinking to intoxication on weekends. She smokes marijuana, 1-2 joints at a time, 1-2 times a week. She started smoking marijuana as a teenager in high school, sometimes mixing it with PCP.

She claims to want to help to stop using all the psychoactive substances but especially the cocaine because while she likes some of the psychoactive effects, she doesn't like being "out of it" even minimally. She had a DUI about two years ago (she does not know what her BAC was). Recently Sandy found herself wandering in a park near her home and does not remember how she got there. This has frightened her. Medically, she admits to having a heart murmur that she's had since childhood. During the assessment, Sandy appeared anxious and depressed, some of which may have been accounted for by the assessment situation. She also looked "ragged out" on the day of the assessment, looking older than her 26 years, and also looking somewhat dirty.

Sandy and her husband have been separated twice, once for three weeks and once for one month in the last two years. She has been able to stay off all drugs and alcohol during the time they were separated and for about one month each time after he returned from the marital separations. She stated that her husband supports her in her attempts to get help for her substance use.

They have two young children and Sandy admits she sometimes worries about their safety. Sandy tells you she is willing and wants to go inpatient for a month because that will help her. She insists that her insurance will cover it.

How would you proceed with your assessment?

Ann

DSM-5 Diagnosis: Alcohol Use Disorder, moderate and Cannabis Use Disorder, mild; Major Depression

Ann, a 32-year-old divorced female, came in for assessment for the first time ever. She has been abstinent for 48 hours from alcohol and reports that she has remained so far up to 72 hours during the past three months. When she has done this she states she has experienced sweats, internal tremors and nausea, but has never hallucinated, experienced D.T.'s or seizures. She states she is in good health except for alcoholic hepatitis for which she was just released from the hospital one week ago. Her doctor referred her for assessment. She smokes up to 3 or 4 joints a day, but stopped yesterday. In addition to the above, Ann describes two past suicide attempts using sleeping pills, but the most recent attempt was three years ago and she sees a psychiatrist once a month for review of her medication. She takes Prozac for the depression and doesn't report abuse of her medication.

Ann reported that she lives in a rented apartment and has very few friends since moving away after her divorce a year ago. She is currently unemployed after being laid off when the supermarket she worked at closed. She has worked as a waitress, check-out person and sales person before and says she has never lost job due to addiction.

Ann appears slightly anxious, but is not flushed. She speaks calmly and is cooperative. Ann shows awareness of her consequences from chemical use, but tends to minimize it and blame others including her ex-husband who left her without warning. She doesn't know much about alcoholism/chemical dependency, but wants to learn more. She has one son, age 11, who doesn't see any problems with her drinking and doesn't know about her marijuana use.

Matt

Matt is a forty-two year old man. He reports completing the eleventh grade and obtaining his GED. Matt indicates he is married and has two children. He is currently incarcerated on the charge of Theft by Unlawful Taking. Matt reports first drinking alcohol when he was 15 years old. Matt indicates he began to drink excessively at about 30 years old. He confirms drinking has been a problem in the past and describes drinking “sun up to sun down,” going to bars and after-hours clubs. He states that he continues to drink alcohol but only drinks one or two times per month, and has approximately two or three drinks at a time. Matt indicates he has been to AA meetings in the past, but doubts he has ever applied their principles to his life. Matt reports his first use of marijuana at age 13. He describes marijuana as his drug of choice, and second to that he prefers to drink rum and cokes. Matt reports first using cocaine at age 27. He indicates only using cocaine three times in his life. He said he first used methamphetamine at age 30. Matt said his last use of alcohol and drugs as six months ago before being incarcerated.

Matt said he has never completed a Drug/Alcohol Treatment Program in his lifetime. Motivational enhancement for treatment could include focusing on how his substance use has affected his family, employment, and his physical health. Matt could benefit from a Cognitive Restructuring Class to increase self-awareness of the relationship between his thoughts and actions. A Twelve Step Program may also be effective for Matt in order to begin living with more principles. Matt has a lengthy legal history including Possession of Marijuana (4 times), Driving Under the Influence(3 times), Driving Under Suspension (4 times, 15 year. Suspension), Possession of Controlled Substance- Meth (18-36 Months).

Carl

Carl is a 15 y.o. male who you suspect meets DSM criteria for Alcohol and Cannabis Use Disorder, with occasional cocaine (crack) use on weekends. He reports no withdrawal symptoms, but then he really doesn't think he has a problem and you are basing your tentative diagnosis on reports from the school, probation officer, and older sister. Carl has been arrested three times in the past eighteen months for petty theft/shoplifting offenses. Each time he has been acting intoxicated but says he has not been using any drugs. The school reports acting up behavior, declining grades and erratic attendance, but no evidence of alcohol/drug use directly. They know he is part of a crowd that uses drugs frequently. Yolanda, Carl's 24 y.o. sister, has custody of Carl following his mother's death from a car accident eighteen months ago. She is single, employed by the telephone company as a secretary, and has a three y.o. daughter she cares for. She reports that Carl stays out all night on weekends and refuses to obey her or follow her rules. On two occasions she has observed Carl drunk. On both occasions he has been verbally aggressive and has broken furniture. A search of his room produced evidence of marijuana and crack which Carl claims he is holding for a friend

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Save the Date(s)

Authorization Training

Join us for this full day training on the IME Authorization Process. This training will describe the process and requirements for authorization requests and approvals. The training will include a review of the changes in NJSAMS.

April 22nd or May 5th - Burlington County Human Services

April 25th or May 2nd - Morris County Police and Fire Academy

April 29th or May 6th - State Police Training Center, Hamilton

Invitation, Directions and the Registration Link will follow

PART 9

What questions do you have?

