LENAWEE-LIVINGSTON-MONROE-WASHTENAW
OVERSIGHT POLICY BOARD

VISION

"We envision that our communities have both an awareness of the impact of substance abuse and use, and the ability to embrace wellness, recovery and strive for a greater quality of life."

AGENDA
March 28, 2019

705 N. Zeeb Road, Ann Arbor

Patrick Barrie Conference Room
9:30 a.m. – 11:30 a.m.

1. ***Introductions & Welcome Board Members***– 5 minutes

2. Approval of Agenda (Board Action) – 2 minutes

3. Approval of February 28, 2019 OPB Minutes {Att. #1} (Board Action) – 5 minutes

4. Audience Participation – 3 minutes per person

5. Old Business – 15 minutes
   a. Finance Report {Att. #2} – 15 minutes

6. New Business – 35 minutes
   a. Funding for Peer services at MAT Providers {Att. #3}– (Board Action)
   b. Policy Review - (Board Action)
      1. Communicable Disease Policy {Att. #4}
      2. Outpatient Treatment and Recovery Continuum of Services {Att. #5}

7. Report from Regional Board (Discussion) – 15 minutes

8. SUD Director Updates (Discussion) – 10 minutes

Next meeting: April 25, 2019

Parking Lot:

LENAWEE-LIVINGSTON-MONROE-WASHTENAW
OVERSIGHT POLICY BOARD
February 28, 2019 meeting
705 N. Zeeb Road
Ann Arbor, MI 48103

Members Present: Amy Fullerton (phone), David Oblak, William Green, Tom Waldecker, Kim Comerzan Mark Cochran, Blake LaFuente, John Lapham, Ralph Tillotson, Charles Coleman, Dave O'Dell

Members Absent: Dianne McCormick, Monique Uzelac

Guests:

Staff Present: Stephannie Weary, Marci Scalera, Suzanne Stolz, Amy Johnston (phone), Katie Postmus, Nicole Adelman, James Colaianne, Jackie Bradley

D. Oblak called the meeting to order at 9:33 a.m.

1. Introductions

2. Approval of the agenda

   Motion by R. Tillotson, supported by W. Green, to approve the agenda
   Motion carried

3. Approval of the January 24, 2019 OPB Minutes

   Motion by K. Comerzan, supported by M. Cochran, to approve the January 24, 2019 OPB Minutes
   Motion carried

4. Audience Participation
   - None

5. Old Business
   a. Finance Report
      - S. Stolz presented. Discussion followed.
      - S. Stolz, J. Colaianne and M. Scalera will be doing a deep analysis of SUD funding.

      Motion by R. Tillotson, supported by C. Coleman, to accept the finance report
      Motion carried

6. New Business
   a. CCAR Training
      - OPB approved funding for a CCAR training last year. It will happen at the end of March.
   b. Able Change Process

- M. Scalera provided an overview of the recent Able Change summit, and the process that's taking place in Washtenaw.
- Is this something OPB would like to engage the region in?
- D. Oblak would like to see a regional initiative involving all 4 counties together.
- C. Coleman would like to give the Washtenaw effort time to show results, to learn from the experience and implement the successful elements.
- M. Scalera suggested possibly reviewing each county separately, and then bringing the 4 counties together for discussion.
- A survey will also be considered, which will contribute to a town hall.

c. Data Review
   1. Treatment Trends
      - OPB would like an asterisk (delineation) indicating what "Total admissions in xx county" means: residency, service took place in, etc.
   2. Narcan Saves report
      - OPB reviewed saves statistics for Narcan across the region.

7. Report from Regional Board
   - There was discussion of the 360-degree review of the CEO. The results should be ready by the middle of March.
   - There was also discussion of the regional finances.

8. SUD Director Updates
   a. Grants and program implementation
      - SOR grants are up and running.
      - C. Coleman would like to do what we can to retain the grant coordinator positions, if the grant funding does end in the future. He'd like the PIHP to think outside of the box re: staffing.
      - The PIHP Leadership team is reviewing staffing, including the SUD and Clinical Director position, to determine staffing needs.
   b. MDOC services status
      - It's not clear what's going to happen, but it seems that everyone will be required to
      - manage the MDOC clients.
      - MIRep in Monroe: The state has put the money into the EGrAMS system.
      - K. Postmus reported on the Prevention team's plan to do another continuation year for the funding cycle. Initial cycle was FY18-19, would like to extend it through FY20. Prevention is also getting some funding requests to expand some programs that have been very successful.

9. Adjourn

Motion by T. Waldecker, supported by C. Coleman, to adjourn the meeting
Motion carried

- Meeting adjourned at 11:17 a.m.

Community Mental Health Partnership Of Southeast Michigan
SUD SUMMARY OF REVENUE AND EXPENSE BY FUND
January 2019 FY19

Summary Of Revenue & Expense	Funding Source							Total Funding Sources
	Medicaid	Healthy Michigan	SUD - Block Grant	SUD - SOR	SUD - STR	Gambling Prev	SUD-COBO/PA2	
Revenues								
Funding From MDCH	807,120	1,479,849	2,061,960	52,001	139,687	33,333		$ 4,573,950
PA2/COBO Tax Funding Current Year	-	-	-	-	-	-	620,020	$ 620,020
PA2/COBO Reserve Utilization	-	-	-	-	-	-	521,477	$ 521,477
Other	-	-	-	-	-	-	-	$ -
Total Revenues	$ 807,120	$ 1,479,849	$ 2,061,960	$ 52,001	$ 139,687	$ 33,333	$ 1,141,497	$ 5,715,447
Expenses								
Funding for County SUD Programs								
CMHPSM				52,001	151,611	22,530		226,142
Lenawee	152,158	293,448	153,763				83,809	683,179
Livingston	100,297	234,038	300,785				173,223	808,343
Monroe	91,237	211,796	304,871				105,272	713,175
Washtenaw	367,615	892,265	543,701				310,037	2,113,618
Total SUD Expenses	$ 711,307	$ 1,631,548	$ 1,303,120	$ 52,001	$ 151,611	$ 22,530	$ 672,341	$ 4,544,457
Administrative Cost Allocation	37,847	86,809	87,454		8,187	1,217	-	$ 221,513
Total Expenses	$ 749,154	$ 1,718,356	$ 1,390,574	$ 52,001	$ 159,798	$ 23,747	$ 672,341	$ 4,765,971
Revenues Over/(Under) Expenses	$ 57,966	$ (238,508)	$ 671,386	$ -	$ (20,111)	$ 9,586	$ 469,156	$ 949,476

Current fiscal year utilization of PA2	Revenues	Expenditures	Revenues Over/(Under) Expenses
PA2 by County			
Lenawee	91,504	83,809	7,695
Livingston	275,595	173,223	102,372
Monroe	201,705	105,272	96,433
Washtenaw	572,693	310,037	262,656
Totals	$ 1,141,497	$ 672,341	$ 469,156

Unallocated PA2	FY 19 Beginning Balance	FY19 Projected Utilization	FY20 Projected Utilization	FY20 Projected Ending Balance
Lenawee	924,325	(222,723)	(222,723)	478,878
Livingston	3,039,734	(613,133)	(613,133)	1,813,468
Monroe	522,226	(164,037)	(164,037)	194,152
Washtenaw	2,730,440	(598,506)	(598,506)	1,533,429
Total	$ 7,216,725	$ (1,598,399)	$ (1,598,399)	$ 4,019,927

Attachment #3

CMHPSM SUD OVERSIGHT POLICY BOARD

ACTION REQUEST

Board Meeting Date: March 28, 2019

Action Requested: Approve PA2 Funding for Peer services at Medication Assisted Treatment provider agencies.

Background: Peer services have been crucial for building recovery paths and supports for persons served in our provider network. All providers have incorporated peer recovery coaches in their programs and their services are funded through staffing grants or fee for service through the various funding streams available to the CMHPSM. However, we have identified a gap in provision of peer services at our contracted Methadone clinics. These clinics have been expanding their MAT services beyond traditional methadone and provide other medication treatments as well. Emphasis on Peers in MAT clinics is a focus of the SOR and STR grants, but funding for all MAT programs is limited and we have focused on using these funds at our primary care clinics. Our region has methadone clinics within our boundaries– Passion of Mind in Monroe; Ann Arbor Treatment Clinic in Western Washtenaw, and Therapeutics soon to open in Eastern Washtenaw. We also have Victory Clinic in Jackson serving Lenawee county clients and Therapeutics in Wixom, serving Livingston County.

Given the expanding opiate epidemic, we are proposing to offer funding for peer services specifically at these clinics using a staffing grant of $37,856 per program. This would cover a 1.0 FTE peer at $13.00/hour plus fringes (40% estimate). The peer must be trained and hold a CCAR certificate, MCBAP peer certification or MDHHS certified recovery coach credential. Additional training will be offered through the state on working with individuals receiving MAT services. The maximum investment would be $189,280.

Connection to PIHP/MDCH Contract, Regional Strategic Plan or Shared Governance Model:

Improving capacity for consumers in the region

Recommendation:

Approval of funding opportunity for peer services at designated MAT clinics.

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy* **Communicable Disease Policy**
Department: Substance Use Disorder Services **Author: Marci Scalera**	**Local Policy Number (if used)**
Oversight Policy Board Review/Approval: 3/28/2019 **Regional Operations Committee Approval Date 9/14/2016**	**Implementation Date 10/1/2016**

I. PURPOSE

This policy establishes the responsibilities of substance abuse providers in addressing communicable diseases in the populations being served within the Community Mental Health Partnership of Southeast Michigan (CMHPSM) jurisdiction. The policy recognizes the primary purpose of communicable disease efforts is to prevent the spread of infection among substance using populations. This policy requires that providers of services to individuals with substance use disorders have adequate training and resources to ensure proper screening and referral for persons with potential risk of having a communicable disease.

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
6/2010		Original document
2/2012	1.0	Language changes/updates
9/8/16	2.0	Language changes/updates
3/2019	3.0	Language changes/updates

III. APPLICATION

This policy applies to all CMHPSM network treatment providers of substance abuse and co-occurring disorders services.

IV. POLICY

This policy establishes that all individuals with substance use disorders at risk for and/or living with Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted diseases (STDs), tuberculosis (TB), Hepatitis C (HEP C) and other communicable disease will have the opportunity for access to culturally sensitive and appropriate substance abuse prevention and treatment services to address their multiple needs in a respectful and dignified manner

Given the causal relationship between HIV/AIDS, hepatitis, other communicable diseases (CDs), substance abuse and the importance of recognizing the role of CD assessment in the development of substance abuse treatment plans for individuals, a comprehensive approach is the most effective strategy for preventing infections in the drug using populations and their communities.

The CMHPSM must assure persons with substance use disorders (SUDs) who are at-risk for and/or living with HIV/AIDS, sexually transmitted diseases/infections (STD/Is), tuberculosis (TB), hepatitis C (Hep C) or other CDs have access to culturally sensitive and appropriate substance abuse prevention and treatment to address their multiple needs in a respectful and dignified manner.

V. DEFINITIONS

High Risk Population: Communicable disease priority populations include all clients with a history of IDU and pregnant women presenting for treatment. Additionally, women, African Americans, and other communities of color are considered high risk.

VI. RESPONSIBILITIES

The CMHPSM is responsible for the monitoring and oversight of the contracted substance abuse provider network in assessing for communicable diseases and referring their clients for testing and treatment where appropriate.

The substance abuse provider network is responsible for meeting or exceeding the standards set forth by the CMHPSM in the assessment of communicable diseases and referral for appropriate testing and treatment, and for ensuring that all substance abuse staff is properly trained in communicable diseases. Documentation of training and required updates are the responsibility of the provider and must be available upon request.

VII. STANDARDS

This policy establishes the standards that licensed substance abuse provider staff have a basic knowledge of HIV/AIDS, TB, hepatitis, STDs and their relationship to substance abuse.

Level 1 requirement - At a minimum, **all** substance abuse program staff should have basic knowledge regarding communicable diseases, including:

- HIV/AIDS, TB, Hepatitis (especially A, B, and C) and STDs as they related to the agency target population;
- Modes of transmission (risk factors, myths and facts, etc.);
- Linkage between substance abuse and these communicable diseases;
- Overview of treatment possibilities; and
- Local resources available for further information / screening.

Level 1 requirement may be adequately covered in a two-hour session, with update trainings every two years, and may be provided by agency staff that has completed Level 2 training.

Level 1 training is available electronically at https://www.improvingmipractices.org/ located in the SUD training section.

Level 2 requirements – All clinicians serving clients in a treatment setting may have an expanded level of training on HIV/AIDS, TB, Hepatitis and STD.

The Level 2 training requirements could be adequately covered in a three-hour session, with two-hour update trainings every two years. This level of training would require a

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Deleted: <#>Expanded basics of HIV/AIDS, TB, and Hepatitis C:¶
<#>Statistics (statewide and local geographic area, modes of transmission, how to interpret).¶
<#>HIV/AIDS, TB and Hepatitis C (what they are, cause, definition, types).¶
<#>Stages/phases of HIVIAIDS and Hepatitis infection (immune response and viral load, impact on other body organs, co-factors, signs and symptoms of related disease, including those specific to women and children, related infections and cancers).¶
<#>Factors for assessing risk and willingness and/or ability for client behavior change (ways to eliminate/reduce risk; infection control).¶
¶
<#>Treatment options/possibilities (anti-retroviral, prophylaxis, anti-invectives, immune modulators, clinical trials, nutrition, complementary/alternative treatments, impact of substance use on medication/treatment effectiveness).¶
¶
<#>Testing:¶
<#>HIV Antibody testing (philosophy, goals, legal requirements, benefits/ risks, types (i.e. serum, OraSure), laboratory tests used, limitations, overview of testing processes).¶
<#>Hepatitis testing and vaccines.¶
<#>TB testing and treatment.¶
<#>Options for STD screening/testing.¶
¶
<#>Overview of psychosocial Issues:¶
<#>Psychosocial Framework (issues for people with HIV/AIDS).¶
<#>Overview of Psychological Issues (social isolation, alteration in quality of life, self-esteem, intensity of emotion, control, denial, financial and employment issues).¶
¶
<#>Professional Challenges (discussion on what some key issues may be for clinicians in a substance abuse treatment program, conceptions, attitudes/values, etc.).¶
¶
<#>Confidentiality, especially for HIV/AIDS (felony, partner notification, testing, reporting, ADA, HIPPA).¶
¶
<#>Resources (local, state, federal).¶

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more advanced level of expertise for the trainer, which could be achieved through the MDHHS, HAPIS, and HIV Specialist training certification process. Providers requesting level 2 training must contact CMHPSM for assistance. Services:

1. All persons receiving SUD services who are infected by mycobacterium tuberculosis must be referred for appropriate medical evaluation and treatment. The CMHPSMs responsibility extends to ensuring that the agency to which the client is referred to, has the capacity to provide these medical services or to make these services available, based on the individual's ability to pay. If no such agency can be identified locally (within reasonable distance), the CMHPSM must notify MDHHS/OROSC.

2. All clients entering residential treatment and residential detoxification must be tested for TB upon admission. With respect to individuals who exhibit symptoms of active TB, policies and procedures must be in place to avoid a potential spread of the disease. These policies and procedures must be consistent with the Centers for Disease Control (CDC) guidelines and/or communicable disease best practice.
3. All pregnant women presenting for treatment must have access to STD and HIV testing.
4. Each provider is required to assure that all SUD clients entering treatment have been appropriately screened for risk of HIV/AIDS, STD/Is, TB and hepatitis, and that they are provided basic information about risk.
5. For those individuals entering SUD treatment identified with high-risk behaviors, additional information about the resources available, and referral to testing and treatment must be made available.

Financial and Reporting Requirements:
For the required services set forth in policy set forth by MDHHS/OROSC, there are no separate financial or reporting requirements.

If a CMHPSM chooses to utilize state funds to provide communicable disease services beyond the scope of this policy:

1. The CMHPSM designated provider must ensure that individuals are persons with SUD
2. The Communicable Disease Provider Information Plan must be completed within at the beginning of each fiscal year in conjunction with the CMHPSM Action Plan submission where applicable.
3. The Communicable Disease Provider Information Report must be completed within sixty (60) days following the end of a fiscal year and submitted to MDHHS.
4. The CMHPSM designated provider must submit data to the HIV Event System (HES) for Health Education/Risk Reduction Informational Sessions and Single Session Skills Building Workgroups, as well as HIV Counseling, Testing and Referral Services (CTRS), consistent with MDHHS HIV/AIDS Prevention and Intervention Section (HAPIS) data collection methods.

VIII. EXHIBITS

None

IX. REFERENCES

Deleted: Targeted and focused training on one or two specific topics from the above list may be appropriate based on need identified within a region or specific agency, once basic level of training has been achieved.

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Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)		
45 CFR Parts 160 & 164 (HIPAA)	X	
42 CFR Part 2 (Substance Abuse)	X	
Michigan Mental Health Code Act 258 of 1974		
The Joint Commission - Behavioral Health Standards		
Michigan Department of Community Health (MDHHS) Medicaid Contract	X	
MDHHS Substance Abuse Contract	X	
Michigan Medicaid Provider Manual	X	
PIHP Policy Review Schedule		
Policy Tracking Form		

Center for Substance Abuse Treatment. (Reprinted 2000). *Substance Abuse Treatment for Persons with HIV/AIDS,* Treatment Improvement Protocol (TIP) Series 37. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Rockville, MD.

Center for Substance Abuse Treatment. (Reprinted 1995). *Screening for Infectious Disease Among Substance Abusers*, Treatment Improvement Protocol (TIP) Series 6, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Rockville, MD.

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy* **Outpatient Treatment and Recovery Continuum of Services**
Department: Substance Use Disorder Services **Author: Marci Scalera**	**Local Policy Number (if used)**
Oversight Policy Board Approval 3/28/2019 **Regional Operations Committee Approval Date 9/14/2016**	**Implementation Date 10/1/2016**

I. PURPOSE

The purpose of this policy is to establish the requirements for outpatient and recovery services that endorse use of American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria and to ensure that services are individualized and culturally, age and gender appropriate.

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
March 2012	1	
8/30/16	2	Language updates
3/28/2019	3	Language updates

III. APPLICATION

This policy applies to all staff, students, volunteers, and contractual organizations receiving any funding directly or sub-contractually, within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

IV. DEFINITIONS

American Society of Addiction Medicine (ASAM): The national standard used for determining level of care needs for individuals with substance use disorders.

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Bundled Services: An approach to treatment that ties multiple covered services together and provides them in a single treatment setting. Specific activities are not differentiated in billing or reimbursement.

Counseling: An interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

Individual Counseling - face-to-face intervention for the purpose of goal setting and achievement, and skill building. This is distinct from treatment planning, as this may be goals and achievements identified in case management or through peer based services.

Individual Treatment Planning - direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed, and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires, and strengths of each client and be specific to the diagnostic impression and assessment.

Interactive Education (didactic): Refers to services that are designed or intended to teach information about addiction and/or recovery skills.

Medical Necessity: Treatment that is reasonable, necessary and appropriate based on individualized treatment planning and evidence-based clinical standards.

Psychotherapy (therapy): The assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio-psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals (from Social Work Administrative Rules).

Recovery: A voluntarily maintained lifestyle comprised of sobriety, personal health and socially responsible living.

Recovery Planning - purpose is to highlight and organize a person's goals, strengths, and capacities and to determine what barriers need to be removed or problems resolved to help a person achieve their goals. This should include an asset and strength-based assessment of the client.

Recovery Support and Preparation - services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

Substance Use Disorder: A term inclusive of substance abuse and dependence that also encompasses problematic use of substances that does not meet the criteria for substance abuse or dependence.

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Unbundled Services: An approach to treatment that seeks to provide the appropriate service or combination of specific services to match the needs of a client. Billing and reimbursement is specific to the service provided.

V. POLICY

This policy establishes that outpatient treatment and recovery services include a wide variety of covered services with the expectation that authorizations for these services are individualized to the needs of the client.

VI. STANDARDS

Throughout the outpatient LOC, assessment, treatment plan and recovery support preparations are required as they must be included in the authorized treatment services. As a client's needs change, the frequency and/or duration of services may be increased or decreased as medically necessary. The ASAM levels correspond with planned hours of services, in a group and/or individual setting during a week and as scheduled with the client.

Historically, services have been described as follows:

Outpatient- treatment that may be offered in a variety of settings, but often takes place in an office-type setting. Can include group and/or individual therapy services.

Intensive Outpatient- treatment that often takes place in an office-type setting, but can be offered in other settings, and consists of a minimum of nine hours, maximum of 19 hours of services per week. Services include individual, group and interactive education-(didactic) type services.

Enhanced Outpatient- similar to intensive outpatient service because it also offers expanded hours per week, but with a greater emphasis on individualized treatment to meet the client's needs.

Ambulatory Detoxification (Withdrawal Management) - detoxification that does not take place in a continuously monitored program/setting.

ASAM levels of care describe the need for treatment from the perspective of weekly service intensity based on the needs of the client. The identification of these needs is intended to drive service selection and authorization for care. The determination of service intensity, within outpatient services, is based on the client's ASAM LOC determination; not the designation of the provider program as being early intervention, outpatient, intensive outpatient, or partial hospitalization. For purposes of treatment episode data set (TEDS) admission reporting, LOC may be established on the basis of the authorization for service rather than service participation.

Requirements:
All CMHPSM providers (Core/general providers) must have the capacity to provide or refer to an outpatient continuum that will meet the needs of clients at all ASAM levels of intensity. Outpatient care is defined as treatment services that are provided in a setting that does not require the client to have an overnight stay at a facility as part of the treatment service but involves regularly scheduled sessions. Outpatient treatment is an organized, non-residential treatment service or an office practice with clinicians educated/trained in providing professionally directed alcohol and other drug treatment. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week, but

Deleted: Throughout the outpatient level of care (LOC), assessment, treatment plan and recovery, support preparations are required as they must be included in the authorized treatment services. As a client's needs change, the frequency and/or duration of services may be increased or decreased as medically necessary. The ASAM levels correspond with planned hours of services, in a group and/or individual setting during a week and as scheduled with the client.

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ASAM Level 0.5 Early Intervention – These services are not differentiated by the number of hours received during a week. The amount and type of services provided are based on individual needs including consideration of both the client's motivation to change and other risk factors that may be present.¶
¶
ASAM Level I.0 Outpatient- Services are less than nine hours during a week.¶
¶
ASAM Level I-D Ambulatory Detoxification (Withdrawal Management) Without Extended On-Site Monitoring¶
– Services are not established by hours but are set up to effectively monitor/educate an individual going through the detoxification process. Medical monitoring is at a minimum.¶
¶
ASAM Level II.1 Intensive Outpatient – Services 9-19 hours in a week. The services are provided at least three days a week to fulfill the minimum nine-hour commitment.¶
¶
ASAM Level II-D Ambulatory Detoxification (Withdrawal Management) With Extended On-Site Monitoring- Services are not established by hours but must be sufficient to effectively monitor/educate an individual going through the detoxification process. Medical monitoring is more routine to determine impact of withdrawal.¶
¶
ASAM Level II.5 Partial Hospitalization – Services that are provided 20 or more hours in a week. (Hospitalization is used as a descriptor by ASAM. It is not meant to indicate that the service must take place in a hospital setting.)¶

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when medically necessary can total over 20 hours in a week. The combination of days and hours and nature of services is based on the client's needs. A program director is responsible for the overall management of the clinical program and appropriate, credentialed and certified staff members provide treatment.

Treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include age, gender, culture and development. Authorization decisions regarding length of stay (including continued stay), change in LOC and discharge, must be based on the ASAM patient placement criteria. Client participation in referral and continuing care planning must occur prior to transfer or discharge.

ASAM Level 0.5 Early Intervention – These services are not differentiated by the number of hours received during a week. The amount and type of services provided are based on individual needs including consideration of both the client's motivation to change and other risk factors that may be present. This level of care is typically mandated through an impaired driving program that requires completion before reinstating driving privileges.

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Prior to admission, a diagnostic assessment should be performed in conjunction with a comprehensive multidimensional assessment to determine whether the person meets the admission criteria for Level 0.5, which requires that the person does not meet the requirements for a substance use disorder. If new information, through the reassessment process indicates substance use disorder, and the person needs treatment, there are three options. Transfer individual to a clinically appropriate level of care, facilitate treatment at required 0.5 Level of care, or transfer them to the appropriate level of care as soon as 0.5 Level is completed.

Length of service at this level depends on an individual's ability to comprehend the information they are provided and use the information to make behavior changes, if the person acquires new problems and needs additional treatment, or regulatory mandated service.

Staff Requirements
This level of care requires staff that are trained professionally and know about the biopsychosocial dimensions of substance use and addictive disorders. They should be able to recognize addictive and substance-related disorders, know about alcohol, tobacco and other drug education, as well as motivational counseling. In addition, these professionals should have knowledge of adolescent development, the legal and personal consequences of high-risk substance use and addictive behavior. Physicians may be directly involved in Screening and Brief Intervention activities with a person with high-risk drinking, drugging, non-medical use of prescription drugs and high-risk addictive behaviors. Addiction specialist physicians are not involved with this process, but are influential in clinical teams and design and oversee SBIRT activities carried out by other staff. Certified or licensed staff in addiction counseling may be involved with screening and especially brief intervention activities, but this will often fall on generalist health care professionals. Educational programs designed to reduce or eliminate at-risk substance use are generally staffed by certified and/or licensed addiction counselors, social workers, or health educators and not by physicians.

Interventions at this level may involve individual, group, or family counseling, SBIRT

services as well as planned educational experiences focused on helping the individual recognize and avoid harmful or high-risk substance use and/or addictive behavior.

ASAM Level 1 Outpatient –This level encompasses organized outpatient treatment services that can be delivered in a wide variety of settings. Addiction, mental health treatment or general health care personnel, provide professionally directed screening, evaluation, treatment and ongoing recovery and disease management services. These services are less than nine hours during a week. These services are catered to each patient's level of clinical severity and function and are designed to help the patient achieve changes in drug/alcohol use. Treatment must address major lifestyle changes such as attitudinal and behavioral issues that have the potential to undermine the goals of treatment or to impair the individual's ability to cope with major life tasks with the use of addictive substances.

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These services promote greater access to care for individual's not interested in recovery who are mandated into treatment or those who previously only had access to care if they agreed to intensive periods of primary treatment; patients with co-occurring substance use and physical and mental health conditions; individuals in early stages of readiness to change; patients in early recovery who need education about addiction and person-centered treatment; and patients in ongoing recovery who need monitoring and continuing disease management.

Support Systems
This level of care is appropriate for the initial level of care for a patient whose severity of illness and level of function warrants this intensity of treatment. This patient should be able to complete professionally directed addiction and/or mental health treatment at this level using only one level of care unless there is an unanticipated event that causes change in his/her level of functioning; there is recurring evidence of patient's inability to use this level of care; this level represents a "step down" from a more intensive level of care for a patient whose progress warrants transfer; this level can be used for a patient who is in the early stages of change and who is not yet ready to commit to a full recovery; may be used for patients as a direct admission if their co-occurring condition is stable and monitored whether or not they have responded to more intensive services; or for patients that have achieved stability in recovery so this level is used for ongoing monitoring and disease management.

Staff Requirements
This level programming should be staffed by staff that are trained professionally and know about the biopsychosocial dimensions of substance use and addictive disorders. They should be able to recognize addictive and substance-related disorders, know about alcohol, tobacco and other drug education. These staff should be capable of monitoring stabilized mental health problems and recognizing any instability of patients with co-occurring mental health conditions. This level of care is similar to Level 0.5, but staff are trained in medication management services and require the involvement of licensed independent practitioner with prescribing authority as granted by state-based professional licensing boards. Physicians and physician assistants are the common prescribers, but office-based nurses often are involved with medication management in support of physicians. When cooccurring mental health or general medical conditions are present, assessment services for both diagnostic and treatment planning purposes may require the most highly skilled clinician available or require collaboration from credentialed or licensed mental health or addiction professionals.

ASAM Level 2.1 Intensive Outpatient – Services 9-19 hours in a week consisting primarily of counseling and education about addiction-related and mental health problems. Patient's needs for psychiatric and medical services are addressed through consultation and referral arrangements if patient is stable and only requires maintenance monitoring. The services are provided at least three days a week to fulfill the minimum nine-hour commitment. If a patient requires less than nine hours per week, use this as a transition step down in intensity to be considered as a continuation of the IOP program for one or two weeks. This program differs from partial hospitalization programs and the intensity of clinical services that are available. Most intensive outpatient programs have less capacity to treat patients who have substantial unstable medical and psychiatric problems than do partial hospitalization programs.

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Support Systems
Necessary support systems in this level include medical psychological, laboratory, and toxicology services that are available through consultation or referral. Emergency services should also be available by telephone 24-hours a day, seven days a week when treatment program is not in session. These services should also have direct affiliation with more and less intensive levels of care and supportive housing services.

Staff Requirements
Co-occurring enhanced programs should be staffed by appropriately credentialed mental health professionals who assess and treat co-occurring mental disorders. Clinical leadership and oversight may be offered by an addiction specialist physician. If not, capacity to consult with addiction psychiatrist should be available. These programs are designed for people with co-occurring disorders to tolerate and benefit from the services offered.

Overall, these programs should be staffed by an interdisciplinary team of appropriately credentialed addiction treatment professionals, including counselors, psychologists, social workers, and addiction credentialed physicians who can assess and treat substance use and other disorders. Physicians should have specialty training and/or experience in in addiction medicine or addiction psychiatry. Staff should be able to obtain and interpret information regarding the patient's biopsychosocial needs. Generalist physicians may be involved in providing general medical evaluations and concurrent/integrated general medical care. Some, if not all program staff should have sufficient cross-training to understand the signs and symptoms of mental disorders and to understand and be able to explain the uses of psychotropic medications and their interactions with substance use and other addictive disorders.

ASAM Level 2.5 Partial Hospitalization – Services that are provided 20 or more hours in a week. (Hospitalization is used as a descriptor by ASAM. It is not meant to indicate that the service must take place in a hospital setting.) These partial hospitalization services typically have direct access to psychiatric, medical, and laboratory services and are better able to meet needs in Dimensions 1, 2, and 3, which warrant daily monitoring or management, but which can be appropriately addressed in a structured outpatient setting. Patients who would otherwise be placed in Level 2.1 program may be considered for placement in this level if the patient resides in a facility that provides 24-hour support and structure and that limits access to alcohol and other drugs. (Such as a correctional facility or other licensed health care facility or supervised living situation.)

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Support Systems

Necessary support systems include medical, psychological, psychiatric, laboratory, and toxicology services that are available within 8 hours by telephone and within 48 hours in person. They should also include emergency services, which are available by telephone 24 hours a day, 7 days a week when treatment program is not in session. They should also have direct affiliation with more and less intensive levels of care and supportive housing services. Co-occurring enhanced programs offer psychiatric services appropriate to the patient's mental health condition. Such services should be available by telephone and on site, or closely coordinated off site, within a shorter time than in a co-occurring capable program. Clinical leadership and oversight may be offered by a certified addiction medicine physician with at least the capacity to consult with an addiction psychiatrist.

Staff Requirements
These programs should be staffed by an interdisciplinary team of appropriately credentialed addiction treatment professionals, including counselors, psychologists, social workers, and addiction credentialed physicians who can assess and treat substance use and other disorders. Physicians should have specialty training and/or experience in in addiction medicine or addiction psychiatry. Staff should be able to obtain and interpret information regarding the patient's biopsychosocial needs. These staff should also have sufficient cross-training to understand the signs and symptoms of mental disorders and to understand and be able to explain the uses of psychotropic medications and their interactions with substance use disorders. In addition, clinical leadership and oversight may be offered by a certified and/or licensed addiction psychiatrist. These programs also provide ongoing intensive case management for highly crisis-prone patients with co-occurring disorders. Such case management is delivered by cross-trained, interdisciplinary staff through mobile outreach, and involves engagement-oriented addiction treatment and psychiatric programming.

Adult Dimensional Admission Criteria
Dimension 1: Acute intoxication and/or withdrawal potential
See separate withdrawal management for how to approach unbundled withdrawal management for adults

Dimension 2: Biomedical Conditions and Complications
Individual's biomedical conditions are stable or are being actively addressed and will not interfere with therapeutic interventions

Dimension 3: Emotional, behavioral, or cognitive conditions and complications
Individual's emotional, behavioral, or cognitive conditions and complications are being addressed through appropriate mental health services and will not interfere with interventions

Dimension 4: Readiness to change Individual expresses willingness to gain understanding of current addictive behavior Dimension 5: Continued Problem Potential Individual does not understand the need to alter current behavior or needs to acquire specific skills needed to change current pattern of use/behavior Dimension 6: Living Environment Individual's social support system composed primarily of persons who substance use prevent them from meeting obligations, their family members are currently using, significant other expresses value of substances that counter individual's progress, or significant other encourages or condones addictive behavior

Dimension 5: Continued Problem Potential Individual does not understand the need to alter

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current behavior or needs to acquire specific skills needed to change current pattern of use/behavior

Dimension 6: Living Environment Individual's social support system composed primarily of persons who substance use prevent them from meeting obligations, their family members are currently using, significant other expresses value of substances that counter individual's progress, or significant other encourages or condones addictive behavior

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Covered Services

Moved (insertion) [1]

The following services can be provided in the outpatient setting:

Individual Assessment- A face-to-face service for the purpose of identifying functional and treatment needs; and, to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

Individual Treatment Planning- Refers to the direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client and be specific to the diagnostic impression and assessment.

Individual Therapy- Face-to-face interventions with the client.

Group Therapy- Face-to-face interventions with three or more clients, which includes therapeutic interventions/counseling.

Counseling- Face-to-face intervention (by non-professional staff) with a client, for the purpose of goal setting and achievement and skill building.

Interactive Education (didactic) Groups- Activities that center on teaching skills to clients and are necessary to support recovery. These groups can be led by non-masters prepared staff.

Family Therapy- Face-to-face interventions with the client and significant other and/or traditional or non-traditional family members. *Note: In these situations, the identified client need not be present for the intervention.*

Crisis Intervention- A service for the purpose of addressing problems/issues that may arise during treatment, which could result in the client requiring a higher LOC if intervention is not provided.

Referral/Linking/Coordinating of Services- Office-based service activity performed by the primary clinician *or case manager* to address needs identified through the assessment, and/or ensuring follow through with access to outside services, and/or to establish the client with another substance use disorder provider.

Recovery Support and Preparation – Services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

Compliance Monitoring- For the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program (i.e., onsite testing such as Preliminary Breath Tests (PBT's) or non-laboratory urinalysis).

Early Intervention-Treatment services for individuals with substance use disorders and/or individuals who may not meet the threshold of abuse or dependence but are experiencing functional/social impairment as a result of use. Services may be initiated at any stage of change but are expected to be stage-based.

Detoxification/Withdrawal Management Monitoring- For the purpose of preventing/alleviating medical complications related to no longer using or decreasing the use of a substance.

Substance Abuse Outpatient Program- Programs that are individualized and include assessment, treatment planning, stage-based interventions, referral linking and monitoring, recovery support preparation and treatment based on medical necessity. These may include individual, group
and family treatment. These services are billed under the "H" code sequence.

Note: The Substance Abuse Outpatient Program is the bundled outpatient category while the above are various optional services within outpatient programs.

Procedure:

Outpatient care may be provided only when the service meets all of the following criteria:

- Medical necessity;
- The current edition of the Diagnostic and Statistical Manual of Mental Disorders is used to determine an initial diagnostic impression of a substance use disorder, abuse or dependence (also known as provisional diagnosis) – the diagnostic impression must include all five axes;
- Is based on individualized determination of need; and,
- ASAM Patient Placement Criteria are used to determine substance use disorder treatment placement/admission and/or continued stay needs and are based on a LOC determination using the six assessment dimensions of the current ASAM Patient Placement Criteria below:

1) Withdrawal potential
2) Medical conditions and complications
3) Emotional, behavioral or cognitive conditions and complications
4) Readiness to change
5) Relapse, continued use or continued problem potential
6) Recovery/living environment

Moved up [2]: Core providers must have the capacity to provide or refer to an outpatient continuum that will meet the needs of clients at all ASAM levels of intensity. Outpatient care is defined as treatment services that are provided in a setting that does not require the client to have an overnight stay at a facility as part of the treatment service but involves regularly scheduled sessions. Outpatient treatment is an organized, non-residential treatment service or an office practice with clinicians educated/trained in providing professionally directed alcohol and other drug treatment. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week, but when medically necessary can total over 20 hours in a week. The combination of days and hours and nature of services is based on the client's needs. A program director is responsible for the overall management of the clinical program and appropriate, credentialed and certified staff members provide treatment.¶
¶
Treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include age, gender, culture and development. Authorization decisions regarding length of stay (including continued stay), change in LOC and discharge, must be based on the ASAM patient placement criteria. Client participation in referral and continuing care planning must occur prior to transfer or discharge.¶

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Outpatient treatment services are appropriate for those clients with minimal or manageable medical conditions; minimal or manageable withdrawal risks; emotional, behavioral and cognitive conditions that will not prevent the client from benefiting from this level of care; services must address treatment readiness; minimal or manageable relapse potential; and, a minimally to fully supportive recovery environment. Clients who continue to demonstrate a lack of benefit from outpatient services, whether they are actively or sporadically involved in their treatment, may be referred to the SUD Access Specialist for another level of care determination and discharged if the client is unwilling to accept other services appropriate to their level of care determination. Relapse alone is not sufficient justification to discharge a client from treatment, but it does indicate that a change in treatment services may be needed.

Admission Criteria

Outpatient services must be authorized based on the number of hours and/or types of services that are medically necessary. Re-authorization or continued treatment must take place when it has been demonstrated that the client is benefiting from treatment, but additional covered services are needed for the client to be able to sustain recovery independently.

The services provided in the outpatient setting can be provided through a bundled substance abuse outpatient program or in an unbundled manner. The PIHP may decide if services in their region will be bundled or unbundled. Regardless of how services are purchased by the PIHP, services must be based on the individual needs of the client and services must be individually tailored to the client's needs.

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Moved up [1]: Covered Services¶
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The following services can be provided in the outpatient setting:¶
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Individual Assessment- A face-to-face service for the purpose of identifying functional and treatment needs; and, to formulate the basis for the Individualized Treatment Plan to be implemented by the provider. ¶
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Individual Treatment Planning- Refers to the direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client and be specific to the diagnostic impression and assessment.¶
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Individual Therapy- Face-to-face interventions with the client.¶
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Group Therapy- Face-to-face interventions with three or more clients, which includes therapeutic interventions/counseling.¶
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Counseling- Face-to-face intervention (by non-professional staff) with a client, for the purpose of goal setting and achievement and skill building.¶
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Interactive Education (didactic) Groups- Activities that center on teaching skills to clients and are necessary to support recovery. These groups can be led by non-masters prepared staff.¶
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Family Therapy- Face-to-face interventions with the client and significant other and/or traditional or non-traditional family members. *Note: In these situations, the identified client need not be present for the intervention.*¶
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Crisis Intervention- A service for the purpose of addressing problems/issues that may arise during treatment, which could result in the

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VII. EXHIBITS
None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)	X	
45 CFR Parts 160 & 164 (HIPPA)	X	
42 CFR Part 2 (Substance Abuse)	X	
THE ASAM CRITERIA	X	
Michigan Mental Health Code Act 258 of 1974	X	
JCAHO- Behavioral Health Standards		
MDHHS Medicaid Contract	X	
	X	

Michigan Medicaid Provider Manual	X	
HITECH Act of 2009	X	

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