

ASAM

The ASAM is completed at time of assessment/intake/admission and then updated throughout the client's length of stay in treatment. The ASAM is a snap-shot in time of what is going on with the client at the present time.

ASAM — PPC2R			
Dimension	Level of Risk	Level of Care	Comments
1 - Acute Intoxication and/or Withdrawal Potential	<input type="text" value=""/>	<input type="text" value=""/>	
2 - Biomedical Conditions and Complications	<input type="text" value=""/>	<input type="text" value=""/>	
3 - Emotional, Behavioral, or Cognitive Conditions and Complications	<input type="text" value=""/>	<input type="text" value=""/>	
4 - Readiness to Change	<input type="text" value=""/>	<input type="text" value=""/>	
5 - Relapse, Continued Use, or Continued Problem Potential	<input type="text" value=""/>	<input type="text" value=""/>	
6 - Recovery / Living Environment	<input type="text" value=""/>	<input type="text" value=""/>	
Recommended Environment	<input type="text" value=""/>		Clinical Override <input type="text" value=""/>
Actual Environment	<input type="text" value=""/>		Comments

The first ASAM is completed at the time of the client's initial appointment with the agency. For outpatient clients this would be completed in the Placement Screening module of ISmart at the time of their assessment/intake. For Residential/Halfway House clients who are directly admitted to us from another facility this would be completed in the Admission module.

The Admission ASAM must be updated to show the existing status of the client. This pertains to clients with a recent assessment/intake done with our agency within the past 90 days. The ASAM screen in the Admission module is pulled forward from the Placement Screening module. You need to eliminate any inappropriate and/or unnecessary items in the comments boxes and adjust the level of risk/care as needed.

Once the client is admitted to treatment the ASAM needs to be updated again with in the time frame defined by licensure standards for the current level of care the client is in. This is done throughout their entire treatment episode.

IOP/Res/Day Tx	= every 7 Days
EOP/Hwh	=every 30 Days
Continuing Care	=every 90 Days

The first time the ASAM is updated after the client is admitted into treatment will be entered into a Misc. Note. See F-14 of the manual for more information on how to enter this note. This is usually posted around the same time the initial Treatment Plan is developed and entered into ISmart but it must be done at the established time frames whether or not the TP has been completed. The rest of the ASAMs can be updated utilizing the Treatment Review module of ISmart.

Explanation of ASAM fields

Dimension 1: indicate last date of use and if there is potential for withdrawals. (It would not be a zero if the client is using.)

Dimension 2: indicate if the client has physical health problems and if it could interfere with treatment. If the client is on meds due to health issues, list the med and the dosage. Note any physical health treatment the client is receiving.

Dimension 3: indicate if the client has emotional, behavioral or cognitive conditions. If the client is on meds due to a mental health issues, list the med and the dosage. Indicate any specific mental health diagnosis; note any current mental health treatment.

Dimension 4: indicate the stage of change we believe the client to be in at the time of assessment, admission, treatment reviews and discharge. (meaning this info is updated each time.)

Dimension 5: indicate if the client has potential for relapse or continued problem potential. This would be criminal behavior, co-dependency, etc.

Dimension 6: indicate the clients' recovery and living environment. Please explain their living environment and if it's supportive or not. If this is a self report then it must be supported by a collateral contact. List the client's employment status, peer groups, if attending meetings, does client has a sponsor, etc.

Recommended Environment:

Environment (level of care) the client was recommended for.

Actual Environment:

Environment the client is going to be admitted to (or if this is an admission this is the level they are admitted to.) This also needs to be the level of care the client agrees to participate in.

Clinical Override:

Use this box to explain why the Recommended and the Actual Environments are different, if they are not use 0-N/A. If they are different this needs to be explained in the Bottom Comments box.

0-N/A

1-Lack of insurance benefits

- 2-Managed care refusal
- 3-Clinical judgment
- 4-Patient opinion
- 5-Level of care not available
- 6-Legal issues
- 7-Other

Bottom Comments box of ASAM:

This box should be updated each time. Do not put your DAP note in this box. Each time the ASAM is updated this box should have unnecessary info deleted and the new info added. This is not copied pieces from the Notes box of the Placement Screening or TAP modules

Info to be included at the Eval or Direct Admit:

- Date of assessment or Direct Admit to Tx
- Info to support and assure that substance use and co-occurring issues (problem gambling, mental health, and physical health) were assessed.
- Was client referred to an outside agency for any concerns (i.e.- mental or physical health), was appointment scheduled, etc.
- Source of referral
- Lie/Bet info. If the client answered Yes you need to document your referral and if the client accepted it or not.
- Race/Gender the client describes themselves to be. (Client states they are....) We must document that we asked the client what race, gender and ethnicity group they belong to.
- Test Scores: document the tests results. (SASSI/DEF, AUP, MAST, DAST, etc.) This should be written in such a way that an outside person would be able to understand what you mean. I.e. "Client's score on the Michigan Alcoholism Screening Test is suggestive of an alcohol problem."
- Children's names, gender, race/ethnicity and age.
- If the client came to us from another Tx Agency then you need to record that you have accepted a referral from XX (giving the name of the agency), that you received assessment and ASAM info with the recommended environment and if you agree to that recommendation. If you do not agree then you need to explain why.
- Info to support level of care recommendation. This is your validation for the recommending environment.
- Explain why the recommended and actual environments are different (if applicable.) Example: explain that they are appropriate for IOP and that they are scheduled for IOP group on mm/dd/yyyy, but that client will be EOP until that date.
- Explain the disposition of the client. I.e. - client is going to Orientation group on mm/dd/yyyy, or client declined services, or

they are set up for an appointment with this counselor on this date, etc. Explain what is next for the client.

- Flood Affected. List if the client is Flood Affected or not. I.e. “Flood Affected=No” or “Flood Affected=Yes” (If yes please make sure the client has a flood affected program enrollment.)

Info to be included at time of Admission (not a direct Ad.):

Remember to get rid of the unnecessary info that pulled forward from the Placement Screening.

- Admission Date
- What has happened since the evaluation (i.e. - drug use, UA results, arrest, etc.)
- Is client still appropriate for the recommended level of care, what’s the plan of action for the client (groups, individual, etc.)
- Information to validate client’s level of care
- Update child info if applicable. (Leave in the information from the time of evaluation, but update if there are changes in the children.)
- Flood Affected. List if the client is Flood Affected or not. I.e. “Flood Affected=No” or “Flood Affected=Yes” (If yes please make sure the client has a flood affected program enrollment.)

Info to be included in Tx Review:

Remember to get rid of unnecessary info that is pulled forward from the previous ASAM.

- Information validating client’s current level or recommended level of care for clients transferring to a new level (i.e.-progress, lack of progress, usage, UA results, arrest, etc.)
- Update child info if applicable. (I.e. – if the female client was pregnant and had her baby during treatment we need to have the information added.)

Directions for printing an ASAM:

You have two options for printing the ASAM. If you have problems getting these to open call the IT Manager.

Using the Print View button-

This is the easiest and fastest way of printing an ASAM but it does not look very professional because it prints the navigation buttons along with the ASAM.

- At the ASAM screen click on the Print View button. This will open up another window with the ASAM in it.
- Click on File/Print.

Using the Print Report button-

Printing an ASAM this way does not print the navigation buttons. It will print a header and a footer which looks more professional.

- At the ASAM screen click on Print Report. This will open up the entire module in another window.
- Scroll down to the ASAM information.
- Highlight just the ASAM information
- From the toolbar choose File/Print and then in the Print box you need to select the radio button for Selection in the Page Range box.