COLORADO
Behavioral Health Administration

COLORADO
Department of Health Care Policy & Financing

2025

ASAM 3.5 Comprehensive Transition Planning Tool

PROVIDER AMBASSADOR PROGRAM

Updated May 2025

ASAM 3.5 Comprehensive Transition Planning Tool (Fourth Edition)

This self-assessment tool is designed to help agencies evaluate whether they are implementing comprehensive transition planning and closed-loop referral pathways in alignment with the ASAM Fourth Edition. ASAM emphasizes that discharge and transition planning should begin at admission and include coordination with medical, mental health, substance use, housing, and recovery support services. Closed-loop referrals require follow-up to confirm that services were not only referred but accessed and integrated into the individual's recovery plan.

Instructions: Review each statement below and rate your program's current level of implementation. Use the following scale:
1 = Not Yet Implemented
2 = Partially Implemented
3 = Fully Implemented

Self-Assessment Statement	Rating (1-3)	Evidence/Notes	Action Steps/Responsible Parties
Transition planning begins at the time of admission and is revisited throughout the course of care.			
Transition plans address the individual's substance use, mental health, medical,			

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Self-Assessment Statement	Rating (1-3)	Evidence/Notes	Action Steps/Responsible Parties
housing, employment, and social needs.			
Transition planning includes signed consent to share information to conduct transition activities, conduct warm hand-offs and follow-up after transition.			
The program uses person-centered practices to develop transition goals in collaboration with the individual.			
Referrals to external providers (e.g., outpatient SUD, mental health, primary care) are documented in the transition plan.			
Referral sources are contacted to confirm receipt of referral and			

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Self-Assessment Statement	Rating (1-3)	Evidence/Notes	Action Steps/Responsible Parties
willingness to accept the individual.			
The program follows up after transition to confirm that the individual accessed referred services.			
Personnel document attempts and outcomes of follow-up (e.g., contact logs, confirmed appointments, or missed connections).			
When referrals fall through, personnel engage in problem-solving with the individual to identify alternatives.			
The transition plan includes medications, dosage instructions, and arrangements for follow-up with prescribers.			

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Individuals are given copies of their transition plan and are supported in understanding it.			
Warm hand-offs (e.g., joint meetings or provider-to-provider communication) are used whenever possible.			
The agency tracks referral success rates and uses data to improve closed-loop coordination.			
Peer support or care coordination personnel assist with navigating transitions and accessing ongoing services.			
Personnel are trained in transition planning and closed-loop referral procedures.			

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Self-Assessment Statement	Rating (1-3)	Evidence/Notes	Action Steps/Responsible Parties
Transition planning incorporates culturally responsive supports.			
Transition planning incorporates and addresses barriers related to transportation, childcare, or other needs assessed as part of the social determinants of health (SDOH) assessment process.			