

The Role and Current Status of Patent Placement Criteria

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Chapter 2—The Role of PPC in a Managed Care Environment

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Concern about healthcare costs, coupled with the perception that much care is unnecessary or provided inefficiently, has given rise to new techniques for managing health benefits and holding clinicians accountable for services provided (Institute of Medicine, 1989). Using these techniques means that access to quality care must be carefully balanced with the demands of cost containment through a process known as managed care.

Initially, managed care was associated with medical treatment in the private sector. But with the push for national healthcare reform and the States' move toward providing managed care for patients receiving care in the public sector, the boundary between "public" and "private" healthcare is becoming blurred. The substance abuse field has not been exempt from having to adapt itself to managed care approaches now in place or being established in numerous States.

There is an urgent need for the addiction treatment field to "retool" by finding more efficient and cost-effective ways to provide care by protecting the quality of and access to addiction treatment, and by fully integrating research findings into practice.

The Transition to Cost-Conscious Treatment

Outside the United States, one finds a wide variety of treatment modalities, models, and settings. Within the U.S. (in the private-sector addiction treatment field), there has been just one major approach to treatment, based on the Alcoholics Anonymous 12-step philosophy and the fixed length of inpatient stay pioneered in Minnesota. This treatment approach, with its inpatient treatment philosophy (Institute of Medicine, 1990), has been more commonly used for treating alcohol and other drug abuse than any other approach. This is the treatment model that has been

used in a "one size fits all" approach for almost all patients who met the criteria for the treatment of alcohol or other drug addiction. The Minnesota model has been significantly revised since its development in the late 1940s and 1950s, and other models have come into existence to choose from. However, the Minnesota model has remained the dominant type of treatment (Institute of Medicine, 1990).

In the public sector, there has been a wider variety of models and settings covering both inpatient and outpatient programs. This variety arose from a multitude of perspectives, ideologies, and funding initiatives, rather than from a deliberate, cost-conscious systems development strategy.

Today, in the alcohol and other drug abuse treatment (AOD) field, there is a movement toward using a variety of treatment models to ensure access to quality treatment and conserve healthcare

resources. Now clinicians must focus on matching patients to appropriate, specific treatment, rather than on placing patients in established programs. The success of clinically driven treatment depends on the importance of an accurate diagnosis. However, it is not only a diagnosis of addiction, but also of the severity of addiction, that must determine the kind of treatment an individual patient should receive. This determination can result in: placement of patients in the correct level of care, movement to less intensive or more intensive levels when appropriate, and matching patients individually to a variety of treatment modalities at all levels of care.

Implicit in this scenario is the existence of many types of treatment programs, such as narcotic addiction treatment, and outpatient and residential settings within a community. Also implicit is the growth of a variety of treatment approaches creatively developed to address underserved populations and less than adequate outcomes. Uniform patient placement criteria (UPPC) can promote the comparison of research findings, just as common diagnostic criteria in the *Diagnostic and Statistical Manual* (DSM) have allowed for coherent research and new knowledge by providing common definitions of psychiatric diagnoses. UPPC need not stifle creativity. They can allow a common base and starting point on which to establish research, build, and improve.

Development of Patient Placement Criteria

Over the last 10 years, several important models of patient placement criteria have been developed. In 1981, the Minnesota legislature asked the commissioner of human services (under whom the State authority on alcohol and drug abuse is placed) to establish criteria for use in determining the appropriate level of chemical dependency care for public assistance recipients. These criteria were developed in 1985 by a 23-member advisory committee, and drafts were distributed throughout the treatment field for comment.

The addiction treatment field needs:

- **Uniform criteria to guide proper patient placement**
- **Practice guidelines to promote the establishment of effective individualized treatment modalities**
- **Outcomes data to continually improve both the criteria and the guidelines**

In 1986, two groups, the Northern Ohio Chemical Dependency Treatment Directors Association in Cleveland and the National Association of Addiction Treatment Providers (NAATP), worked on criteria, and their efforts resulted in the publication of criteria for a continuum of care that attracted national attention. In 1989, NAATP joined forces with the American Society of Addiction Medicine (ASAM). These organizations built criteria based on a review of the literature and on 2 years of work by two task forces, whose members included addiction treatment specialists such as counselors, psychologists, social workers, and physicians. These task forces integrated and revised the Cleveland Criteria of the Northern Ohio Chemical

Dependency Treatment Directors Association (Hoffmann et al., 1987) and the NAATP Criteria (Weedman, 1987). In the interests of the field, both organizations agreed to have their PPC superseded by the third national criteria document produced by ASAM.

Thus, in March 1991, the American Society of Addiction Medicine published *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders* (Hoffmann et al., 1991). These criteria for admission, continued stay, and discharge were described in terms of four levels of care, for both adults and adolescents. However, the ASAM criteria were not as applicable to publicly funded programs as to hospitals, practices of private practitioners, group practices, or other medical settings. Therefore, some States supplemented or adapted ASAM criteria. Massachusetts, for example, developed criteria for outpatient counseling, detoxification services, youth residential treatment, and methadone treatment, using the assessment dimensions, format, and structure of the ASAM criteria as a basis.

Some third-party payers and managed care organizations have developed their own sets of patient placement criteria. Until recently, these criteria were not readily available to treatment providers due to concerns that providers would slant patient information to achieve more favorable utilization management decisions. There has also been claim to the proprietary nature of the various sets of criteria. However, with increasing interest in the accreditation of managed care organizations, sets of patient placement criteria and guidelines are now more widely available.

Assessment Follows Theory

When almost everyone diagnosed with AOD abuse received the same course of treatment, there was little need for careful assessment. The course of treatment varied from program to program, depending on ideology and length of stay, but within the program there was little variation from patient to patient. "Assessment" was, in actuality, the paperwork necessary to minimally meet licensure and accreditation standards.

Attitudes about assessment across the country are important. What we believe about the causes and consequences of addiction shapes the assessment and, in turn, the treatment prescribed. The many beliefs about assessment must give way to a common standard. If the addiction field is to uniformly offer quality, accessible care at reasonable cost, some agreement must be reached among the various cognitive, theoretical, and geographic styles of assessment. The biopsychosocial definition of addiction provides a framework for making such agreement possible.

Biopsychosocial Perspective On Addiction

Donovan and Wallace have articulated a biopsychosocial model in addictive behaviors (Donovan, 1988; Wallace, 1990). Such a model helps in assessing the many clinical presentations in addiction treatment from biological, psychological, and social perspectives.

Understanding addiction as a biopsychosocial illness in its origins, expression, and treatment has four important results. Such an understanding:

1. Promotes the integration of different perspectives of the illness
2. Explains and preserves common clinical dimensions
3. Necessitates multidimensional assessment
4. Promotes effective matching of the patient with individually prescribed treatment.

Biopsychosocial Assessment

The biopsychosocial model as a broad, inclusive umbrella allows clinicians to focus on the assessment of overall clinical severity. As with the treatment of other disorders, the severity of the addiction should determine the type and intensity of treatment.

When a clinician tries to do meaningful assessment of clinical severity, there is not full agreement on the best methods for assessment. In the case of alcoholism, some researchers focus on "a) severity of current or cumulative consequences of drinking, b) level of alcohol consumption, c) severity of current or cumulative signs of alcohol dependence, or d) problem duration" (Miller and Hester, 1986).

The Addiction Severity Index (ASI) broadens severity assessment to patients using or abusing drugs other than alcohol and focuses on seven problem areas commonly found in addiction patients (McLellan et al., 1980). The ASI is not and was never intended to be a placement tool, but rather an instrument to measure severity of illness. The severity profile in the ASI is based on the numbers and types of problems the client has experienced in the last 30 days and in the past year.

The Recovery Attitude and Treatment Evaluator (RAATE) is an instrument for determining severity using multidimensional assessment focusing on five dimensions. The biopsychosocial severity profile produced is the result of clinical judgment based on history data and examination of current functioning (Mee-Lee, 1988). Since it measures severity at a cross-sectional point in time, the severity of illness will show change, sometimes within a day or two.

Gastfriend and associates (1994) have reviewed both the ASI and the RAATE in detail. They provided a comparative analysis that is oriented toward managed care and patient placement criteria.

The Minnesota criteria use a Level of Chemical Involvement Scale that puts clients in one of four levels of severity, ranging from Level 0, which describes clients who present for assessment but for whom chemical use is not currently a problem; up to Level 3, which represents the most severe level of chemical involvement. Placement is guided by the Level of Chemical Involvement in conjunction with a variety of behavioral and social factors such as legal or family problems.

The ASAM patient placement criteria focus on six dimensions to define biopsychosocial severity:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications

3. Emotional/behavioral conditions and complications
4. Treatment acceptance/resistance
5. Relapse potential
6. Recovery environment.

Criteria listed under these six dimensions help guide placement of the patient in one of four levels of care described below. This is the first step in matching patients to treatment.

Biopsychosocial Treatment and Matching

To achieve cost-conscious addiction treatment, the next step, after a unified model of addiction and assessment of severity is agreed upon, is to define the biopsychosocial treatment to match the patient's clinical severity. Biopsychosocial treatment of alcohol and other drug disorders depends on the availability of a comprehensive system of levels of care, a range of treatment modalities within those levels, and a continuum of care (Miller et al., 1984).

Patient placement criteria are a necessary but not sufficient determinant of patient-treatment matching. Once a patient is placed in an appropriate level of care, selection of the specific assessment-based modalities, eventually guided by empirically based practice guidelines, completes the individualized treatment match.

Levels of Care

Minnesota developed placement criteria for its continuum of care that ranges from primary residential treatment in a hospital or nonhospital setting to outpatient treatment, extended care, and halfway house settings. Patients are placed in a particular level of care as determined by their level of

chemical involvement and other criteria.

The report of the Institute of Medicine (IOM) defines four levels of care that constitute the continuum of care (Institute of Medicine, 1990):

1. Inpatient
2. Residential
3. Intermediate
4. Outpatient.

The ASAM patient placement criteria also describe four levels of care but they are more descriptive of the *intensity* of service provided.

While the ASAM criteria provide specific guidelines on the kinds of setting, services, staff, assessments, and documentation that pertain to each level of care, they contain no mandate on the location necessary for each level, for example, that Level III must be in a freestanding residential facility. Level III might well be provided in a hospital in conjunction with a Level IV program, allowing efficient flexible movement of patients through the continuum.

Modalities of Treatment

The range of treatment modalities depends on the variety of theoretical models integrated into the biopsychosocial model. The IOM report describes modalities as "the specific activities that are used to relieve symptoms or to induce behavior change." It also notes that "the content of treatment is usually referred to as the technique, method, procedure, or modality" (Institute of Medicine, 1990).

Biomedical modalities focus on improved detoxification regimens, anticraving medication, antagonist medication, methadone treatment, and psychopharmacological approaches.

Psychological treatment modalities range from addiction counseling to psychodynamic and cognitive-behavioral treatment modalities, including insight-oriented psychotherapy, aversion therapy, and behavioral self-control training.

Sociocultural treatment modalities include the community reinforcement approach, family therapy, therapeutic communities, vocational rehabilitation, various motivational techniques, culturally specific interventions, and contingency management. In fact, many modalities include more than one dimension such as social skills training, relapse prevention techniques, self- and mutual-help programs, 12-step programs, Rational Recovery, and chemical aversion therapy.

In the case of program-driven treatment, all or most patients receive the same service components, irrespective of individual needs. Using biopsychosocial assessment, the choice of treatment is more clinically driven. Thus, the use of PPC can make it possible to relate clinical determination of biopsychosocial clinical severity to intensities of service. Specific problems can be identified that require specific types of attention. Treatment planning can then be conducted, responding to the identified problems by selecting from a range of biopsychosocial treatment modalities. The appropriate intensity of services can be selected, with the result that the patient can be placed in the least intensive, safe level of care and specifically treated with strategies selected from a range of biopsychosocial treatment modalities.

The patient's response to treatment and treatment outcomes can then be monitored by assessing the changing biopsychosocial clinical severity for improvement or deterioration in any or all of the dimensions, especially the high-severity dimensions. Individualized treatment is the ongoing repetition of this cycle as the regularly assessed clinical severity is matched with the appropriate level of care and range of treatment modalities.

Asam Levels of Care

- **Level I: Outpatient treatment**
- **Level II: Intensive outpatient/partial hospitalization**
- **Level III: Medically monitored intensive inpatient treatment**
- **Level IV: Medically managed intensive inpatient treatment (Hoffman et al., 1991)**

Implications

The "retooling" of the addiction treatment system necessary to promote individualized treatment requires a shift that has broad implications for the AOD abuse treatment field, public- and private-sector programs, payment systems, clinicians, and patients. If this shift occurs successfully:

- The AOD treatment field will develop one uniform set of clinically based placement criteria.
- Public and private-sector programs will develop a single system of comprehensive care that can be matched with the placement criteria.
- Programs will expand their continuums of care to provide multiple levels of care with flexible lengths of stay.
- Payers will reimburse and fund all levels of care to allow patients to be placed in and move around among the most efficient and effective settings.
- Clinicians will become more skilled at comprehensive assessment and have a broader knowledge of placement criteria and treatment modalities for better patient-treatment matching.
- Patients will receive care that is not only more cost efficient, but more cost effective.
- 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.

Healthcare costs can no longer support inefficient care born out of programs with one level of care and one treatment protocol for all patients regardless of the clinical heterogeneity assessed, or too often, not assessed. Patients who present for treatment are becoming increasingly diverse. Many are polydrug users. Some have dual diagnoses (mental illness and substance abuse). As a group, they are young, with psychological and social impoverishment.

Increasingly, there is a greater gender and ethnic mix. Consequently, staff skills and treatment options must also become more diverse.

Summary

Within the managed care environment, as providers struggle with the pressures of cost containment, accountability, and documentation, it often seems there is little time to focus on the patient. Yet, if we are to protect access to quality care, managed care organizations and the treatment community must work together to make the transition to new cost-conscious systems of care that incorporate careful assessment and individualized treatment. Uniform patient placement criteria can play an important unifying role in this process.

Endnote

1. This chapter, initially written by David Mee-Lee, M.D., and revised for this TIP, describes the rationale and challenge of the transition to more cost-conscious systems of care.