# Using substance use disorder needs assessments for addiction treatment capacity and quality improvement

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# Today's Learning Objectives

- Describe the purpose of substance use disorder needs assessments
- Understand how needs assessment data can be used to help with capacity planning and quality improvement
- Understand the potential limitations of needs assessment data and how to address them

# Polling Question

Affiliation:

- Provider organization
- Managed care organization
- Government agency
- Other

# Overview of Substance Use Disorder Needs Assessments and Patient Placement Medical Necessity Criteria

# Substance use disorder (SUD) needs assessments have many goals in addition to helping determine appropriate level of care

- ✓ Diagnosis & treatment planning
- ✓ Therapeutic alliance & shared decision-making
- ✓ Documentation & communicating to other clinicians and providers
- ✓ Determine the most clinically appropriate level of care

# Brief history of the development of substance use disorder patient placement criteria.

# Substance Use Disorder Treatment in 1970s

Alcoholics and narcotics anonymous

Methadone Maintenance

Federal Block Grant Funding

Antabuse

# Substance Use Disorder Treatment in 1980s

Alcoholics and narcotics anonymous

Outpatient therapies

Methadone Maintenance

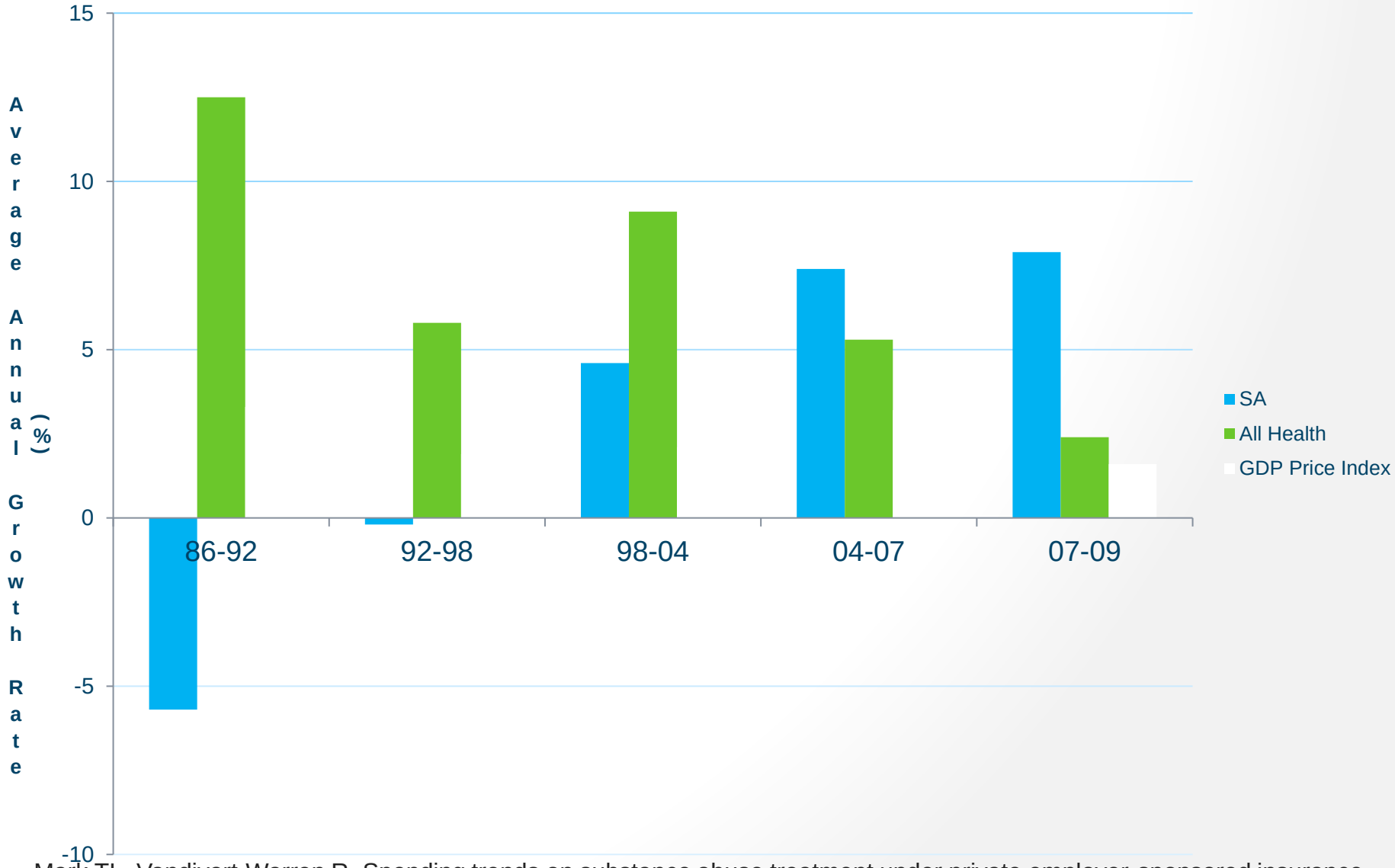
Antabuse

Residential rehabilitation centers

Private Insurance managed care

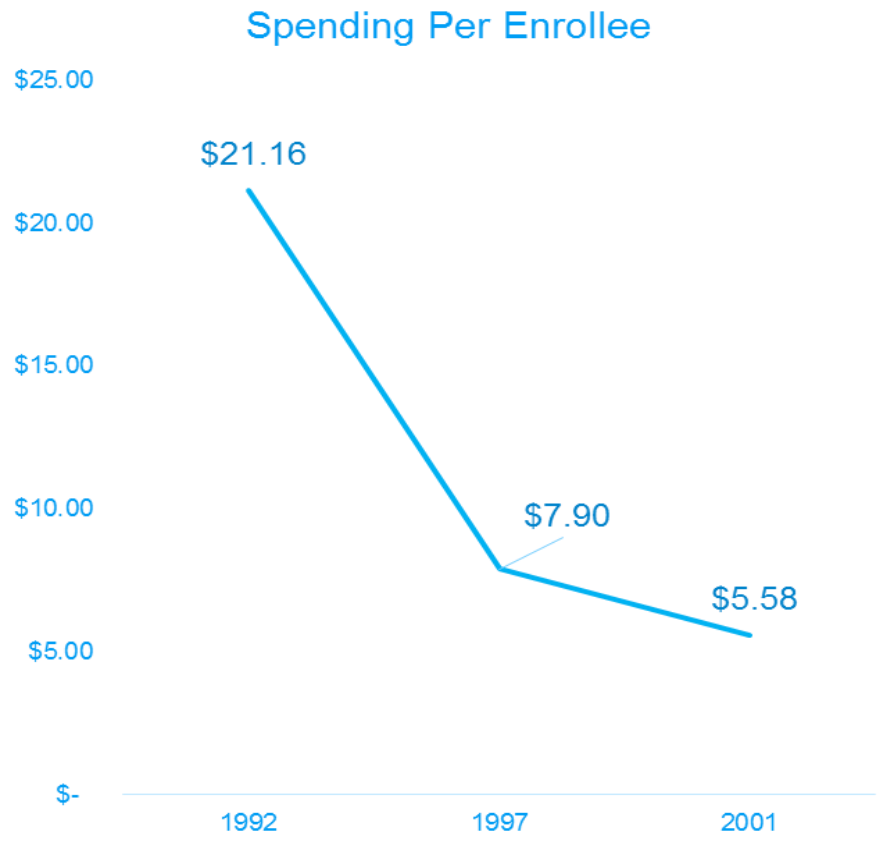
Federal block grants

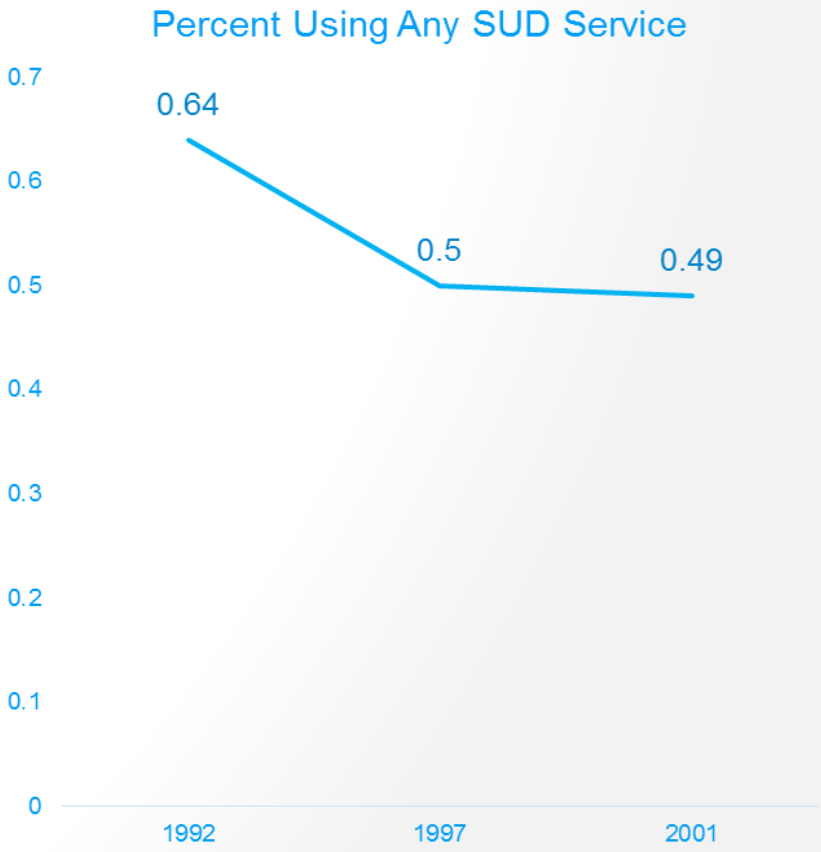
# Private insurance spending on substance abuse plunged from 1986 – 1992 as a result of MCO constraints on usage




Mark TL, Vandivort-Warren R. Spending trends on substance abuse treatment under private employer-sponsored insurance, 001-2009. Drug Alcohol Depend. 2012 Oct 1;125(3):203-7. doi: 10.1016/j.drugalcdep.2012.02.013.

# Percent Using Any SUD Services Declined As Well




Source: **Mark TL**, Coffey RM. Decline in receipt of substance abuse treatment by the privately insured, 1992-2001. *Health Affairs.* 2004 Nov-Dec;23(6):157-62

# Patients stuck between providers and MCOs

# AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM's Criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

## DIMENSION 1

**Acute Intoxication and/or Withdrawal Potential**

Exploring an individual's past and current experiences of substance use and withdrawal

## DIMENSION 2

**Biomedical Conditions and Complications**

Exploring an individual's health history and current physical health needs

## DIMENSION 3

**Emotional, Behavioral, or Cognitive Conditions and Complications**

Exploring an individual's mental health history and current cognitive and mental health needs

## DIMENSION 4

**Readiness to Change**

Exploring an individual's readiness for and interest in changing

## DIMENSION 5

**Relapse, Continued Use or Continued Problem Potential**

Exploring an individual's unique needs that influence their risk for relapse or continued use

## DIMENSION 6

**Recovering/Living Environment**

Exploring an individual's recovery or living situation, and the people and places that can support or hinder their recovery

# ASAM CONTINUUM OF CARE

## ADULT


.5 Early Intervention
1 Outpatient Services
2.1 Intensive Outpatient Services
2.5 Partial Hospitalization Services
3.1 Clinically Managed Low-Intensity Residential Services
3.3 Clinically Managed Population-Specific High-Intensity Residential Services
3.5 Clinically Managed High-Intensity Residential Services
3.7 Medically Monitored Intensive Inpatient Services
4 Medically Managed Intensive Inpatient Services

## ADOLESCENT


.5 Early Intervention
1 Outpatient Services
2.1 Intensive Outpatient Services
2.5 Partial Hospitalization Services
3.1 Clinically Managed Low-Intensity Residential Services
3.5 Clinically Managed Medium-Intensity Residential Services
3.7 Medically Monitored High-Intensity Inpatient Services
4 Medically Managed Intensive Inpatient Services

# Assessment → Level of Care Matching

## ASAM PLACEMENT CRITERIA

| LEVELS OF OF CARE CRITERIA | 1. OUTPT | 2. INTENSIVE OUTPT | 3. MED MON INPT | 4. MED MGD INPT |
|---|---|---|---|---|
| Intoxication/ Withdrawal | no risk | minimal | some risk medical | severe risk 24-hr acute |
| Medical Complications | no risk | manageable | monitoring required | med. care required |
| Psych/Behav Complications | no risk | mild severity | moderate | 24-hr psych. & addiction Tx required |
| Readiness For Change | cooperative | cooperative but requires structure | high resist., needs 24-hr motivating | |
| Relapse Potential | maintains abstinence | more symptoms, needs close monitoring | unable to control use in outpt care | |
| Recovery Environment | supportive | less support, w/ structure can cope | danger to recovery, logistical incapacity for outpt | |

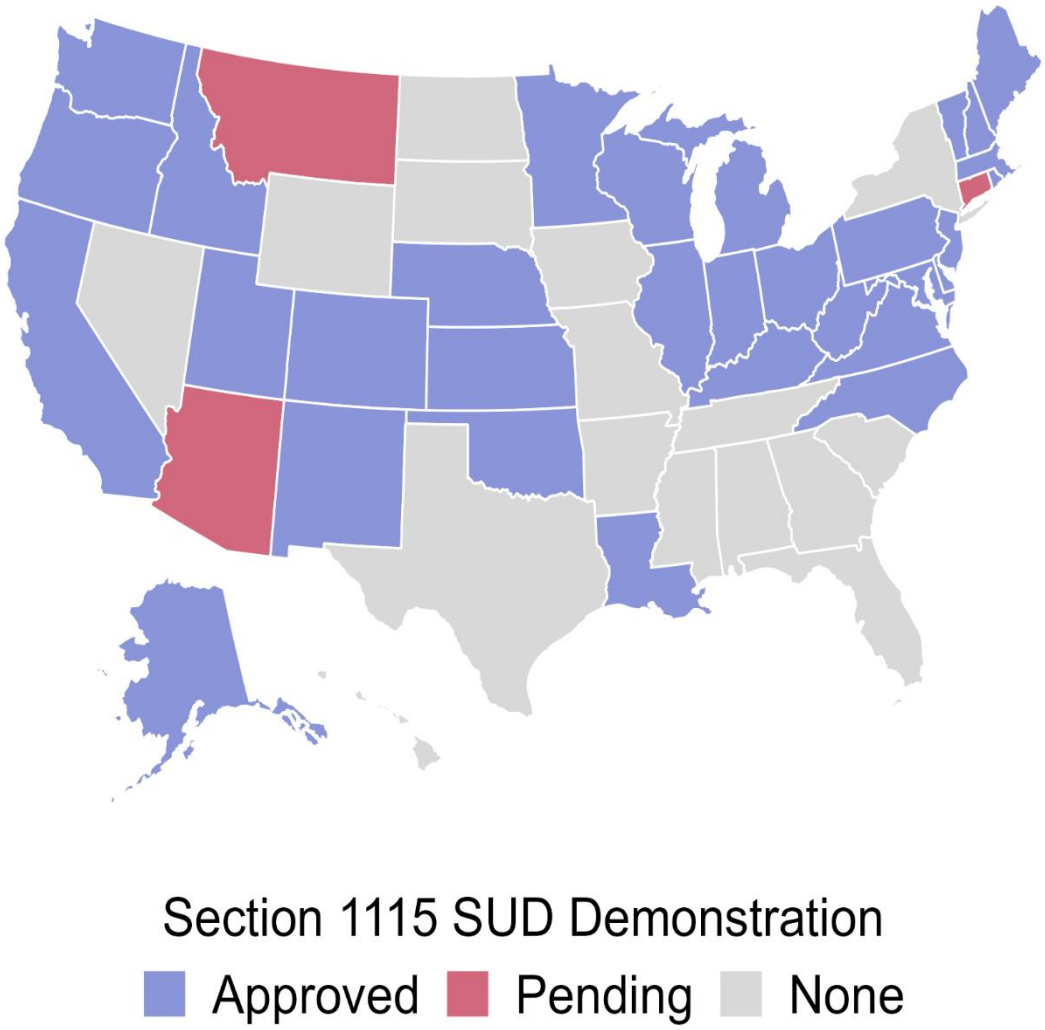
# Advantages ASAM Patient Placement Criteria

- Moves from program-driven, one-sized fits all approach focused on substance use to individualized treatment planning based on multidimensional assessment
- Educates patients, families, providers, judges, payers about addiction and treatment programs facilitating shared decision-making
- Gets payers and providers on the “same page”
- Helps ensure parity compliance

# Criteria have evolved and improved overtime

- Research demonstrates that LOC tools are reliable
- Research shows that LOC tools are valid (patients matched to correct level of care have better outcomes )
- Research shows that ASAM improves patient understanding of and agreement with LOC recommendations.
- Software and training to encourage fidelity
- Standards for level of cares

# Medicaid 1115 Demonstrations Accelerated Use of SUD Level of Care Criteria



# Questions/Comments

- Does this timeline align with your experience?
- Is my description of ASAM consistent with how it is being used in your organizations?

# Using Level of Care Assessment Data for Capacity Planning and Quality Improvement

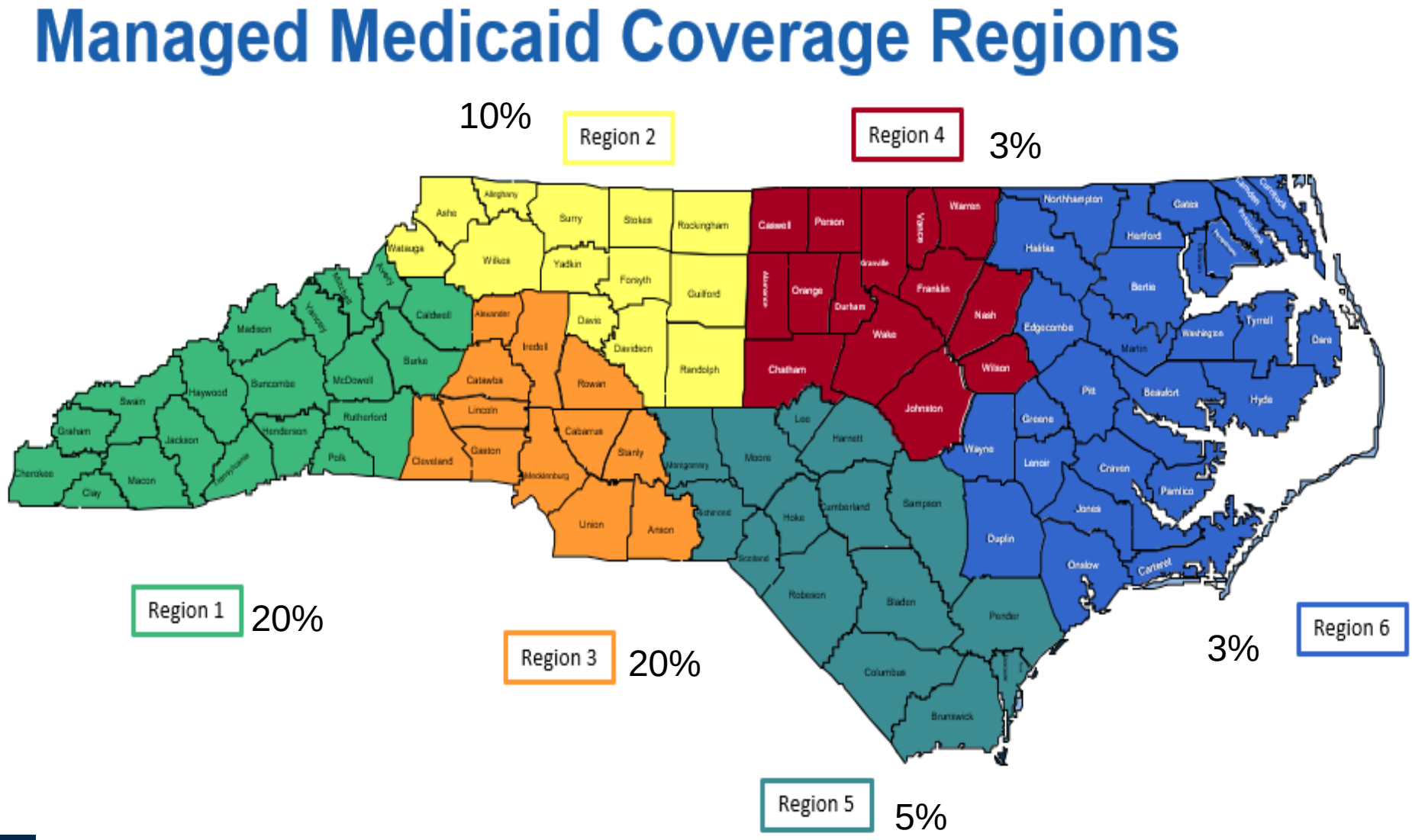
# Network Adequacy Toolkit

- Time and distance calculations
- Wait time
- Patient surveys
- Simulated shopper calls
- Level of care assessment data

# ASAM Data From California Counties

| | | |
|---|---|---|
| No Difference ASAM & Referral | 76% | 81,579 |
| Patient Preference | 7% | 7,361 |
| Clinical Judgment | 9% | 9,718 |
| LOC Not Available | 0.1% | 161 |
| Geographic Accessibility | 0.3% | 364 |
| Family Responsibility | 0.2% | 191 |
| Legal Issues | 1% | 1,229 |
| Lack of Insurance/Payment Source | 0.1% | 107 |
| Other | 6% | 6,609 |
| | 100% | 107,319 |

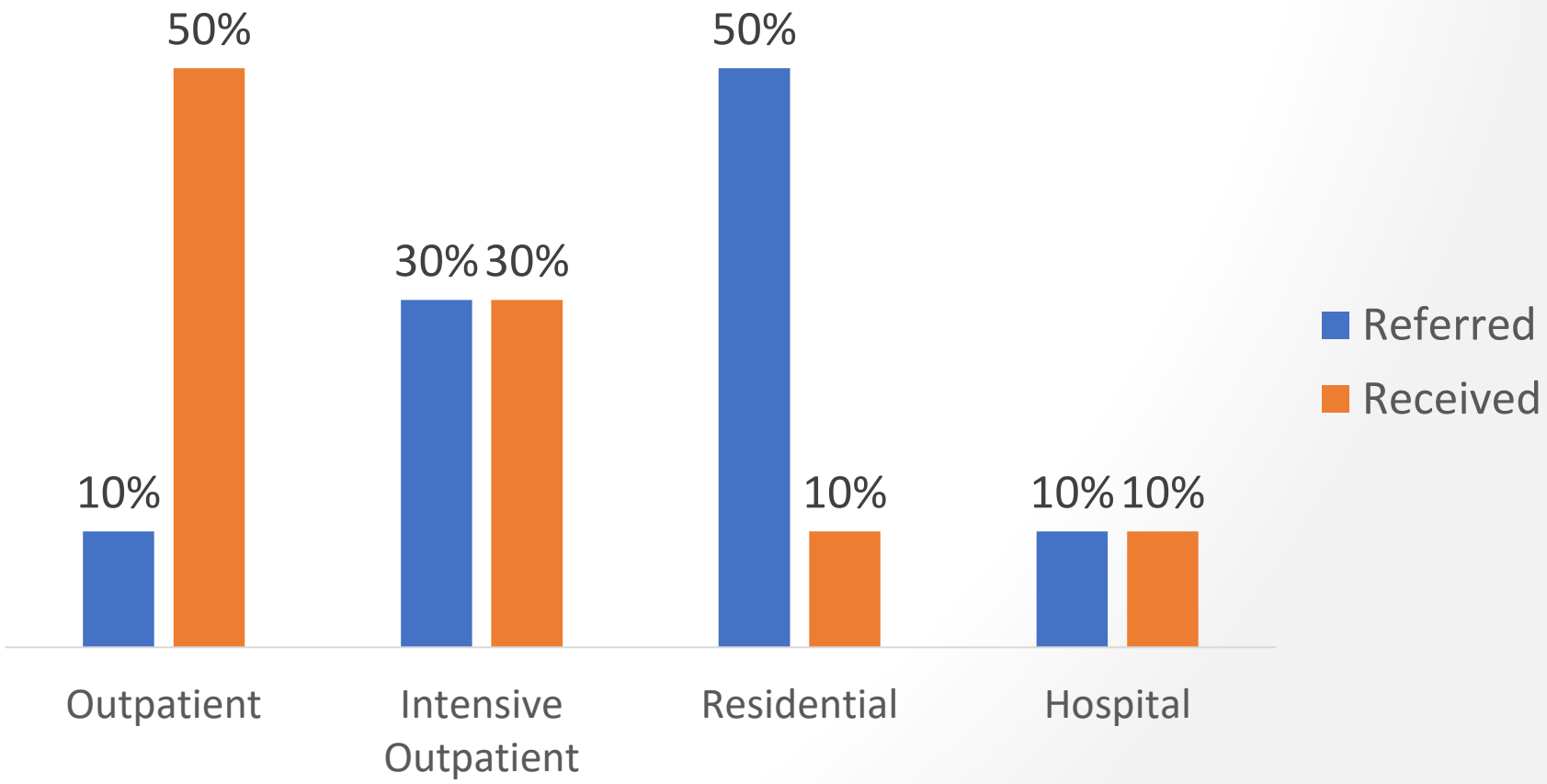
# Percent Reporting Care Not Available (Hypothetical Data)



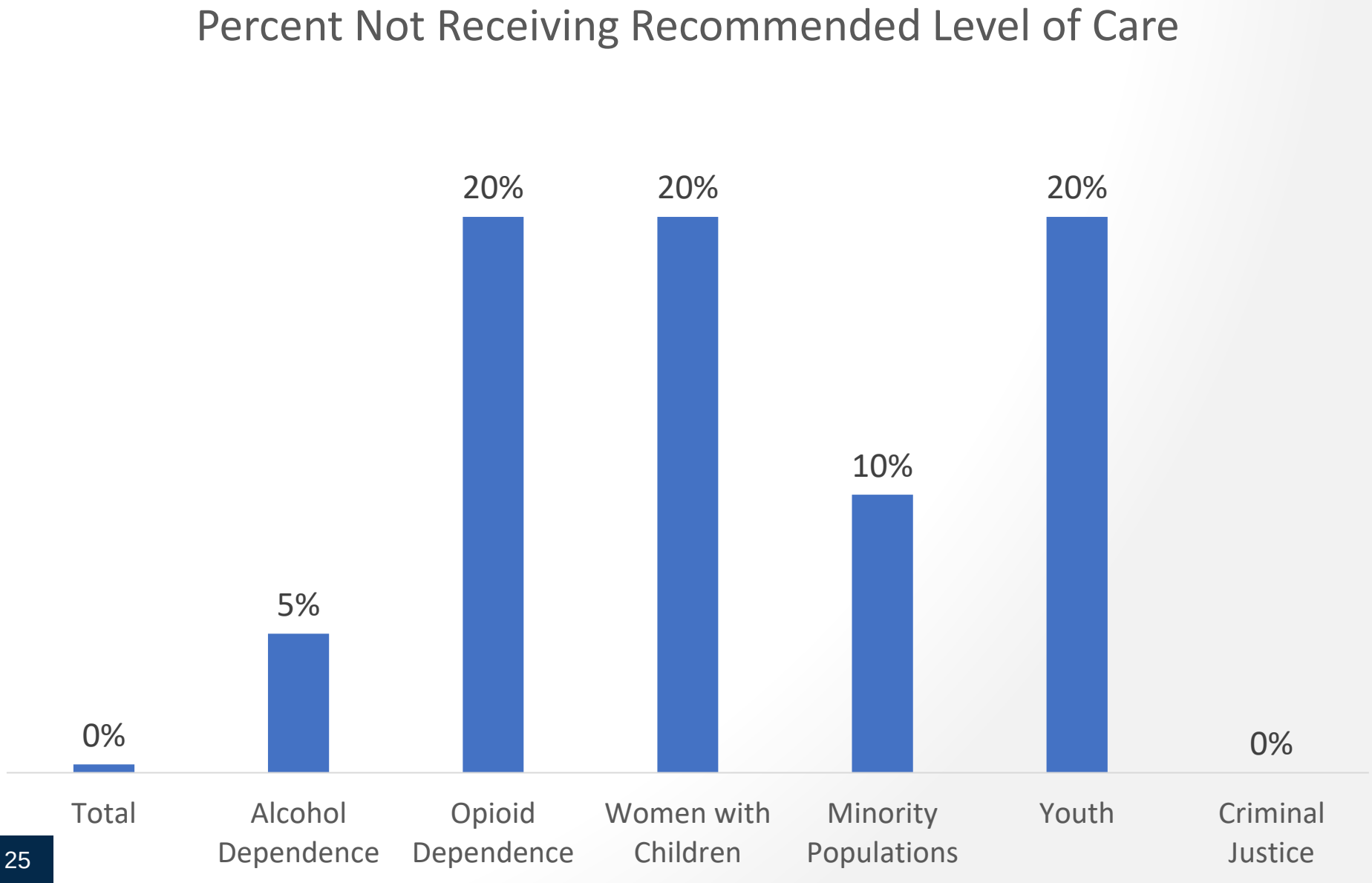
# Disagreement between Recommended and Referred by Patient Characteristics (Hypothetical Data)

| | | | Reasons for Difference | | |
|---|---|---|---|---|---|
| | | **Difference Recommended and Referred** | **Patient preference** | **Clinical judgement** | **Lack of Access** |
| **Age** | | | | | |
| | 18-24 | **30%** | 22% | **54%** | 30% |
| | 25-34 | 20% | 30% | 24% | 19% |
| | 35-44 | 10% | 12% | 4% | 21% |
| | 55-64 | 15% | 36% | 18% | 30% |
| **Gender** | | | | | |
| | Female | 20% | 74% | 66% | 5% |
| | Male | 40% | 26% | 34% | 95% |
| **Primary SUD** | | | | | |
| | Opioids | 20% | 4% | 35% | 22% |
| | Alcohol | 40% | 72% | 26% | 69% |
| | Cannabis | 10% | 24% | 39% | 9% |
| | Other | 5% | 10% | 15% | 12% |

# Differences between Referred and Received Level of Care (Hypothetical Data)



# Differences between Referred and Received by Clinical Characteristics (Hypothetical Data)



# Reasons for Clinical Judgment Over-ride

| Possible Reasons for Over-ride | Opportunities for Quality Improvement |
|---|---|
| LOC Decision Criteria/ Algorithm not "correct" for my client | Work with ASAM to change the algorithm |
| Referred to residential rather than outpatient because my client needs housing | Develop sober housing |
| Referred to outpatient rather than residential because residential programs have poor care transitions | |
| *Other ideas?* | |

- Other ideas: *Type in chat or raise hand and verbalize*

# Reasons for Client Preference Over-ride

| Possible Reasons for Over-ride | Opportunities for Quality Improvement |
|---|---|
| I can't go to residential because I don't childcare | Provide programs for mothers with their children. |
| I can't go to intensive outpatient because I can't miss work and the clinic is located too far away | Provide evening hours, telehealth counseling, transportation support |
| *Other Ideas?* | |

- Other ideas: *Type in chat or raise hand and verbalize*

# Reasons for MCO denial of ASAM recommended LOC

- Possible reasons
  - Did not go to a lower level of care first
  - Failed drug tests or dropped out of prior programs
  - Lack of clinician fidelity to criteria
  - Other: *Put in chat or raise hand and verbalize*
- Possible quality improvement opportunities

  - Other: *Put in chat or raise hand and verbalize*

# Benefits for ASAM Review for Parity Compliance

- Parity Compliance example from NY AG Decision

- Denied 47% of its members' claims for inpatient substance use versus than 18% of its members' inpatient medical/surgical claims during the same period.

- Adverse determination letters denying behavioral health claims are generic and lack specific detail about why coverage was denied for particular members. The letters also fail to explain adequately the medical necessity criteria used in making the determinations and why members failed to meet such criteria.

- **Remedy** – Use LOCADTR for determining medical necessity criteria.

# Example from New York

- When plan does not agree with the LOC based on the clinical assessment information, the plan can complete the LOCADTR tool separately, based on the clinical assessment information.
- ***It is expected that the plan will contact the provider to walk through the answers to the LOCADTR questions and determine the differences in how the assessment is being interpreted. Ideally, this will be a clinically- oriented conversation between the plan and provider and will result in a mutually agreed upon level of care.***

# Limitations for Level of Care Data

# Limitations and Trade-offs

- How much can clinicians influence the assessment?
- How much can clinicians influence the LOC algorithm/decision?
- Computerized versions are more standardized, but typically must be purchased from third party vendors.
- Longer assessments may be more accurate for LOC determination, but patient burden and intrusiveness may undermine therapeutic alliance and treatment effectiveness.
- Longer assessments are particularly problematic when patients are just entering treatment.
- LOC recommendations may change as patient develops trust with clinician and clinician learns more about the patient.
- *Other limitations or trade-offs that you have experienced?*

# Summary

- Patient placement criteria have helped improve SUD system
- SUD LOC data maybe a valuable resource for improving capacity and quality of treatment

# References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# Questions & Discussion

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