Improved outcomes, managed care reform and the unification of the field

The ASAM CRITERIA and Addiction Treatment Matching

David R. Gastfriend MD
Chief Architect, CONTINUUM™ – The ASAM Criteria Decision Engine
### Disclosure of Relevant Financial Relationships

<table>
<thead>
<tr>
<th>Name</th>
<th>Commercial Interests</th>
<th>Relevant Financial Relationships: What Was Received</th>
<th>Relevant Financial Relationships: For What Role</th>
<th>No Relevant Financial Relationships with Any Commercial Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Gastfriend</td>
<td>Recovery Search, Inc</td>
<td>Royalty</td>
<td>Pres. &amp; CEO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alkermes, Inc</td>
<td>Shareholder, Consultant</td>
<td>Former VP, Sci. Communications</td>
<td></td>
</tr>
</tbody>
</table>
Addiction assessment:  
A sorry state of affairs

- Non-standard, “intuitive”, then “find out the rest later…”
- Managed Care wants more data: Telephone tag (90 min – 3 days)
- Most insurers’ medical necessity criteria are Proprietary
- Absent precision & validity, emphasis is on cost, not quality
- 1991: ASAM Patient Placement Criteria…a teaching tool
- States create their own Criteria (CASAM, MASAM, NYSAM,…)
- “ASAM” in Major US MCO: ~50% of cases were denials
  - on appeal: ~50% reversed; on review ~50% reversed again!
- By 2000s, SAMHSA & CSAT called on ASAM for a standard
Advances in Treatment Matching

Modality Matching: many studies, e.g., Project MATCH – but few findings
(Gastfriend & McLellan, Med Clin NA, 1997)

Placement Matching: Multiple studies; ASAM model – consistent signals
(Gastfriend, Addiction Treatment Matching, Haworth Press, 2004)

Support:

- NIDA: Validation - R01-DA08781 & K24-DA00427
- NIAAA: PPC-2R Assessment Software - SBIR grant R44-AA12004
- CSAT: Access to Recovery Initiative - grant 270-02-7120
- Belgian National Fund for Scientific Research
- Belgian American Educational Foundation
- Central Norway Health Trust /Rusbehandling Midt-Norge
- SAMHSA: Open Behavioral Health IT Architecture Program
ASAM text: hundreds of decision rules
To place patients in the least intensive & restrictive care that meets the patient’s multi-dimensional needs and affords optimal treatment outcome

www.ASAMcriteria.org

www.haworthpress.com
ASAM Patient Placement Criteria

**Screening** → **Diagnosis** → **Severity** → **Readiness & Relapse Potential**

**Patient Placement Criteria**

**DIMENSIONS**

1. Intoxication Withdrawal
2. Biomedical
3. Emotional Behavioral
4. Treatment Acceptance/Resistance
5. Relapse Potential
6. Recovery Environment

**Decision Rules**

**LEVEL OF CARE**

1. Outpatient
2. Intensive Outpatient
3. Medically Monitored Intensive Inpatient
4. Medically Managed Intensive Inpatient
<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>1. OUTPT</th>
<th>2. INTENSIVE OUTPT</th>
<th>3. MED MON INPT</th>
<th>4. MED MGD INPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intoxication/Withdrawal</td>
<td>no risk</td>
<td>minimal</td>
<td>some risk medical</td>
<td>severe risk 24-hr acute</td>
</tr>
<tr>
<td>Medical Complications</td>
<td>no risk</td>
<td>manageable</td>
<td>monitoring required</td>
<td>med. care required</td>
</tr>
<tr>
<td>Psych/Behav Complications</td>
<td>no risk</td>
<td>mild severity</td>
<td>moderate</td>
<td>24-hr psych. &amp; addiction Tx required</td>
</tr>
<tr>
<td>Readiness For Change</td>
<td>cooperative but requires structure</td>
<td>high resist., needs 24-hr motivating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relapse Potential</td>
<td>maintains abstinence</td>
<td>needs close monitoring</td>
<td>unable to control use in outpt care</td>
<td></td>
</tr>
<tr>
<td>Recovery Environment</td>
<td>supportive</td>
<td>less support, w/ structure</td>
<td>can cope</td>
<td>danger to recovery, logistical incapacity for outpt</td>
</tr>
</tbody>
</table>
ASAM PPC Decision Rules – Mr. D.

- Mr. D. is a 41 y/o MWM unemployed carpenter, referred by his wife, a nurse, who, after a recent relapse, will soon throw him out if he continues his daily 6-pack habit and Percocet.

- His history includes no prior withdrawal symptoms, but + major depression with suicidal ideation, intermittent prescribed opiates for low back injury, & alcoholism in his father.

- He would now accept treatment, including abstinence from any opiates, restarting his antidepressant, & attending some AA meetings.
ASAM PPC Decision Rules – Mr. D.

**LEVEL OF CARE**

**DIMENSION**

1. WD
2. Bio
3. Psy
4. Mot
5. Rel
6. Env

1 - Outpatient
2 - Day Tx
3 - Med Mon
4 - Med Mgd

Level 2
### ASAM Placement Criteria

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Levels:</th>
<th>Opioid Treatment</th>
<th>Day Treatment</th>
<th>Residential Rehabilitation</th>
<th>Hospital (Medically Managed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5</td>
<td>1</td>
<td>OTP</td>
<td>2.1, 2.5</td>
<td>3.1, 3.3, 3.5, 3.7</td>
<td>4</td>
</tr>
</tbody>
</table>

1. Intox/WD
- **Sub-levels:**
  - Withdrawal Management (L-1, 2.5, 3.2, 3.7, 4)
  - Biomedical Enhanced (L-3.7)

2. Biomedical
- Co-Occurring Disorders Capable (L-2, 3)
- Co-Occurring Disorders Enhanced (L-2, 3)

3. Emot’l/Behav’l

4. Readiness

5. Relapse Potential

6. Environment
MGH-Harvard ASAM Criteria Validity Study
Gastfriend, et al.  Supported by NIDA grants # R01-DA08781 & K24-DA00427

• Randomized controlled trial (RCT) in 3 Cities in Eastern MA

• Tested matched v. mismatched assignments with PPC-1

• Compared Levels II (IOP) & III (Residential)

• Outcomes: No-show to step-down care

• Balanced for gender, ethnicity (N=700)

• Used computerized algorithm with blinded raters, patients & treaters
  – Based on instruments with known reliability
  – B.A. level interviewers achieved inter-rater reliability of 0.77 (ICC)
Under-Matching Worsens No Show to Treatment

From Inpatient Detox to Either Residential Rehab or Day Treatment:
All patients, High Frequency Cocaine Users and Heroin Users

Under-matched patients’ no-show rate:
- ~25% worse
- ~100% worse
- ~300% worse

Percent No-Shows to Next Treatment

- All Patients (N=700)
- Cocaine (N=183)
- Heroin (N=279)
ASAM in Patients with + Comorbid Symptoms
(Angarita et al., JAM 2007)

Supported by NIDA grants # R01-DA08781 & K24-DA00427

No-Show for Treatment in Substance Abuse Patients with Comorbid Symptomatology: Validity Results from a Controlled Trial of the ASAM Patient Placement Criteria

Gustavo A. Angarita, MD, Sharon Reif, PhD, Sandrine Pirard, MD, Sang Lee, BSc, Estee Sharon, PsyD, and David R. Gastfriend, MD

Purpose: Mismatched placement, according to the American Society of Addiction Medicine's (ASAM) Patient Placement Criteria (PPC), promotes no-shows to treatment; however, little is known about the impact on patients with psychiatrically comorbid substance use disorder.

Methods: In a multisite trial, public-sector treatment-seeking adults (N = 700), following a computer-assisted ASAM PPC-1 structured interview, were blindly scored and randomly assigned to Level-of-supportive environment as predictors of treatment no-shows (odds ratios = 2.69, P < 0.05; 3.27, P < 0.05; 5.32, P < 0.001; and 3.12, P < 0.05, respectively).

Key Words: substance use disorder, no-shows, ASAM levels of care, treatment matching criteria, co-occurring disorders

(J Addict Med 2007;1: 79–87)
ASAM in Patients with + Comorbid Symptoms
(Angarita et al., JAM 2007)

No-show rates: Comorbids vs. Non-Comorbids, by Matching Status

- Under-matched to IOP but needs Resid’l: ~90%
- Matched to IOP: ~60%
- Matched to Residential: ~30%
- Over-matched to Resid’l but needs IOP: ~20%

*P < 0.01
Programs in 4 LOCs, naturalistically rated 201 subjects

Recruited in equal proportions from the 4 LOCs

Assessed by trained psychologists

Outcomes: 1 month, 5-point global rating scale

Assessors, patients, programs, & raters – all blind

Results: Adequate matches (n = 140) were significantly better than mismatches (n = 27) (p<0.05)
Predictive Validity of the ASAM Patient Placement Criteria for Naturalistically Matched vs. Mismatched Alcoholism Patients

Stephen Magura, PhD, CSW
Graham Staines, PhD
Nicole Kosanke, PhD
Andrew Rosenblum, PhD
Jeffrey Foote, PhD
Alexander DeLuca, MD
Priti Bali, BA

Stephen Magura, Graham Staines, Nicole Kosanke, Andrew Rosenblum, and Priti Bali are affiliated with the Institute for Treatment and Services Research, National Development and Research Institutes (NDRI), New York, NY.
Jeffrey Foote was affiliated with the Smithham Treatment Center, St. Louis, PA.
ASAM Criteria Validity at 3 Months in NYC
(Magura et al., Am J Add’n 2003)

Alcohol use by naturalistic Levels of Care & mismatching (N=219)
Bed-Day Utilization over 1-Yr in the VA
(Sharon et al., JAD 2003)
Supported by NIDA grants # R01-DA08781 & K24-DA00427

Predictive Validity
of the ASAM Patient Placement Criteria
for Hospital Utilization

Estee Sharon, PsyD
Chris Krebs, MA
Winston Turner, PhD
Nitigna Desai, MD
Gregory Binus, MD
Walter Penk, PhD
David R. Gastfriend, MD

SUMMARY. We tested the validity of the ASAM Patient Placement Criteria (PPC) using the first complete and reliable computerized imple-
Bed-Day Utilization over 1-Yr in the VA

*Bedford MA VA, N = 97 (Sharon et al., JAD 2003)*

Bed-day Use Pre- vs. Post-Naturalistic L-III Placements

![Bar chart showing annualized bed-days before and after naturalistic L-III placements.](chart.png)
Predictive Validity: The Norwegian Study
Stallvik M, Gastfriend DR, Nordahl HM
Funded by the Central Norway Health Trust

• Prospective, double-blind, multi-site (n=10) naturalistic design
• N= 261, naturally placed by counselors across 3 counties
• Baseline (BL) interview & 3 mo. follow-up (F/U)
• Independent raters used ASAM Criteria Software 2nd Ed.-Rev.
• Outcomes at 3 Month Follow-Up:
  1) Dropout
  2) Drug use frequency
  3) ASI Composite Score Changes
  4) Recommended level of care at F/U
3-mo Drop-Out, Improvement & Stepdown Need

% Drop Out at 3-Mo F/U

- Under-Matched: 50%
- Matched: 60%
- Over-Matched: 60%

Matched patients have 30% better show rates.

# ASI Subscales Improved at F/U

- Under-Matched: 2
- Matched: 6
- Over-Matched: 4

Match yields 3X better outcomes.

% of Patients Ready for Stepdown at F/U (vs. BL)

- Under-Matched: 50%
- Matched: 60%
- Over-Matched: 70%

Naturalistic Match Status – According to ASAM Software
Conclusions

• The ASAM Criteria Software decision rules show **face validity**
• Technology provides good **reliability & feasibility**
• Comparison to other instruments shows good **concurrent validity**
• **Predictive validity** overall & with heroin, cocaine & comorbidity
• Valid for undermatching, AND for **overmatching**
• Predictive validity:
  – in multiple cultures/systems: public/VA; MA/NYC; Belgium/Norway
  – at multiple time-frames: immediate, 30-d, 90-d & 1-year
  – with multiple outcomes:
    no-show, global improvement, substance use, step-down readiness, rehospitalization
Addiction assessment: A Sea Change

Three laws end discriminatory, firewalled, fee-for-service models

- The Affordable Care Act
- The Parity Act
- The Health Information Technology Act

Change is HERE for payers, programs and clinicians:

- Parity REQUIRES published medical necessity criteria
- SUD managed care UR will become equitable
- Clinicians will be able to use the ASAM Criteria to definitively describe patient needs – and reform UR
Stakeholders in the Health IT Revolution

Client

Counselor

Supervisor

System

Managed Care

Employer/Payer

Researcher

Accreditation Body, Government

Society
ASAM Criteria – Health Services Research

• National Treatment Center Study - 450 programs (U. of GA)
• >70% of respondents using ASAM Criteria by 1996
• Single-level programs: 34% - 42% less likely than multi-levels (p<.01)
• Dual diagnosis capable programs:
  3.4 times more likely to adopt (p ≤.01)
• Programs closing within 24 mos.
  were less likely to be ASAM adopters in 1996 (p<.05)
• Programs closing within 6 mos. – even lower baseline adoption
Factors Associated With Use of ASAM Criteria and Service Provision in a National Sample of Outpatient Substance Abuse Treatment Units

Emmeline Chuang, BA, Rebecca Wells, PhD, Jeffrey A. Alexander, PhD, Peter D. Friedmann, MD, and I-Heng Lee, MA

Abstract: Standardized patient placement criteria such as those developed by the American Society of Addiction Medicine are increasingly common in substance abuse treatment, but it is unclear what factors are associated with their use or with treatment units' provision of related services. This study examined these issues in the context of a national survey of outpatient substance abuse treatment units. Regressions using 2005 data revealed that both public and private managed care were associated with a greater likelihood of using American Society of Addiction Medicine criteria to develop client treatment plans. However, only public managed care was (ASAM) created the first professional consensus-driven, publicly released set of standardized patient placement criteria (PPC), which have become known as the ASAM-PPC. These guidelines, subsequently revised in 1996 and 2001 to accommodate new developments in the field, are currently the most prominent in substance abuse treatment. Approximately, 30 state systems and a significant number of managed care companies, covering well over 50 million people, currently use the ASAM criteria when making decisions on what type of addiction treatment to authorize.
Predictors of ASAM Criteria Adoption
(Chuang et al., JAM 2009)

• More than half (57%) of programs routinely use ASAM

• Public managed care – significantly associated with use of PPC (OR 1.010, p<.05)

• Private managed care – significantly associated with use of PPC (OR 1.024, p<.05)

• CARF accreditation – significantly associated with use of PPC (OR 3.187, p<.01)
  Note: CARF tends to focus on rehabilitation & behavioral health standards (vs. JCAHO, which is hospital-oriented)
Case Study: CRC Health

- Operates 145 sites treating 30,000 people
- Largest behavioral health provider in U.S.
- Devotes significant resources to payer approval
  - Each center has 3-5 FTEs dedicated to UR
  - ~20% of cases are contested by payers
  - ~30% of MD time is lost interacting w/payers
- If this administrative time is reduced only slightly, the ASAM Software could yield substantial savings.
Beta Testing: Milwaukee County

N= 7 counselors, daily use over 6 months in Central Intake Units

- “...overwhelmingly positive, very user friendly”
- “already use ASAM & ASI, but not as consolidated or organized as the software – a big plus from the Central Intake Staff”
- “no challenges in the learning curve – very easy to use”
- “very comparable duration (~2 hrs) vs. the prior approach; the Software does not add to the time”
- “a deeper look into the patient & what’s going on”

- County would like to expand County-wide (~30 Intake Counselors)
- Would like Recovery Support Services & Mental Health modules
In the past year, think about your use of alcohol.

“Do you need to use more alcohol to get the same feelings you used to by using less? Or do you get less of a high by using the same amount? (Tolerance indicates either need for increased dose for same effect or reduced effect with same dose.)”

“Do you ever get physically sick when you stop using alcohol? (Indicates characteristic physical or psychological withdrawal symptoms.)”

“When you are using alcohol, do you ever feel that you don’t stop when you want to or feel that you should? Indicates substance often taken in larger amounts or over longer period than was intended.”
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Do you feel sick to your stomach? Have you vomited?&quot;</td>
<td>No nausea and no vomiting, Mild nausea with no vomiting, Intermittent nausea with dry heaves, Constant nausea, frequent dry heaves and vomiting</td>
</tr>
<tr>
<td>Tremor: Arms extended and fingers spread apart. Observation:</td>
<td></td>
</tr>
<tr>
<td>Paroxysmal Sweats: Observation:</td>
<td></td>
</tr>
<tr>
<td>&quot;Anxiety: Ask, Do you feel nervous? Observation:&quot;</td>
<td></td>
</tr>
<tr>
<td>&quot;Tactile Disturbances: Ask, Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling under your skin? Observation:&quot;</td>
<td></td>
</tr>
<tr>
<td>&quot;Headache, Fullness in Head: Ask, Does your&quot;</td>
<td></td>
</tr>
</tbody>
</table>
Addiction Treatment History

“Have you had any previous treatment for alcohol or other drug use problems?” Alcohol only

“How many times in your life have you been treated for alcohol use problems?” 5

“Counting the times in your life you have been treated for alcohol use problems, how many of these were withdrawal management only?” 5

“Have you usually left withdrawal management before you were advised to, in the past?” Yes No

“After withdrawal management, have you usually entered continued treatment?” Yes No

“How many days have you been treated in an inpatient setting?”
“How strong is your desire to use any drug right now?”

“Have your addiction symptoms increased recently? How...? (Ask about any items below not mentioned by the patient) Have you had more craving, risk behaviors, more frequent use, increased amount of substance or have you used a more rapid route of administration?"

“Do you feel you are likely to continue using or, if not using, that you are in danger of relapsing? How soon...? Do you feel at risk, even if you have had some treatment previously?"

“Do you have any concerns about pursuing treatment...? Would anything possibly hold you back, such as money, insurance, schedule, attending groups, having to take medicines, drug tests, or drinking or drug-using friends?”

- No
- Increased thoughts or craving
- More risk taking behaviors but not use
- Relapsed; but to less use than when using before
- Increased use or more acute route of administration than before
“How strong is your desire to use any drug right now?”

“Have your addiction symptoms increased recently? How...? (Ask about any items below not mentioned by the patient) Have you had more craving, risk behaviors, more frequent use, increased amount of substance or have you used a more rapid route of administration?”

“Do you feel you are likely to continue using or, if not using, that you are in danger of relapsing? How soon...? Do you feel at risk, even if you have had some treatment previously?”

“Do you have any concerns about pursuing treatment...? Would anything possibly hold you back, such as money, insurance, schedule, attending groups, having to take medicines, drug tests, or drinking or drug-using friends?”

- No; has been fully participating in all recommended treatments
- No; open to fully participating in any recommended treatments
- Passive or some hesitations
- Resists important components
- Rejecting or obstructs plan with many contingencies
<table>
<thead>
<tr>
<th>Question</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Have you been emotionally abused during the past 30 days?&quot;</td>
<td>Not at all</td>
<td>Slightly</td>
<td>Moderately</td>
<td>Considerably</td>
<td>Extremely</td>
</tr>
<tr>
<td>&quot;Have you been physically abused during the past 30 days?&quot;</td>
<td>Not at all</td>
<td>Slightly</td>
<td>Moderately</td>
<td>Considerably</td>
<td>Extremely</td>
</tr>
<tr>
<td>&quot;Have you been sexually abused during the past 30 days?&quot;</td>
<td>Not at all</td>
<td>Slightly</td>
<td>Moderately</td>
<td>Considerably</td>
<td>Extremely</td>
</tr>
<tr>
<td>&quot;Who is the person (or persons) with whom you have had contact during the past 4 months and who has been most important to you?&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Have you recently neglected/abused family members?&quot;</td>
<td>Not at all</td>
<td>Slightly</td>
<td>Moderately</td>
<td>Considerably</td>
<td>Extremely</td>
</tr>
<tr>
<td>&quot;How much help will this person (or these persons) need to assist in your treatment and recovery and how likely is it that he/she/they&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Trouble with your attitude or holding onto relationships with others?

In your lifetime?
Not at all 1 Slightly 2 Moderately 3 Considerably 4 Extremely

Serious thoughts of suicide, i.e. that you would be better off dead, or wanting to hurt yourself?

In your lifetime?
Not at all 1 Slightly 2 Moderately 3 Considerably 4 Extremely

Thoughts of how you might hurt yourself?

In your lifetime?
Not at all 1 Slightly 2 Moderately 3 Considerably 4 Extremely

Attempted suicide?

In your lifetime?
Not at all 1 Slightly 2 Moderately 3 Considerably 4 Extremely
Dynamically driven report with variable content regions.
Clinical Decision Support: Output

- DSM-IV and DSM-5 Substance Use Disorders: Diagnoses & Criteria
- CIWA-Ar & CINA withdrawal scores (alcohol/BZs, opioids)
- Addiction Severity Index (ASI) Composite Scores
- Imminent Risk Considerations
- Access & Support Needs/Capabilities
- ASAM Level of Care recommendations
  - Including Withdrawal Management
  - Including Biomedically Enhanced Sub-level
  - Including Co-occurring Disorder Sub-levels (Capable, Enhanced)

- Also: If actual placement disagrees with Software, the clinician gets to justify the discrepancy
25 Participating Health IT Vendors*

- BestNotes
- Brain Resource.com
- Caminar
- Cerner
- Compulink
- Computalogic's MethodOne
- DocuTrak
- eHana
- Ensoftek/Dr Cloud
- Foothold Technology
- Lauris / Integrated Imaging
- ManageAttendance
- Meadows Edge
- Medivance
- Orion Systems
- Procomp
- Qualifacts
- Ramsell
- Sigmund Software
- Smart
- Stratus EMR
- The ECHO Group
- TenEleven Group
- Welligent
- WITS

*as of March 10, 2015; others in process
A National Addictions Patient Registry

- Treatment Program
- Protected Raw Data (Identifiers + Health Info)
- Copied Data (Stripped of Identifiers but with Unique Case #)

- EHR
- Managed Care
- Employer/Payer
- Client
- Counselor
- Supervisor
- System
- Accreditation Body, Government
- ASAM’s National Coalition
- Researcher
Implications & Opportunities

- Patient trajectories – stepdown, step up, drop out & re-entry
- Episode of Care – what is it? Analysis & characterization
- Level of Care Need as a disease staging system?
- Follow-up/reassessment & change over time analysis
- High resolution data for treatment planning
- Multi-factorial patterns of placement discrepancies (proximity, coverage restriction, counselor bias, patient preference, algorithm error)
- Needs assessment – for states, counties, insurers
- Casemix analysis & trajectories
  - For planning capitated contracts
  - For controlled clinical trials – now can control for Level of Care need
- MediCal & Other Waivers: precise, real-time UR w/detailed data
July 27, 2015
SMD # 15-003
Re: New Service Delivery Opportunities
for Individuals with a Substance Use Disorder

Dear State Medicaid Director:

...States should use the ASAM Criteria as they develop a residential or inpatient SUD service continuum...
In order to receive approval...the assessment for all SUD services, level of care and length of stay recommendations must be performed by an independent third party that has the necessary competencies to use ASAM Patient Placement Criteria. Specifically, an entity other than the rendering provider will use the ASAM Criteria...

OPTIONS for States/Counties to propose the 1115 Waiver:
1. Managed care organization vendor contract
2. ASAM’s CONTINUUM™
Addiction assessment: A new, state-of-the-art standard

THE PAST...
• Non-standard, intuitive
• Telephone tag
• Proprietary criteria
• Emphasis on cost, not quality
• 1991: ASAM...a teaching tool
• Each state creates its own Criteria
• Managed Care Study: ~50% of cases reversed
• By 2000s, SAMHSA wants a standard

NOW...
• Standardized, quantitative
• Rapid Prior Authorization
• Public domain criteria
• Emphasis on cost AND quality
• 2015: ASAM...a decision tool
• A single national standard for Criteria
• Managed care: Willing to pilot AUTOMATIC prior authorization
• 2015, SAMHSA has a standard
Making Budgets Go Further & Outcomes Better

**ASAM’s CONTINUUM™:**
(compared to usual assessment/placement)

- 25% - 300% reductions in no shows to next stage of treatment
- 30% reduction in dropout from treatment
- 3X improvement in addiction severity outcomes at 3 months
- 25% increase in numbers of patients ready for stepdown

**Leading to...**
- Increased patient flow & revenues
- Decreased staffing demands for incomplete intakes & UR delays
Making Budgets Go Further & Outcomes Better

**ASAM’s CONTINUUM™:**
Moves intake effort up front, reducing intake & dropout “churn”
- More admissions/less staff time/lower costs AND better morale
- Better performance on the HEDIS *Engagement* indicator
- Consistently greater improvements in substance use & severity
- Decreases in overall hospital bed-days

**Payer/MCO gets:** faster, better telephone prior auth & UR data;
- Potentially eliminating phone prior auth AND most UR
- With precise, quantitative, real-time data
- Opportunity for: Determination of Need analyses
- Opportunity for: QI “hotspots” alerts & targeting
For more information:

• gastfriend@gmail.com

• www.ASAMcontinuum.org