The Alcohol and Drug Abuse Administration (ADAA) is in the process of reviewing and standardizing "levels of service" definitions for Maryland’s Substance Abuse Treatment System. The revised standards match uniform patient placement criteria defined by the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC) II-R (Revised). The ASAM Criteria, developed in 1991, has evolved into a nationally recognized standard over the past 15 years. Such standards ensure increased uniformity of treatment and improved cost-effective allocation of resources. According to Substance Abuse and Mental Health Services Administration (SAMHSA), "Uniform patient placement criteria play an important role in unifying public and private resources that makeup the substance abuse treatment system in the United States." (DHHS Publication No. (SMA) 95-3021, Substance Abuse and Mental Health Services Administration, TIP 13, 1995.)

Standards for defining the continuum of care in the treatment system have historically been unclear. On examination, the same level of service can have multiple labels defining a variety of services, depending not only on the services provided but also on the defining agent (i.e. COMAR*, SAMIS**, TFRAN***, OHCQ****, etc.). For example, an ICF (Intensive Care Facility) can presently be defined by any of the following labels: 1) Level III.7 - Medically Monitored Intensive Inpatient Treatment, 2) Residential Services - Medically Monitored Intensive Inpatient Treatment, 3) Intermediate Care, 4) III.7 Medically Monitored Inpatient (ICF), and/or 5) Inpatient Treatment Center.

This multiplicity of definitions has created challenges in data collection and reporting. The ASAM Criteria applied and used across all reporting venues puts into play a “common language” of shared definitions. Shared definitions improve communication, clarify organizational structure, and in general improve accountability of outcome measures. A “common language” allows stakeholders to know exactly how treatment programs and clinicians make decisions about patient placement and ongoing care. It also facilitates communication between and among all parties involved in the planning process.

By adopting the ASAM language ADAA looked to a science-based measure to provide the framework for a continuum of care that can be understood across all treatment jurisdictions and throughout the nation. On the federal level, dollars for treatment are increasingly dependent on the ability to measure performance. Uniform placement standards allow for data collection that can be analyzed, compared and contrasted across a broad spectrum of populations. The shared definition of placement criteria levels the playing field for practitioners by ensuring standards practiced in any region can be met both statewide and nationally. This means that jurisdictions can focus more accurately on program improvement measures that enhance outcomes without being bogged down by the task of defining and re-defining labels.

Importantly, as jurisdictions work with their local Drug and Alcohol Abuse Council to develop regional plans and the state council moves to recommend a state treatment plan, this practice encourages the early identification of gaps in service, and under or over utilized resources.
Just under 30 percent of ADAA-funded admissions were to residential treatment compared to under 20 percent for non-funded. Over 12 percent of non-funded patients entered methadone treatment compared to seven percent of ADAA-funded. Twenty percent of non-funded admissions were to Level II, intensive outpatient; it is possible some of these are being reported by programs not certified for IOP, or Level II.

Type outpatient (OP), intensive outpatient. The other maintenance ASAM categories came from the effectiveness of the ASAM PPC II-R in a substance abuse treatment program that tried to minimize barriers to treatment. The authors assessed the amount of mismatches in treatment placement and whether patients received over-treatment or under-treatment. They found clients were matched correctly 72 percent of the time. When mismatched, patients were more likely to receive over-treatment than under-treatment (59 percent to 41 percent).

Footnotes

The table below distributes FY 2004 admissions to ADAA-funded and non-funded treatment programs by ASAM levels of care. Treatment programs are placed in the ADAA-Funded category if they are known to have received any funding administered by ADAA during the year. This is a change from the way we have attempted to categorize admissions in the past. In prior years, the staffs of Grants and MIS would put their estimable heads together and struggle to assign treatment slots to a funding source -- ADAA or other - self, subdivision, local, private, insurance, foundation, fee-for-service, etc. In many cases this was a relatively clear decision, but in truth, almost no programs are exclusively operated with ADAA dollars, and it is often impossible in a grant funding system to tie patients to a particular funding source. In some programs ADAA might fund a particular modality or setting, or a subset of beds in a residential program. As federal and state dollars have shrunk programs have been forced to become more creative in order to maintain comparable levels of service. As the varied needs of patients are identified and the complex nature of addiction more recognized the funding picture in treatment programs has become correspondingly muddled. While ADAA has stepped up efforts to identify the primary sources of funding in each treatment entity, it has become more practical from a data standpoint to follow the federal lead and classify programs as receiving some state dollars or none.

Fifty-nine percent of FY 2004 admissions were to programs receiving at least some funding from ADAA. Just under 30 percent of ADAA-funded admissions were to residential treatment compared to under 20 percent for non-funded. Over 12 percent of non-funded patients entered methadone treatment compared to seven percent of ADAA-funded. Twenty percent of non-funded admissions were to Level II, intensive outpatient; it is possible some of these are being reported by programs not certified for IOP, or Level II.

Since the reporting of ASAM levels of care will be implemented in July, the current categories had to be developed by cross-walking from the SAMIS Service Category item and other information maintained in the SAMIS database. Using this process Level 0.5, Early Intervention, was assigned to patients identified as having high risk adolescents in the Type of Client item. Levels I, II and MAT came directly from service categories outpatient (OP), intensive outpatient and methadone maintenance. The other ASAM categories came from combining service category information with a 16 category listing of provider identifiers according to level of treatment and setting that has been maintained in SAMIS for many years. These are the following -- halfway house, ICP, long term residential, group home, non-hospital detox, other residential, health department OP, other OP, intensive OP, ambulatory detox, jail, correctional, methadone, methadone detox, hospital and hospital detox.

Staying up-to-date with these categories as programs change services and new programs open has been difficult – reporting the ASAM levels will contribute to more accurate data.

### Admissions to Maryland Treatment Programs by ASAM Level of Care

<table>
<thead>
<tr>
<th>ASAM Level of Care</th>
<th>ADAA Funded</th>
<th>Non-Funded</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0.5</td>
<td>417</td>
<td>1,007</td>
<td>1,424</td>
</tr>
<tr>
<td>Level I</td>
<td>2,071</td>
<td>6,715</td>
<td>8,786</td>
</tr>
<tr>
<td>Level II</td>
<td>4,722</td>
<td>1,089</td>
<td>5,811</td>
</tr>
<tr>
<td>Level III.1</td>
<td>1,080</td>
<td>229</td>
<td>1,309</td>
</tr>
<tr>
<td>Level III.2</td>
<td>1,223</td>
<td>248</td>
<td>1,471</td>
</tr>
<tr>
<td>Level III.3</td>
<td>350</td>
<td>0</td>
<td>350</td>
</tr>
<tr>
<td>Level III.4</td>
<td>6,577</td>
<td>4,410</td>
<td>10,987</td>
</tr>
<tr>
<td>Level III.5</td>
<td>144</td>
<td>299</td>
<td>443</td>
</tr>
<tr>
<td>Level IV.1</td>
<td>0</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Level IV.2</td>
<td>0</td>
<td>143</td>
<td>143</td>
</tr>
<tr>
<td>Level IV.3</td>
<td>585</td>
<td>0</td>
<td>585</td>
</tr>
<tr>
<td>Total</td>
<td>4,385</td>
<td>1,073</td>
<td>5,458</td>
</tr>
</tbody>
</table>

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WORKFORCE ISSUES

ADAA is concerned with issues related to the recruitment, retention and professional development of the of Maryland’s substance abuse treatment professionals. We recognize that a major component of improving the quality of addiction treatment for Maryland citizens is to develop and retain a competent and professional workforce.

To address workforce issues, the ADAA, in conjunction with the Central East Addiction Technology Transfer Center (CEATTTC) and the Mid-Atlantic Addiction Technology Transfer Center (Mid-ATTTC), have developed a survey. The survey is the first step in evaluating and assessing issues pertaining to the recruitment and retention of professionals in the substance abuse treatment system. This survey is of great importance to the work we must do in Maryland.

When you receive a survey please take a few minutes to fill it out and return it to us. This will allow us to incorporate your views into any future initiatives.

Surveys will be mailed to programs in the coming weeks. If you do not receive a survey and would like to participate, contact Linda Oney at 410-402-8585 or e-mail loney@dhmh.state.md.us.

This column has been rolling around in my head for years. I have fought the urge to write it for the past 10 years, sensing that it wasn’t yet ripe for the writing. Some of it leaked out in an earlier edition of the Compass lessening the inhibition to write and sharpening a bit more of the focus (see, “The Problem of Change,” Fall, 2004). That discussion noted that the language of change often substituted for actual change. There is no need to fight it any longer. I surrender.

The Myth of C3 is brilliantly simple, intuitively charming, appealing and easy to understand. The short version: change happens if there is sufficient coordination, collaboration and cooperation (C3) by stakeholders. The idea is that C3 is not only a necessary, but a sufficient, condition for change. That is, by energy, synergy, and sheer process, things happen for the better with people coordinating, collaborating and cooperating. C3 sounds good. It is now pretty standard language of change often substituted for actual change. There is no need to fight it any longer. I surrender.

End of the Myth of C3.

The Myth of C3 is only a theoretical construct. There is no need to fight it any longer. I surrender.

And here starts another management tale. If you are doing your job, everyone is happy. And why would you disrupt it? Good luck on that one. If you see an organization that has implicitly embraced this ethic (and I know of no organization, human service or not, that would explicitly take this position) you are looking at an organization dedicated to the status quo. This group works C3 as well as anyone, has content knowledge but values the getting along part more than the change part. The truth is change can be disruptive, destabilizing and confusing and inspiring. Not in this organization, it doesn’t happen.

“This Action” is only a theoretical construct.

Why would I write about this now? Apart from my almost pathological aversion to management books and classes (well earned, I might add). I am fascinated with how the field continues to move forward and change. Practitioners and managers are refreshingly candid about what they are thinking about and tend toward another classical American trait ... talking about. You better have the facts right. Also, you better not try to get by with just C3. American pragmatism is alive in the substance abuse field.

The substance abuse business in Maryland is serious business. We are collectively setting standards, building on what we know while staying open to learning what we don’t yet know. This is hard work and sometimes uncomfortable work. It is going to require getting to C4 and adding the “A”, ...and that is not a myth.

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If you have not applied, NOW is the time to register for the OETAS residential training at Salisbury, University July 25-28 and August 8-11. There are nine courses offered each session. Hurry sections are filling quickly!

Download the catalogue and registration forms from the ADAA Web site: www.maryland-adaa.org or call the OETAS at 410-402-8585 for your catalogue.

Spring 2005
Compass
Page 6

Concerned About Meeting Performance Measures?
Consider Having A Performance Measures Workshop for your Staff

“CODING FOR SAMIS AND HOW IT AFFECTS PERFORMANCE MEASURES”

Presented by ADAA Staff
Bill Rusinko
Vickie Kaneko
Chad Basham
Call Vickie Kaneko
410-402-8662

Save the Date
Mark October 5-7 on your calendar. It is the date of the fourth annual ADAA Management Conference. This year’s Management Conference will be held in Easton, Maryland.

Conference details will be released soon!

And that’s it. The trick here is to do something. Yes, do something. This would be the part where “Action” comes in. Use the process, use the content knowledge and act. Without the action there is no change. There is the language of change, process and content, but sadly, no change. End of the Myth of C3.

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are going to be in the expertise needed to address both addiction and mental illnesses. Those of us who have practiced in the field know there is seldom the patient who is suffering from an “addiction only” diagnosis.

The individual and the provider. Efforts that merely increase paperwork are counterproductive. Productive application should improve communication with managed care organizations, add structure to acute case management and enhance the productivity of clinicians and administrators alike.

However, at times productivity requirements essential to program survival become counter-productive to the clinician’s ability to truly use evidence-based practice. Often, clinicians are not compensated for the time it takes to measure treatment effectiveness. This type of follow-up requires the clinician to administer assessment tools again and again; a very time consuming process. Yet, the only way to truly show change over time, and enhance the accuracy of the ASAM PPC II-R process is to conduct follow-up assessments at key intervals in the treatment process. If one suggests there is no time to continually assess, they are implying that they either do not understand the importance of assessing accuracy of placement, do not know how to assess, or they are overwhelmed by the demands of the treatment. In any case, training can effectively solve most dilemmas.

One of the biggest problems for the field of behavioral health involves speaking a common language both inside and outside the clinical community. What a quagmire… We can’t explain ourselves to ourselves, and we can’t explain ourselves to others. Sound a bit like a cognitive disorder? Professional esteem goes down and self-perceived competency takes a beating. In the end, the complexity of behavioral health treatment is maximized when we as providers are unable to communicate with one another and with the lay world.

Fortunately, the field of behavioral health treatment, specifically addiction treatment, has developed a foundation solid with potential and hopefulness. The past 15 or so years have been filled with major strides such as the advent of a “centralized” patient placement criterion, ASAM PPC II-R. “Centralized” means that everyone can and should work from one theoretical and practical model. Efficacy and effectiveness are jeopardized when too many models are being utilized for what one hopes will be the same outcome. Validity and reliability are hard concepts to ascertain when data sets are small due to a diluted implementation process. In other words, when everyone “is doing their own thing.”

Addiction treatment providers stand to gain a great deal if synergy is achieved in certain key areas of patient assessment, placement and treatment. The synergy or similarity between provider practice models will allow for better data collection and comparison between groups. If we all simply conduct ourselves in the way “we” think is best, some will use patient placement criteria some will not. Some will change their models periodically, some will use gut instinct, so on and so forth. The important thing to remember here, is that patient placement criteria, in no way changes the individualized approach to treatment that we all know is crucial to successful treatment. I believe in everyone using their great ideas to move the field ahead, but patient placement criteria is one of those arenas that will suffer by each group doing it their own way.

Programmatic Benefits
So what do we have to gain by standardizing placement criteria? First and foremost we need to recognize that one of the key variables in analyzing the effectiveness of treatment is the ability to measure treatment outcomes relative to patient placement. If the patient is matched to the right treatment type the treatment will address the individual’s assessed biological, psychological, and social needs. Once you are confident that you have the patient in the right level of care, you need only the skills and resources to treat. One’s aptitude to treat can only be enhanced by such a patient placement process.

So, what happens if the patient is not doing well in the treatment process? Historically, we labeled that individual as a “treatment failure.” In contrast if someone has cancer and the treatment process is not successful, we as a society do not look at that individual and say “Gee, what a failure you are.” In fact, we take an opposite approach. We typically add more treatment, by intensifying the radiation, chemotherapy, or diet changes, etc. Similarly, the patient in treatment for a substance abuse disorder often needs a change in the treatment intensity. When confronting addiction and other mental illnesses, society loses patience quickly. ASAM PPC II-R recognizes this pattern and provides the practitioner with the resources to support another perspective: “There is no such thing as failure.” Regional planners and program administrators can support this mind-set by establishing program parameters that encourage patients to utilize the treatment continuum. A system that has the flexibility to adjust treatment intensity to patient need improves not only treatment outcomes, but staff morale and patient satisfaction.

In the most recent version of the ASAM placement criteria, “other co-occurring mental health treatment” is included in the placement spectrum. Finally after years of research and pragmatic interpretation of patient needs in behavioral health treatment there is a push for the field to define its approach to the complexity of co-occurring illnesses. A program can still focus on addiction only, but each facility should make an effort to understand just how involved they

Follow up is the only way to go…

Let us not forget the front line efforts of practitioners. All too often “the powers that be” attempt implementation without evaluating the impact on those working in the trenches. ASAM criteria should be applied thoughtfully in a way that enhances treatment outcomes for both the individual and the provider. Efforts that merely increase paperwork are counterproductive. Productive application should improve communication with managed care organizations, add structure to acute case management and enhance the productivity of clinicians and administrators alike.

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The idea of measuring or managing more data is not appealing to many. Program managers will need to develop easy, quality assurance measures to assist in the clinical community. There is plenty of data out there to prove that treatment for substance abuse and related mental health disorders saves society tax dollars, reduces violence and improves the overall health of a community. Stakeholders at all levels stand to gain from effective addiction treatment. As practitioners we have a responsibility to make sure our assessments of patient needs are robust, psychometrically sound, and provide accurate details that enhance the fidelity of patient placement efforts. In other words, even the best bucket in the world loses its “best practices” functionality if it has even one little hole in the bottom.

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Improved Outcomes

For those unfamiliar with placement criteria, the scope of the ASAM PPC II-R covers the assessment of a vast array of clinical needs. The dimensions of substance abuse, medical problems, emotional health (psychological), treatment readiness, relapse potential and family/social dysfunction are evaluated to determine the severity of the individual’s illness. From that assessment the intensity of the treatment is determined. Using the proper tools to assess these dimensions is essential. Research tools such as the Addiction Severity Index (ASI), give credibility to the ASAM criteria.

Patient placement is a concept, and the criterion is a template. The success of the entire package hinges on the professionalism, knowledge and skill set of the individuals implementing it in their treatment settings. The more we [addiction and mental health professionals] are in sync with the implementation of ASAM, the more analytical power we have to develop outcomes; thus the further along we will be in our pursuit of a “best practices” approach to treatment.

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...From the Field

Am I Speaking Your Language?

By Steven Herr

Challenges

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Programmatic Benefits

So what do we have to gain by standardizing placement criteria? First and foremost we need to recognize that one of the key variables in analyzing the effectiveness of treatment is the ability to measure treatment outcomes relative to patient placement. If the patient is matched to the right treatment type the treatment will address the individual’s assessed biological, psychological, and social needs. Once you are confident that you have the patient in the right level of care, you need only the skills and resources to treat. One’s aptitude to treat can only be enhanced by such a patient placement process.

So, what happens if the patient is not doing well in the treatment process? Historically, we labeled that individual as a “treatment failure.” In contrast if someone has cancer and the treatment process is not successful, we as a society do not look at that individual and say “Gee, what a failure you are.” In fact, we take an opposite approach. We typically add more treatment, by intensifying the radiation, chemotherapy, or diet changes, etc. Similarly, the patient in treatment for a substance abuse disorder often needs a change in the treatment intensity. When confronting addiction and other mental illnesses, society loses patience quickly. ASAM PPC II-R recognizes this pattern and provides the practitioner with the resources to support another perspective: “There is no such thing as failure.” Regional planners and program administrators can support this mind-set by establishing program parameters that encourage patients to utilize the treatment continuum. A system that has the flexibility to adjust treatment intensity to patient need improves not only treatment outcomes, but staff morale and patient satisfaction.

In the most recent version of the ASAM placement criteria, “other co-occurring mental health treatment” is included in the placement spectrum. Finally after years of research and pragmatic interpretation of patient needs in behavioral health treatment there is a push for the field to define its approach to the complexity of co-occurring illnesses. A program can still focus on addiction only, but each facility should make an effort to understand just how involved they
ADAA is concerned with issues related to the recruitment, retention and professional development of the of Maryland’s substance abuse treatment professionals. We recognize that a major component of improving the quality of addiction treatment for Maryland citizens is to develop and retain a competent and professional workforce.

To address workforce issues, the ADAA, in conjunction with the Central East Addiction Technology Transfer Center (CEATTC) and the Mid-Atlantic Addiction Technology Transfer Center (Mid-ATTTC), have developed a survey. The survey is the first step in evaluating performance measures and assessing issues pertaining to the recruitment and retention of professionals in the substance abuse treatment system. This survey is of great importance to the work we must do in Maryland.

When you receive a survey please take a few minutes to fill it out and return it to us. This will allow us to incorporate your views into any future initiatives.

Surveys will be mailed to programs in the coming weeks. If you do not receive a survey and would like to participate, contact Linda Oney at 410-402-8585 or e-mail loney@dhumh.state.md.us.

This column has been roiling around in my head for years. I have fought the urge to write it for the past 10 years, sensing that it wasn’t yet ripe for the writing. Some of it leaked out in an earlier edition of the Compass lessening the inhibition to write and sharpening a bit more of the focus (see, “The Problem of Change,” Fall, 2004). That discussion noted that the language of change often substituted for actual change. There is no need to fight it any longer. I surrender.

Here it comes.

The Myth of C3 is brilliantly simple, intuitively charming, appealing and easy to understand. The short version: change happens if there is sufficient coordination, collaboration and cooperation (C3) by stakeholders. The idea is that C3 is not only a necessary, but a sufficient, condition for change. That is, by energy, synergy, and sheer process, things happen for the better with people coordinating, collaborating and cooperating. C3 sounds good. It is now pretty standard stuff, classically American in a positive way and OK - usually. Participating on a task force, a community coalition, a local advisory council and other work groups is routine and expected. What’s the myth then? It is that C3 process makes the change.

I don’t think so. There is a fourth “C” that makes change possible: “Content.” We’re talking C4 here. Process is important. So is content knowledge. The process flounders when content knowledge is out of date or simply lacking. Here is how to tell a process that is in trouble and mired in C3: successive meetings that require expanding the number of participants, frequent calls to review mission statements, calls for outside consultants and endless meetings noted for both frequency and duration with no end in sight. This is not good. Diagnosis: “A content free process.” I wouldn’t get comfortable with the idea that getting to C4 guarantees the right result, either. You might just get a great group process with content knowledge.

And that’s it. The trick here is to do something. Yes, do something. This would be the part where “action” comes in. Use the process, use the content knowledge and act. Without the action there is no change. There is the language of change, process and content, but sadly, no change. End of the Myth of C3.

And here starts another management tale. If you are doing your job, everyone is happy. And why would you disrupt it? Good luck on that one. If you see an organization that has implicitly embraced this ethic (and I know of no organization, human service or not, that would explicitly take this position) you are looking at an organization dedicated to the status quo. This group works C3 as well as anyone, has content knowledge but values the getting along part more than the change part. The truth is change can be disruptive, destabilizing and confusing and inspiring. Not in this organization, it doesn’t happen. “Action” is only a theoretical construct.

Why would I write about this now? Apart from my almost pathological aversion to management books and classes (well earned, I might add). I am fascinated with how the field continues to move forward and change. Practitioners and managers are refreshingly candid about what they are thinking about and tend toward another classical American trait – pragmatism. Of all my professional associations as a clinician, clinical administrator and educator I know of no group that is more willing to try to do things differently. There are several caveats. You better know what you are talking about. You better have the facts right. Also, you better not try to get by with just C3. American pragmatism is alive in the substance abuse field.

The substance abuse business in Maryland is serious business. We are collectively setting standards, building on what we know while staying open to learning what we don’t yet know. This is hard work and sometimes uncomfortable work. It is going to require getting to C4 and adding the “A”; ....and that is not a myth.
just under 30 percent of ADAA-funded admissions were to residential treatment compared to under 20 percent for non-funded. Over 12 percent of non-funded patients entered intensive outpatient; it is possible some of these are being reported by programs not certified for IOP, or Level II.1.

Since the reporting of Type of Client item. Levels I, II.1 outpatient (OP) and MAT came directly from service categories intensive and methadone. The other maintenance ASAM categories came from combining service category information with a 16 category listing of provider identifiers according to treatment and setting that has been maintained in SAMIS for many years. These are the following – halfway house, ICF, long term residential, group home, non-hospital detox, other residential, health department OP, other OP, intensive OP, ambulatory detox, jail, correctional, methadone, methadone detox, hospital and detox.

Change services and new programs open has been difficult – reporting the ASAM levels will contribute to more accurate data.

Footnotes

ASAM PPC II-R Research

Magura et al (2003) performed a study examining the predictive validity of the ASAM PPC II-R for matching alcoholism patients to different levels of care. They found that patients matched to the recommended level of care had better outcomes than those mismatched to under-treatment. In general the ASAM PPC II-R was effective in reducing both under-treatment and over-treatment.1

Kosanke et al (2002) examined the effectiveness of the ASAM PPC II-R in a substance abuse treatment program that tried to minimize barriers to treatment. The authors assessed the amount of mismatches in treatment placement and whether patients received over-treatment or under-treatment. They found clients were matched correctly 72 percent of the time. When mismatched, patients were more likely to receive over-treatment than under-treatment (59 percent to 41 percent).2

National Alcohol and Drug Addiction Recovery Month toolkits are now available for ordering or downloading at www.recoverymonth.gov. You will find everything you need to prepare for your 2005 events and activities. The toolkit includes materials tailored to key constituent groups with steps to improve treatment and recovery programs, templates of media outreach materials that you can customize to publicize your events, and suggestions for educating your community about addiction treatment and recovery.

Treatment coordinators are invited to participate in the planning for a showcase of treatment programs for display during the Kick-Off Festival. You can contact Laura Burns-Heffner at 410-402-8611 or lburns-heffner@dhmh.state.md.us with your ideas and suggestions for this year’s celebration.

This year’s theme is “Healing Lives, Families, and Communities”. Let’s join together to make this our biggest and best celebration to date!
## Patient Placement Crosswalk

<table>
<thead>
<tr>
<th>ASAM Level</th>
<th>ASAM Level of Care</th>
<th>COMAR Level of Treatment (Chapter)</th>
<th>SAMIS Items: Service/Referral Categories</th>
<th>T.F.R.A.N. Level of Care</th>
<th>Examples of Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5</td>
<td>Early Intervention</td>
<td>Early intervention 10.02.03 Education Programs 10.47.04</td>
<td>Item 4: High Risk Adolescent (3)</td>
<td>0.5 Early Intervention</td>
<td>1:1 counseling with at-risk individuals DUI programs</td>
</tr>
<tr>
<td>I</td>
<td>Outpatient Treatment</td>
<td>Outpatient Treatment 10.02.04</td>
<td>Item 6: Outpatient (2) Item 50: Other OP (03)</td>
<td>I Outpatient</td>
<td>Office practice, health clinics, primary care clinics, mental health clinics, “Step down” programs</td>
</tr>
<tr>
<td>I-OMT</td>
<td>Opioid Maintenance Therapy</td>
<td>Medication Assisted Treatment 10.02.11</td>
<td>Item 6: Methadone Maintenance (1) Item 50: Methadone (01)</td>
<td>MAT Medication Assisted Treatment MAT.D Medication Assisted Treatment Detox</td>
<td>Methadone Maintenance Programs</td>
</tr>
<tr>
<td>II.1</td>
<td>Intensive Outpatient</td>
<td>Intensive Outpatient Treatment 10.02.05</td>
<td>Item 6: Intensive Outpatient (6) Item 50: Intensive OP (2)</td>
<td>II.1 Intensive Outpatient</td>
<td>Day or evening outpatient programs</td>
</tr>
<tr>
<td>II.5</td>
<td>Partial Hospitalization</td>
<td>Partial Hospitalization 10.02.05</td>
<td>None noted</td>
<td>II.5 Partial Hospitalization</td>
<td>Day treatment programs</td>
</tr>
<tr>
<td>III.1</td>
<td>Clinically Managed Low Intensity Residential Treatment</td>
<td>Residential Service - Halfway House 10.02.06</td>
<td>* Item 6: Residential (3) Item 50: Halfway House/Group Home (06) ** Item A8: Residential Alcohol or Drug Treatment (3)</td>
<td>III.1 Halfway House</td>
<td>Halfway Houses with “Recovery” Services or “Discovery” (precontemplative) Services; Sober Houses, boarding houses, or group homes with in-house Level I intensity services and a structured recovery environment</td>
</tr>
<tr>
<td>III.3</td>
<td>Clinically Managed Medium-Intensity Residential Treatment</td>
<td>Residential Services - Long Term Residential Care 10.02.07</td>
<td>Item 50: Long Term Care (07) * **</td>
<td>III.3 Long Term Residential Care</td>
<td>Therapeutic Rehabilitation Facility for extended or long-term care</td>
</tr>
<tr>
<td>III.5</td>
<td>Clinically Managed High Intensity Residential Treatment</td>
<td>Residential Services - Therapeutic Community 10.02.08</td>
<td>Item 50: Other Residential Substance Abuse Program (08) * **</td>
<td>III.5 Therapeutic Community</td>
<td>Therapeutic Community or Residential Treatment Center Step-down from III.7</td>
</tr>
<tr>
<td>III.7</td>
<td>Medically Monitored Intensive Inpatient Treatment</td>
<td>Residential Services - Medically Monitored Intensive Inpatient Treatment (Intermediate Care Facility C/D) 10.02.09</td>
<td>Item 50: Intermediate Care (05) * **</td>
<td>III.7 Medically Monitored Inpatient (ICF)</td>
<td>Inpatient Treatment Center</td>
</tr>
<tr>
<td>IV</td>
<td>Medically Managed Intensive Inpatient Services</td>
<td></td>
<td>Item 50: General Hospital (11), Psychiatric Hospital (12) Item A8 Inpatient: Medical Treatment (4), Psychiatric Treatment (5)</td>
<td></td>
<td>Acute Care General Hospital, Acute Psychiatric Hospital or Unit within a general hospital, Licensed Chemical Dependence Specialty Hospital with Acute Care Medical and Nursing Staff</td>
</tr>
</tbody>
</table>

* Item 6 Residential (3)
** Item A8 Residential Alcohol or Drug Treatment (3)
DEFINING “LEVEL OF SERVICE” CATAGORIES

By Peter Cohen, M.D., ADAA Medical Director and Debbie Green, Compass Editorial Staff

The Alcohol and Drug Abuse Administration (ADAA) is in the process of reviewing and standardizing “levels of service” definitions for Maryland’s Substance Abuse Treatment System. The revised standards match uniform patient placement criteria defined by the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC) II-R (Revised). The ASAM Criteria, developed in 1991, has evolved into a nation-ally recognized standard over the past 15 years. Such standards ensure increased uniformity of treatment and improved cost-effective allocation of resources. According to Substance Abuse and Mental Health Services Administration (SAMHSA), “Uniform patient placement criteria play an important role in unifying public and private resources that makeup the substance abuse treatment system in the United States.” (DHHS Publica-
tion No. (SMA) 95-3021, Substance Abuse and Mental Health Services Administration, TIP 13, 1995.)

Standards for defining the continuum of care in the treatment system have historically been unclear. On examination, the same level of service can have multiple labels defining a variety of services, depending not only on the services provided but also on the defning agent (i.e.: COMAR*, SAMIS**, TFRAN***, OHCQ****, etc.). For example, an ICF (Intensive Care Facility) can presently be defned by any of the following labels; 1) Level III.7 - Medically Monitored Intensive Inpatient Treatment, 2) Residential Services - Medically Moni-tored Intensive, 3) III.7 Medically Monitored Inpatient (ICF), and/or 5) Inpatient Treatment Center.

This multiplicity of defnitions has created challenges in data collection and reporting. The ASAM Criteria applied and used across all reporting venues puts into play a “common language” of shared defnitions. Shared defnitions improve communication, clarify organiza-
tional structure, and in general improve accountability of outcome measures. A “common language” allows stakeholders to know exactly how treatment programs and clinicians make decisions about patient placement and on-going care. It also facilitates communication between and among all parties involved in the planning process.

By adopting the ASAM language ADAA looked to a sci-
ence-based measure to provide the framework for a con-tinuum of care that can be understood across all treatment jurisdictions and throughout the nation. On the federal level, dollars for treatment are increasingly dependent on the ability to measure performance. Uniform placement standards allow for data collection that can be analyzed, compared and contrasted across a broad spectrum of pop-
ulations. The shared defnition of placement criteria levels the playing field for practitioners by ensuring standards practiced in any region can be met both statewide and na-
tionally. This means that jurisdictions can focus more ac-
curately on program improvement measures that enhance outcomes without being bogged down by the task of defin-
ing and re-defning labels.

Importantly, as jurisdictions work with their local Drug
and Alcohol Abuse Council to develop regional plans and the state council moves to recommend a state treat-
ment plan, this shared language will clarify the goals of Maryland’s treatment system for all of the stakeholders. This practice encourages the early identifi-cation of gaps in service, and under or over utilized resources.

ADAA is working with the Department of Health and Mental Hygiene’s Office of Health Care Quality to ensure compliance to standards during the certifi-cation and re-
certification process. This Compass issue includes a cross-
walk of ADAA’s adopted ASAM codes, the levels of care, the defnition of each level, and examples of current care levels and where they would fi t in the new standards. (See Insert)

* COMAR - Code of Maryland Regulations
** SAMIS- Substance Abuse Management Information Systems
*** TFRAN- Treatment Financial Reporting and Allocation Network
**** OHCQ- Office of Health Care Quality