WISCONSIN UNIFORM PLACEMENT CRITERIA

WI-UPC

FOR ADULT SUBSTANCE USE DISORDERS

September 2000

TABLE OF CONTENTS

WI-UPC Introduction ..... **Section I**
- **Overview**
- **WI-UPC History**
- **Purpose and Concepts of Uniform Placement Criteria**
- **Instructions for Use**
- **Frequently Asked Questions (FAQ)**
- **Terms Used in the Manual**

WI-UPC Assets and Needs Criteria ..... **Section II**
- **Intoxication Monitoring and Withdrawal Services**
- **Rehabilitation Services**

WI-UPC Placement Scoring Instrument ..... **Section III**

WI-UPC Reference Materials ..... **Section IV**
- **Withdrawal Screening Instruments**
- **Narcotic Withdrawal Scale**
- **CIWA-Ar**
- **SSA**
- **Sample Interview Questions**

WI-UPC Appendices ..... **Section V**
- **Appendix A References Prepared by CSAT**
- **Appendix B Resource List Prepared by CSAT**
- **Appendix C WI-UPC BSAS Resource List**

Wisconsin Uniform Placement Criteria
WI-UPC

Introduction to WI – UPC

Section I

WISCONSIN UNIFORM PLACEMENT CRITERIA OVERVIEW

The national focus upon health care has created an opportunity for substance abuse treatment providers to enter into a process of system review, analysis and redesign. In some states this process has led to dramatic and far-reaching modification of the traditional system of substance abuse treatment. In many states it has provided the opportunity for both treatment providers and insurance/managed care representatives to take a critical look at the most clinically and fiscally sound and effective means of determining appropriate placement for individuals seeking treatment for substance use disorders.

In recognition of the changing health care climate, the Wisconsin Bureau of Substance Abuse Services, in close collaboration with the State Council on Alcohol and Other Drug Abuse and key treatment, insurance industry and managed care representatives, entered into a project in 1994 to develop and implement uniform placement criteria for substance use disorder treatment in Wisconsin.

This reference manual describing Wisconsin Uniform Placement Criteria (WI-UPC) was developed through the efforts of a group whose members reflect the geographic diversity of this state. These members represent treatment programs along the continuum of care, managed care entities, county board representatives and public policy makers.

WISCONSIN UNIFORM PLACEMENT HISTORY

Since the early 1980s, a number of models that address patient placement criteria have been developed nationwide. In 1981, the Minnesota legislature asked the Human Services Commissioner of that state to develop criteria to determine the appropriate level of care for public assistance recipients with chemical dependency problems. In 1986, the Northern Ohio Chemical Dependency Treatment Directors Association, working in conjunction with the National Association of Addiction Treatment Providers (NAATP), published a criteria for a continuum of care that was recognized nationally. In 1989, NAATP began collaborating with the American Society of Addiction Medicine (ASAM) in the development of criteria. The American Society of Addiction Medicine is composed of physicians who specialize in the treatment of substance abuse. Their efforts consisted of an extensive review of treatment literature and two years of work by two task forces. In the early 1990s ASAM, the States of Oregon, Iowa, Kansas and the Commonwealth of Massachusetts developed patient placement criteria for substance use disorders.

Wisconsin activities regarding development of substance abuse placement criteria formally began in September 1994. Jointly sponsored by the State Council on Alcohol and Other Drug Abuse and the Bureau of Substance Abuse Services, a patient placement criteria conference entitled "On The Cutting Edge" served as a focal point to introduce this concept to Wisconsin substance abuse treatment professionals. Meetings were held during the following year which were attended by major stakeholders in the substance abuse treatment field and by managed care/insurance industry representatives. These individuals have since developed a placement criterion for adoption by all stakeholders in the Wisconsin substance abuse treatment delivery system. It represents the full continuum of care ranging from medically monitored to outpatient treatment service and all levels of detoxification services.

On August 1, 2000 HFS 75 went into effect requiring the use of either the WI-UPC or ASAM in initial placement, continued stay, transfer between levels of care, and discharge from treatment for inidividuals served by Wisconsin certified substance use disorder treatment providers.

PURPOSE AND CONCEPT OF UNIFORM PLACEMENT CRITERIA

Development of Uniform Placement Criteria for the State of Wisconsin was based upon the goal of establishing a common set of standards accepted by providers, payers and agencies that develop public policy in Wisconsin. WI-UPC promotes consistency in the identification of the consumer's individual needs as well as formalizing the decision-making process. This in turn leads to the effective placement of the consumer in the most appropriate, least restrictive treatment setting.

There are a variety of advantages associated with WI-UPC, including the following:

- WI-UPC developed a common language that describes the multidimensional assessment process and identifies the core components of the continuum of care. This enables clinicians, individuals and payers to discuss treatment planning, utilizing a common language with uniform definitions of levels of care.
- WI-UPC helped to address placement consistency by ensuring that individuals obtain treatment based upon appropriateness rather than on funding limitations or program availability. Conversely, WI-UPC helps to minimize costs by ensuring that individuals obtain appropriate treatment based on agreed-upon criteria.
- WI-UPC led to the adoption of uniform definitions, common standards of program admission, continued stay and discharge criteria in order to standardize a statewide system of care. This process offers a framework applicable to both public and private treatment and payer systems.
- WI-UPC provided a guideline that focuses upon the least intrusive and least restrictive form of treatment based upon the patient’s individual needs as identified within standardized criteria.
- WI-UPC led to a standardized collection of data that will be useful in the development of evaluation studies to assess the efficacy of placement and treatment outcomes.

WI-UPC is a rationally-based response to managed health care planning, because it is clinically focused and represents a "best practice" standard produced through a consensus-building effort within the substance abuse treatment delivery system. Benefits of adopting WI-UPC include the following clinical and systems improvements:

- Pursuit of quality care with an individualized focus.
- Multidimensional treatment planning.
- Treatment based upon a cost effective approach.
- Routine process for evaluating treatment outcomes and program planning.
- Recognition of the need for a seamless system of care, ranging from outpatient to medically monitored, and encourages the development of this continuum.
- Provision of benchmarks and the foundation for consumers, providers and payers to gauge the appropriateness of a level of treatment, monitor progress and identify expected outcomes.

WISCONSIN UNIFORM PLACEMENT CRITERIA

INSTRUCTIONS FOR USE

The following instructions may be used as a training document for WI-UPC and as a companion to the WI-UPC Scoring Instrument and the Assets and Needs Criteria. As a companion to the Scoring Instrument, this section is helpful in providing more in-depth detail for evaluating individual characteristics in each of the dimensions. Additionally, the Assets and Needs Criteria should be reviewed on a regular basis, in accordance with HFS 75, in determining the need for continuing stay, level of care transfer and discharge. The terms used in this manual can be found immediately following this section.

Individual placement recommendations are determined by evaluating five dimensions of a consumer's condition or status. These dimensions are:

1. Withdrawal Potential
2. Physical/Mental Health Condition(s) and/or Complication(s)
3. Emotional/Behavioral Condition(s) and/or Complication(s)
4. Relapse Potential
5. Recovery Environment

Appropriate placement is determined by matching individual characteristics within each of these dimensions with the frequency and intensity of services needed as indicated by the individual's symptoms. The WI-UPC Scoring Instrument (Section III) is used for initial placement while the Assets and Needs Criteria (Section II) outlined for each level of care is used to determine continued stay, level of care transfer or discharge.

The first step in recommending the appropriate level of care is to determine if the individual is intoxicated or incapacitated. If alcohol intoxication is present without incapacitation, and there is need for monitoring for the individual to safely resolve intoxication, the lowest appropriate level of care is Residential Intoxication Monitoring Service (Level D-1). It should be noted that this level of care is non-medical in nature. If or when withdrawal symptoms develop, the individual should be evaluated for possible placement in a medically managed or monitored level of withdrawal service. The evaluation to determine the need for a more intensive placement is conducted by completing a withdrawal screen as defined in this section and in Section IV, and by completing Dimension #1 of the Scoring Instrument.

If incapacitation is present, the lowest appropriate level of service is Medically Monitored, Residential Detoxification Service (Level D-3). If the individual's condition is such that withdrawal potential can be adequately assessed, either directly or through history offered by reliable collateral sources, Dimension #1 of the Scoring Instrument should be completed. An individual's withdrawal history under situations similar to what he or she is currently experiencing may provide information sufficient to indicate the need to increase the level of care.

There are a number of nationally recognized withdrawal screening instruments that produce a meaningful score. The CIWA-Ar, the SSA and the Narcotic Withdrawal Scale are examples of such instruments (samples may be found in Section IV of the manual). WI-UPC references a withdrawal severity scoring structure as follows: minimal, mild, moderate and severe. It is therefore important that the withdrawal screening instrument you select has a similar structure to determine the severity of the individual's withdrawal symptoms. If the withdrawal screening and evaluation of Dimension #1 produce a recommendation for care in any level of withdrawal or intoxication monitoring service other than Ambulatory Detoxification Service (Level D-2), a referral should be initiated as soon as possible. It is not necessary to evaluate the remaining four dimensions of WI-UPC before initiating the referral. The remaining four dimensions should be completed once his or her symptoms have cleared sufficiently to

allow evaluation by the service in which the individual is placed. The detoxification service providing the withdrawal care is responsible for the determination of continued stay, transfer to a different level of care, or discharge from services.

If, however, initial screening and evaluation of withdrawal potential culminates in a recommended placement to Ambulatory Withdrawal Service, and such a service is available to the individual, the remaining WI-UPC dimensions should be evaluated prior to initiating a referral to the withdrawal service. Since it is possible for a individual to receive care in Ambulatory Detoxification Service and a level of rehabilitation treatment service concurrently, any need for such a combination of services should be explored prior to a referral.

Step three in the WI-UPC process begins with evaluation of the seven Treatment Service Qualifying Criteria. The qualifying criteria are used to determine if the individual presents a possible need for treatment services in the formal service delivery system (services certified under the Wisconsin Administrative Code, HFS 75). A substance use disorder screening of the individual must be completed in order to obtain the necessary information to adequately respond to the seven qualifying criteria and the five dimension questions in WI-UPC. Any screening instrument may be used as long as it examines each of these areas. In Section IV of the manual, there are several sample screening questions. Information from the substance use disorder screen is applied to the seven qualifying criteria. If the response to ANY of the qualifying questions is "Yes," the individual is determined to be in possible need of referral to some level of formal substance abuse treatment services, and the remaining four dimensions should be evaluated. If the response to ALL of the qualifying questions is "No," the individual is determined to not be in need of services in the formal treatment delivery system. If the need for formal services is not identified, it is important to determine whether the individual should be referred to informal community support groups, other community resources or to a service delivery system other than substance use disorder treatment. The selected qualifiers (#1 - #7) should also be recorded on the Summary Sheet in the spaces provided.

Each of the remaining four dimensions are then evaluated using the information from the substance use disorder screening. Next to the Severity Indicator Questions that are located directly below each of the dimension questions, a number is underlined. If the response to the question is "Yes," this number should be recorded in the appropriate place on the grid found on the Summary Sheet. These numbers represent the level of care indicated by the severity indicator. When each of the dimension questions have been reviewed, the scoring grid should be completed. Instructions on the Summary Sheet ask that the single highest number for Dimension #1 be recorded as Score 1. The single highest number in all of the remaining dimensions, collectively, should then be recorded as Score 2. Please note that scores are not to be added or averaged; the single highest number under each of the two categories (Withdrawal/Detoxification and Treatment) should be selected and recorded.

Any extenuating circumstances should be explored for each consumer on an individual basis. For instance, the recommended level of service may be Day Treatment Service according to the Scoring Instrument, but that specific substance use disorder service may not be available in the individual's geographic area, or funding for the recommended level of care may not be available. This would necessitate some adjustment in the referral for services, and the reason should be documented in the "Interviewer's Comments" section of the Summary Sheet.

You may note that Transitional Residential Treatment Services (Level 1-A) are not included in the initial scoring process as a level of care. The reason for this is because an individual may not be admitted to this level of care without previous treatment in one or more of the other levels of rehabilitation care (Level 1 - Level 4). In most instances, this level of care will be used in a transfer process, and the criteria will be identified in the Assets and Needs from Section II. The exception to this rule is if an individual is being initially placed in either Day Treatment or Outpatient, he or she may additionally be placed in Transitional Residential Treatment Service if there is sufficient need, even though it may be the individual's first placement for substance use disorder rehabilitative care. If this exception is sought, specific language from the Assets and Needs in Section II and HFS 75 for this level of care should be included in the Interviewer's Comments Section.

Another reason for selecting an alternative level of care may be the identification of availability of additional resources to the consumer. For instance, an individual may be able to address identified needs through accessing available resources such as community, friends or family members. The important thing to consider in selecting an alternative level of care is that the indicator identified in the scoring process, which produces the recommendation for level of care, must be addressed in a manner that safely and effectively meets the needs of the consumer.

The consumer's willingness to accept and participate in the recommended level of care should be considered. For instance, if the individual has transportation or child care issues that prohibit the recommended placement, there may be a need to adjust the referral. Additionally, an individual may simply be unmotivated to participate in the recommended intensity of service. Consideration should be given to decreasing the service intensity, focussing treatment planning on the issue of the consumer's motivation, and providing the individual with assistance in self determination of any existing problems associated with their substance use disorder.

In any situation that necessitates deviation from the level of service recommended by the Scoring Instrument, sufficient documentation must be included.

Finally, the recommendations should be recorded on the final page of the Summary Sheet and signatures collected. At a minimum, the Summary sheet should be transferred to the clinical record, and a copy should be provided to the referring agency. The information from the Summary Sheet may be included in alternative format, provided that ALL information is included.

The Assets and Needs Criteria are found in Section II of the manual. This criteria, which are specific for each of the nine levels of care, should be reviewed and the results recorded on a regular basis to determine the need for continued stay, level of care transfer or discharge. When the criteria are reviewed, all of the assets listed, plus one or more of the needs must apply in order for the level of care to be appropriate. It is not necessary to identify a need for each of the identified dimensions, but rather one need identified in any dimension for a level of care is sufficient to determine appropriateness. Recording this information in the individual's record may be accomplished in a number of ways, however all of the information must be included in the clinical record.

LEVEL OF CARE KEY	
D-1	**Residential Intoxication Monitoring Service**
D-2	**Ambulatory Detoxification Service**
D-3	**Medically Monitored, Residential Detoxification Service**
D-4	**Medically Managed Inpatient Detoxification Service**
1A	**Transitional Residential Treatment Service**
1	**Outpatient Treatment Service**
2	**Day Treatment Service**
3	**Medically Monitored Treatment Service**
4	**Medically Managed Inpatient Treatment Service**

A full description of each level of care can be found immediately following this section.

FREQUENTLY ASKED QUESTIONS (FAQ)

WI-UPC provides the foundation for and establishes the benchmarks by which consumers, providers and payers can gauge the appropriateness of a level of treatment, monitor progress and identify expected outcomes.

1. **Is WI-UPC a requirement for program certification?**
   HFS 75 , the Department of Health and Family Services Community substance abuse service standards, has integrated the requirement for use of a Department approved placement criteria into the certification standards for alcohol and other drug abuse treatment agencies. The initially approved criteria are the Wisconsin Uniform Placement Criteria (WI-UPC) and the American Society of Addiction Medicine (ASAM) criteria, or similar placement criteria that may be approved by the Department.

2. **Will managed care follow these criteria? What do we do if they do not?**
   Managed care organizations have been involved in the development of WI-UPC from the beginning of this effort. It is expected that payer organizations will continue to express support for this process as it will improve the placement decision-making process and thereby should lead to improved treatment results. However, as in all treatment decisions, it is the responsibility of the treatment facility to make treatment decisions based on the needs of the individual. The criteria are designed to represent a "best practice" standard for placing individuals at the most appropriate and least restrictive level of care. The criteria provide rationale for treatment decisions that are clinically based and subsequently should be accepted by managed care. MCOs who contract with the state to provide health care services are required to utilize providers who are approved by the Department of Health and Family Services and who meet the minimum standards set forth in HFS 75

3. **Do providers have to offer all levels of care? If we do not operate a level of care, do we refer the patient to the next highest or next lowest level of care?**
   No. It is envisioned that not all providers will have the resources or the need to develop services at all levels of care. Several factors can influence service development, including geography, demand, other community resources and accessibility. However, the criteria are designed to place individuals at the least restrictive level of care. It is expected that providers will have the ability and creativity to develop individualized treatment plans to meet needs by modifying the levels of care that are available or by working collaboratively with other treatment providers within the community or geographic area.

4. **When does WI-UPC go into effect?**
   HFS 75 Community substance abuse service standards went into effect August 1, 2000. The Departmental - approved criteria are the Wisconsin Uniform Placement Criteria (WI-UPC) and the American Society of Addiction Medicine (ASAM) criteria, or similar placement criteria that may be approved by the Department.

5. **What about Medicaid? Will they fund all levels of care?**
   Most of the Medicaid population will ultimately be enrolled in managed care organizations. Payment for individual levels of care will be negotiable dependent upon federal limitations and existing waivers of federal guidelines. Medicaid has identified two residential detoxification levels (D-1 and D-3) and two medically monitored rehabilitation levels (1-A and 3) that are reimbursable.

6. **Will HMOs or managed care fund the level of care that we determine to be necessary?**
   The availability of funding may continue to vary according to benefit designs. It is hoped that the implementation of consistent placement decisions based on the criteria will establish the value and cost-effectiveness of alternative levels of care. This information may influence benefit designs in the future. Most HMOs and managed care companies are looking to establish relationships with providers that offer a variety of levels of care. It is anticipated that WI-UPC will, over time, demonstrate its efficacy and be voluntarily adopted as a means of objectively determining individual placement and maximizing uniformity of the public and private payer/treatment system.

7. **If the consumer refuses a level of care, what do we do?**
   Consumer choice has been included as a basic element in the development of the WI-UPC criteria. Though treatment must be medically necessary, the decision on the part of the individual to participate is voluntary. Placement decisions will have to be negotiated, on an individual basis, by the payer, the treatment staff and the individual. Refusal to accept the recommended care does not necessarily indicate that placement into a higher level of care is appropriate. It is at the discretion of the provider to offer the individual services in a lower level of care than the criteria recommend. However the ability to effectively and safely address identified risk factors must be documented if a lower level of care is selected.

8. **Will funding be tied to outcome studies? Will funders use this to decide who is awarded contracts?**
   WI-UPC represents current thinking as to accepted clinical care guidelines. Clinical outcomes are expected to be used as a basis for negotiating performance contracts between payers and treatment providers.

9. **How are various psychosocial factors, such as cultural background, lack of child care, etc. addressed?**
   WI-UPC defines a level of care based upon medical necessity. The cultural and psychosocial components of a specific service vary dramatically. Every effort should be made to appropriately match need/preference with available resources. Wraparound services (child care, transportation, etc.) must be accounted for, addressed and included into an effective case management system. Funding of wraparound services (or bundled services) remains uncertain and will need to be negotiated among the payer, the individual and other available resources.

10. **What level of education or certification will be necessary to work in the field or at different levels of care?**
    Program standards, professional credentialing requirements and external accreditation processes will continue to dictate educational requirements. Training will be made available on a regional basis through training events, conference presentations and in other venues to familiarize treatment staff and others with WI-UPC.

11. **How do you resolve differences between different providers and between payers and providers regarding level of care? Will a peer review process be used to resolve such differences?**
    It is the goal of the standards to provide the foundation for making consistent placement decisions throughout the substance abuse treatment delivery system based on objective criteria. Disparity may result due to individual interpretation of the criteria, especially those criteria more subjective in nature. It is believed that most differences can be resolved through open discussion between providers and payers. However, when agreement cannot be reached, particularly in regard to

providers and payers, it may be necessary to request the opinion of and/or an appeal with an independent peer reviewer.

12. **Is there liability with placing or not placing an individual at a certain level of care?**
Liability remains the same as with any clinical decision for both provider and payer. Providers must make treatment decisions based on their assessment of the clinical presentation of the individual. The WI-UPC criteria has been established to place individuals at the most appropriate, least restrictive level of care. Appropriate application of the criteria should ensure proper placement.

13. **Will inpatient treatment still be a part of the continuum?**
Yes. The severity of an individual's medical and/or psychiatric need is part of the criteria that will recommend placement in any of the levels of care. For a recommendation to Inpatient Treatment Service, an individual's medical and/or psychiatric needs must be sufficiently severe to require hospitalization as determined by a physician.

14. **Who do we call when we have questions?**
The Bureau of Substance Abuse Services will have staff available to answer questions regarding WI-UPC implementation. Phone numbers are listed on the last page of Appendix C in Section V of this manual. A toll free hot line is also available (888-PLACEMT or 888-752-2368).

15. **How do we reconcile differences between standards and the placement criteria in the short term?**
There will be a transition period during which the Bureau of Substance Abuse Services and the Division of Supportive Living program certification staff will work cooperatively with programs to maximize the smooth implementation of WI-UPC and minimize problems associated with interpretation of Wisconsin Administrative Code HFS 75.

16. **Will there be a review of this process and a feedback mechanism? How will changes in the criteria be made?**
Yes. Evaluation and revision of the criteria will be a continuous process based on feedback from providers and payers, as well as treatment outcomes. Principles of continuous quality improvement will play a key role in enhancing the criteria to increase usability and effectiveness. Providers will receive updates and additional training as needed. A Clinical Q&A site will also be maintained on the BSAS web site and be updated monthly to address WI-UPC questions.

17. **Does this process apply to both private and public sector substance abuse treatment providers?**
The use of placement criteria will be required by any certified treatment provider in the state. Establishment of a uniform tool will provide consistent data for outcome studies, evaluation and comparison of treatment services.

18. **Are there any situations when the criteria would not be applied? If so, when?**
In extenuating circumstances there may be the need to deviate from the recommendation provided by the criteria. However, it is anticipated that this will occur very infrequently and will be based on the clinical presentation of the individual. This would preclude the individual's ability to function within the level of care identified by the criteria or the identification of additional resources available to the individual that would allow safe and effective placement in an alternative level of care. These situations will require resolution on a case-by-case basis. The resolution should include review by a clinical supervisor, concurrence by the paying agency and clear articulation of the basis for the alternative placement decision.

19. Is there a way to override the placement criteria?

Yes. Individualized circumstances may require deviating from these criteria, for example, geographic inaccessibility to all levels of care, lack of available funding for the recommended level of care, or the identification of additional resources necessary to the fully engage the individual. Such an override or selection of an alternative level of care should be based upon extenuating circumstances which are clearly defined, have been reviewed by a clinical supervisor and agreed upon by the provider, the consumer, and the payer.

20. How much room is there for clinical discretion?

WI-UPC represents good practice guidelines that have been developed to assist clinicians with the treatment placement process. They are not intended to replace competent clinical judgment. The section titled "Interviewer's Comments" is provided as a means of incorporating case specific clinical comments and recommendations.

21. Will treatment cost more or less?

Resources available for substance use disorder treatment will not increase due to implementation of the criteria; however, WI-UPC will result in more cost-effective treatment due to the treatment matching process.

22. Will training be made available? If so by whom, at what cost (if any) and when?

Initial training will be made available by the Bureau of Substance Abuse Services on a regional basis; there is a charge for the training. In addition, in-service training may be sponsored by associations or by the Wisconsin Certification Board. There may be costs associated with the latter training events.

23. Do you need a diagnosis prior to determining level of care?

No. You don't need a diagnosis to use this instrument or to determine level of care recommendations. Screening is the first step in administering WI-UPC, and the assessment does not occur until the individual reaches a provider at the recommended level of care. Since screening does not necessarily provide a diagnosis, one is not required to use WI-UPC or to determine recommended level of care. However, some funding sources may require a diagnosis in order to approve a placement. Sufficient information is gathered through the screening process conducted prior to the WI-UPC application to identify at least an initial diagnosis. As in any case, the diagnosis may change as ongoing assessment and evaluation occurs throughout the treatment process.

24. Is the WI-UPC Scoring Instrument a screening instrument or an assessment instrument?

It is neither. WI-UPC is a scorable placement determination instrument. Although a substance use disorder and possibly a withdrawal screen must be conducted in order to obtain the information necessary to score the placement instrument, it should not be considered a screen in and of itself. WI-UPC is designed to enhance rather than replace any existing prior authorization process.

25. How often does the WI-UPC Scoring Instrument have to be used?

The scoring instrument must be used at initial entry into the treatment service delivery system and should follow the individual to an appropriate level of care. Ongoing review of the individual's condition should be conducted using the WI-UPC Assets and Needs Criteria. Sufficient change in the severity of the individual's condition(s) will indicate the appropriate change in the necessary level of care, e.g. transfer to another level or discharge. An individual would remain in the current level of care (continued stay), if they continue to meet all of the Assets and one or more of the

Needs Criteria for that level of care. It is recommended (though not required) that the Assets and Needs Criteria be reviewed on at least a bi-weekly basis for individuals who receive clinical services more frequently than one time per week.

26. Will there be new state or other funds available with the use of WI-UPC?
WI-UPC is not designed to produce new funds for treatment; however, it will help in managing existing dollars.

27. Will WI-UPC result in the development of more specialized services?
One impact of WI-UPC and HFS 75 is the diversification of services within both individual agencies and provider networks. These service delivery systems may be able to include the availability of more levels of care in one setting as barriers are identified and removed from HFS 75. As agencies and networks begin to diversify, they may also increase their marketing potential to funding sources by providing a full range, or at least full access, to the continuum of care. In this way, specialty services can be included as the needs of the treatment population demand. The emphasis is on the service needs of the consumer rather than on fitting consumers into pre-defined program structures.

28. How will Level D-1, Residential Intoxication Monitoring Service, be funded since it is not based on medical necessity?
While this service is not likely to be funded by private or public insurance because it is not a medical service, other funding sources may be available. This level of care most closely resembles the level currently known as "Social Setting Detoxification," which is usually funded through county funding systems, foundations or other grants. It is important to note that this level is an intoxication monitoring service. If withdrawal symptoms develop, the individual should be referred to the appropriate level of withdrawal service, if necessary. Individuals in Level D-1 may never have a diagnosis of either dependency or abuse, and, in fact, may not develop any significant withdrawal symptoms.

29. Does the CIWA-Ar or the SSA need to be conducted by medical personnel?
Neither the CIWA-Ar nor the SSA requires medical training to administer. The SSA does require the ability to determine pulse rate and temperature. If your agency's current practice is to evaluate more detailed vital sign conditions, this can be continued. However, documentation available on the CIWA-Ar suggests that while vital sign monitoring may be necessary in the treatment of withdrawal symptoms, it is not necessary in determining placement. Please refer to HFS 75 for specific staffing and personnel requirments.

30. Is there any part of this program that can be dissected for special circumstances (i.e., individual comes in at night and is up and gone before seeing the counselor)?
WI-UPC is expected to assist in the development of good practice standards. In the example given here, WI-UPC will not change the ability for a consumer to leave a service against staff advice; however, every effort should be made to screen and refer the individual to the appropriate level of care.

31. Should the counselor who administers WI-UPC initiate referral or simply present a number of options and leave the referral initiation to the consumer?

While it is necessary to offer the individual information on the available options, it is important for the counselor to make every effort to initiate the referral for the individual as soon as possible.

Wisconsin Uniform Placement Criteria
WI-UPC

Terms Used In This Manual

TABLE OF CONTENTS

Aftercare (see Continuing Care) 19
Alternative Placement 19
Ambulatory 19
Assessment 19
Assets 19
Behavioral Patterns 19
Carve Outs 19
Case Management 20
Certification 20
  Counselor 20
  Program or Service 20
CIWA 20
Collateral Source 20
Cognitive Status 20
Continued Stay 20
Continuing Care 21
Creates a Danger to Self or Others 21
Current 21
Dimensions 21
Discharge 21
Dual Diagnosis 21
ERISA 21
Facility 22
Frequency and Intensity of Care 22
Health Management Organization HMO 22
Incapacitation 22
Individual 22
Intervention 22
Intoxicated Person 22
Levels of Care 22
  Level D-1 Residential Intoxication Monitoring Service 22
  Level D-2 Ambulatory Detoxification Service 23
  Level D-3 Medically Monitored, Residential Detoxification Service 23
  Level D-4 Medically Managed Inpatient Detoxification Service 23
  Level 1A Transitional Residential Treatment Service 23
  Level 1 Outpatient Treatment Service 23
  Level 2 Day Treatment Service 23
  Level 3 Medically Monitored Treatment Service 23
  Level 4 Medically Managed Inpatient Treatment Service 23
Licensure - Facility 24
Life Stressors 24
Living Environment 24
Managed Care 24
Managed Care Organizations (MCO) 24
Medicaid Benefits 24
Medicaid 24
Medical Personnel 24
Medically Managed 24
Medically Monitored 25

Narcotic Withdrawal Scale 25
Terms used in Withdrawal Scales/Screening Instruments 25
Needs 25
Non-Ambulatory 25
Point of Service POS 25
Preferred Provider Organization PPO 26
Personal Support 26
Pre-Admission Review 26
Program 26
Recent 26
Referral 26
Relapse 26
Due to Lack of Coping or Daily Living Skills 26
High Risk 26
Sabotages to Recovery Efforts (Purposely or Unintentionally) 26
Scorable Screening Instrument 27
Screening 27
Selective Severity Assessment (SSA) 27
Services 27
Stability. 27
Psychiatric Stability 27
Emotional Stability 27
Behavioral Stability 28
Substance Use Triggers/Cues 28
Substance Free Intervals 28
Transfer (Level of Care) 28
Treatment 28
Treatment Plan 28
Treatment Planning 28
Unbundled Services 29
Utilization Management 29
Wisconsin Uniform Placement Criteria (WI-UPC) 29

WORKING DEFINITIONS FOR
WISCONSIN UNIFORM PLACEMENT CRITERIA

Aftercare (see Continuing Care)

Alternative Placement
If there is a need to deviate from the placement recommended through the scoring process of WI-UPC or the review of the Assets and Needs Criteria, the placement is known as an alternative placement. Examples of the need for an alternative placement may occur when the recommended level of care is not available within the individual's geographical area or funding for the recommended level of care is not available.

Ambulatory
This term, as it is used in WI-UPC, serves as a descriptor for the intensity of the level of care. Ambulatory services are provided on an outpatient basis, so that the individual does not reside for 24 hours or more at the site where services are provided.

Assessment
Assessment is the process and procedures by which a counselor or service identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of the treatment plan. Assessment is an ongoing function throughout the continuum of care and is directly tied to treatment planning.

Assets
Assets refer to the strengths the individual possesses. Some examples may include: the individual is free of withdrawal symptoms, the individual is not under the influence of substances, the individual has a supportive and safe living environment, and the individual is willing to follow the agreed upon elements of the treatment plan.

Behavioral Patterns
The references in WI-UPC pertain to established patterns of problematic behavior. Some examples of behavioral patterns may include, but are not limited to:

- Violence
- Driving while intoxicated
- Self mutilation
- Child abuse or neglect
- Inability to complete critical self-care needs, for instance, not taking a vital medication as prescribed.

Carve Outs
This is a benefit strategy in which a benefits purchaser separates (carves out) the mental health and substance abuse portion of health care benefits from other health care services and hires a Managed Health Care (MHC) company to manage or provide these benefits through its network. This strategy is meant to afford the employer with specialized management for this portion of the overall benefit package.

Case Management
Case Management refers to the activities guided by the treatment plan, which bring services, agencies, resources or people together within a planned framework of action toward the achievement of established goals. Liaison activities and collateral contacts may be included.

Certification
Counselor

In Wisconsin, certification is the process by which a non-governmental agency known as the Wisconsin Certification Board or association grants recognition to an individual who has met certain predetermined qualifications/specifications and successfully completed competency, based testing by the Wisconsin Certification Board or association.

Service

Service certification is the approval of a service for a specific purpose by a duly authorized agency. The substance abuse service standards found in HFS 75 represent the minimum standards a service must meet in order to be approved by the Wisconsin Department of Health and Family Services.

CIWA
The Clinical Institute Withdrawal Assessment (CIWA) is a scorable validated withdrawal screening instrument that is widely recognized and used in the field of substance abuse treatment. Documentation of this instrument states that it can be administered in approximately two minutes and can be accurately applied every half hour. The CIWA-Ar has four distinct levels of severity identified by the score received when it is applied. The severity levels are as follows:

Minimal	score of 0 to 4
Mild	score of 5 to 12
Moderate	score of 13 to 19
Severe	score of 20 or greater

Collateral Source
Is a source from which information may be obtained regarding the individual. Some examples of collateral sources may include: clinical records, family members, friends, co-workers, probation/parole agents, and/or other health care providers.

Cognitive Status
Cognitive status refers to an individual's ability to receive and understand, or to be cognizant of, information or situations. When a cognitive or developmental disability status is part of the evaluation, these impairments must be taken into consideration. In evaluating an individual's cognitive status, it is necessary to determine his or her degree of cognitive functioning. An example of a individual who evidences some degree of cognitive impairment is an individual who reports that each time a certain function is attended he or she abuses substances which, in turn, creates a problem for the individual. However, this individual at the same time does not appear to recognize the advisability of avoiding attendance at the function as a part of their recovery plan. In evaluating cognitive status, impairment due to intoxication should not be considered for the purposes of scoring WI-UPC.

Continued Stay
Once an individual has been placed in a level of care, the person's condition should be reviewed on a regular basis. Upon review, if the individual still meets all of the assets and at least one of the needs for that level of care, a continued stay recommendation is indicated.

Continuing Care
Continuing care is the stage of treatment in which the individual no longer requires counseling at the intensity described in § HFS 75.10 – 75.12. Continuing care is also treatment that follows a treatment plan, is designed to support and sustain the process of recovery and is provided on an outpatient basis and at a frequency agreed upon between the individual and the provider.

Creates a Danger to Self or Others
This phrase, as used in WI-UPC, refers to a risk factor that exists if an individual returns to active substance use. It is linked in the criteria to the presence of high risk of relapse and also the existence of an identified condition or behavioral pattern. Some examples may include, but are not limited to:

- An individual who has an established behavioral pattern of violence while under the influence. If there is a high risk of relapse identified for this individual, the established behavioral pattern creates a danger to the individual or others encountered if the individual returns to substance use.
- An individual who has a physical or mental health condition that could create a danger to either themselves or others if the individual returns to substance use. This may be, for instance, a pregnant woman whose return to substance use could endanger the health of the baby. Another example is an individual who is currently being treated with medication for a physical/mental health condition, particularly if it is known that the medication dangerously interacts with the individual's drug(s) of choice.

Current
Current as it is used in WI-UPC refers to conditions, complications, situations or behaviors that are: presently elapsing, occurring in or existing at the present time, and/or prevalent at the moment.

Dimensions
The term dimensions refers to potential problem areas or characteristics of a individual's life. These areas are evaluated to make placement decisions. The dimensions include:

1. Withdrawal potential
2. Physical/mental health conditions or complications
3. Emotional/behavioral conditions or complications
4. Relapse potential
5. Environmental conditions

Discharge
Discharge from substance abuse services occurs when the individual no longer meets criteria for any level of care in the formal substance abuse treatment delivery system. An individual moving from one level of care to another is a level of care transfer not a discharge.

Dual Diagnosis
Dual Diagnosis means a diagnosed substance use disorder as described in the most current Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) that includes dependency, abuse and dementia, and a diagnosed mental disorder.

ERISA
Employee Retirement Income Security Act (ERISA) of 1974 is a federal law regulating private sector pension and employee welfare plans. It allows self-funded health care benefits provided to employees to be exempted from state mandated benefits. While a self-funded plan may contract with an insurance entity to perform administrative functions, it may not purchase actual insurance policies from the entity. If the purchase of a policy occurs, the benefits are then subject to the state mandates.

Facility
Facility refers to the physical structure in which a program is housed or operated. Facilities are licensed by the Department of Health and Family Services to ensure that fire safety codes and other safety issues are maintained at a minimum standard. Facilities are approved through a license while substance use disorder services provided in that licensed facility are certified.

Frequency and Intensity of Care
The continuum of care ranges from Non-Medical, Non-Ambulatory Intoxication Monitoring Service to Inpatient Treatment Service. The full range of services are divided into two groups: withdrawal services (Levels D-1 through D-4) and rehabilitation services (Levels 1A through Level 4). Within each of these groups, the levels are arranged in order of increasing intensity and/or frequency of the care they provide. Intensity of services refers to both the degree of restrictiveness for a individual to participate and to the range of specific services expected, including the involvement of medical professionals in the delivery of care. Frequency refers to how often the services may be provided or made available to the individual based on minimum requirements of HFS 75.

Health Management Organization (HMO)
This is a prepaid, capitation-based, comprehensive health care system providing services to an enrolled beneficiary population.

Incapacitation
Per Wisconsin State Statute 51.45, "Incapacitated by alcohol" means that a person, as a result of the use of or withdrawal from alcohol is unconscious or has his or her judgment otherwise so impaired that the individual is incapable of making a rational decision This may be evidenced objectively by such indicators as extreme physical debilitation, physical harm or threats of harm to self or to any other person or to property.

Individual
As referenced in WI-UPC, "individual" means any person who has applied for, participated in, or received an interview, counseling or any other substance use disorder treatment.

Intervention
In severity indicator "a" of Dimension Four, the phrase "despite one or more interventions" refers to the fact that the individual has attempted to obtain abstinence with help from others. This may include such resources as educational programs, assistance from non-AODA professionals, support groups or formal treatment.

Intoxicated Person
Per Wisconsin State Statute 51.45, "Intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol.

Levels of Care
Level D-1 Residential Intoxication Monitoring Service

This is a service providing 24-hour-per-day observation by non-medical staff to monitor the safe resolution of alcohol and/or sedative intoxication and to monitor for the development of alcohol withdrawal.

Level D-2 Ambulatory Detoxification Service

This is a medically managed or medically monitored structured withdrawal service, delivered on an outpatient basis and provided by a physician or other health care professional acting under the supervision of a physician.

Level D-3 Medically Monitored, Residential Detoxification Service

This is a 24-hour-per-day withdrawal monitoring and withdrawal service provided in a non-ambulatory setting, by a multi-disciplinary team of health care professionals, including 24 hour nursing care under the supervision of a physician.

Level D-4 Medically Managed Inpatient Detoxification Service

This is a 24-hour-per -day observation and monitoring detoxification service in a hospital setting, with 24 hour nursing care, physician management and all the resources of a general or specialty hospital setting.

Level 1A Transitional Residential Treatment Service

This is a clinically supervised, peer-supported therapeutic environment with clinical involvement. The service provides substance use disorder treatment in the form of counseling for 3 to 11 hours weekly, per individual immediate access to peer support through the environment and intensive case management, that may include direct education and monitoring in the areas of personal health and hygiene, community socialization, job readiness, problem resolution counseling, housekeeping and financial planning.

Level 1 Outpatient Treatment Service

This is an ambulatory treatment service totaling less than twelve hours of treatment services per week.

Level 2 Day Treatment Service

This is a medically-monitored structured ambulatory treatment service. Day Treatment Service consists of regularly scheduled (minimum 12 hours per week that consists of at least 3 hours a day, 4 days a week) treatment rehabilitation services.

Level 3 Medically Monitored Treatment Service

This is a community or hospital based 24-hour, non-ambulatory treatment service that includes observation and monitoring under the supervision of a physician, with a minimum of 12 hours of counseling per week for each individual.

Level 4 Medically Managed Inpatient Treatment Service

This is an inpatient treatment service is provided in a general or specialty hospital with 24 hour nursing care, physician management and availability of all the resources of a hospital.

Licensure – Facility

Licensure means the issuance of formal approval by a duly authorized agency. In relation to the provision of substance abuse services, the two most common facility licenses are HSS 83, which is for Community Based Residential Facilities (CBRF), and HSS 124 for hospitals. There is a distinct difference between facility licensing and service certification. Licensure speaks primarily to fire safety issues while certification addresses the minimal components the service must provide in order to be approved by the Department of Health and Family Services.

Life Stressors
Life stressors refers to situations or conditions in an individual's life that create stress. Some examples of stressors may include a job, a relationship or a health condition, that create difficulties for the individual in their daily life.

Living Environment
This refers to the elements surrounding an individual where he or she lives. It is important to note that an individual's living environment may be the streets or a shelter as easily as it may be the individual's own home.

Managed Care
Managed Care refers to any of a variety of systems and strategies aimed at coordinating appropriate clinical and financial resources to ensure needed care for consumers. It features increased structure and accountability for providers and the overall coordination of care, while eliminating duplicate or unnecessary services.

Managed Care Organization (MCO)
MCOs are management organizations that usually work to provide health care benefits in the most cost-effective manner possible. MCOs typically achieve this end by managing the care provided as opposed to managing access or managing benefits. This is done by performing utilization management instead of utilization review, with a greater emphasis on treatment planning, delivery of the most appropriate care in the most appropriate setting, and by moving individuals through a continuum of services.

Medicaid Benefit
Minimum Medicaid benefit levels for substance use disorder services are established by statutes enacted by state legislature. These vary from state to state and can add to overall health care costs (in Wisconsin the state statute is 632.89). ERISA exempts employers who are self-insured from these mandates. The minimum dollar amount reflected in Wisconsin's mandated benefits is:

$7,000	less 10% co-pay	$6,300	Inpatient
$3,000	less 10% co-pay	$2,700	Transitional (includes Medically-monitored and Day Treatment)
$2,000	less 10% co-pay	$1,800	Outpatient

Although these mandates were originally created as a minimum dollar amount that licensed insurance entities must provide for substance abuse services, they have in practice become maximum benefits over the years. Currently, Medicaid benefits are not subject to the mandated benefits.

Medicaid
Medicaid or Title XIX of the Social Security Amendments of 1965 is a federal-state program under which the categorically and medically needy are assisted in paying their health care costs. The federal legislation authorizes federal grants to states to cover varying shares of the costs of designated services.

Medical Personnel
Medical personnel means a physician, physician's assistant, nurse practitioner, or other personnel having at a minimum a LPN or RN degree, as that level of training is necessary to function under "standing orders" of a physician.

Medically Managed
This refers to services provided that are directly managed by a physician. In a medically managed service a physician directly administers care to the individual.

Medically Monitored
Medically monitored services are provided under the direction and supervision of a physician. The physician may or may not directly administer care to the individual.

Narcotic Withdrawal Scale

Grade 1	Lacrimation, rhinorrhea, diaphoresis, yawning, restlessness, and insomnia.
Grade 2	Dilated pupils, piloerection, muscle twitching, myalgia, arthralgia, and abdominal pain.
Grade 3	Tachycardia, hypertension, tachypnea, fever, anorexia, nausea, and extreme restlessness.
Grade 4	Diarrhea, vomiting, dehydration, hyperglycemia, hypotension, and curled-up position.

Terms used in Withdrawal Scale/Screening Instrument

Anorexia	Loss of appetite, especially when prolonged.
Arthralgia	Pain in one or more joints.
Dehydration	An abnormal depletion of body fluids.
Diaphoresis	Profuse perspiration artificially induced.
Hallucination	A perception of something (a visual image or a sound) with no external cause usually arising from a disorder of the nervous system (as in delirium tremens) or in response to drugs (as LSD).
Hyperglycemia	An excess of sugar in the blood.
Hypertension	Abnormally high arterial blood pressure.
Hypotension	Abnormally low blood pressure.
Lacrimation	Abnormal or excessive secretion of tears.
Myalgia	Pain in one or more muscles.
Orientation	Awareness of the existing situation with reference to time, place, and identity of persons.
Paroxysmal	A sudden attack or spasm.
Piloerection	Involuntary bristling or erection of the hair.
Rhinorrhea	Excessive mucous secretion from the nose.
Sensorium	Ability of the brain to receive and interpret sensory stimuli, the state of consciousness judged in terms of this ability.
Tachycardia	Relatively rapid heart action.
Tachypnea	Increased rate of respiration.

Needs
Needs refer to the identified problems or conditions of a individual that help in determining the level of intensity of service the individual requires in order to engage and progress with treatment goals and recovery.

Non-Ambulatory
This term, as it is used in WI-UPC, serves as a descriptor for the intensity of the level of care. Services include 24-hour monitoring and/or supervision. Individuals in these levels reside temporarily at the site where services are provided.

Point of Service (POS)
A POS is a benefit design by which consumers may select, at a point-of-service, a network provider with greater out-of-pocket expenses or reduced benefits. This design increases consumer choice, but makes management of overall care more difficult.

Preferred Provider Organization PPO
PPOs are formed when an entity contracts with an organization of providers for specified services. These services are delivered on a discounted fee basis and the providers are guaranteed a volume of referrals and prompt claims payment. The providers also agree to comply with utilization management procedures.

Personal Support
As the phrase "personal support" is used in WI-UPC, it refers to support for recovery efforts available to the individual from key relationships in his or her life such as family, friends and co-workers.

Pre-Admission Review
Pre-admission review is a common function in various managed care systems also known as pre-certification for admission. The review typically checks on the coverage eligibility of the individual for available benefits, whether the facility or program in which services are being sought is an approved provider with the plan and whether the services being requested are appropriate.

Program
Program is community service for the prevention or treatment of substance use disorders or the rehabilitation of persons who are substance abusers. This term is interchangeable with "service."

Recent
This means having lately come into existence, of or relating to a time not long past. The DSM refers to a period of 12 months in establishing patterns that determine dependence and a period of at least one month to establish stages of remission. In the context of WI-UPC, this time frame may be used as a guideline, but should not be considered an absolute.

Referral
Referral means the active initiation of linking a individual with a service, through written and verbal communication to that service, including follow-up action within one week as to the disposition of the referral.

Relapse
Due to Lack of Coping or Daily Living Skills
The individual's inability to cope or the lack of daily living skills is not a result of the individual's relapse, but rather is a cause for the substance use.

High Risk
Relapse potential can be identified most frequently by reviewing the individual's recent history. Factors that create a high risk can be very individualized; however, there are conditions which are commonly reported such as substance use history, environment and contributing stresses. While an individual's level of motivation may be a factor, in early recovery the individual may be highly motivated but simply lack the skills and resources necessary to avoid relapse. An example of an individual who may be at high risk of relapse is an individual who has a recent history of daily use, particularly if the individual reports having failed at previous attempts at abstinence. Another may be an individual whose living environment holds many cues or triggers to use substances, and the individual has not yet developed an adequate support network to offset this negative force.

Sabotages to Recovery Efforts (Purposely or Unintentionally)
This phrase in WI-UPC refers to elements within the individual's living environment that may sabotage the individual's recovery efforts. An example of one element that may be purposely sabotaging is a family member or friend who is vested in the individual's continued substance use and continues active

use in the individuals' presence or overtly encourages a return to use. Elements that may be unintentionally sabotaging may be a bar located beneath the individual's apartment. It is notable that these elements may or may not present a real sabotage to the individual's efforts. Again the risk of these elements producing sabotage is an individual issue that can be assessed by reviewing the individual's substance use history, self reporting, and any past recovery efforts.

Scorable Screening Instrument
This instrument is a set of evaluation questions targeting specific problem areas. These tools are developed from data collected from a sampling of the target group for which the tool is to be used. From this data a norm is established, and scales above and below the norm provide a score regarding the severity of various problems.

Screening
Screening is a process by which data relating to impairment due to substance use is collected. This process is completed prior to the application of WI-UPC. It is necessary to include questions in the screening process that will yield sufficient data to respond adequately to WI-UPC.

Selective Severity Assessment (SSA)
This is a scorable withdrawal screening instrument that is widely recognized and used in the treatment of substance use disorders.

Services
Services mean the individual components of a treatment service. Examples of components of a treatment service include, but are not limited to:

- Screening
- Assessment
- Referral
- Collateral source contacts
- Application of placement criteria
- Intake
- Treatment planning
- Crisis intervention
- Discharge planning
- Record keeping and consultation with other professionals regarding the individual's treatment and services
- Orientation
- Case management
- Client education
- Counseling (individual/group/family)

Stability
Stability describes the quality, state, or degree of being stable in specified life areas, to the extent that an individual exhibits the strength to stand or to endure. In relation to stability as it is referenced in WI-UPC, this definition pertains to the symptoms of an individual's identified problems such as behavioral patterns, emotional status, and physical/mental health conditions.

Psychiatric Stability
This term refers to the stage in an individual's treatment for a mental health condition, that allows the individual to adequately and safely function. An example of this is an individual who has a diagnosed psychiatric condition such as clinical depression. It frequently takes a period of time, once treatment for the condition has begun, for the symptoms to be reduced to the extent that they do not significantly interfere with the individual's ability to function.

Emotional Stability
Individuals entering treatment for substance use disorders typically have a variety of personal problems or crisis areas that have brought them to the point of seeking help. It is important to assess the status of their emotional condition in determining the most appropriate level of care.

Severe emotional distress may require more frequent clinical interventions in order for the individual to adequately benefit from treatment. The period of time or point at which any existing emotional conditions or complications do not significantly interfere with the individual's ability to adequately and safely function is referred to as emotional stability. In evaluating emotional stability (unless specifically directed by WI-UPC to link condition under the influence), impairment due to intoxication should not be considered for the purposes of scoring WI-UPC.

Behavioral Stability

This is the ability to refrain from or not engage in behaviors that are either dangerous or destructive to the individual or to others. In addition it may be the period of time or point at which any existing negative behavioral patterns do not significantly interfere with the individual's ability to adequately and safely function. In evaluating behavioral stability (unless specifically directed by WI-UPC to link condition under the influence), impairment due to intoxication should not be considered for the purposes of scoring WI-UPC.

Substance Use Triggers/Cues

Cues and triggers that produce urges for a individual to return or continue to use substances can vary. However, there are some general areas that should be considered within the context of the individual's self report and substance use history. Some examples may include: active substance use by others in the individual's work or living environment or the presence of substances or close proximity to a bar or drug using establishment in the individual's living or work environment.

Substance Free Intervals

This is a period of time, at least 24 consecutive hours in duration, in which the individual does not use substance(s).

Transfer (Level of Care)

Level of care transfer means the change from one level of care to another for a individual. This may occur either by the individual physically moving to a different site for the new level of care or the new level of care being provided at the same location. The transfer relates to the degree of frequency and intensity of the services being delivered.

Treatment

Treatment means the planned provision of services conducted under clinical supervision to assist the substance use disordered individual through a process of recovery. Treatment functions include: screening, application of placement criteria, intake, orientation, assessment, treatment planning, counseling (individual/group/family), case management, crisis intervention, client education, collateral source contacts, referral, discharge planning, record keeping, and consultation with other professionals regarding the individual's treatment and services.

Treatment Plan

Documentation reflecting the identification and ranking of goals, objectives and resources agreed upon by the individual, the counselor and the medical director to be utilized in the facilitation of the individual's recovery efforts make up the treatment plan.

Treatment Planning

Treatment planning is the process by which a counselor, the individual and the family, whenever possible, identify and rank problems needing resolution, establish agreed upon immediate, short-term and long-term goals, and decide on a treatment process and resources to be utilized in the facilitation of the individual's recovery efforts.

Unbundled Services
Unbundling is a practice that allows any individualized or diverse set of clinical services (such as psychiatric consultation) to be delivered in any setting (such as a therapeutic community). The type and intensity of treatment are based on individual needs and not on limitations imposed by the category of care or the setting. The unbundling concept is designed to maximize individualized care and encourage the delivery of necessary and appropriate care and treatment regardless of setting.

Utilization Management
Utilization management is one of several techniques and procedures used to monitor and evaluate the necessity of care.

Wisconsin Uniform Placement Criteria (WI-UPC)
WI-UPC is a placement determination method for individuals seeking substance use disorder treatment services. The criteria are designed to provide recommendation for the least restrictive level of substance abuse service appropriate for the individual. The criteria examine five dimensions of the individual's illness and match the severity indicators with the intensity levels available in various levels of care. WI-UPC includes criteria for making decisions about moving the individual through the continuum of services when treatment progress or relapse occurs and for discharge from substance abuse services.

Wisconsin Uniform Placement Criteria
WI-UPC

Assets and Needs Criteria

Section II

WI-UPC Assets and Needs Criteria for Intoxication Monitoring & Withdrawal Services

Level D-1 RESIDENTIAL INTOXICATION MONITORING SERVICE

A service providing 24-hour-per-day observation by non-medical staff to monitor the safe resolution of alcohol and/or sedative intoxication and to monitor for the development of withdrawal symptoms.

Assets (all must be present)	Needs (one or more must be present)
A. PLACEMENT CRITERIA	
DIMENSION I	
1. Individual is not incapacitated	1. Individual is functionally impaired due to alcohol and/or severe intoxication.
2. Individual is not functionally impaired due to intoxication with substances other than alcohol and/or sedatives.	
3. Individual is not evidencing opiate withdrawal symptoms.	
4. Individual is not evidencing alcohol and/or sedative withdrawal symptoms in the *mild* range or above.	
5. Available information (self-report or collateral source, *including individual records*) does not indicate a history of *moderate* or above withdrawal following episodes of alcohol and/or sedative use similar to the one currently described.	
DIMENSION II	
1. Individual does not demonstrate the presence of any physical and/or mental health conditions or complications that require hospitalization per physician screen or consultation.	
2. Individual does not demonstrate the presence of any physical and/or mental health conditions, including cognitive or developmental diabilities, or complications that create a significant medical or safety risk to self or others.	
DIMENSION III	
1. Individual does not demonstrate the presence of any emotional conditions and/or behavioral patterns that create a significant risk to self or others.	
DIMENSION V	
	1. Individual has no family and/or community support systems that have the capacity and willingness to understand withdrawal care instructions and to assist the individual in safely resolving current alcohol and/or sedative intoxication.

B. OTHER REASONS FOR DISCHARGE
1. Individual has recovered from acute alcohol and/or sedative intoxication.
2. Individual is unwilling to cooperate with service offered and leaves Against Staff Advice (ASA)
3. Individual is evidencing alcohol and/or sedative withdrawal symptoms in the *mild* range or above.
C. OTHER REASONS THAT PREVENT PLACEMENT AT THIS LEVEL OF CARE
1. Placement at this level of care is appropriate; however, this level of service is not available in the area.
2. Individual has capitated the medical benefit for coverage of this level of care.
3. General funding for this level of care is unavailable.
4. Certain supportive services (child care/transportation) are unavailable for the individual to fully engage in treatment.

LEVEL D-2 AMBULATORY DETOXIFICATION SERVICE

A medically managed or medically monitored structured withdrawal service, delivered on an outpatient basis and provided by a physician or other health care professional acting under the supervision of a physician.

Assets (all must be present)	Needs (one or more must be present)
A. PLACEMENT CRITERIA	
DIMENSION I	
1. Individual is not functionally impaired due to intoxication with any mood-altering substance.	1. Individual is evidencing alcohol sedative withdrawal symptoms in the *mild* range.
2. Individual is not incapacitated.	2. Individual's withdrawal symptoms have responded (or are likely to) to medically administered substitute doses of sedatives and/or hypnotics in an appropriate therapeutic range within 2 hours.
3. Individual is not evidencing alcohol and/or sedative withdrawal symptoms in the *moderate* range or above.	3. Although the individual is not currently evidencing *moderate* or above withdrawal symptoms, there is a risk of *moderate* or above withdrawal based upon: • A history or this condition while experiencing withdrawal from a similar amount of alcohol and/or sedatives. • Individual has had no significant (24 consecutive hours) substance free intervals over the past 30 to 60 days. • Daily use of sedatives and/or hypnotics for a period of over six months, in combination with daily alcohol use.
4. Individual is not evidencing opiate withdrawal symptoms in a *Grade 3* range or above.	4. Individual is evidencing opiate withdrawal symptoms in a *Grade 2* range.
5. If individual's history indicates heavy stimulant use over the past 30 days, there is no evidence (self-report or collateral source, *including individual records***.**) • Significant hyper-somnolence • Significant lethargy • Suicidal thinking	5. Individual's withdrawal symptoms are in the *mild* range
	6. Individual meets criteria for admission to a licensed methadone detoxification program.

DIMENSION II	
1. Individual does not demonstrate the presence of any physical/mental health conditions or complications to the extent that: • Hospitalization is required per physician's screen or consultation. • A significant medical or safety risk to the individual or others would be present if substance use/abuse recurs, AND the individual is identified as being at high risk of relapse (UNLESS CONCURRENTLY TREATED IN MEDICALLY-MONITORED OR INPATIENT TREATMENT SERVICE). • There is a risk of seizure based upon a history of recent seizure occurrence. • Impaired cognitive status requires 24-hour per day monitoring in order to promote treatment progress/recovery.	
2. Emergency medical services are available within a reasonable geographical area, in the event that the individual's general medical condition were to worsen.	
3. Individual's psychiatric and cognitive status sufficiently allows him or her to understand and/or independently participate in Ambulatory Withdrawal Service.	
4. Individual is not evidencing an altered mental status (particularly critical in individuals over age 60) and is not known or suspected to be under the influence of mood altering substances to the extent that participation in Ambulatory Withdrawal Service is contraindicated. Examples of this include: • Disorientation • Incoherence • Falls	
DIMENSION III	
1. Individual demonstrates treatment acceptance or willingness to comply to the extent that Ambulatory Withdrawal Service is likely to be completed successfully.	
DIMENSION V	
1. Individual has family and/or community support systems that have the capacity and willingness to understand withdrawal care instructions and to assist the individual in safely completing withdrawal.	

2. There are no other members of the individual's living environment who exhibit abusive behaviors (physical/sexual) that would impair the individual's ability to focus on treatment/recovery goals.	
B. OTHER REASONS FOR DISCHARGE	
1. Individual exhibits clinical improvement with appropriate treatment and withdrawal symptoms in the *minimal* range for at least 24 hours.	
2. Individual exhibits clinical improvement with appropriate treatment and opiate withdrawal symptoms below a *Grade 2* range for at least 24-hours.	
3. Individual does not follow through with scheduled appointments.	
C. OTHER REASONS THAT PREVENT PLACEMENT AT THIS LEVEL OF CARE	
1. Placement at this level of care is appropriate; however, this level of service is not available in the area.	
2. Individual has capitated the medical benefit for coverage of this level of care.	
3. General funding for this level of care is unavailable.	
4. Certain supportive services (child care/transportation) are unavailable for the individual to fully engage in treatment.	

Level D-3 MEDICALLY MONITORED, RESIDENTIAL DETOXIFICATION SERVICE

A 24-hour-per-day withdrawal monitoring and withdrawal service provided in a non-ambulatory setting, by a multi-disciplinary team of health care professionals, including 24-hour nursing care under the supervision of a physician.

Assets (all must be present)	Needs (one or more must be present)
A. PLACEMENT CRITERIA	
DIMENSION I	
1. Individual is not evidencing any signs and/or symptoms of delirium.	1. Individual is incapacitated.
2. Individual is not evidencing alcohol and/or sedative withdrawal symptoms in the *severe* range.	2. Individual is evidencing alcohol and/or sedative withdrawal symptoms in the *moderate* range.
3. Individual is not evidencing opiate withdrawal symptoms in a *Grade 4* range.	3. Although the individual is not currently evidencing *severe* withdrawal symptoms, there is a risk of *sever**e*** withdrawal based upon: • A history of seizures • Hallucinations • Myoclonic contractions • Delirium tremens during withdrawal from similar amounts of alcohol, other sedatives and/or hypnotic drugs in the past • A history of suicidal behavior during previous episodes of stimulant withdrawal
4. Individual's withdrawal symptoms in the *moderate* range have stabilized or decreased by the end of a period of observation and monitoring that may be up to 23 hours.	4. Individual is evidencing opiate withdrawal symptoms in a *Grade **3*** range.
	5. Individual has recent involvement in Medically Managed Inpatient Detoxification Service with clinical improvement to the extent that: • Withdrawal symptoms have improved to a range of *moderate* or below for eight consecutive hours. • Opiate withdrawal symptoms have improved to a range of *Grade 3* or below for eight consecutive hours.
	6. Individual is receiving withdrawal management that requires medical monitoring (e.g., pharmacological induction of opiate withdrawal via use of antagonist medication).
	7. Recent generalized convulsion, best explained by alcohol and/or sedative withdrawal.

DIMENSION II	
1. Individual does not demonstrate the presence of any physical/mental health conditions or complications that require hospitalization. Some examples of such conditions may include: • Stupor or coma • Multiple seizures • Delirium tremens • Significant disulfiram-ethanol reaction • Recent (within 24 hours) serious head trauma or loss of consciousness • Drug overdose compromising mental status, cardiorespiratory function, or vital signs • Imminent (impending) danger to self or others • Signs of substance-induced psychosis given history of recent ingestion of PCP, cocaine, or other stimulants	
B. OTHER REASONS FOR DISCHARGE	
1. Individual has recovered from incapacitation.	
2. Individual evidences clinical improvement with appropriate treatment and withdrawal symptoms in the *mild* range or below for 12 consecutive hours.	
3. Individual evidences clinical improvement with appropriate treatment and opiate withdrawal symptoms in a *Grade 2* range or below for 12 consecutive hours.	
C. OTHER REASONS THAT PREVENT PLACEMENT AT THIS LEVEL OF CARE	
1. Placement at this level of care is appropriate; however, this level of service is not available in the area.	
2. Individual has capitated the medical benefit for coverage of this level of care.	
3. General funding for this level of care is unavailable.	
4. Certain supportive services (child care/transportation) are unavailable for the individual to fully engage in treatment.	

Level D-4 MEDICALLY MANAGED INPATIENT DETOXIFICATION SERVICE

A 24-hour-per-day observation and monitoring detoxification service in a hospital setting, with 24-hour nursing care, physician management and all the resources of a general or specialty hospital setting.

Assets (all must be present)	Needs (one or more must be present)
A. PLACEMENT CRITERIA	
DIMENSION I	
	1. Individual is evidencing alcohol and/or sedative withdrawal in the *severe* range, as manifested by signs and/or symptoms of delirium.
	2. Individual is evidencing alcohol and/or sedative withdrawal symptoms in the *severe* range.
	3. Individual is evidencing opiate withdrawal symptoms in a *Grade 4* range.
DIMENSION II	
	1. Individual has demonstrated the presence of physical/mental health conditions or complications that require hospitalization per physician screen or consultation.
B. OTHER REASONS FOR DISCHARGE	
1. Resolution of physical/mental health conditions or complications that required hospitalization.	
2. Individual evidences clinical improvement with appropriate treatment and withdrawal symptoms in the *moderate* range or below for eight consecutive hours.	
3. Individual evidences clinical improvement with appropriate treatment and opiate withdrawal symptoms in a *Grade 3* range or below for eight consecutive hours.	
C. OTHER REASONS THAT PREVENT PLACEMENT AT THIS LEVEL OF CARE	
1. Placement at this level of care is appropriate; however, this level of service is not available in the area.	
2. Individual has capitated the medical benefit for coverage of this level of care.	
3. General funding for this level of care is unavailable.	
4. Certain supportive services (child care/transportation) are unavailable for the individual to fully engage in treatment.	

WI-UPC Assets and Needs Criteria for Rehabilitation Services

Level 1-A TRANSITIONAL RESIDENTIAL TREATMENT SERVICE

A clinically supervised, peer-supported therapeutic environment with clinical involvement. The service provides substance use disorder treatment in the form of counseling for 3 to 11 hours weekly per individual, immediate access to peer support through the environment and intensive case management, that may include direct education and monitoring in the areas of personal health and hygiene, community socialization, job readiness, problem resolution counseling, housekeeping and financial planning.

Assets (all must be present)	Needs (one or more must be present)
A. PLACEMENT CRITERIA	
DIMENSION I	
1. Individual is not functionally impaired due to intoxication or incapacitation	
2. Individual is not evidencing opiate withdrawal symptoms in the *Grade 2* range, UNLESS INDIVIDUAL IS BEING TREATED CONCURRENTLY FOR THAT CONDITION IN AMBULATORY WITHDRAWAL SERVICE.	
3. Individual is not evidencing opiate withdrawal symptoms in the *Grade 3* or above range.	
4. Individual is not evidencing alcohol and/or sedative withdrawal in the *mild* range UNLESS INDIVIDUAL IS BEING TREATED CONCURRENTLY FOR THAT CONDITION IN AMBULATORY WITHDRAWAL SERVICE.	
5. Individual is not evidencing alcohol and/or sedative withdrawal in the *moderate* range or above.	
6. Available information (self-report or collateral source, including individual records) does not indicate a history of moderate or above withdrawal following episodes of alcohol and/or sedative use similar to the one currently described.	
7. The individual reports having experienced some substance free intervals (24 consecutive hours) over the past 30 to 60 days.	
DIMENSION II	
1. Any physical/mental health condition(s) requiring care can be safely and effectively addressed in coordination with Transitional Residential Treatment Service (TRTS).	1. Individual has physical/mental health conditions or complications that, while under the influence of substance(s) create a danger to self or others AND individual is at high risk of relapse.

2. Individual demonstrates cognitive ability to the extent that he or she is able to comprehend, understand and participate in a TRTS.	2. Individual requires 24-hour therapeutic milieu in order to maintain stability in regard to physical/mental health conditions. Some examples may include: • Moderate or ongoing depression • Occasional suicidal ideation • Physical condition for which individual does not consistently follow prescribed or recommended care
3. Individual does not demonstrate the presence of any psychiatric condition(s) that creates a significant safety risk to self or others.	3. Individual requires 24-hour therapeutic milieu in order to maintain cognitive stability.
4. Individuals admitted to this level of care shall have been involved, or are currently involved in one or more of the four levels of primary rehabilitation services (Level 1 - Level 4) within the past 12 months, OR shall have an extensive lifetime treatment history and has experienced at least two detoxification episodes during the past year.	4. Although the individual has been involved in TRTS, her or she has not yet demonstrated the ability to recognize the severity of his or her substance use problem sufficiently to promote treatment progress/recovery goals on an ambulatory basis.
	5. Individual requires frequent cognitive reinforcement of treatment goals and objectives in order to maintain and progress in recovery.
	6. Although the individual has been involved in TRTS, he or she has not yet demonstrated the ability to recognize that some life problems are attributable to substance use sufficiently to promote treatment progress/recovery on an ambulatory basis.
DIMENSION III	
1. Any emotional condition(s) and/or behavioral patterns requiring care can be safely and effectively addressed in coordination with TRTS.	1. Individual requires 24-hour therapeutic milieu in order to maintain stability in regard to emotional status and/or behavioral patterns. Some examples may include: • Self-mutilating behaviors • Compulsive behaviors that present a significant safety risk to self or others
2. Individual does not demonstrate the presence of any emotional condition(s) or behavioral patterns that creates a significant safety risk to self or others.	2. Individual has evidenced an inability to apply the life skills necessary to maintain the recovery program without frequent interventions to reinforce the daily coping or living skills to allow the individual to function independently.
	3. Individual's emotional status and/or behavioral patterns, while under the influence of substances, create a danger to self or others AND individual is at high risk of relapse.

DIMENSION IV	
1. Individual demonstrates ability and a degree of willingness to participate in TRTS substance free.	1. Individual demonstrates an inability to manage life stressors to the extent that he or she is at high risk of relapse without ongoing interventions in a 24-hour therapeutic milieu as evidenced by prior treatment history. This inability significantly interferes with his or her ability to maintain and/or progress with recovery.
2. Although individual may experience relapse while in this level of care, he or she continues to demonstrate a degree of willingness to maintain and/or progress with treatment goals and recovery.	2. Individual has demonstrated an inability to remain consistently abstinent during the past 30 to 60 days, and the individual has been determined to have reached the maximum therapeutic benefit at more clinically intense levels of care.
DIMENSION V	
	1. Individual or a collateral source reports that other members of the individual's living environment exhibit abusive behaviors, (physical/sexual) such that safety concerns significantly interfere with his/her ability to engage and progress with treatment goals/recovery on an ambulatory basis.
	2. The individual's living environment purposely or unintentionally sabotages (e.g. substance use triggers/cues, ongoing substance use/abuse) treatment goals/recovery AND friends, family or co-workers are not supportive of individual's recovery efforts, and the individual is unable to maintain recovery goals in a non-residential setting.
	3. Although the individual has been involved in TRTS, s/he has not yet demonstrated the ability to apply essential skills necessary to maintain adequate abstinence on an ambulatory basis.
B. OTHER REASONS FOR DISCHARGE	
1. Individual has been actively involved in TRTS and, despite revisions to the treatment plan, has been determined to reach the maximum therapeutic benefit of this level of care.	
2. The individual has developed, or has had identified physical/mental health conditions or complications that require hospitalization.	
C. OTHER REASONS THAT PREVENT PLACEMENT AT THIS LEVEL OF CARE	
1. Placement at this level of care is appropriate; however, this level of service is not available in the area.	
2. Individual has capitated the medical benefit for coverage of this level of care.	
3. General funding for this level of care is unavailable.	
4. Certain supportive services (child care/transportation) are unavailable for the individual to fully engage in treatment.	

Level 1 OUTPATIENT TREATMENT SERVICE

An ambulatory treatment service totaling less than twelve hours of clinical services per week.

Assets (all must be present)	Needs (one or more must be present)
A. PLACEMENT CRITERIA	
DIMENSION I	
1. Individual is not functionally impaired due to intoxication or incapacitation**.**	
2. Individual is not evidencing opiate withdrawal symptoms in the *Grade 2* range**,** UNLESS INDIVIDUAL IS BEING TREATED CONCURRENTLY FOR THAT CONDITION IN AMBULATORY WITHDRAWAL SERVICE.	
3. Individual is not evidencing opiate withdrawal symptoms in the *Grade 3* or above range	
4. Individual is not evidencing alcohol and/or sedative withdrawal in the *mild* range, UNLESS INDIVIDUAL IS BEING TREATED CONCURRENTLY FOR THAT CONDITION IN AMBULATORY WITHDRAWAL SERVICE.	
5. Individual is not evidencing alcohol and/or sedative withdrawal in the *moderat**e*** range or above.	
6. Available information (self-report or collateral source, *including individual records*) does not indicate a history of *moderate* or above withdrawal following episodes of alcohol and/or sedative use similar to the one currently described.	
7. The individual reports having experienced *some* substance free intervals (24 consecutive hours) over the past 30 to 60 days.	
DIMENSION II	
1. Any physical/ mental health conditions or complications requiring care can be safely and effectively addressed in coordination with Outpatient Treatment Service.	1. The individual's mental health conditions or complications require monitoring and intervention (less than 12 hours weekly) in order to maintain and/or progress with recovery; i.e., individual has demonstrated that he or she is able to maintain psychiatric stability for more than 72 consecutive hours, but not more than seven consecutive days, during the past 30 days.

2. Individual does not demonstrate the presence of any physical/mental health conditions or complications that create a significant medical or safety risk to self or others if use/abuse recurs, or if conditions are present, he or she is not identified as being at high risk of relapse.	2. Although the individual has been involved in Outpatient Treatment Service, he or she has not yet sufficiently demonstrated an acquisition of alternative thinking patterns to the extent that: • A self-directed recovery plan (without periodic professional services) would be likely to allow the individual to maintain continued abstinence and recovery goals.
3. Individual demonstrates cognitive ability to the extent that he or she is able to comprehend, understand and participate in Outpatient Treatment Service.	3. Although the individual has been involved in Outpatient Treatment Service s/he has not yet sufficiently demonstrated the ability to recognize that some life problems are attributable to substance use/abuse to the extent that: - A self-directed recovery plan (without periodic professional services) would be likely to allow the individual to maintain continued abstinence and recovery goals.
4. Individual has demonstrated that he or she is able to maintain psychiatric stability for more than consecutive 72 hours during the past 30 days.	4. Although the individual has been involved in Outpatient Treatment Services, he or she has not yet sufficiently demonstrated alternative lifestyle choices to the extent that: - A self-directed recovery plan (without periodic professional services) would be likely to allow the individual to maintain continued abstinence and recovery goals.
DIMENSION III	
1. Individual has demonstrated that he or she is able to maintain emotional/behavioral stability for more than 72 consecutive hours during the past 30 days.	1. Individual's emotional status and/or behavioral patterns require monitoring and intervention (less than 12 hours weekly) in order to promote treatment progress/recovery; i.e., individual has demonstrated that he or she is able to maintain emotional/behavioral stability for more than 72 consecutive hours, but not more than seven consecutive days during the past 30 days.
DIMENSION IV	
1. Individual has demonstrated an ability and willingness to consistently attend outpatient treatment sessions substance free.	1. Individual has demonstrated that s/he is unable to remain substance free for more than seven consecutive days during the past 30 days.
	2. Individual has demonstrated that s/he is unable to avoid relapse due to his or her lack of coping/daily living skills, and this combination significantly interferes with his or her ability to maintain and/or progress with recovery.
	3. The individual has demonstrated that she is unable to be completely substance free during current pregnancy.

	4. Individual demonstrates preoccupation with substance use to the extent that he or she is at high risk of relapse that significantly interferes with his or her ability to maintain and/or progress with recovery.
	5. Individual demonstrates lack of appropriate reaction to life stressors to the extent that he or she is at high risk of relapse that significantly interferes with his/her ability to maintain and/or progress with recovery.
DIMENSION V	
1. The psychosocial recovery environment makes outpatient treatment feasible because one or more of the following is true: • Coercion for treatment participation from the workplace, the legal system, or the social welfare system is concordant with treatment goals. • Transportation or child care barriers to treatment are not insurmountable. • Individual has personal support for recovery efforts from friends, family or co-workers. • Individual's living and/or work environment is free of treatment/recovery sabotage (e.g. substance use triggers/cues, ongoing substance use/abuse.)	1. Individual's friends, family, or co-workers are not supportive of individual's recovery efforts.
2. The individual's living environment is free of safety risk factors that significantly interfere with his or her ability to engage and progress with treatment goals/recovery on an ambulatory basis. One example of a significant safety risk factors is: • Presence of other members of the individual's living environment that exhibits abusive behaviors, (physical/ sexual.)	2. Individual's living and/or work environment purposely or unintentionally sabotages (e.g. substance use triggers/cues, ongoing substance use/abuse) treatment goals/recovery; HOWEVER**,** the individual has some personal recovery support from friends, family or co-workers.
B. OTHER REASONS FOR DISCHARGE	
1. Individual has been involved in Outpatient Treatment Service, and despite revisions in the treatment plan has been determined to have: • Reached maximum therapeutic benefit of this level of care, OR • The inability to maintain current level of functioning without clinical deterioration at this level of intensity and frequency of services.	
2. Though the individual has been recently involved in an Outpatient Treatment Service he or she has experienced repeated relapse, despite amendments in the treatment plan to address relapse prevention.	

C. OTHER REASONS THAT PREVENT PLACEMENT AT THIS LEVEL OF CARE
1. Placement at this level of care is appropriate; however, this level of service is not available in the area.
2. Individual has capitated the medical benefit for coverage of this level of care.
3. General funding for this level of care is unavailable.
4. Certain supportive services (child care/transportation) are unavailable for the individual to fully engage in treatment.

Level 2 DAY TREATMENT SERVICE

A medically-monitored structured ambulatory treatment service. Day Treatment Service consists of regularly scheduled (minimum 12 hours per week that consists of at least 3 hours a day, 4 days a week) treatment rehabilitation services.

Assets (all must be present)	Needs (one or more must be present)
A. PLACEMENT CRITERIA	
DIMENSION I	
1. Individual is not functionally impaired due to intoxication or incapacitation.	
2. Individual is not evidencing opiate withdrawal symptoms in the *Grade 2* range, UNLESS INDIVIDUAL IS BEING TREATED CONCURRENTLY FOR THAT CONDITION IN AMBULATORY WITHDRAWAL SERVICE.	
3. Individual is not evidencing opiate withdrawal symptoms in the *Grade 3* or above range.	
4. Individual is not evidencing alcohol and/or sedative withdrawal in the *mild* range, UNLESS INDIVIDUAL IS BEING TREATED CONCURRENTLY FOR THAT CONDITION IN AMBULATORY WITHDRAWAL SERVICE.	
5. Individual is not evidencing alcohol and/or sedative withdrawal in the *moderate* range or above.	
6. Available information (self-report or collateral source, *including individual records*) does not indicate a history of *moderate* or above withdrawal following episodes of alcohol and/or sedative use similar to the one currently described.	
7. The individual reports having experienced *some* substance free intervals (24 consecutive hours) over the past 30 to 60 days.	
DIMENSION II	
1. Any physical and/or psychiatric condition(s) requiring care can be safely and effectively addressed in coordination with Day Treatment Service.	1. Individuals mental health conditions or complications require frequent (minimum of 12 hours weekly) intervention in order to promote treatment progress/recovery, i.e. individual has demonstrated s/he is able to maintain psychiatric stability for more than 24 hours, but not more than 72 consecutive hours during the past 30 days. 2. Individual's cognitive status requires intensive and frequents (minimum of 12 hours weekly) intervention in order to promote treatment progress/recovery. Some examples of impaired cognitive status or thinking errors may include: - inability to recognize the need for change in some life areas in order to achieve recovery goals - inability to link obvious problems /consequences with substance use/abuse
2. Individual does not demonstrate the presence any physical/mental health conditions or complications that create a significant medical or safety risk to self or others if use/abuse recurs, OR • If conditions are present, he or she is not identified as being at high risk of relapse.	

3. Individual demonstrates cognitive ability to the extent that he or she is able to comprehend, understand and participate in Day Treatment Service.	3. Although the individual has been involved in Day Treatment Service he or she has not yet sufficiently demonstrated the acquisition of alternative thinking patterns to the extent that: • A recovery plan (with professional interventions provided at the frequency of less than 12 hours weekly) would be likely to allow the individual to maintain abstinence and recovery goals.
4. Individual demonstrates the ability to maintain psychiatric stability for more than 24 consecutive hours during the past 30 days.	4. Although the individual has been involved in Day Treatment Service he or she has not yet sufficiently demonstrated the ability to recognize that some life problems are attributable to substance use/abuse to the extent that: • A recovery plan (with professional interventions provided at the frequency of less than 12 hours weekly) would be likely to allow the individual to maintain abstinence and recovery goals.
	5. Although the individual has been involved in Day Treatment Services, he or she has not yet sufficiently demonstrated alternative lifestyle choices to the extent that: • A recovery plan (with professional interventions provided at the frequency of less than 12 hours weekly) would be likely to allow the individual to maintain abstinence and recovery goals.
DIMENSION III	
1. Any emotional conditions and/or behavioral patterns that may require care can be safely and effectively addressed in coordination with Day Treatment Service.	1. Individual's emotional status and/or behavioral patterns require intensive and frequent (minimum of 12 hours weekly) intervention in order to promote treatment progress/recovery; i.e., individual has demonstrated he or she is able to maintain emotional/behavioral stability for more than 24 consecutive hours, but not more than 72 consecutive hours during the past 30 days. Impaired emotional status may include intense fear, anger or anxiety.
2. Individual demonstrates the ability to maintain emotional/behavioral stability for more than 24 consecutive hours during the past 30 days.	

DIMENSION IV	
1. Individual demonstrates the ability and willingness to consistently attend day treatment session's substance free.	1. Individual has been involved in Outpatient Treatment Service and, even though amendments were made to the treatment plan (i.e., to enhance recognition of relapse cues and to encourage a decrease in involvement with substance-using individuals from previous social network) there is a presence of increased ***risk*** of return to active substance use/abuse as identified by: • Persistent inability to recognize relapse cues/triggers • Difficulty postponing immediate gratification and related drug-seeking behavior • Increased ambivalence about maintaining abstinence and about maintaining involvement in treatment.
	2. Individual has demonstrated a consistent inability to attend outpatient treatment session's substances free, despite amendments in the treatment plan to address relapse.
	3. The individual does not yet demonstrate the ability to apply essential skills necessary to maintain abstinence through a recovery plan (with professional interventions provided at the frequency of less than 12 hours weekly) that would be likely to allow the individual to maintain abstinence and recovery goals.
	4. Individual has demonstrated that he or she is unable to remain substance free for more than 72 consecutive hours during the past 30 days, despite one or more interventions, that significantly interferes with his or her ability to engage and progress with treatment goals and recovery.
	5. Although the individual has been involved in Day Treatment Service, s/he has not yet demonstrated the ability to apply essential skills to the extent that: • A recovery plan (with professional interventions provided at the frequency of less than 12 hours weekly) would be likely to allow the individual to maintain abstinence and recovery goals.

DIMENSION V	
	1. Individual's living environment purposely or unintentionally sabotages (e.g. substance use triggers/cues, ongoing substance use/abuse), treatment goals/recovery AND friends, family or co-workers are not supportive of individual's recovery efforts.
B. OTHER REASONS FOR DISCHARGE	
1. Individual has been involved in Day Treatment Service, and despite revisions in the treatment plan has been determined to have: • Reached maximum therapeutic benefit of this level of care, OR • The inability to maintain current level of functioning without clinical deterioration at this level of intensity and frequency of services.	
2. Though the individual has been recently involved in a Day Treatment Service he or she has experienced repeated relapse, despite amendments in the treatment plan to address relapse prevention.	
C. OTHER REASONS THAT PREVENT PLACEMENT AT THIS LEVEL OF CARE	
1. Placement at this level of care is appropriate; however, this level of service is not available in the area.	
2. Individual has capitated the medical benefit for coverage of this level of care.	
3. General funding for this level of care is unavailable.	
4. Certain supportive services (child care/transportation) are unavailable for the individual to fully engage in treatment.	

Level 3 MEDICALLY MONITORED TREATMENT SERVICE

A community or hospital based 24-hour non-ambulatory treatment service that includes observation and monitoring under the supervision of a physician, with a minimum of 12 hours of counseling per week for each individual.

Assets (all must be present)	Needs (one or more must be present)
A. PLACEMENT CRITERIA	
DIMENSION I	
1. Individual is not functionally impaired due to intoxication or incapacitation.	
2. Individual is not evidencing opiate withdrawal symptoms in the *Grade 1 or Grade 2* range, UNLESS INDIVIDUAL IS BEING TREATED CONCURRENTLY FOR THAT CONDITION IN AMBULATORY WITHDRAWAL SERVICE.	
3. Individual is not evidencing opiate withdrawal symptoms in the *Grade **3*** or above range.	
4. Individual is not evidencing alcohol and/or sedative withdrawal in the *mild* range or below, UNLESS INDIVIDUAL IS BEING TREATED CONCURRENTLY FOR THAT CONDITION IN AMBULATORY WITHDRAWAL SERVICE.	
5. Individual is not evidencing alcohol and/or sedative withdrawal in the *moderate* range or above.	
6. Available information (self-report or collateral source, *including individual records*) does not indicate a history of *moderat**e*** or above withdrawal following episodes of alcohol and/or sedative use similar to the one currently described.	
DIMENSION II	
1. Any physical/mental health condition(s) requiring care can be safely and effectively addressed in coordination with Medically Monitored Treatment Service.	1. Individual has physical/mental health conditions or complications that, while under the influence of substance(s) create a danger to self or others AND individual is at high risk of relapse.

	2. Individual's physical/mental health conditions or complications require 24 hour per day monitoring and intervention in order to promote treatment progress/recovery; i.e., individual has demonstrated that he or she is unable to maintain psychiatric stability for more than 24 consecutive hours during the past 30 days. Some examples are: • Severe depression • Suicidal thinking or ideation • Serious physical condition for which individual does not follow prescribed or recommended care.
	3. Individual's cognitive status requires 24-hour per day monitoring and intervention in order to promote treatment progress/recovery.
	4. Although the individual has been involved in Medically Monitored Treatment Service, he or she has not yet demonstrated the ability to recognize the severity of his or her substance use problem sufficiently to promote treatment progress/recovery goals on an ambulatory basis.
	5. Although the individual has been involved in Medically Monitored Treatment Services, he or she has not yet demonstrated the ability to recognize that some life problems are attributable to substance use sufficiently to promote treatment progress/recovery goals on an ambulatory basis.
DIMENSION III	
1. Any emotional conditions and/or behavioral patterns that may require care can be safely and effectively addressed in coordination with Medically Monitored Treatment Service.	1. Individual's emotional status and/or behavioral patterns requires 24-hour per day monitoring and intervention in order to promote treatment progress/recovery; i.e., individual has demonstrated that he or she is unable to maintain emotional/behavioral stability for more than 24 consecutive hours during the past 30 days. Some examples may include: • Self-mutilating behaviors • Compulsive behaviors that present a significant safety risk to self or others.
	2. Individual's emotional status and/or behavioral patterns, while under the influence of substances, create a danger to self or others AND the individual is at high risk of relapse.

DIMENSION IV	
	1. Individual has demonstrated that he or she is unable to remain substance free for 24 consecutive hours during the past 30 days despite one or more interventions, that significantly interferes with his or her ability to engage and progress with treatment goals and recovery.
	2. Individual has demonstrated he or she is consistently unable to attend day treatment sessions substance free, that significantly interferes with his or her ability to engage and progress with treatment goals and recovery.
DIMENSION V	
	1. Individual or a collateral source reports that other members of the individual's living environment exhibit abusive behaviors, (physical/sexual) such that safety concerns significantly interfere with his or her ability to engage and progress with treatment goals/recovery on an ambulatory basis.
	2. Although the individual has been involved in Medically Monitored Treatment Services, he or she has not yet demonstrated the ability to apply essential skills necessary to maintain adequate abstinence on an ambulatory basis.
B. OTHER REASONS FOR DISCHARGE	
1. Individual has been actively involved in Medically Monitored Treatment Service and, despite revisions in the treatment plan, has been determined to have reached the maximum therapeutic benefit of this level of care.	
2. The individual has developed, or has had identified physical/mental health conditions or complications that require hospitalization.	
C. OTHER REASONS THAT PREVENT PLACEMENT AT THIS LEVEL OF CARE	
1. Placement at this level of care is appropriate; however, this level of service is not available in the area.	
2. Individual has capitated the medical benefit for coverage of this level of care.	
3. General funding for this level of care is unavailable.	
4. Certain supportive services (child care/transportation) are unavailable for the individual to fully engage in treatment.	

Level 4 MEDICALLY MANAGED INPATIENT TREATMENT SERVICE

Inpatient treatment service is provided in a general or specialty hospital with 24-hour nursing care, physician management and availability of all the resources of a hospital.

Assets (all must be present)	Needs (one or more must be present)
A. PLACEMENT CRITERIA	
DIMENSION I	
1. Individual is not functionally impaired due to intoxication or incapacitation.	
2. Individual is not evidencing opiate withdrawal symptoms in the *Grade 2* range, UNLESS INDIVIDUAL IS BEING TREATED CONCURRENTLY FOR THAT CONDITION IN AMBULATORY WITHDRAWAL SERVICE.	
3. Individual is not evidencing opiate withdrawal symptoms in the *Grade **3*** or above range.	
4. Individual is not evidencing alcohol and/or sedative withdrawal in the *mild* range, UNLESS INDIVIDUAL IS BEING TREATED CONCURRENTLY FOR THAT CONDITION IN AMBULATORY WITHDRAWAL SERVICE.	
5. Individual is not evidencing alcohol and/or sedative withdrawal in the *moderate* range or above.	
6. Available information (self-report or collateral source, *including individual records*) does not indicate a history of *moderat**e*** or above withdrawal following episodes of alcohol and/or sedative use similar to the one currently described.	
DIMENSION II	
	1. Presence of physical/mental health condition(s) that require hospitalization per physician screen or consultation.
B. OTHER REASONS FOR DISCHARGE	
1. Resolution or stabilization of physical mental health condition(s) that require hospitalization.	
C. OTHER REASONS THAT PREVENT PLACEMENT AT THIS LEVEL OF CARE	
1. Placement at this level of care is appropriate; however, this level of service is not available in the area.	
2. Individual has capitated the medical benefit for coverage of this level of care.	
3. General funding for this level of care is unavailable.	
4. Certain supportive services (child care/transportation) are unavailable for the individual to fully engage in treatment.	

Wisconsin Uniform Placement Criteria
WI-UPC

Adult
Placement Scoring Instrument

Section III

WI-UPC
Adult Placement Scoring Instrument

	Today's Date	
Individual's Name	Date of Birth	
Address	Phone Number: ( )	
City	State	Zip Code
Interviewer's Name	Phone Number: ( )	
Agency Name	Agency Phone Number: ( )	
Address		
City	State	Zip Code

Instructions for Completion of WI-UPC Adult Placement Scoring Instrument

1. Identify/rule out intoxication and/or incapacitation. Evaluate withdrawal potential.
2. Complete substance use disorder screening.
3. Evaluate the individual for treatment service qualifying criteria based on information acquired from the substance use disorder screening.
4. Evaluate the individual within treatment dimensions and severity indicators.
5. Transfer treatment indicator scores to grid and identify recommended level of care.
6. Complete interviewer's comments and record any need for an alternative level of care.
7. Record the individual's willingness/acceptance statement.
8. Complete referral information and signature section.

WITHDRAWAL SERVICE QUALIFYING CRITERIA

A. Is the individual intoxicated?	**B. Is the individual incapacitated?**
☐ Yes If the individual is intoxicated but not incapacitated, and is in need of monitoring to safely recover from intoxication, the lowest level of care appropriate is Non-Medical, Non-Ambulatory Intoxication Monitoring Service (Level D-1). If the individual's condition is such that withdrawal potential can be adequately assessed, either directly or through collateral sources, please go to Dimension Question 1.	☐ Yes If the individual is incapacitated, the lowest level of care appropriate is Medically Monitored, Non-Ambulatory Withdrawal Service (Level D-3). If the individual's condition is such that withdrawal potential can be adequately assessed, either directly or through collateral sources, please go to Dimension Question 1.
☐ No Please go to next Question B	☐ No Please go to Dimension Question 1

Dimension Question #1

Does the patient exhibit any signs or symptoms of WITHDRAWAL, and/or is there history to suggest that a significant risk of withdrawal is present?

☐ No Please go to the seven TREATMENT SERVICE QUALIFYING QUESTIONS below.

☐ Yes Please answer each of the five SEVERITY INDICATORS below.

SEVERITY INDICATOR QUESTIONS

a. ☐ Yes D-4 The withdrawal screening score indicates a severe alcohol and/or sedative withdrawal, or *Grade 4* opiate withdrawal.

b. ☐ Yes D-3 The withdrawal screening score indicates *moderate* alcohol and/or sedative withdrawal, or *Grade 3* opiate withdrawal.

c. ☐ Yes D-2 The withdrawal screening score indicates *mild* alcohol and/or sedative withdrawal, or *Grade 2* opiate withdrawal.

d. ☐ Yes D-1 The withdrawal screening score indicates *minimal* alcohol and/or sedative withdrawal, and although the patient is functionally impaired, there is no evidence of intoxication with substances other than alcohol and/or sedatives.

e. ☐ Yes D-1 The individual *lacks family/community support* such that a structured setting of professional observation is necessary to achieve safe resolution of current alcohol and/or sedative intoxication.

TREATMENT SERVICE QUALIFYING CRITERIA

1. ☐ Yes Individual has recently experienced negative *educational/vocational* consequences that are linked to a substance use disorder.

2. ☐ Yes Individual has recently experienced negative *physical/mental health* consequences that are linked to a substance use disorder.

3. ☐ Yes Individual has recently experienced negative *financial* consequences that are linked to a substance use disorder.

4. ☐ Yes Individual has recently experienced negative *legal* consequences that are linked to a substance use disorder.

5. ☐ Yes Individual has recently experienced negative *personal relationship* consequences that are linked to a substance use disorder.

6. ☐ Yes Individual has recently experienced impairment in his or her *role as a caregiver and/or homemaker* that is linked to a substance use disorder.

7. ☐ Yes Individual has a *history* of having experienced one or more of the above consequences, has successfully completed treatment, but is currently at high risk of relapse.

- If the response to ALL of the above questions was "NO." Substance abuse symptoms sufficient to indicate the need for services in the formal substance abuse treatment delivery system, as defined in HFS 75, **have not been reported**. You may want to consider a referral to a community support group or other referral system if indicated. Go to SUMMARY page to complete WI-UPC.

- If the response to ANY of the above questions was "YES." Substance abuse symptoms sufficient to indicate the *possible need* for some level of services in the formal substance abuse treatment delivery system, as defined in HFS 75, **have been reported**. Please complete the following questions (Dimension and Severity Questions 2 through 5) to determine appropriate level(s) of treatment frequency and intensity.

DIMENSION AND SEVERITY INDICATORS

Dimension Question #2

Are there current PHYSICAL/MENTAL HEALTH conditions or complications evident or any which become evident when patient is under the influence?

☐ NO Please go to Dimension Question # 3, disregard severity indicators below.

☐ YES Please answer each of the seven severity indicators below.

SEVERITY INDICATOR QUESTIONS

a. ☐ Yes **4** The individual has physical/mental health conditions or complications that require hospitalization per physician screen or consultation.

b. ☐ Yes **3** The individual has physical/mental health conditions or complications that, while under the influence of substance(s), create a danger to self or others AND is at high risk of relapse.

c. ☐ Yes **3** The individual's physical/mental health conditions or complications require 24-hour-per-day monitoring and intervention in order to promote treatment progress/recovery; i.e., has demonstrated that he or she is unable to maintain psychiatric stability for more than 24 consecutive hours during the past 30 days.

d. ☐ Yes **3** The individual's cognitive status requires 24-hour-per-day monitoring and intervention in order to promote treatment progress/recovery.

e. ☐ Yes **2** The individual's cognitive status requires intensive and frequent (minimum of 12 hours weekly) intervention in order to promote treatment progress/recovery.

f. ☐ Yes **2** The individual's mental health conditions or complications require intensive and frequent (minimum of 12 hours weekly) intervention in order to promote treatment progress/recovery; i.e., has demonstrated he or she is able to maintain psychiatric stability for more than 24 consecutive hours, but not more than 72 consecutive hours during the past 30 days.

g. ☐ Yes **1** The individual's mental health conditions or complications require monitoring and intervention (less than 12 hours weekly) in order to promote treatment progress/recovery; i.e., has demonstrated that he or she is able to maintain psychiatric stability for more than 72 consecutive hours, but not more than seven consecutive days during the past 30 days.

Dimension Question #3

Are there current EMOTIONAL conditions or complications and/or BEHAVIORAL patterns evident or any which become evident when patient is under the influence?

☐ NO Please go to Dimension Question # 4, disregard severity indicators below.

☐ YES Please answer each of the four severity indicators below.

SEVERITY INDICATOR QUESTIONS

a. ☐ Yes **3** The individual's emotional status and/or behavioral patterns, while under the influence of substance(s), create a danger to self or others AND is at high risk of relapse.

b. ☐ Yes **3** The individual's emotional status and/or behavioral patterns require 24 hour per day monitoring and intervention in order to promote treatment progress/recovery; i.e., patient has demonstrated that he or she is unable to maintain emotional/behavioral stability for more than 24 consecutive hours during the past 30 days.

c. ☐ Yes **2** The individual's emotional status and/or behavioral patterns require intensive and frequent (minimum of 12 hours weekly) intervention in order to promote treatment progress/recovery; i.e., has demonstrated he or she is able to maintain emotional/behavioral stability for more than 24 consecutive hours, but not more than 72 consecutive hours during the past 30 days.

d. ☐ Yes **1** The individual's emotional status and/or behavioral patterns require monitoring and intervention (less than 12 hours weekly) in order to promote treatment progress/recovery; i.e., has demonstrated that he or she is able to maintain emotional/behavioral stability for more than 72 consecutive hours, but not more than seven consecutive days during the past 30 days.

Dimension Question #4

Does the individual present significant RELAPSE POTENTIAL?

☐ NO Please go to Dimension Question # 5, disregard severity indicators below.

☐ YES Please answer each of the nine severity indicators below.

SEVERITY INDICATOR QUESTIONS

a. ☐ Yes **3** The individual has demonstrated that he or she is unable to remain substance free for any 24 consecutive hours period during the past 30 days, despite one or more interventions, which significantly interferes with his/her ability to engage and progress with treatment goals and recovery.

b. ☐ Yes **3** The individual has demonstrated that he or she is consistently unable to attend day treatment sessions substance free, which significantly interferes with his/her ability to engage and progress with treatment goals and recovery.

c. ☐ Yes **2** The individual has demonstrated that he or she is unable to remain substance free for more than 72 consecutive hours during the past 30 days, despite one or more interventions, which significantly interferes with his or her ability to engage and progress with treatment goals and recovery.

d. ☐ Yes **2** The individual has demonstrated that he or she is consistently unable to attend outpatient treatment sessions substance free, which significantly interferes with his or her ability to engage and progress with treatment goals and recovery.

e. ☐ Yes **1** The individual has demonstrated that he or she is unable to remain substance free for more than seven consecutive days during the past 30 days, which significantly interferes with his or her ability to engage and progress with treatment goals and recovery.

f. ☐ Yes **1** The individual has demonstrated that he or she is unable to avoid relapse due to his or her lack of coping/daily living skills, and this combination significantly interferes with his or her ability to maintain and/or progress with recovery.

g. ☐ Yes **1** The individual has demonstrated that she is unable to be completely substance free during current pregnancy.

h. ☐ Yes **1** The individual demonstrates preoccupation with substance use to the extent that he or she is at high risk of relapse, which significantly interferes with his or her ability to maintain and/or progress with recovery.

i. ☐ Yes **1** The individual demonstrates lack of appropriate reaction to life stressors to the extent that he or she is at high risk of relapse, which significantly interferes with his or her ability to maintain and/or progress with recovery.

Dimension Question #5

Does the patient's ENVIRONMENT create a coercion to continue or return to substance abuse?

☐ NO Please go to WI-UPC Summary sheet, disregard severity indicators below.

☐ YES Please answer each of the four severity indicators below.

SEVERITY INDICATOR QUESTIONS

a. ☐ Yes **3** The individual or a collateral source reports that other members of the individual's living environment exhibit abusive behaviors, (physical/sexual) such that safety concerns significantly interfere with his or her ability to engage and progress with treatment goals/recovery on an ambulatory basis.

b. ☐ Yes **2** The individual's living environment purposely or unintentionally sabotages (i.e. substance use triggers/cues, ongoing substance use/abuse) treatment goals/recovery AND friends, family, OR co-workers are not supportive of the individual's recovery efforts.

c. ☐ Yes **1** The individual's living and/or work environment purposely or unintentionally sabotages (i.e. substance use triggers/cues, ongoing substance use/abuse), treatment goals/recovery; HOWEVER, the individual has some personal support for recovery efforts from friends, family OR co-workers.

d. ☐ Yes **1** The individual's friends, family or co-workers are not supportive of his or her recovery efforts.

Wisconsin Uniform Placement Criteria (WI-UPC)
SUMMARY

1.	2.	3.	4.	5.	6.	7.

(Record selected qualifying criteria above by placing an "X" in the appropriate space.)

*Transfer the scores to the grid below from each **"Yes"** response recorded in the severity indicators of each dimension*

Withdrawal/ Detoxification	**Treatment**			
Dimension #1	Dimension #2	Dimension #3	Dimension #4	Dimension #5
a.	a.	a.	a.	a.
b.	b.	b.	b.	b.
c.	c.	c.	c.	c.
d.	d.	d.	d.	d.
e.	e.		e.	
	f.		f.	
	g.		g.	
			h.	
			i.	

Score 1 _____
Select the single highest score found under Dimension 1 in the scoring grid

Score 2 _____
*Select the single highest score found under Dimensions 2, 3, 4, **and** 5 in the scoring grid.*

NOTE: Transitional Residential Treatment Service - In accordance with HFS 75.14(7), admission to a transitional residential treatment service is appropriate only for one of the following reasons:

1. The individual was admitted and discharged from another level of rehabilitation care (Level 1 - Level 4) within the last 12 months, or is currently being served in Day Treatment or Outpatient Treatment Service. This information must be included in the Interviewer's Comments section.

OR

2. The individual has an extensive lifetime treatment history and has experienced at least two detoxification episodes during the past 12 months and, the specific criteria from the Assets and Needs in Section II for this level of care have been met. This information must be included in the Interviewer's Comments section.

Match any score from Score 1 and Score 2 with the appropriate level of care indicated in the Level of Care Key.

These scores indicate the lowest recommended level of service appropriate for this patient. **If special circumstances exist which allow an alternative level of care for this individual, please indicate them in the Interviewer's Comments section and select the appropriate alternative level of care.**

LEVEL OF CARE KEY			
		1A	Transitional Residential Treatment Service
D-1	Residential Intoxication Monitoring Service	1	Outpatient Treatment Service
D-2	Ambulatory Detoxification Service	2	Day Treatment Service
D-3	Medically Monitored, Residential Detoxification Service	3	Medically Monitored Treatment Service
D-4	Medically Managed, Inpatient Detoxification Service	4	Medically Managed, Inpatient Treatment Service

Interviewer's Comments:

Individual's Statement – Willingness to Accept Recommended Level of Care:

WI-UPC Recommended level(s) of service from Score 1 and/or Score 2:

Level(s) of Care

Alternative level(s) of service identified due to special circumstances outlined in Interviewer's Comments:

Level(s) of Care

Agency Individual is Being Referred:

Agency Phone Number:
( )

Agency Address:

Individual's Signature	Today's Date
Interviewer's Signature	Today's Date

Wisconsin Uniform Placement Criteria
WI-UPC

Reference Materials

Section IV

WITHDRAWAL SCREENING INSTRUMENTS

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT FOR ALCOHOL (CIWA-AR)

The CIWA-Ar is a revised version of the former CIWA-A, which evaluates 10 dimensions. The instrument may be administered every half-hour and does not require vital sign evaluation or monitoring. The earlier version of the instrument contained a seizure score, which has been removed from the update because it could not be utilized every 30 minutes and still be meaningful. Quality of contact was also removed due to the lack of reliability of the interpreter. Hallucinations, flushing face and thought disturbances were also removed, since they are all covered under other dimensions. The screening takes approximately two minutes to complete.

The dimension areas evaluated in the CIWA-Ar are as follows:

- Nausea/Vomiting
- Anxiety
- Headache
- Visual Disturbances
- Tactile Disturbances
- Agitation
- Clouding of Sensorium
- Tremor
- Auditory Disturbances
- Paroxysmal Sweats

A score below 20 indicates the ability to manage the individual's care without medication. Psychological support can be utilized, and the belief that the individual is receiving medical assistance will be helpful. Those with a score above 20 are likely to need intensive support and/or medication.

A study of the CIWA-Ar conducted in 1988 by Foy, March & Drinkwater reported individuals with a score greater than 15 were at increased risk of severe alcohol withdrawal. The higher the score the greater the risk. The study revealed that some individuals still suffered complications, despite low scores, if they were left untreated.

The CIWA-Ar is not copyrighted and may be used freely.

SELECTIVE SEVERITY ASSESSMENT (SSA)

This instrument also produces a score based on the evaluation of 10 dimensions. The SSA does require that some vital signs be evaluated and monitored. The scoring scales and the dimensions evaluated are very similar to the CIWA-Ar.

The dimension areas evaluated in the SSA are as follows:

- Eating Disturbances
- Clouding or Sensorium
- Agitation
- Pulse
- Tremor
- Hallucinations
- Paroxysmal Sweats
- Sleep Disturbances
- Quality of Contact
- Temperature

Other Withdrawal Screening Instruments: While WI-UPC does not require the use of one specific withdrawal screen, it does require the use of a scorable instrument. In selecting a screen to use it is important that it meet the criteria established in the two examples identified above. The instrument should evaluate the same 10 dimensions and have a similar scoring structure for the severity indicators in each of the dimensions.

Narcotic Withdrawal Scale

Grade 1	Lacrimation, rhinorrhea, diaphoresis, yawning, restlessness, and insomnia.
Grade 2	Dilated pupils, piloerection, muscle twitching, myalgia, arthralgia, and abdominal pain.
Grade 3	Tachycardia, hypertension, tachypnea, fever, anorexia, nausea, and extreme restlessness.
Grade 4	Diarrhea, vomiting, dehydration, hyperglycemia, hypotension, and curled-up position.

ADDICTION RESEARCH FOUNDATION CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT FOR ALCOHOL (CIWA-Ar)

1. TACTILE DISTURBANCES - Ask "Have you any itching, pins and needles, burning or numbness or bugs crawling on or under your skin?" Observation. 0 - none 1 - very mild itching, pins & needles, etc. 2 - mild itching, etc. 3 - moderate itching, etc. 4 - moderately severe hallucinations. 5 - severe hallucinations 6 - extremely severe hallucinations 7 - continuous hallucinations	**2. ANXIETY** - Ask "Do you feel nervous?" Observation. 0 - no anxiety, at ease 1 - mildly anxious 2 - 3 - 4 - moderately anxious, or guarded, so anxiety is inferred 5 - 6 - 7 - equivalent to acute panic states, as seen in severe delirium or acute schizophrenic states	**3. TREMOR** - Arms extended and fingers spread apart. Observation. 0 - no tremor 1 - not visible, but can be felt fingertip to fingertip 2 - 3 - 4 - moderate, with arms extended 5 - 6 - 7 - severe, even with arms not extended
4. AUDITORY DISTURBANCES - Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing things that you know are not there?" Observation. 0 - not present 1 - very mild harshness or ability to frighten 2 - mild harshness or ability to frighten 3 - moderate harshness or ability to frighten 4 - moderately severe hallucinations 5 - severe hallucinations 6 - extremely severe hallucinations 7 - continuous hallucinations	**5. PAROXYSMAL SWEATS** Observation. 0 - no sweat visible 1 - barely perceptible sweating, palms moist 2 - 3 - 4 - beads of sweat obvious on forehead 5 - 6 - 7 - drenching sweats	**6. VISUAL DISTURBANCES** - Ask "Does the light appear to be too bright? Is the color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things that you know are not there?" Observation. 0 - not present 1 - very mild sensitivity 2 - mild sensitivity 3 - moderate sensitivity 4 - moderately severe hallucinations 5 - severe hallucinations 6 - extremely severe hallucinations hallucinations

ADDICTION RESEARCH FOUNDATION CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT FOR ALCOHOL (CIWA-Ar) (continued)		
7. AGITATION – Observation. 0 - normal activity 1 - somewhat more than normal activity 2 - 3 - 4 - moderately fidgety and restless 5 - 6 - 7 - paces back and forth, constant thrashing about	**8. HEADACHE, FULLNESS IN HEAD** - Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate dizziness or light-headedness, rate severity. 0 - not present 1 - very mild 2 - mild 3 - moderate 4 - moderately severe 5 - severe 6 - very severe 7 - extremely severe	**9. NAUSEA AND VOMITING** – Ask "Do you feel sick to your stomach? Have you vomited?" Observation. 0 - no nausea or vomiting 1 - mild nausea with no vomiting 2 - 3 - 4 - intermittent nausea with dry heaves 5 - 6 - 7 -constant nausea, frequent dry heaves and vomiting
10. ORIENTATION AND CLOUDING OF SENSORIUM - Ask "What day is this? Where are you? Whom am I?" 0 - oriented and can do serial additions 1 - cannot do serial additions or is uncertain about dates 2 - disoriented for date by no more than 2 calendar days 3 - disoriented by more than 2 calendar days 4 - disoriented for place and/or person	**Addiction Research Foundation Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar)	

Circle the appropriate score in each of the dimensions on this page. Transfer the scores to the table on the next page.

Screening Date									
Screening Time									
Screener's Initials									
1. Tactile									
2. Anxiety									
3. Tremor									
4. Auditory									
5. Paroxysmal Sweats									
6. Visual									
7. Agitation									
8. Headache									
9. Nausea/ Vomiting									
10. Orientation									
Total Score									
Max. Score	67	67	67	67	67	67	67	67	67

SEVERITY SCORING SCALE:

Minimal = 0to 4 **Mild = 5 to 12** **Moderate = 13 to 19** **Severe = 20 or above**

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Screener's Comments:

SELECTIVE SEVERITY ASSESSMENT (SSA)

Signs and Symptoms	Present	Notes
Eating Disturbances	Based on Meals Prior to Exam 0 - Ate and enjoyed it all. 3+ - 4+ Ate about half of what was given 7+ Ate none at all.	New admission by history substantial snack may be considered a meal. If individual doesn't eat - score it - don't interpret why.
Tremor	1+ Tremor not visibly apparent, but can be felt by the examiner placing his fingertips lightly against the patient's fingertips. 3+ - 4+ Tremor is moderate with arms extended. 7+ Marked tremor even when arms are not extended.	Automatic 7 for tongue tremor. ** Don't attempt to judge if tremor is anxiety or from withdrawal. Older individual with senile tremor - score it. ** If tongue tremors are only factor elevated, we don't need to call the doctor.
Sleep Disturbance	1+ Gets up once. 4+ Awake half the night. 7+ Completely sleepless.	New individual by history. After 1st night by staff observation. Score - even if normally works nights and stays up. Weekends - score from scheduled lights out time.
Clouding of Sensorium	0 No evidence of clouding of sensorium. 1+ Cannot do serial 7s or knows correct date but is uncertain. 2+ Disoriented for time by no more than 2 calendar days. 3+ Disoriented for time for more than 2 calendar days.	Not confusion - strict orientation and serial 7s. Individual with obvious learning disability. Do not score failure on serial 7.
Hallucinations Record frequency, content, intensity, and if the individual has insight into hallucination.	0 No hallucinations. 1+ Auditory hallucinations. 2+ Visual hallucinations. 3+ Non-fused auditory and visual.	**REPORT IMMEDIATELY TO PHYSICIAN!** Since individual may be progressing to stage II or III. Call on each individual episode. Score based on time since last SSA.

SELECTIVE SEVERITY ASSESSMENT (SSA) (continuted)		
Quality of Contact	<u>Awareness of Examiner & People Around Him/Her.</u> 1+ Drifts off slightly. 2+ Appears to be in contact with examiner, but is unaware of, or oblivious to the surroundings or other people around him/her. 3+ - 4+ Periodically appears to become detached. 7+ Makes no contact with examiner.	Critical in relation to progression of stage I, II, and III. Observe in period just prior to SSA.
Agitation	<u>Based on amount of movement(not anxiety or tremor).</u> 1+ Somewhat more than normal activity. 3+ - 4+ Moderately fidgety and restless. 7+ Paces back and forth during most of the interview.	Not anxiety or tremor. Measure all movement or inability to be still.
Paroxysmal Sweats	1+ Barely perceptible sweating. 3+ - 4+ Beads of sweats obviously observable. 7+ Drenching sweats.	Palms or forehead damp --1+.
Temperature	99.5 or below 1+ 99.6 - 99.9 2+ 100 – 100.4 3+ 100.5 – 101 4+ 101 – 101.4 5+ 101.5 – 101.9 6+ 102 – 102.4 7+ 102.5 – 102.9 8+ 103 and over 9+	If temperature is over 102 notify physician immediately.
Pulse	79 or below 1+ 80 - 89 2+ 90 – 99 3+ 100 – 109 4+ 110 – 119 5+ 120 – 129 6+ 130 – 139 7+ 140 – 149 8+ 150 and over 9+	

General Comments: May give 0 except with temperature and pulse. Be objective. If score is over 20+ or above discuss with physician. If lower and you are concerned on any specific item mentioned above call physician.

SAMPLE INTERVIEW QUESTIONS

1. When was the last time you ingested any form of a mood altering chemical?

2. What was the substance?

3. How much of each of the substance(s) did you ingest?

4. When was the last time you ingested any substance(s) prior to that use?

5. Have you used substance(s) on a weekly basis over the past six months?

6. What is the longest period of time you have been completely substance free in the past 6 months?

7. What is the longest period of time you have been able to avoid the use/abuse of substance(s) since your use began?

8. Have you ever experienced withdrawal symptoms?

   Please describe the symptoms you have experienced.

   Please describe the type and amount of substance(s) used when you experienced withdrawal symptoms.

9. Do you have friends or family members who are able and willing to assist you with your withdrawal care?

10. Do you have a history of any physical health conditions or complications?

    If yes, please describe the condition(s), and who has treated you for it?

11. Are you currently being treated for any physical health conditions?

    If yes, please describe the condition(s), and who is treating you for it?

12. Have you ever been hospitalized or treated due to mental health condition(s) or complication(s)?

    If yes, please describe the condition(s), and who has treated you for it?

13. Are you currently being treated for any mental health condition(s) or complication(s)?

    If yes, please describe the condition(s), and who is treating you for it?

14. Do you, or have you, had thoughts of hurting yourself or someone else?

    When the thoughts occur, do you imagine a specific plan as to how you would carry out the action?

    How often do these thoughts occur?

Have these thoughts ever occurred when you were not under the influence of substance(s)?

15. Have you ever been violent toward yourself or anyone else?

    Has this ever occurred when you were not under the influence of substance(s)?

    How often has this occurred?

16. Have you experienced other symptoms of your mental health condition other than those mentioned?

    If yes, please describe the symptom, and how you have responded to it?

17. Are you experiencing any difficulty tracking information or remembering things?

18. Check for orientation (today's date, time, where are you, why are you here).

19. Have you ever received treatment for your substance use/abuse condition?

20. In which of the following levels of intensity were you treated?
    (please indicate the number of treatment experiences next to each level of care)

    ___ Inpatient ___ Residential ___ Day Treatment ___Intensive Outpatient ___Outpatient

21. Did you continue or return to substance(s) use/abuse while you were involved in any of these treatment experiences?

22. What do you believe have been contributing factors to the relapses you have experienced?

23. Do you have any circumstances in your life that would inhibit your participation in treatment in the following levels of treatment?

    ___ Inpatient ___ Residential ___ Day Treatment ___Intensive Outpatient ___Outpatient

    Please describe what the circumstances are?

24. Please list the members of your household and their relationships to you?

    Name _____Relationship to You

    Name _____Relationship to You

    Name _____Relationship to You

    Name _____Relationship to You

    Name _____Relationship to You

    Name _____Relationship to You

25. If you have children, have you been unable to adequately care for them at any time because of your substance use/abuse?

    Have your children ever been:

    _____temporarily removed from your custody?

    _____permanently removed from your custody?

    _____formally removed from your custody?

    _____informally removed from your custody?

26. Have you experienced any forms of abuse from any of the members of your household?

27. Do you have any concerns for your safety in your current living situation?

28. Do any of the members of your household use/abuse substance(s)?

29. Where are you employed and what type of work do you do?

30. Does substance(s) use/abuse occur at your place of employment?

31. Are your family and/or household members supportive of your recovery efforts?

32. Are your friends/peers supportive of your recovery efforts?

33. Are your co-workers supportive of your recovery efforts?

Wisconsin Uniform Placement Criteria
WI-UPC

Appendices

Section V

APPENDIX A
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APPENDIX B
RESOURCE LIST PREPARED BY CSAT

Several types of materials may be useful to programs or systems seeking to create or adapt patient placement criteria (PPC). Information gained from careful assessment is essential for making appropriate placement decisions. This appendix describes instruments for assessing the severity of alcohol and other drug (AOD) use and related problems, the potential for withdrawal symptoms, and attitudes toward treatment. The Level of Care Index (LOCI) and Recovery Attitude and Treatment Evaluator (RAATE) instruments were designed to be compatible with the PPC developed by the American Society of Addiction Medicine. The authors of these instruments were members of the consensus panel that developed this Treatment Improvement Protocol. Two software packages to aid clinical management and treatment planning are also described. Dr. Paul Earley, who developed one of the software packages, is an *ex officio* member of ASAM's board of directors.

For readers who wish to examine existing criteria in more detail, the second section lists information about how to obtain criteria sets from various States and private organizations. The final section of the appendix presents information on ordering a variety of materials on managed care to help programs and systems prepare for health care reform.

Alcohol and Other Drug Use and Psychosocial Assessment Instruments

A comprehensive assessment of each patient entering treatment is needed and should include the following:

- History of alcohol and other drug abuse
- Medical history
- Mental health history
- Psychosocial history.

A number of assessment instruments are widely used to collect information that is helpful in diagnosis and treatment planning. The instruments that are especially pertinent to the concepts discussed in this TIP are listed below. Other instruments are also available that illustrate the ways in which individual treatment programs have developed or tailored assessment tools to meet the particular needs of their patient populations.

The listing of a particular assessment instrument in no way implies an endorsement of that instrument, nor is the following list intended to be inclusive or representative of all assessment instruments that may be used by treatment programs. The instruments included here are used or recommended by some treatment providers.

A collection of sample assessment instruments is available as a package from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20847-2345; (800) 729-6686; TDD (for hearing impaired): (800) 487-4889; fax: (301) 4686433.

Addiction Severity Index (ASI) The ASI, now in its fifth edition, is the most widely used standardized assessment tool in the field. It is a highly structured clinical interview consisting of 161 items. 'Me ASI is designed for a trained technician to rate the severity of problems in six areas: medical, psychological, legal, family and social, employment and support, and use of alcohol and other drugs.

Source: McLellan, A.T.; Kushner, H., and Metzger, D. The @ edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment* 9(3):199-213, 1992. The National Institute on Drug Abuse (NIDA) has developed a technology transfer package, which includes the ASI, two 60-minute training videotapes on use of the ASI, a training facilitator's manual, and a program administrator's handbook addressing managerial concerns such as quality control.

Ordering Information: Available from NCADI; (800) 729-6686; fax: (301) 4686433. Also, the clinical version of the fifth edition of the ASI is reproduced in the *TIP Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System,* which is also available from NCADI.

Cost: None

Clinical Institute Withdrawal Assessment for Alcohol Scale Revised (CIWA-Ar) The CIWA-AR aids in measuring acute intoxication and/or withdrawal potential. With the use of CIWA-AR, 15 symptoms of withdrawal can be measured in 3 to 5 minutes. A 60-minute videotape, "The Alcohol Withdrawal Syndrome," has been developed to train clinical staff in use of the CIWA-A (longer version of revised CIWA).

Source: Sullivan, J., Sykora, K., Schneiderman, J., Naranjo, C., and Sellers, F. Assessment of alcohol withdrawal: the revised Clinical Institute Withdrawal Assessment for Alcohol Scale. *British Journal of Addiction* 84:1353-1357, 1989.

Ordering Information: Available from the Addiction Research Foundation, Marketing Department, 33 Russell St., Toronto, Ontario M5S-2SI; (800) 661-1111.

Cost: Instrument: none; videotape: $250, plus $25 shipping

Level of Care Index (LOCI) , The LOCI tools are clinical checklists that aid in decision-making about the appropriate level of care for patients with substance use disorders. Separate tools address decisions about: admission, continued stay, and discharge/transfer. The indexes are designed to be compatible with the ASAM patient placement criteria and summarize dimensions and decision points contained in those criteria. 'Mere are separate indexes for adults and adolescents.

Source: Mee-Lee, D., and Hoffmann, N.G. *LOCI-Level of Care Index: A Concise Summary of ASAM Criteria's Factors to Document for Placement, Continued Stay, and Discharge.* St. Paul, Minnesota: New Standards, 1992.

Ordering Information: Available from New Standards, Inc., 1080 Montreal Ave., Suite 300, St. Paul, MN 55116; (612) 690-1002; fax: 612-690-1303. Forms for the separate assessment areas (admission, continued stay, and discharge/transfer) and are sold separately in packs of 25.

Cost: $24.50 for a pack of 25

Recovery Attitude and Treatment Evaluator (RAATE) The RAATE is an instrument used for determining severity of addiction based on assessment of five dimensions. These include: resistance to treatment, resistance to continuing care, acuity of biomedical problems, acuity of psychiatric and psychological problems, and social/family environmental status. The RAATE Clinical Evaluation is completed by the clinician, and scores in each dimension are keyed to the four levels of care described in the ASAM criteria. The RAATE Questionnaire I is a 94-item true-false instrument completed by the patient, which elicits information about the five dimensions.

Source: Mee-Lee, D. An instrument for treatment progress and matching: the Recovery Attitude and Treatment Evaluator (RAATE). *Journal of Substance Abuse Treatment* 5183-186, 1988.

Ordering information: Available from New Standards, Inc., 1080 Montreal Ave., Suite 300, St. Paul, MN 55116; (612) 690-1002; fax: 612-690-1303. An introductory kit is available that includes a manual, 25 Clinical Evaluation (CE) forms, 25 Questionnaire I (Ql) forms, and a scoring template. PC disks can be prepared upon request.

Cost: Introductory kit: $125; Extra CE and Ql forms: $56.25 for pack of 25 forms; PC disk, $4.50 per interview

Problem Oriented Screening Instrument for Teenagers (POSIT) The POSIT is a self-administered 139-item screening questionnaire that was developed by NIDA. It was designed as part of a more extensive system for adolescents, the Adolescent Assessment/Referral System (AARS). It measures problem severity in 10 domains that are often related to substance abuse and that are amenable to treatment intervention. Domains include substance abuse, physical health, mental health, family relations, peer relations, educational status, vocational status, social skills, leisure/recreation, and aggressive behavior.

Source: Radhert, E.R. The Problem Oriented Screening Instrument for Teenagers, in Radhert, E.R., ed., *The Adolescent Assessment Referral System Manual.* DHHS pub. (ADM)91-1735. Washington, D.C.: Government Printing Office, 1991.

Ordering information: Available from NCADI; (800) 729-6686; TDD (for hearing impaired), (800) 487-4889; fax: (301) 468-6433. Request the *Adolescent Assessment Referral System Manual.*

Cost: None

SOFTWARE

Computerized Placement System This patient placement management software allows users to structure the system according to their own criteria and rules. Based on the criteria, the system generates a placement form to be filled out by the clinician during patient assessment When these data are entered, the system produces a placement matrix and a continued stay review form, **with** a due date based on placement rules, for the clinician's use. Additional continued stay forms for each patient are generated as needed. To facilitate management of large numbers of patients, the system generates a list of forms and reports due each day, as well as summary data of several kinds. A treatment planning module is being developed.

Ordering information: Contact Michael Ruppert, MRM Enterprises, P.O. Box 1153, Helena, MT 59624; fax only: (406) 443-5490.

Cost: $2 per patient unit; discounts for large orders

TxPlan, TxPlan is a professionally developed, highly customizable, clinical management software system. It tracks patients from intake and facilitates the writing of individualized treatment plans, progress notes, and discharge summaries. Problem databases can be created for any patient population or level of care. TxPlan's chemical dependency database of approximately 100 problems is organized according to the six dimensions of the ASAM criteria. Clinicians can identify a patient's problems in each dimension and then have a choice of up to 15 objectives and interventions for each problem.

Ordering information: Contact Judith K. Earley, Ph.D., President, Earley Corp., 407 Ponce De Leon Ave., Decatur, GA 30030; (404) 370-1212; fax: (404) 378-0346.

Cost: Single-user license: $1,295; network license: $2,590 (up to three users) to $10,590 (unlimited users); customization programming: $80/hour; onsite installation and training: $975/day plus expenses.

APPENDIX B
RESOURCE LIST PREPARED BY CSAT

CRITERIA SETS

Patient placement criteria developed by the American Society of Addiction Medicine and by several States and private organizations can be used as models in creating, adapting, or amending patient placement criteria. Several criteria sets are described below, with ordering information.

American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders These criteria offer clinical guidelines for matching patients with substance use disorders to appropriate levels of care. Four levels of care are described: outpatient treatment, intensive outpatient/partial hospitalization, medically monitored intensive inpatient treatment, and medically managed intensive inpatient treatment

Ordering information: Available from the American Society of Addiction Medicine, 4601 North Park Ave., Suite 101, Chevy Chase, MD 20815; (301) 656-3920.

Cost: ASAM members: $45; non-members, $65

STATE CRITERIA

Iowa, *Iowa Client Patient Placement Criteria: Treatment of Psychoactive Substance Use Disorders (1991)* 1 -These criteria were developed by the Chemical Dependency Treatment Programs of Iowa and Iowa Substance Abuse Program Directors Association. Seven levels of care are described: continuing care, halfway house, extended outpatient treatment, intensive outpatient treatment, primary/extended residential treatment, medically monitored inpatient treatment, and medically managed inpatient treatment.

Ordering information: Contact Janet Zwick, Director, Division of Substance Abuse, Iowa Department of Public Health, Lucas State Office Building, Third Floor, Des Moines, IA 50319; (515) 281-3641; fax: (515) 281-4535.

Cost: No cost at this time

Massachusetts, Substance Abuse Outpatient Counseling; Detoxification Services; Youth Residential Criteria; Methadone Treatment Criteria (draft) The Bureau of Substance Abuse Services has collaborated with substance abuse treatment providers throughout the State to develop standardized admission, discharge, and continuing care criteria for several substance abuse treatment modalities, which are available in a single document. The criteria are modeled on the ASAM patient placement criteria but were modified and supplemented to better represent needs of public-sector clients and available services. The State is now developing criteria for residential recovery services.

Ordering information: Contact Shelly Steenrod, M.S.W., L.I.C.S.W., Regional Manager, Massachusetts Bureau of Substance Abuse Services, 150 Tremont Street, Boston, MA 02111; (617) 727-7985.

Cost: No cost at this time

Minnesota Rule 25: Assessment and Placement for Public Assistance Recipients The single State agency developed these criteria in collaboration with treatment providers and county social service agencies. They were implemented in 1988 in conjunction with a consolidated funding system. Rule 25 is more concise and user 'friendly than the ASAM criteria but does not describe as comprehensive an assessment or contain continued stay criteria.

Ordering information: Contact Lee Gartner, Planner Principal, Chemical Dependency Program Division, Minnesota Department of Human Services, 444 Lafayette Road, St. Paul, MN 55155-3823; (612) 296-3991; fax: (612) 297-1862.

Cost: No cost at this time

Montana Administrative Rules of Montana, Chapter 3, Chemical Dependency Rules, The Montana rules for patient placement are conceptually based on the ASAM criteria. Three levels were added to ASAM's four levels to allow more flexibility within the medical levels of care.

Ordering information: Contact Norma Jean Boles, R.N., Manager, Montana Department of Corrections and Human Services, 1539 11th Ave., Helena, MT 59620; (406) 444-4931; fax: (406) 444-4920.

Cost: None

Washington State, Criteria for the Admission and Transfer/Discharge of Adult Chemical Dependency Patients in Washington State These criteria were developed by chemical dependency assessment and treatment professionals, in consultation with representatives of the insurance industry and their agents, to address problems created by the impact of managed care practices on the chemical dependency treatment system and patients. They were modeled on the ASAM criteria, and modified to better reflect needs of the public sector and of small outpatient treatment providers.

Ordering information: Contact Henry L. Govert, M.A., Program Manager, Division of Alcohol and Substance Abuse, Washington Department of Social and Health Services; (206) 438-8092.

Cost: None

PRIVATE CRITERIA

Green Spring Health Services, Inc., Green Spring Utilization Review Criteria These criteria, developed to guide patient placement in the least intensive, least restrictive level of care, describe six levels of substance abuse treatment, and include guidelines for admission, continued stay, and discharge.

Ordering information: Contact Jonathan Book, M.D., Senior Vice President, Chief Medical Officer, Green Spring Health Services, Inc., 5565 Sterrett Pl., Suite 500, Columbia, NM 21044; (410) 964-6092.

Cost: None

Health Management Strategies International, Inc.
Mental Health Review Criteria,. These psychiatric and substance use criteria constitute the entire spectrum of utilization management screening guidelines used by Health Management Strategies International, Inc.

Ordering information: Write Health Management Strategies International, Inc., 1725 Duke St., Attention: Criteria Request, Suite 300, Alexandria, VA 22314.

Cost: $l0

Level of Care Guidelines for Mental Health; and Substance Abuse Preferred Practices Guide, MCC Behavioral Care These two documents provide information to decision-makers about appropriate mental health and substance abuse treatment. The level of care guidelines help define and promote an appropriate and flexible approach to the treatment continuum. The practices guide is used by case managers to review proposed levels of mental health and substance abuse placement.

Ordering information: Contact John Bartlett, M.D., Vice President, Corporate Medical Director, MCC Behavioral Care, 11095 Viking Dr., Suite 350, Eden Prairie, MN 55344; (612) 943-9577.

Cost: None

Mental Health/Substance Abuse Medical Necessity Utilization Review Criteria, Mutual of Omaha Insurance Companies. Mutual of Omaha Companies' Integrated Behavioral Services has developed five sets of utilization management criteria for mental health/substance abuse treatment services. These criteria are designed to assist in matching patient need, level of functioning, or status with the characteristics of each level of care. The criteria sets are: adult/adolescent mental health 24-hour services, adult/adolescent substance abuse 24-hour services detoxification, adult/adolescent substance abuse 24-

hour post-detoxification services, child mental health 24-hour services, and mental health/substance abuse non-24-hour services.

Ordering information: Contact Mutual Of Omaha Companies-Integrated Behavioral Services, Mutual of Omaha Plaza, Omaha, NE 68175; (402) 342-7600.

Cost: $49.95

Guidelines for Level of Care Decisions, U.S. Behavioral Health. This document is designed to assist care managers in determining appropriate levels of care for patients with substance use disorders.

Ordering information: Contact Bill Goldman, Senior Vice President for Medical Affairs, U.S. Behavioral Health, 2000 Powell St., Suite 1180, Emeryville, CA 946081832; (510) 601-2230.

Cost: None

Clinical Protocol and Procedures Manual, Section D, Adult/Adolescent Substance Abuse (draft), Value Behavioral Health, Inc. Patient placement criteria and substance abuse treatment planning guidelines for adults and adolescents are included.

Ordering information: Contact Ian Schaffer, M.D., Executive Vice President and Chief Medical Officer, Value Behavioral Health, Inc., 3110 Fairview Park Drive South, Falls Church, VA 22042; (703) 205-6700.

Cost: None

APPENDIX B
RESOURCE LIST PREPARED BY CSAT

MANAGED CARE RESOURCES

The Center for Substance Abuse Treatment (CSAT) has developed a variety of reports and other documents to assist States in preparing for health care reform and the effects of managed care on the delivery of substance abuse treatment services. Some of them are described below. Other documents and articles that may be helpful are included.

Annotated Bibliography of Managed Care Materials, (October 1994)Center for Substance Abuse Treatment. This bibliography lists useful materials, many of which are free of charge, on topics related to managed care. Sections include: preparing for managed care, needs assessment, performance measures, screening and assessment tools, uniform patient placement and utilization review criteria, peer review, finance, program evaluation, treatment outcomes monitoring systems, and outcomes evaluation.

Ordering information: Contact David Griffith, M.S., M.Ed., Public Health Advisor, CSAT, Division of State Programs; (301) 443-8391.

Cost: None

Managed Care Readiness Guide and Checklist (July 1994). This checklist identifies strengths and weaknesses in substance abuse provider systems and can be used to facilitate a strategic planning- process to assist an organization in preparing to succeed in a managed care environment. The accompanying guide provides suggestions on how to use the checklist and enhance discussion of the critical issues.

Ordering information: Contact David Griffith, M.S., M.Ed., Public Health Advisor, CSAT, Division of State Programs; (301) 443-8391.

Cost: None

Managed Care and Substance Abuse Treatment: A Need for Dialogue (September 1992) This document explores managed care and its relationship to AOD abuse treatment. Sections include: the current fiscal crisis within the health care system, the development and expansion of managed care as a key response to the crisis in health care, and the critical importance of establishing treatment protocols for different levels of care.

Ordering information: Contact David Griffith, M.S., M.Ed., Public Health Advisor, CSAT, Division of State Programs; (301) 443-8391.

Cost: None

Essential Elements and Policy Issues of Contracts for Purchasing Managed Care Service (December 1994) This publication illustrates the processes involved in purchasing, monitoring, and managing managed care services for individuals with alcohol or other drug problems. It is designed to help prepare single State agency (SSA) directors to successfully interface with managed care entities in the context of current health care reform committed to regulating health insurance, and the key activities insurance departments perform.

Ordering information: Contact Documents Distribution, GAO; (202) 512-6000.

Cost: None

APPENDIX B
RESOURCE LIST PREPARED BY CSAT

Join Together: A National Resource for Communities Fighting Substance Abuse Health Reform for Communities: Financing Substance Abuse Services (no date) This document includes seven recommendations from a national policy panel for ensuring financing for substance abuse services.

Ordering information: Contact Ben Rivers, Join Together, 441 Stuart St., 6th Floor, Boston, MA 02116; (617) 437-1500.

Cost: First copy free; additional copies $1.00 each.

APPENDIX C
BMHSAS STAFF RESOURCES

Substance Abuse Web: http://www.dhfs.state.wi.us/substabuse
See Web Links for:
Training Schedule,
Registration Form,
UPC 2000 version updates

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