Proposed Updates to *The ASAM Criteria*, 4th Edition

Request for public comments, October 2022

Background

The ASAM Criteria®, first published in 1991, provides national standards for conducting a comprehensive multidimensional assessment and determining the appropriate level of care for patients with addiction. In addition, these standards offer a model for the infrastructure of addiction care, including the types and intensities of treatment and the staff and services needed for each level of care. Since the release of the 3rd edition in 2013, there has been widespread adoption of *The ASAM Criteria* by treatment programs as well as payers, managed care organizations, and states across the country that are using these standards as the foundation of efforts to improve their addiction treatment systems. ASAM is currently working to develop the 4th Edition of *The ASAM Criteria* under the guidance of a new editorial team, led by Dr. R. Corey Waller, MD, MS, FACEP, DFASAM, and using a rigorous methodology for evidence review and formal consensus development.

In March 2021, ASAM released a survey seeking comments from diverse stakeholders including treatment providers, system administrators, health plans, policy makers, patients, and families on what is working well in the implementation of *The ASAM Criteria*, what barriers or challenges they have faced, and what can be improved in the next edition. In December 2021, ASAM released a preliminary outline of Major Changes Proposed for the 4th Edition for stakeholder feedback to understand any potential unintended consequences. ASAM received comments from 124 individuals and organizations. ASAM staff and the editorial team carefully analyzed this feedback to inform the development of the draft standards presented here.

ASAM's methodology for updating *The ASAM Criteria* standards has included:

- Completion of 17 structured literature reviews to support the development of the adult volume of *The ASAM Criteria*
- Convening 17 writing groups to draft standards
  - Conflict of interest (COI) review
  - Each writing group reviewed the public stakeholder input, literature review findings, and 3rd edition standards, and considered their own clinical experiences in implementing *The ASAM Criteria* along with their knowledge of evolving systems of care to develop the draft standards.
- Modified Delphi process with independent voting panels (with no-low COI) rating the appropriateness of each standard
- Reconciliation of voting panel feedback

ASAM is seeking input from diverse stakeholders on the core standards proposed for the 4th Edition of *The ASAM Criteria*. We recognize that *The ASAM Criteria* are implemented in different ways in systems across the country. No one person has insight into all these implementations. Thus, input from diverse stakeholders is needed to inform final decisions regarding these proposed changes.

Request for Input

This document outlines the draft ASAM Criteria standards for Adult levels of care, including the standards for:

- Assessment and Treatment Planning
- The ASAM Continuum of Care
- Service Characteristics for each Level of Care
- Dimensional Admission Criteria

The full narrative text will not be released for public comment. See the draft Table of Contents in Appendix C for an outline of the topics that will be covered.

As noted in the previous public comment periods, ASAM plans to release separate volumes addressing:

a. Adolescent and Transition Age Youth
b. Addiction Treatment within Jails and Prisons
c. Behavioral Addictions (i.e., gambling, internet and gaming addiction, sex addiction)

The comment period will close **at 11:59pm ET on November 11th, 2022**. We will be collecting comments through an electronic survey. For each comment you will be asked to input the page and line number (not a range, just a single number) in the appropriate boxes. Please submit your comments here: bit.ly/ASAM4th

Please note that your comments may be made public.

Note: While the system does not allow you to save your progress to return later, you may submit multiple responses. You can enter a subset of your comments and then restart the survey later and enter new comments starting from where you left off. If you need to submit multiple responses, be sure to submit your responses at the end of each page so that your final response is saved. Once you have completed the survey, you will be taken to a thank you page.

Questions? ASAMCriteria@ASAM.org

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Summary of Major Changes

The editorial team is proposing major changes in the 4th Edition of *The ASAM Criteria* to facilitate dissemination and implementation and to address known gaps in the quality of addiction treatment. The core principles of *The ASAM Criteria* remain the same, including:

- Admission into treatment is based on patient need rather than arbitrary prerequisites (e.g., prior treatment failure).
- Patients receive a multidimensional assessment that addresses the broad biological, psychological, social, and cultural factors that contribute to addiction and recovery.
- Treatment plans are individualized based on a patient's needs and preferences.
- Care is interdisciplinary, evidence based, delivered from a place of empathy, and centered on the patient.
- Patients move along a clinical continuum of care based on progress and outcomes.
- Informed consent and shared decision making accompany all treatment decisions.

These central principles of *The ASAM Criteria* reflect the biopsychosocial nature of addiction. They recognize that there is a complex interplay between an individual patient's biology, psychology, and environment that influences both risk for substance use disorder (SUD) and prognosis. The standards in T*he ASAM Criteria* promote a holistic view of patients, acknowledging the role that physical and mental health, life circumstances (e.g., education, employment, social support, housing, trauma history, criminal legal involvement, etc.), and individual needs, strengths, and goals play in the development and maintenance of addiction. All these factors are assessed to develop an individualized treatment plan. *The ASAM Criteria* emphasizes the importance of treatment plans tailored to the needs of individual patients and regular reassessment and modification of treatment plans that reflect both response to treatment and the evolving needs of the patient as life circumstances change.

To reflect the evolving needs of the field the 4th Edition the editorial team is proposing updates to *The ASAM Criteria* to:

- ***Update the continuum of care*** to:
  - Reflect the diversity of care that occurs at Level 1 outpatient treatment
  - Better describe the biomedical, psychosocial and recovery support services needed at each level of care
  - Emphasize the importance of treating this chronic disease with a team-based chronic care model, including incorporating standards for remission monitoring.
  - Integrate withdrawal management and biomedical care into the main continuum of care
  - Clarify the role of risk ratings in determining initial level of care placement
- ***Update the ASAM Criteria Assessment and Treatment planning standards***.
  - Provide separate standards for an initial Level of Care Assessment and a Treatment Planning Assessment.
  - Address how social determinants of health influence prognosis and how they should be addressed within the treatment plan.
  - Incorporate principles of measurement-based care to support a patient-centered approach to symptom and progress monitoring.
- ***Increase access to addiction pharmacotherapies***. The editorial team is proposing to incorporate standards into each level of care to either directly or through a formal affiliation

(i.e., contract or memorandum of understanding), provide access to all addiction pharmacotherapies, with limited exceptions for access to methadone when no Opioid Treatment Programs exist within a reasonable distance of the program.

- ***Promote more integrated care for co-occurring mental health conditions*** by incorporating standards for co-occurring capable care into the core standards for each level of care.
- ***Promote better integration of SUD treatment into general healthcare*** by emphasizing the role of primary care providers in managing patients with stable SUD and the role of emergency departments in initiating treatment and supporting engagement in ongoing care.
- ***Incorporate treatment of individuals with cognitive impairments across the continuum.*** The 4th edition will eliminate Level 3.3 and add a chapter that discusses standards for addressing cognitive impairments within any level of care in the continuum.
- ***Support better communication of medical necessity.*** The 4th Edition of *The ASAM Criteria* will take a patient-centered and dimension forward approach to medical necessity by developing more standardized medical necessity criteria as well as standards for medical necessity documentation, in alignment with the clinical assessment standards. This approach is intended to reduce the variance in implementation and usage.
- Discuss how **telehealth, mobile treatment services, and digital therapeutics** can be incorporated into treatment at each level of care.
- Update the language throughout to **reflect evolving terminology in the field**.
- Review and **update the standards with a focus on diversity, equity, and inclusion**.

The following sections provide a comprehensive overview of the proposed changes and present the draft standards.

Assessment and Treatment Planning Standards

A core principle of *The ASAM Criteria* is the use of a multidimensional assessment to drive level of care recommendations and the development of an individualized treatment plan. While the need for a comprehensive assessment and regular reassessments is described in the book, many stakeholders have requested more detailed standards to help guide effective implementation.

A full biopsychosocial assessment is not necessary for determining patient placement, but it is the foundation for a comprehensive treatment plan. The 4th Edition will describe separate standards for the ASAM Criteria Level of Care Assessment that is used to determine the recommended level of care and the ASAM Criteria Treatment Planning Assessment. Both assessments will be multidimensional and consider the patient's full biological, psychological, and sociocultural context.

"Readiness to change" should not contribute to the recommended level of care. The initial recommendation should be determined based on the severity of the illness, any co-occurring conditions, and the environmental factors that may support or impede treatment progress. However, readiness to change may influence what level(s) of care the patient is willing to accept and should be carefully considered in treatment planning. For example, if Level 2.5 is recommended, but the patient is only willing to engage in Level 1.5 the treatment plan at Level 1.5 should incorporate motivational enhancement strategies to increase the patient's readiness to change and encourage further participation and engagement in treatment.

Other commenters emphasized the importance of assessing social determinants of health, including access to transportation or childcare; healthcare access; work, school, or family responsibilities; food and housing insecurity; etc. These factors may influence what level of care a patient is <u>able</u> to

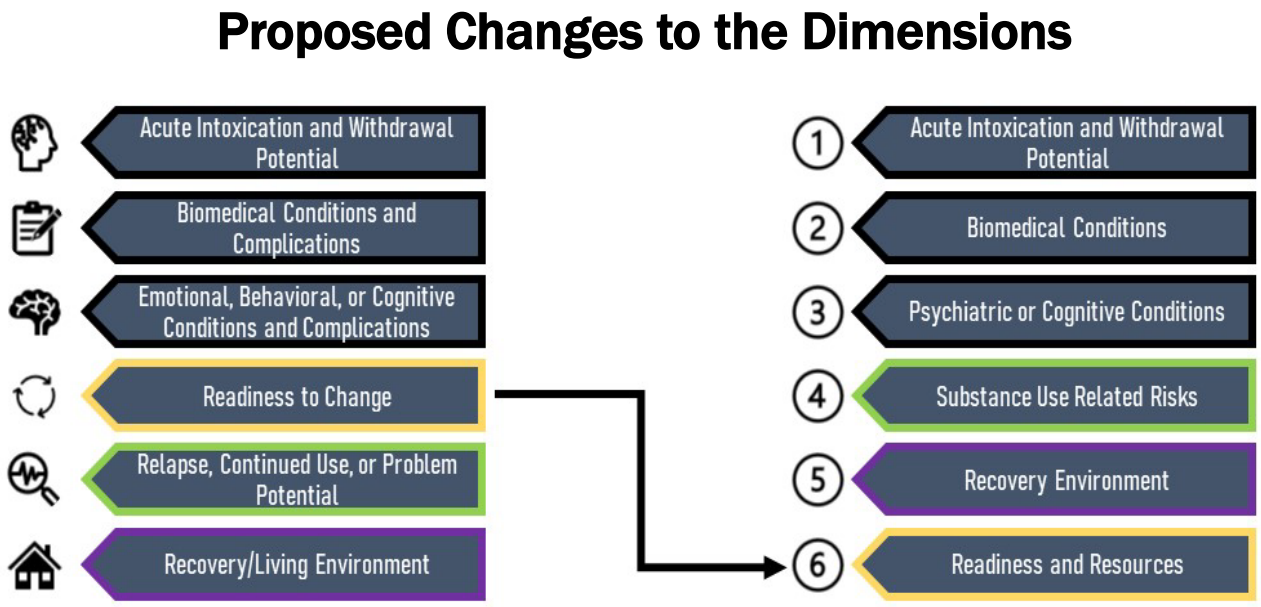
participate in and are important for treatment planning, but as with readiness to change, they should not impact the initial level of care recommendation(s).

To address these needs, the 4th Edition of *The ASAM Criteria* will:

1. Define standards for a more concise level of care assessment to guide initial patient placement with the goal of reducing the time it takes to make an appropriate level of care recommendation.
2. Expand upon the standards for the multidimensional assessment, including descriptions of the subdimensions that should be assessed.
3. Describe standards for using the information gathered during the treatment planning assessment to develop a comprehensive, individualized treatment plan in a collaborative process with the patient.
4. Simplify and update the names of the dimensions to reflect the evolution of the terminology used in the field and facilitate the effective dissemination of these standards.
5. Define which types of clinicians can deliver these assessments, what scopes of practice are required, and when assessment by a more advanced practitioner is indicated.
6. Expand upon the standards regarding patient reassessment, including timeframes for reassessment at each level of care; core information that should be collected at reassessment; and how reassessments should be used to update the patient treatment plan.

The ASAM Criteria Level of Care Assessment

To streamline the Level of Care assessment process, ASAM proposes a deductive approach, first assessing the dimensions with the highest potential for acute medical needs. This approach will require a reorganization of the dimensions with the factors that do not impact the initial level of care recommendation, including readiness to change and social determinants of health, assessed last.



The level of care recommendation will be based on the assessment of dimensions 1-5. Dimension 6 will be used to determine what level of care placement the patient is willing and able to accept.

Issues identified in Dimensions 1 and 2, including intoxication, withdrawal risk, and acute biomedical conditions, have the greatest potential to impart immediate needs or imminent risks that require medically managed care in a Level 3.7 or Level 4 program. Issues identified in Dimension 3, such as severe psychosis or suicidality, may also indicate a need for medically managed care or acute psychiatric interventions. If immediate needs or imminent risks are identified in Dimensions 1-3 that indicate the need for Level 3.7 or 4 treatment, the Level of Care assessment should end, as placement has been determined.

As discussed above, since readiness to change does not contribute to placement, we will re-order the dimensions such that this factor will be considered at the end of the assessment. The new Dimension 4, Substance Use Related Risks, will assess the danger to the patient related to continued substance use or SUD recurrence, such as the risk of overdose or driving while intoxicated. Dimension 5, Recovery Environment, assesses the factors in a person's environment that influence the likelihood of recovery, including support systems, exposure to substances, and daily structure, among others. Severe issues in Dimensions 4 and 5 may indicate a need for residential treatment.

The level of care recommendation will be made based on the assessment of Dimensions 1-5. Dimension 6 (Readiness and Resources) will assess readiness to address substance use as well as other problems and barriers to accessing care (e.g., transportation, childcare, insurance/financial ability to pay, etc.). At this stage, the assessor should work with the patient to determine what level of care they are willing and able to engage in. When developing the treatment plan, these issues should be addressed to encourage and/or facilitate the patient's engagement in the recommended level of care.

The ASAM Criteria Treatment Planning Assessment

While the Level of Care assessment is focused on the factors that may impact the level of care recommendation and placement, the more comprehensive Treatment Planning Assessment supports effective treatment planning. This assessment does not need to be completed all at once and can be completed by multiple clinicians in a multidisciplinary process.

While assessment and treatment planning should be an ongoing process throughout treatment, an initial Treatment Planning Assessment should cover each of the dimensions and subdimensions outlined below in enough depth to develop the initial treatment plan. This assessment should identify:

- Concerns in each dimension that interfere with recovery and need to be addressed while the patient is in the current level of care
- Strengths to build upon
- Care coordination needs
- Recovery support service needs, with a focus on the needs that must be addressed prior to a transition in care (e.g., housing needs)

Patients should regularly be reassessed for progress and treatment plans updated at a frequency appropriate to the level of care (as outlined in the Level of Care Service Characteristics). Assessment should go into more depth over time as the patient gets more deeply engaged in care and develops stronger therapeutic alliance with their clinicians.

Dimensions and Subdimensions

The ASAM Level of Care and Treatment Planning assessments should assess the following dimensions. The dimensions in bold contribute to level of care placement and should be assessed during the Level of Care Assessment. The level of care recommendation is determined by the dimensions "driving" the disease process and should therefore be the focus of treatment at a given level of care. Once the initial dimensional drivers are stabilized, a reassessment should identify the new dimensional drivers to be addressed at the most appropriate next level of care in the continuum.

Dimension 1 – Acute intoxication and withdrawal potential

- **Intoxication and associated risks (including overdose)**
- **Withdrawal and associated risks**
- **Need for medication for opioid use disorder**

Dimension 2 – Biomedical conditions

- **Physical health concerns (including pain)**
- **Pregnancy-related concerns**
- Sleep problems

Dimension 3 - Psychiatric and cognitive conditions

- **Active psychiatric concerns**
- **Persistent disability**
- Cognitive functioning
- Trauma-related needs
- Psychiatric history

Dimension 4 – Substance use related risks

- **Likelihood of engaging in risky substance use**
- **Likelihood of engaging other harmful SUD related behaviors**

Dimension 5 – Recovery environment

- **Ability to interact productively with current environment**
- **Safety in current environment**
- **Support in current environment**
- Cultural perceptions of drug use and addiction

Dimension 6 – Readiness and Resources

- Readiness
- Resources
- Treatment Goals

Level of Care Assessment Standards

Assessment Policies and Procedures

- Prior to admission, each patient should be assessed to determine, at minimum:
  - A provisional diagnosis of Substance Use Disorder (SUD).
  - The recommended Level of Care that represents the least intensive level at which the patient can be safely and effectively treated.
- A provisional SUD diagnosis should be followed soon afterward by a formal DSM-5 substance use disorder diagnosis (for all Levels of Care except 0.5). Treatment programs should have protocols in place for obtaining a diagnosis from a qualified clinician acting within their scope of practice.
- Programs should ensure that clinical staff are trained in collecting information using validated screening and brief-assessment tools to support measurement-based care during treatment.
- Programs should have physician-developed protocols to define when an assessment finding in Dimension 1, 2, or 3 requires further assessment by a medical provider prior to admission.
  - If at any point in the assessment, emergent physical or mental health needs are identified, consider immediate transfer to an emergency department, or call 911.
    - Programs' policies and procedures for patient assessment should address what to do if emergent physical or mental health needs are identified.
  - If the patient is intoxicated or in withdrawal, it may not be possible or appropriate to complete the Level of Care assessment until their condition has been stabilized. If medical evaluation is not available on-site, the program's policies and procedures should address how to rapidly coordinate an appropriate medical evaluation or referral for withdrawal management services.

ASAM Level of Care Assessment Considerations

The Level of Care Assessment should address the following considerations. See Appendix A for detailed questions and recommendations for validated instruments in each dimension.

Dimension 1

1. Is the patient intoxicated? If so:
   a. How severe are signs and symptoms?
   b. Is medical management or monitoring required (as determined by a qualified medical professional)? If so, what level (outpatient, intensive outpatient, residential, intensive inpatient)?
2. Is the patient currently in withdrawal, or expected to enter withdrawal soon? If so, and as determined by a qualified medical professional:
   a. What is peak anticipated severity of signs and symptoms?
   b. What level of medical management and/or monitoring is required?
3. Does the patient have opioid use disorder?
   a. Is the patient currently taking medication for opioid use disorder (MOUD)?
      i. Will the patient transition from one medication to another? If so, are complications or need for medical management/monitoring anticipated?
   b. Does the patient need to initiate or titrate MOUD? If so, and as determined by a qualified medical professional:
      i. Are complications anticipated?

ii. Is the patient at risk for opioid withdrawal AND another withdrawal syndrome?
iii. Does the patient have a history of complications with initiation or titration of MOUD?

Dimension 2

4. Is the patient experiencing physical health problems? If so, and as determined by a qualified medical professional:
    a. What is the current severity?
    b. What level of medical management and/or monitoring is required?
5. Is the patient currently pregnant? If so, and as determined by a qualified medical professional:
    a. What is the status of the pregnancy?
    b. What level of medical management and/or monitoring is required?

Dimension 3

6. Does the patient have active co-occurring mental health concerns? If so, and as determined by a qualified mental health professional:
    a. Does the patient need medical management or monitoring? If yes:
        i. What level of medical management and/or monitoring is required?
        ii. Is specialty psychiatric management and/or monitoring within the SUD program needed?
    b. What level of support, supervision and monitoring are needed to manage the patient's mental health concerns?
7. Does the patient have chronic psychiatric or cognitive problems that cause PERSISTENT DISABILITY? If so, (as determined by a qualified mental health professional) how severe are their symptoms? What level of staff support and/or monitoring does the patient need to manage activities of daily living?
    a. Is specialty psychiatric management within the SUD program needed?

Dimension 4

8. How likely is the patient to engage in risky substance use (without treatment)? What level of structure, supervision, and support does the patient need to minimize substance use-related risk?
9. How likely is the patient to engage in harmful SUD-related behaviors (e.g., drug dealing, risky commercial sex work) in their current environment (without treatment)? What level of structure, supervision, and support does the patient need to minimize harmful consequences of SUD-related behaviors?

Dimension 5

10. Is the patient able to function productively and independently in their current (living/community) environment? If no:
    a. Does the patient need habilitative services to learn basic interpersonal skills and/or skills of independent living? If so, what level of habilitative services are needed?
    b. Does the patient need a supportive environment in which to practice basic interpersonal skills/skills of independent living?

11. Is the patient's current environment safe? Does the patient's environment pose a threat to the patient's safety or well-being (e.g., homelessness and/or physical, sexual, or emotional abuse)?
12. Is the patient's current environment supportive? Does the current environment provide sufficient support to help patient cope with cravings/other recovery threats?

Level of Care Recommendation

- The Level of Care recommendation should be made on the basis of the patient's needs in Dimensions 1 through 5, referring to the dimensional risk ratings and admission criteria. After the clinician arrives at the Level of Care recommendation, Dimension 6 needs should be assessed to determine the patient's readiness and resources needed to attend the recommended Level of Care.
- The Level of Care placement may need to be adjusted based on patient readiness and on the availability of, and patient access to, recommended services. Motivational interviewing should be used during parts of the assessment related to Dimension 6 to encourage the patient to engage in the recommended Level of Care.
- At the end of the assessment, the clinician should document both the indicated Level of Care (determined by assessment of Dimensions 1 through 5) and the adjusted Level of Care, if applicable (based on clinician recommendation following assessment of Dimension 6). If there is a discrepancy between indicated and adjusted Level of Care, the reason(s) for this discrepancy should be documented.

Dimension 6 (Readiness and Resources) should be considered after Level of Care recommendation is determined based on needs identified in Dimensions 1-5.

- Is the patient able to attend the recommended Level of Care?
    - Are any services or resources needed to enable the patient to participate in the recommended Level of Care (e.g., transportation, childcare, financial, etc.)?
    - Are these services/resources available to the patient and sufficient to enable them to participate in the recommended LOC?
    - If not, how should the LOC be adjusted?
- Assuming the patient has sufficient resources and services are available, is the patient willing to attend the recommended Level of Care?
    - If not, what treatment services are acceptable to the patient?
    - If the patient's preferred treatment setting is adjudged to be unsafe or is unlikely to be effective, what can be done to increase the patient's willingness to attend treatment at the recommended Level of Care (e.g., motivational enhancement therapy, family counseling)?
    - Is the patient being compelled to follow clinical recommendations by an external source? If so, what are the requirements?

Treatment Planning Assessment Standards

Assessment Policies and Procedures

- After the patient is placed in a Level of Care, a comprehensive multidimensional assessment ("full biopsychosocial") should be conducted for treatment planning purposes.
- If the patient is being treated for unstable physical or psychiatric symptoms, treatment planning assessment may focus more on short-term goals.
- If the patient requires immediate treatment for acute physical or psychiatric symptoms, the treatment planning assessment should occur once the patient is stabilized, coherent, and able to participate comfortably.

- The treatment planning assessment does not need to be completed in one session and can be completed by multiple clinicians in a multidisciplinary process, and/or over several sessions. See the Level of Care specific standards for recommended timeframes for completion.
- If the treatment planning assessment is spread over multiple days, the patient should begin to receive treatment services while the assessment is being completed based on clinical data known or evident.
- Treatment programs should have protocols developed by a physician that define when assessment findings in Dimensions 1, 2, or 3 indicate a need for further assessment by a medical provider.
- Treatment programs should have protocols to define which data can be carried over from the Level of Care assessment into the treatment planning assessment, depending on the stability of the patient's condition and time between assessments. Previously gathered assessment information should be reviewed with the patient to complete missing information and clarify as needed.
- If the Level of Care assessment was completed by another provider, the treatment program should attempt to obtain a release of information authorization and receipt of the Level of Care assessment. If unable to obtain the Level of Care assessment, the treatment program must repeat the questions.
- If new concerns are identified during the treatment planning assessment that were not captured in the Level of Care assessment, but might impact the Level of Care recommendation, consider reassessing for Level of Care.

Dimension 1 (Acute intoxication and withdrawal potential)

- If no intoxication or withdrawal risks, or MOUD needs were identified during the Level of Care Assessment, Dimension 1 does not need to be assessed during the treatment planning assessment.
    - However, if the patient is intoxicated or there is a concern for a new risk for withdrawal, the appropriateness of the current level of care should be reassessed.
- If intoxication or withdrawal risks, or need for initiation or adjustment of MOUD, were identified during the Level of Care Assessment, the Dimension 1 treatment plan should be developed by a qualified medical professional based on appropriate clinical evaluation.
- If the need for MOUD continuation was identified during the Level of Care Assessment, staff should use the information captured then to inform treatment planning needs, including coordination with the external MOUD prescriber.
- If risk for tobacco/nicotine withdrawal was identified during the Level of Care Assessment, staff should use the information captured then to inform treatment planning needs, including:
    - Pharmacotherapy needs
    - Management of affective symptoms

Dimension 2 (Biomedical conditions)

NOTE: All patients should have a complete medical history and physical exam in accordance with the standards for each Level of Care. If the patient has physical health conditions, a medical provider should conduct this part of the assessment, but clinical staff may have a role in care coordination and addressing psychosocial issues that impact adherence to treatment and health behaviors.

- **Acute physical health concerns**

    - Are there acute physical health concerns (including any acute, undiagnosed, or uncontrolled pain) that require medical treatment or referral?
        - If yes, is the patient currently receiving treatment for their condition? (If no, refer for treatment)
            - Last medical visit for each issue (date, reason, outcome)
            - Additional or different treatment needed?
            - Is care coordination needed?
- Chronic physical health concerns
    - Are there chronic physical health issues, including chronic pain, which require medical treatment or referral?
        - If physical health problems are managed externally, are they well-controlled with current treatment?
            - Last medical visit for each issue (date, reason, outcome))
            - Additional or different treatment needed?
            - Is care coordination needed?
    - Does the patient's continued use of substances, including tobacco/nicotine, exacerbate any current physical health concerns (e.g., cancer, cardiovascular disease, respiratory disease)?
    - Does the patient have post-acute withdrawal symptoms?
        - Does the patient have significant sleep issues associated with the cessation of substance(s)?
        - Have the patient's physical/medical conditions become more difficult to treat since the cessation of substance(s)?
    - For serious chronic health problems, does patient have caregiver/sufficient home support (if not in a residential Level of Care)? Need daily nursing/rehabilitation to control symptoms and maintain function?
    - Does the patient require accommodations for any chronic physical health problems (e.g., physical disability)?
- Pregnancy or contraception-related concerns
    - Is the patient currently on medications for contraception?
    - Does the patient desire medications or interventions for contraception?
    - Currently pregnant or planning to become pregnant?
        - (If yes) Pregnancy-related concerns?
            - If medical pregnancy-related concerns are identified the patient should be referred to their obstetric provider.
        - (If yes) Receiving prenatal care?
        - (If yes) Pregnancy history, including complications
- Medical history (partial – full medical history should be completed by a medical professional)
    - Current and past medical diagnoses
    - Medications for physical health problems (name, dose, frequency, purpose, dose adherence, effectiveness)
        - Current
        - Past (for significant physical health problems that might re-emerge
        - Allergies/adverse events
- Treatment goals
    - What are the patient's goals for addressing any co-occurring physical health conditions?
    - What types of support and services does the patient need to address any co-occurring physical health conditions?

Dimension 3 (Psychiatric or cognitive conditions)

NOTE: If significant Dimension 3 issues are identified, a qualified mental health care professional should assess them. SUD treatment program staff should have sufficient competency in co-occurring mental health issues to provide collaborative care.

- **Acute mental health concerns**
  - Are there current unstable or evolving mental health concerns that require treatment or referral (include acute flares of chronic mental health conditions)?
    - Imminent risk of harm to self or others
    - Relationship of acute symptoms to substance use or withdrawal (are symptoms expected to subside or change after substance use has ceased/withdrawal is complete)
- **Chronic mental health concerns**
  - Are there chronic mental health concerns that require psychiatric treatment or referral
    - If mental health problems are managed externally, are they well-controlled with current treatment
      - Last medical visit for each issue (date, reason, outcome)
      - Additional or different treatment needed?
  - Does the patient have any post-acute withdrawal related mental health concerns?
    - Does the patient have new issues exerting emotional control since the cessation of the substance(s)?
    - Have medications offered symptom relief from these issues?
    - Have the patient's mental health concerns become more difficult to treat since the cessation of the substance(s)?
  - Does the patient's continued use of substances, including tobacco/nicotine, exacerbate any current mental health concerns (e.g., anxiety, suicidality)?
  - Does the patient have pain that impacts their mental health? If yes:
    - Has the patient received treatment for their pain?
    - Have any of these interventions helped?
    - How do the symptoms change with pain relief?
  - Exposure to abuse, including physical, sexual, emotional; and/or neglect
  - Exposure to and impact of trauma
  - Administer standardized mental health measures e.g., PHQ-9, GAD-7, C-SSRS, etc., as needed to establish baseline severity and inform interventions
- **Cognitive functioning deficits**
  - Does the patient have any cognitive deficits that require modified treatment services? If so,
    - Does the patient need specific treatment for cognitive issues? If yes:
      - Do the patient's cognitive issues require external management or medications?
      - Are the patient's cognitive problems currently managed by an external provider?
        - If yes, are they well controlled with current treatment?
        - Last medical visit for each issue (date, reason, outcome)
- **Psychiatric/cognitive history**
  - Mental status examination, as needed (e.g., Mini-Mental State Examination, MoCA)
  - Current and past co-occurring psychiatric/cognitive diagnoses
    - Determine symptomatology present before and after substance use
  - Medications for psychiatric/cognitive conditions (name, dose, frequency, purpose, dose adherence, effectiveness)

        - Current
        - Past (for significant psychiatric/cognitive problems that might re-emerge)
        - Allergies/adverse events
- **Treatment Goals**
    - What are the patient's goals for addressing any co-occurring mental health and/or cognitive conditions?
    - What types of support and services does the patient need to address any co-occurring mental health and/or cognitive conditions?

Dimension 4 (Substance use related risks)

- **Substance use**
    - Substance use history (self-reported or otherwise documented)
        - Age of use onset for each problem substance
        - Pattern of use for each problem substance
        - Date of last use/duration/frequency/route(s) of administration, for each problem substance (including nicotine/tobacco products)
    - Is the patient taking controlled medication(s) for the treatment of pain?
    - SUD treatment history (including nicotine/tobacco use disorder treatment)
    - History of unintentional overdose
    - What risks are posed by the patient's continued substance use (e.g., overdose, infectious disease transmission, skin infections, fire safety due to combustible tobacco or marijuana use, etc.)
    - Longest period of time without problematic substance use
    - Patient concerns regarding unintentional overdose risk
        - Need for overdose reversal training and medication?
    - When did the current period of problematic use begin (if applicable)?
    - Triggers for use
        - Which triggers have been most challenging in the past month?
        - How does patient cope with these triggers?
        - Does the patient need interventions to improve insight into their triggers, and/or to strengthen ability to cope with triggers?
        - Does the patient use substances to prevent or relieve physical pain?
    - Supports for avoiding use
        - What helps the patient avoid use?
        - Does the patient need interventions to strengthen their ability to develop and maintain supports for avoiding use?
    - Validated assessment tools, e.g., Brief Addiction Monitor (risk and protective scores), Visual Analog Scale (for craving), as needed to establish baseline addiction symptom severity
- **Addiction pharmacotherapy needs**
    - If the patient has OUD, AUD, or tobacco use disorder, are they currently prescribed addiction pharmacotherapies?
        - If no:
            - Has the patient been evaluated by a medical provider for addiction pharmacotherapy needs?
            - Does the patient need education on available treatment options?
        - If yes:
            - Does the patient consistently take the medication as prescribed?
            - Are the patient's cravings well controlled with current treatment?
            - Last medical visit for each issue (date, reason, outcome)

        - New appointment needed?
- **Harmful SUD related behaviors (if applicable)**
    - Longest period of time without harmful SUD related behaviors (e.g., risky sexual behaviors, driving under the influence, violence, behaviors that increase vulnerability to victimization)
    - When did the current period of harmful SUD related behaviors begin?
    - Triggers for harmful SUD related behaviors
        - Which triggers have been most challenging in the past month?
        - How does the patient cope with these triggers?
        - Does the patient need interventions to improve insight into their triggers, and/or to strengthen ability to cope with triggers?
- **Treatment Goals**
    - What are the patient's goals for addressing problematic use and (if applicable) harmful SUD related behaviors??
    - What types of support and services does the patient need to address problematic use and (if applicable) harmful SUD related behaviors?

Dimension 5 (Recovery environment)

- **Safety of living environment**
    - If in outpatient treatment, does the patient have a safe, stable place to live?
    - If in residential treatment, does the patient have a place to return to upon transition to outpatient treatment that is safe, stable, and conducive to recovery?
    - Does the patient need services to address housing needs?
- **Functioning in living environment**
    - Daily routine/structure (e.g., work, school, childcare)
        - Does the patient need support or services to build a daily routine/structure that is supportive of recovery?
    - Does the patient need support/services to develop free time activities supportive of recovery?
    - Does the patient need services to support their ability to function effectively in their environment?
        - Able to independently access community resources as needed (e.g., social services, medical care, peer support)?
        - Able to interact with others in a prosocial manner? (e.g., conflict resolution skills, does not sabotage others in recovery setting)?
- **Support in living environment**
    - Does the patient have a network of individuals (e.g., friends, significant others, family, community) who are supportive of recovery?
- **Treatment goals**
    - How does the patient feel their current environment (or the environment to which they will return post-transition from residential treatment) will affect their ability to engage in treatment and recovery?
    - What are patient's goals for attaining a healthy/supportive recovery environment (if applicable)?
    - Once the patient has a healthy/supportive recovery environment, what are the patient's goals for improving their ability to function effectively with that environment?
    - What types of support and services will patient need to help them achieve these goals?

Dimension 6 (Readiness and resources)

- **Readiness**
  - What does the patient believe needs to be addressed or improved with treatment or other professional services (substance use, mental health status, physical health, other)?
  - How ready does the patient feel to address the identified issues?
  - Does the patient have concerns or fears that make it hard for them to attend or remain in treatment?
  - Is the patient willing to participate in the recommended treatment services? Why or why not?
  - For patients with nicotine/tobacco use disorder, is the patient willing to engage in nicotine/tobacco use disorder treatment?
  - What external pressures are motivating the patient to enter into and complete treatment?
  - What external factors are negatively impacting the patient's motivation for treatment?
  - What factors (based on clinician judgement) need to be addressed to improve the patient's readiness to change?
  - What services/interventions are needed to improve the patient's readiness to change?
- **Resources**
  - Does the patient have needs related to social determinants of health that impact the ability to participate fully in treatment and achieve recovery?
    - Transportation or mobility challenges
    - Food or housing security
    - Childcare
    - Income or financial insecurity
    - Lack of educational or employment opportunities
    - Lack of healthcare coverage
    - Lack of appropriate social and community supports
  - Are the support services that the patient needs available to the client in a timely manner in the community? If so, how long will patient need to wait to receive these services?
  - What care coordination or recovery support services will the patient need to maximize their chances of success?
  - What sources of strength does the patient feel they already have to support their recovery? How can these strengths be built upon?
- **Treatment goals**
  - What are the patient's goals for addressing treatment readiness or attaining resources to support them in their recovery?
  - What types of support or services will the patient need to help them achieve these goals?

Reassessment and Measurement Based Care

Reassessment Standards

- After the clinical team has developed and implemented a treatment plan, clinicians should conduct periodic reassessments. (See level-specific service characteristics for the recommended frequency of reassessments.)
- Reassessment should be used to track patients' recovery progress and to inform clinical decision making, including:

  - To make decisions concerning treatment setting and transitions, e.g., continued stay or transfer between Levels of Care.
  - To make midcourse adjustments to treatment plan according to the patient's evolving needs.
- Addiction treatment providers should use standardized measures of withdrawal severity, substance use, cravings, physical and mental health symptoms, and overall recovery progress as deemed appropriate to adjust medications or behavioral treatment.
- The same set of measures should be completed at regular intervals to track changes in the patient's condition in response to treatment interventions.
  - Reassessment should also be conducted in response to significant events or changes in the patient's condition or circumstances that may influence the treatment plan or the patient's recovery process.
- When possible, reassessment should utilize measures shown to be sensitive to change over time. Examples include, but are not limited to, the Brief Addiction Monitor (BAM), the Treatment Effectiveness Assessment (TEA), Patient Health Questionnaire - PHQ-9 - for patients with depression (or the Geriatric Depression Rating Scale for older adult patients with depression), General Anxiety Disorder-7 (GAD-7) for patients with anxiety, and the Columbia-Suicide Severity Rating Scale (C-SSRS) to monitor suicidal ideation and behavior. The Visual Analog Scale (VAS) is often used in clinical settings to track change over time in cravings. The BARC-10 is often used to track change over time in recovery capital. The Montreal Cognitive Assessment (MoCA) has demonstrated sensitivity to change in cognitive function over time and has been tested in SUD treatment settings.
  - Note that several of these standardized instruments have different versions to improve fit for specific treatment contexts and settings. For instance, the BAM-IOP assesses change over the past 7 days, while the BAM and BAM-R assess change over the past 30 days. The C-SSRS includes basic screeners as well as "recent/lifetime" and "since last visit" versions. Treatment programs should select measures and versions that best fit their needs.
- Reassessment should include a core set of measures used for all patients, in addition to measures customized to each patient's individual needs.

Core Reassessment Measures

The following core measures should be administered at baseline, then repeated at regular intervals (and symptom driven as needed):

Outpatient Treatment Settings

- DIMENSION 1 (Acute intoxication and withdrawal potential)
  - If new intoxicated or withdrawal risks are identified the patient should be evaluated by a medical professional.
- DIMENSION 2 (Biomedical conditions)
  - Self-rated physical health (e.g., BAM, TEA)
  - Clinician observed health status
  - Sleep quality (e.g., BAM for short screen; Pittsburgh Sleep Quality Index (PSQI) when sleep issues are identified)
  - Any changes to diet, physical activity since last assessment
- DIMENSION 3 (Psychiatric and cognitive conditions)
  - Changes in mental health/cognitive function since last assessment
    - Patient reported
    - Clinician observed
  - PHQ-2 screener for all patients; PHQ-9 for patients with depression-related diagnoses (or the Geriatric Depression Rating Scale for older adult patients with depression), or for patients not previously diagnosed who screen positive on the PHQ-2

- GAD-2 for all patients; GAD-7 for patients with anxiety-related diagnoses, or for patients not previously diagnosed who screen positive on the GAD-2
- C-SSRS screener for all patients with past or present risk factors for suicidality; C-SSRS full scale for patients who screen positive for current suicidality
- Ability to fulfill responsibilities, functioning in employment, relationships (e.g., TEA)
- MoCA for patients with risk for or current cognitive impairment

- **DIMENSION 4 (Substance Use Related Risks)**
  - Any substance use since last assessment
  - Patient reported (e.g., BAM, TEA)
  - Toxicology results
  - Clinician or 3rd party observed
    - Cravings/urges to use since last assessment (e.g., BAM, VAS)
    - Current self-efficacy to avoid use (e.g., BAM)
    - Steps to maintain recovery since last assessment (e.g., counseling and/or self-help attendance, medications for SUD treatment, mindfulness, stress reduction) (e.g., BAM)
    - Recovery capital (e.g., BARC-10) {Note: Recovery capital is defined as the total resources a person has to find and sustain recovery]
- **DIMENSION 5 (Recovery environment)**
  - Changes in recovery environment since last assessment
  - Concerns with any social relationships or situations (e.g., BAM)
  - Social and community involvement since last assessment (e.g., BAM, TEA)

Residential/Inpatient Treatment Settings

- **DIMENSION 1 (Acute intoxication and withdrawal potential)**
  - If new intoxicated or withdrawal risks are identified the patient should be evaluated by a medical professional.
- **DIMENSION 2 (Biomedical conditions)**
  - Self-rated physical health (e.g., BAM, TEA)
  - Sleep quality (e.g., BAM, PSQI)
- **DIMENSION 3 (Psychiatric and cognitive conditions)**
  - Changes in mental health/cognitive function since last assessment
    - Patient reported
    - Clinician observed
  - PHQ-2 screener for all patients; PHQ-9 for patients with depression-related diagnoses, or for patients not previously diagnosed who screen positive on the PHQ-2
  - GAD-2 screener for all patients; GAD-7 for patients with anxiety-related diagnoses, or for patients not previously diagnosed who screen positive on the GAD-2
  - C-SSRS screener for all patients with past or present risk factors for suicidality; C-SSRS full scale for patients who screen positive for current suicidality
  - MoCA for patients with risk for or current cognitive impairment
- **DIMENSION 4 (Substance use related risks)**
  - Cravings/urges to use since last assessment (e.g., BAM, VAS)
  - Current self-efficacy to avoid use (BAM)
- **DIMENSION 5 (Recovery environment)**
  - Progress towards creating a recovery environment that is safe and supportive.

Treatment Planning Standards

Treatment planning should focus on addressing the dimensional drivers that have led the individual patient to require a given level of care. Reassessments should evaluate when the dimensional

drivers have sufficiently decreased in severity to enable the patient to be safely and effectively treated in a less intensive level of care. Reassessments may also identify an increase in severity; if a patient's illness progresses such that they meet the criteria for a more intensive level of care, transfer to that level of care should be recommended. This framework is intended to provide cohesive and logical rationale for determining the need for continued stay versus transition to a more or less intensive level of care.

- All patients, whether mandated to treatment or pursuing treatment voluntarily, should participate in creating a treatment plan following the treatment planning assessment.
- Provisional treatment plans may be developed prior to completion of the treatment planning assessment, addressing high-risk, immediate needs, and urgent barriers to treatment.
- Treatment planning should be a multidisciplinary process led by the patient's primary therapist.
    - When the patient has concerns in Dimension 1 or 2 that require medical care, the relevant part of the treatment plan should be developed by medical staff or coordinated with appropriate external medical professionals(s)
    - When the patient has concerns in Dimension 3 that require psychiatric services, appropriately qualified mental health professionals should develop the relevant part of the treatment plan.
- Participating clinicians should seek to build therapeutic alliances through establishing shared meaning with understanding and empathy.
- Patients should fully and actively participate in a shared decision-making process to develop an individualized treatment plan.
- The treatment planning process should:
    - Be used to build and strengthen the therapeutic alliance
    - Be patient centered, starting with an initial question of what the patient wants from treatment and why now.
    - Be conducted with cultural humility, in a trauma responsive manner
    - Review any concerns identified in each of the six dimensions
    - Prioritize the problems to be addressed in the current level(s) of care, focusing on the dimensional drivers of admission.
    - Consider the patient's stages of change, and readiness and confidence for change for each problem
    - Consider the availability and anticipated wait times for community services
    - Consider needs related to tobacco use disorder treatment including:
        - Continued care for patients currently receiving treatment
        - Tobacco related pharmacotherapy and psychosocial treatment needs
        - Coordination of care for tobacco-related health issues (e.g., cancer, chronic obstructive pulmonary disease, serious mental illness).
        - Nicotine/tobacco cessation goals
        - Motivational and harm reduction strategies for patients who are ambivalent about quitting.
    - Work with the patient to identify the potential barriers to change and determine how they impact motivation
    - Use a collaborative process to explore which interventions have previously been successful or challenging using a strength-based approach.
    - If therapeutically appropriate and clinically indicated, incorporate the patient's family and/or significant community support persons, as defined by the individual and seek to build strong therapeutic alliances with them (with appropriate consent)
    - Incorporate motivational interviewing skills to engage patients in the treatment planning process

- An individualized treatment plan should include:
  - Problem statements (e.g., Continued alcohol use despite negative impacts on [patient's] marriage and job)
    - Addressing the concerns to be addressed in the current level of care.
      - At minimum addressing the dimensional drivers of admission to the current levels of care.
  - Goal statements (e.g., [Patient's name] wants to cut down on his drinking so he can show up to work on time and improve trust with spouse)
    - Goal statements should be clear and written in the patient's own words and focused on what the patient wants to achieve in this phase of treatment
  - Objective statements should identify short term aims that will help move the patient towards the goals (e.g., I will learn to identify at least three triggers for heavy alcohol use and three healthy coping skills to manage triggers, urges, or cravings)
    - The objectives should be Specific, Measurable, Attainable, Realistic and Time bound (SMART)
  - Action steps (e.g., participate in relapse prevention group 1 times per week; participate in process group 1 time per week; weekly individual counseling with the primary therapist; monthly Vivitrol injection with primary care provider; mental health medication management with psychiatrist]
    - Action steps should identify:
      - The steps that will be taken by the patient to meet the objective
      - The services that will be provided by the program to help the patient meet the objective, including any:
        - Medical
        - Psychotherapeutic
        - Psychoeducational
        - Recovery support services
        - Referrals
        - Coordination with external providers
      - Services that will be provided by external providers
        - How care will be coordinated
    - Provider's title should be incorporated into the goals, (i.e., Therapist/Counselor will provide psychoeducation on distress tolerance skills)
  - Transition plans that address:
    - Continuity of care for SUD and co-occurring biomedical and psychiatric conditions
    - Dimension 5 and 6 concerns that may impact the transition to a less intensive level of care
  - Contingency plans that address interventions to be delivered should an instability in resources, family dynamic, home or community environment develop
  - How success will be measured
  - The date for the next treatment plan review/re-evaluation. (See level-specific service characteristics for the recommended frequency)
  - When developing the problem statement, goals, and objectives, the patient's name may be incorporated into them. If it is preferable to show a person-centered approach or patient/counselor collaboration in developing the treatment plan, consider using an "I" statement in each of these areas.
  - As there may be state, contract, or agency requirements around treatment plan formats, it is important to follow those requirements when developing the treatment plan to ensure compliance.

- The treatment plan should:
  - reflect the patient's personal goals and incorporate the patient's inherent strengths and supports.
  - be informed by the patient's trauma history, cultural backgrounds, preferences, and practices.
  - consider potential vulnerabilities resulting from the patient's trauma history.
- For patients in Level 1 or Level 2 programs, the treatment plan should also include a safety plan that addresses how the patient should seek help in the event of urgent or emergent issues that arise after hours.
- The treatment plan should be signed by the patient and the primary therapist, and dated when initiated and when revised
- Treatment planning should be a continuous process, with updates incorporated as needed when new information is learned, or the patient's circumstances evolve.
- Treatment Plan Reviews (TPRs) should be conducted at regular intervals to capture the patient's progress toward their goals and make appropriate adjustments to the treatment plan (See level-specific service characteristics for the recommended frequency)
  - TPRs should ideally include representation from all members of the patient's multidisciplinary treatment team, e.g., the primary therapist, medical provider(s), social workers, peer recovery support specialists/recovery coaches, and housing manager/staff.
  - All treatment team members should understand and agree upon adjustments to the plan.
  - It is recommended that the patient be included in part of the TPR session to ensure the plan is patient-centered and promotes transparency around why the treatment team suggests new recommendations to the treatment plan
  - The patient's primary therapist should be responsible for auditing/reviewing and record keeping of all updated treatment plans.
- During the TPR, clinicians should review the treatment plan with a focus on the dimensional drivers of placement at the specific level of care, attending to the following areas:
  - Presenting Problem & Goals
    - Why did the patient initially enter treatment?
    - What initial goals were established?
    - Does the treatment goal align with patient priorities and interventions utilized?
    - Has the presenting problem changed significantly enough to consider establishing a new problem statement?
  - Goals for Treatment
    - Have any of the initial goals been met or changed??
    - Has there been a perspective shift from the patient? How might this shift affect the patient's goals?
    - Has new information been presented that is crucial to explore, like drug history and patterns, abuse or neglect, critical relationships, behaviors, etc.? Is the patient's reticence to reveal information indicating a need to re-explore goals??
    - Has anything changed in the patient's life that calls for an adjustment to the treatment plan? Consider all six dimensions. (Refer to Reassessment Standards for more detail)
  - Treatment Engagement

- How is the patient responding to the current treatment plan? What evidence do you have to support your response? (Refer to Reassessment Standards for more detail)
- How is the patient connected with other patients in the program? Has relationship development been appropriate/healthy? Has there been conflict between the patient and others in the cohort, and how was the conflict managed?
- How has the patient engaged in individual therapy and with clinicians? Which modalities have been most effective? Which modalities have been ineffective, or the patient struggled to acclimate?
- How has the patient engaged in group therapy and with clinicians? Which modalities have been most effective? Which modalities have been ineffective, or the patient struggled to acclimate?
- How has the patient engaged in concurrent or family therapy and with clinicians? Which modalities have been most effective? Which modalities have been ineffective, or the patient struggled to acclimate?
- How has the patient engaged in medical care and with medical staff? How has the patient responded to medications and other healthcare strategies (e.g., exercise, stretching, etc.)?
- How has the patient engaged in recovery programming? Which types of support has the patient responded well to? E.g., recovery coaching, SMART Recovery, 12-Step, etc. What recovery aspects have been ineffective or disliked by the patient?

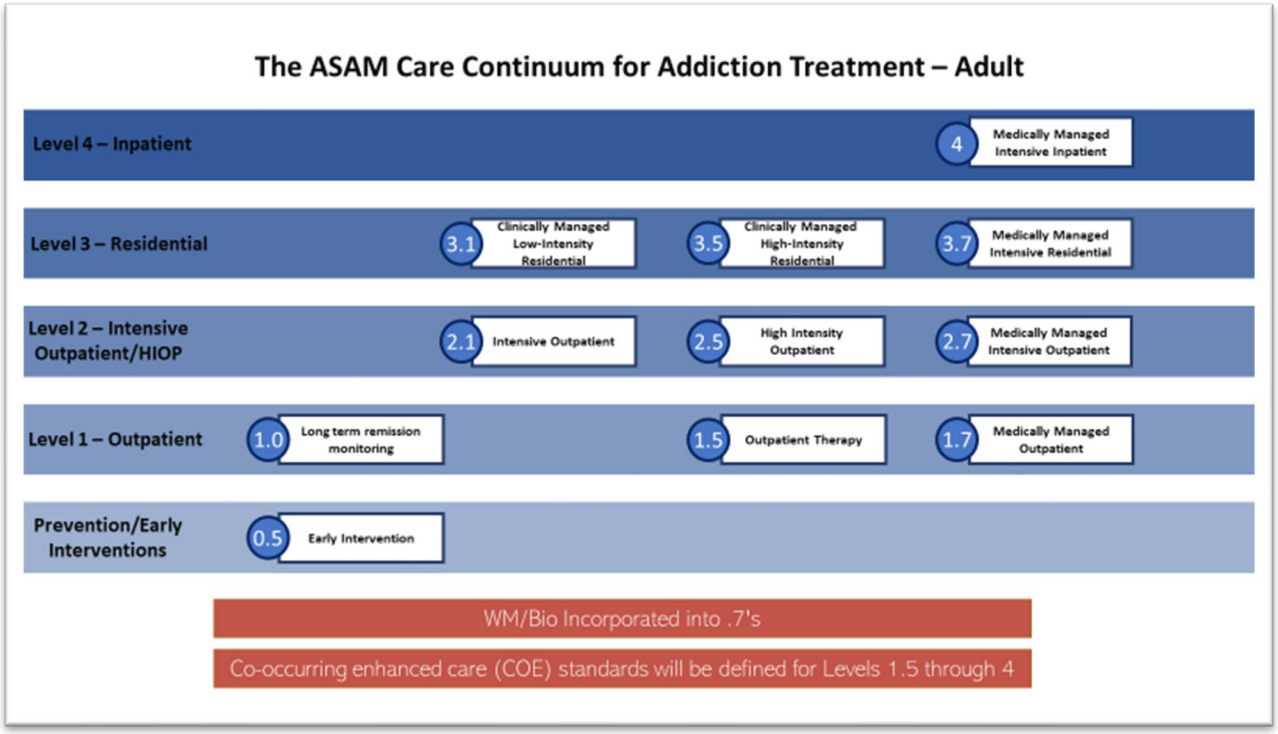
- Patient's Clinical Presentation and Progress
  - Patient needs and progress should be continuously reevaluated during treatment.
  - Updates should be made to problems, goals and objectives as new needs are identified with the patient.
  - The treatment plan should capture progress ratings to track patient progress on goals and objectives. (Refer to the Measurement Based Care Standards for specific validated items assessing clinical progress.)
- In determining whether changes should be made to the treatment plan, the clinical staff should consider:
  - What new change (or changes) does the patient want to make? Did they request the changes?
  - How motivated is the patient to make these changes?
  - How confident is the patient that the changes can be made?
  - Why does the patient want to make these changes?
  - What steps does the patient plan to take?
  - How can other people in the patient's life help?
  - How and when will the patient know the plan is working?
  - What are things that could interfere with the plan?

The ASAM Continuum of Care

Addiction treatment has evolved significantly since the development of the 3rd Edition of *The ASAM Criteria*. In the 4th Edition, the editorial team is seeking to simplify the continuum of care to better

align with the types and intensities of care that are available in communities across the country. These changes include:

- Expanding Levels of Care within Level 1
- Updating Level 3.7 to reflect care in residential settings
- Better integrating withdrawal management and biomedical care into the continuum
- Encourage improved continuity of care along the continuum



Expanding Levels of Care within Level 1

The current Level 1 incorporates a broad range of services that occur in diverse ambulatory care settings, from individual therapy to primary care. The editorial team is proposing to expand the levels of care to provide more detailed standards for the care that occurs at Level 1, including:

- Level 1.0 – Long-term Remission Monitoring
  - Consistent with the chronic care model of treatment, this level would provide ongoing monitoring for patients who have achieved long-term remission. Treatment at this level of care could include ongoing medication management services for patients who are stable in remission. This level of care will not be tied to a specific treatment setting as continuity of care may at times be best provided by the same provider or program that helped the patient achieve remission. This proposed level would reflect a set of services and capabilities that could be provided by a variety of providers or programs, depending upon where the patient is most comfortable.
- Level 1.5 – Outpatient therapy
  - In the 3rd edition, Level 1 incorporates multiple distinct types of outpatient care, including counseling and primary care-based addiction treatment services. The

proposed Level 1.5 would be consistent with the current Level 1 standards for outpatient counseling and psychotherapeutic services.

- Level 1.7 – Medically Monitored Outpatient Care
  - This proposed level would include specialty office based opioid treatment, opioid treatment programs, as well as low intensity, medically managed, ambulatory withdrawal management services. [Note that all levels of care will be expected to support access to addiction pharmacotherapies, discussed below]

Updating Level 3.7 to reflect care in residential settings

The editorial team is proposing to clarify that Level 3.7 is a residential level of care, renaming this level "Medically Managed Intensive Residential Services." Most Level 3.7 programs are in residential settings; however, some jurisdictions do not offer Level 3.7 treatment because of concerns regarding evacuation of patients with unstable biomedical conditions or withdrawal complications in an emergency. Therefore, the editorial team plans to update the service characteristic standards and admission criteria to align with the potential needs of individuals receiving care at this level.

Better integration of biomedical services in the continuum

The current edition of *The ASAM Criteria* outlines standards and admission criteria for biomedically enhanced (BIO) treatment programs. However, identification of programs that provide BIO services is difficult, and these programs are not generally recognized as a distinct, more intensive level of care. This misconception puts patients at risk when the treatment program does not have the capacity to provide the appropriate level of services for an unstable biomedical problem. The editorial team is proposing the integration of BIO service standards into the continuum of care within levels 1.7, 2.7, and 3.7, as these levels will already have the medical and nursing staff to integrate appropriate biomedical care.

Better integration of withdrawal management services in the continuum of care

The 3rd Edition of *The ASAM Criteria* includes separate levels of care for withdrawal management. Withdrawal management services were purposefully "unbundled" from the treatment levels of care in order to "maximize individualized care and to encourage the delivery of requisite treatment in any clinically feasible setting." While individualized care remains a core principle of *The ASAM Criteria*, the delivery of withdrawal management services without engagement in ongoing treatment is a persistent clinical challenge in the field that puts patients at risk for relapse, overdose, and death. Therefore, the editorial team is proposing the re-integration of withdrawal management services into the continuum of care, specifically:

- Levels 1.7 – Medically Managed Outpatient Care
  - This proposed level would provide services consistent with the current Level 1-WM, Ambulatory Withdrawal Management without Extended On-Site Monitoring.
  - As discussed above, this level would also have the capacity to provide services consistent with the current Level 1 Biomedically Enhanced Care (BIO).
- Level 2.7 – Medically Managed Intensive Outpatient Care
  - This proposed level would provide services consistent with the current Level 2-WM, Ambulatory Withdrawal Management with Extended On-Site Monitoring.
  - As discussed above, this level would also have the capacity to provide services consistent with the current Levels 2.1 BIO and 2.5 BIO.
- Level 3.7 - Medically Managed Intensive Residential Services

- There is currently significant confusion in the field between Level 3.7 and Level 3.7 WM. The setting, staffing, and other service characteristics are not significantly different. In addition, the current level 3.7 is not distinguishable from Level 3.5 BIO.
- This proposed level would provide services consistent with the current Level 3.7 WM, Medically Monitored Inpatient Withdrawal Management.
- As discussed above, this level would also have the capacity to provide services consistent with the current Levels 3.1 BIO and 3.5 BIO.

ASAM recognizes that there are many existing standalone withdrawal management programs. However, withdrawal management without continuation of care can be harmful to patients. Given this, the goal is not the elimination of these programs but to ensure they are fully integrated with comprehensive addiction treatment services, which may occur through formal affiliations with other providers and programs.

Better integration of co-occurring capability along the continuum

The 3rd edition of *The ASAM Criteria* described standards for both co-occurring capable (COC) and co-occurring enhanced (COE) programs. In the 4th edition, the COC standards will be integrated into the core program standards for each level of care. Separate COE service characteristic standards and COE admission criteria will continue to be defined for Levels 1.5 through Level 4.

Encourage improved continuity of care along the continuum

Increase the intensity of clinical services at Level 3.1

Most patients who meet the admission criteria for Level 3.1 require concurrent treatment at Level 2.1 or 2.5. For patients in Level 3.1 alone, there is concern that 5 hours of clinical services per week may represent too significant a drop from the intensity of care at Level 3.5. In addition, many Level 3.1 programs do not provide structured services on the weekends. As 24 hours of structure and support are a core need at this level of care, the editorial team is proposing that the clinical requirements align with Level 2.1 (9-19 hours of clinical services per week) and that structured services (including mutual support and other recovery support services) are offered 7 days per week.

Facilitate transitions of care within programs

Disruptions in the continuity of care often occur as patients transition from one program to another. The editorial team plans to align standards within Levels x.1, x.5, and x.7. For example, aligning standards for staffing and scope of practice requirements within Levels 1.7, 2.7, and 3.7 to facilitate and encourage facilities and organization to deliver multiple levels of care within their programs. This convention would also hold true for 1.5, 2.5, and 3.5, as well as 2.1 and 3.1.

Clarify how recovery support services fit into the continuum of care

For many patients, the need for a recovery residence with a supportive social milieu and/or supportive housing may extend past the need for residential treatment. ASAM and the editorial team have worked with the National Association of Recovery Residences (NARR) to define standards for (1) recovery support services that should be available at each level of care (See Level of Care Service Characteristic Standards) and (2) admission criteria for outpatient levels of care plus a recovery residence (e.g., Level 2.1 plus recovery residence) (See Dimension 5 Dimensional Admission Criteria).

1 Changes to the levels of care within the continuum

3rd Edition	4th Edition	Anticipated Change
Prevention/Early Intervention		
Level 0.5 – Early Intervention	Level 0.5 – Early Intervention	No major changes envisioned
Outpatient		
	Level 1.0 – Long term remission monitoring	Consistent with the chronic care model of treatment, this new level would provide ongoing monitoring for patients who have achieved long-term remission. Treatment at this level of care should include ongoing medication management services for patients who are stable in remission when applicable. This proposed level would reflect a set of services and capabilities that could be provided by a variety of providers or programs, depending upon where the patient is most comfortable.
Level 1 – Outpatient	Level 1.5 – Outpatient Therapy	In the 3rd Edition, Level 1 incorporates multiple distinct types of care, including outpatient therapy. The proposed Level 1.5 would be consistent with the previous Level 1 but would delineate the expectations for this specific type of treatment.
Level 1 WM – Ambulatory Withdrawal Management without extended on-site monitoring	Level 1.7 – Medically Managed Outpatient	This new level would include specialty office based opioid treatment, opioid treatment programs, as well as low intensity ambulatory withdrawal management services as well as biomedically enhanced care for patients with physical health comorbidities
Intensive Outpatient		
Level 2.1 – Intensive Outpatient	Level 2.1 – Intensive Outpatient	No major changes envisioned
Level 2.5 – Partial Hospitalization	Level 2.5 – High Intensity Outpatient	No major changes envisioned
Level 2 WM – Ambulatory Withdrawal Management with extended on-site monitoring	Level 2.7 – Medically Managed Intensive Outpatient	New level that incorporates intensive outpatient withdrawal management as well as biomedically enhanced care for patients with physical health comorbidities
Residential		
Level 3.1 – Clinically managed low-intensity residential	Level 3.1 – Clinically managed low-intensity residential	Updates to Level 3.1 are envisioned that would incorporate more clinical hours per week and structured services 7 days per week.

Level 3.2 WM – Clinically managed Residential Withdrawal Management		Standards for Level 3.2 WM will be integrated into Level 3.5 residential programs, which will be expected to provide clinical monitoring for withdrawal that does not require medical management.
Level 3.3 – Clinically managed population specific high-intensity residential		This level will be eliminated, and a new chapter will be added regarding how to address comorbid cognitive impairments
Level 3.5 – Clinically Managed High-Intensity Residential	Level 3.5 – Clinically Managed High-Intensity Residential	No major changes are proposed for the structure of this level. Clinical service hours will be aligned with Level 2.5.
Level 3.7 – Medically Monitored Intensive Inpatient Services	Level 3.7 – Medically Managed Intensive Residential Services	The updated Level 3.7 will combine the current Levels 3.7 and 3.7 WM. These programs will provide residential withdrawal management and biomedically enhanced services. The 4th Edition will also clarify that Level 3.7 is a residential treatment level and align the admission criteria based on the expectations of what a residential Level 3.7 program can safely manage.
Level 3.7 WM – Medically Monitored Inpatient Withdrawal Management		
Inpatient		
Level 4 – Medically Managed Intensive Inpatient	Level 4 – Medically Managed Intensive Inpatient	Level 4 will be reconceptualized to make it clear that this level is typically not a specialty level of care but the patient's local hospital. Level 4 will be recommended for patients with severe acute risks in dimensions 1, 2, or 3.
Level 4 WM – Medically Managed Intensive Inpatient Withdrawal Management		

ASAM Level of Care Service Characteristic Standards

Level 0.5 – Early Intervention

Level of Care Description

Level 0.5 programs provide prevention and early intervention services for individuals who engage in risky substance use but who do not meet diagnostic criteria for a substance use disorder (SUD), with the goal of preventing progression to SUD and other substance use related harms (e.g., overdoses, car crashes).

Level 0.5 services are typically offered in non-specialty medical settings, such as hospital emergency departments, or primary care medical clinics. Level 0.5 may also be offered by clinically delivered programs that aim to prevent impaired driving or other substance use related harms.

Setting

Level 0.5 services may be offered in any appropriate setting that meets state licensing criteria for delivery of medical or clinical services.

Level 0.5 services may be offered in:

- Physician's offices
- Health clinics
- Primary care clinics
- Emergency departments
- Hospitals
- Colleges and university health clinics
- Employee Assistance Programs (EAP)
- Driving under the influence (DUI) prevention programs
- Other clinical or therapeutic settings (e.g., mobile vans)

Staff

- Level 0.5 programs are staffed by appropriately credentialed and/or licensed medical or clinical professionals.
- Level 0.5 program staff will vary significantly based on the setting and services provided.
    - Screening and brief intervention may be provided by addiction counselors or by generalist healthcare professionals, such as social workers and nurses.
    - Psychoeducational interventions designed to reduce or prevent risky substance use are typically staffed by counselors, social workers, and/or psychologists.
- Clinical staff may be supported by allied health professional staff such as peer support specialists and health educators.

Training/Competencies

- All clinicians providing Level 0.5 prevention and early intervention services should be:
    - knowledgeable about the biopsychosocial dimensions of substance use disorders.
    - Trained to:
        - Identify symptoms of risky substance use.
        - Conduct and interpret screening for risky substance use using validated tools.
        - Deliver brief intervention services, including motivational interviewing.
        - Effectively coordinate referral to treatment as indicated.
- Clinical staff who will provide brief intervention services should be trained to deliver these services, and provided appropriate clinical supervision
- See separate competencies document.

Support Systems

Support systems include the following available on-site or through consultation or coordinated referral:

- Biomedical
    - Ability to refer for physical examination or biomedical assessment when needed
- Psychiatric
    - Ability to refer for mental health evaluation when needed

- Established relationships with more intensive levels of care to support coordinated referral for SUD treatment if a person is found to meet diagnostic criteria for SUD.

Screening, Brief Assessment, and Treatment Planning

Level 0.5 provides:

- Screening for risk of SUD utilizing validated tools
- Brief assessment for SUD diagnosis using validated tools, performed prior to initiation of services to determine if care at Level 0.5 is appropriate for the patient.
    - For patients with a diagnosis of SUD, ability to provide or coordinate delivery of ASAM Level of Care Assessment to determine the appropriate level of care for patients who progress to SUD
- Sufficient assessment of the risks and need in each dimension to identify service needs at Level 0.5
- For patients who have not had a physical exam within the past year, the patient should be referred for a physical, ideally performed within one month of treatment initiation.
- Regular reassessment to determine if risky use is progressing to a SUD

Services

Level 0.5 services are designed to prevent the escalation of risky substance use into a SUD by helping individuals recognize, explore, and address harmful consequences related to their substance use.

Level 0.5 program services may include:

- Brief interventions (SBIRT)
- One-to-one counseling for at-risk individuals
- Motivational interventions
- Psychoeducational programs (e.g., clinically delivered psychoeducation to prevent DUI)
- Health education programs (e.g., HIV prevention, harm reduction)
- Coordinated referral for treatment
- Counseling with family, significant others, or other support persons
- Contingency management

All treatment services should be trauma informed responsive and delivered with cultural humility,

Psychosocial Services

Level 0.5 programs primarily provide psychoeducational services which may include:

- Interventions designed to enhance the patient's understanding of SUD and substance use related risks
- Health education services regarding:
    - The causes of addiction
    - The course of addiction
    - Risk of injury when intoxicated
    - Substance refusal skills
    - Pharmacotherapies for SUD

    - Pharmacotherapies for psychiatric disorders
    - Harm reduction strategies including overdose recognition and response training
    - Health-related risk factors associated with SUD (for example: HIV, hepatitis C, sexually transmitted infections, skin and soft tissue infections, unintended pregnancy).
    - The importance of taking care of physical and mental health
        - Level 0.5 programs may provide educational materials routinely available that address common physical and mental health concerns, including trauma.
- Psychoeducational services for the patient's family and significant others (with appropriate patient consent), including:
    - What to expect during Level 0.5 services
    - How to support loved ones
    - Overdose recognition and response training
- Other evidence-based psychoeducation.

Support Services

Level 0.5 programs should consider providing the following support services either directly or through referral to external service providers:

- Assistance accessing social services for housing, nutritional assistance, health insurance, etc.
- Support coordinating with social service agencies (e.g., Children, Youth & Family Services, criminal justice agencies, domestic violence agencies, etc.)
- Assistance identifying community services or supports to address potential challenges to prevention (e.g., legal services, educational services, recovery housing, childcare services, jobs training, parenting training, financial training, etc.)
- Assistance identifying community harm reduction services

Documentation

Documentation for Level 0.5 programs should include:

- Standardized screening and assessment results
- Overview and analysis of any problems within each of the six dimensions that may impact the likelihood of progression to SUD
- Attendance and participation
- Significant clinical events, particularly those that require further assessment and referral
- Documentation of referral to other service providers including:
    - Review of the ASAM Criteria dimensions
    - Recommendations for care
    - Reasons for departures from recommendations if applicable
    - Program(s) that the patient will enroll in
    - Follow up plan to ensure engagement in care and documentation of follow ups

Level 1.0 – Long Term Remission Monitoring

Level of Care Description

Level 1.0 programs provide remission monitoring and early re-intervention services for patients who are in stable long-term remission.

Dimensional Drivers

- Dimension 4
- Dimension 5
- Dimension 6

Setting

Level 1.0 services may be offered in any outpatient or telehealth-based treatment setting that meets state licensure or certification criteria.

Level 1.0 programs may also be staffed with appropriately certified peer support specialists and other allied health staff.

Staff

Level 1.0 programs are staffed by appropriately credentialed and/or licensed treatment professionals, as needed based on the patient's needs and preferences:

Training/Competencies

- All clinicians involved in the assessment or treatment of patients in Level 1.0 should be:
  - knowledgeable about the biopsychosocial dimensions of substance use disorders.
  - trained to conduct and interpret a recovery management checkup.
  - trained to conduct and interpret validated screening tools and multidimensional assessments to determine individual patient needs and make level of care recommendations according to *The ASAM Criteria* when needed.
- See separate competencies document

Support Systems

Support systems include the following available on-site or through consultation or coordinated referral:

- Biomedical
  - Ability to refer for physical examination or biomedical assessment when needed.
- Psychiatric
  - Established relationships with local mental health treatment providers to support access to routine psychiatric consultation and to facilitate mental health care appointment access when needed.
- Psychological
  - If psychotherapeutic services (i.e., counseling, therapy) are not available on site, they should be available through coordinated referral.
- Laboratory services
  - Ability to conduct or arrange for appropriate laboratory testing services.
- Toxicology services
  - CLIA waived point of care testing is preferred but not required.
  - Ability to refer for confirmatory testing when needed.

- Direct affiliation with (or close coordination through referral to) more intensive levels of care, including OTP and buprenorphine prescribers, to facilitate rapid readmission to treatment if needed.

Assessment and Treatment Planning

- Assessment and recovery management planning should be sensitive to trauma and designed to prevent re-traumatization.
- Recovery management checkups, including recovery capital assessments, available at least quarterly.
    - These checkups should include sufficient recovery/remission focused biopsychosocial screening and assessments to identify:
        - Any current or emerging SUD treatment needs
        - Any biomedical health needs that may impact the patient's recovery
        - Any mental health needs that may impact the patient's recovery, using validated tools where available (e.g., PHQ9, GAD7, CSSI, etc.)
        - Any recovery support service needs
    - Checkups may occur more frequently in response to life-events that may lead to instability (e.g., end of a relationship, loss of a loved one, etc.)
- An addiction-focused history should be obtained as part of the initial assessment if the program does not already have this information documented.
- The Level 1.0 program should verify that the patient has had a physical examination conducted by a physician, physician assistant, or nurse practitioner within the past year.
    - If the patient has not had one in the past year the patient should be referred for a physical exam.
    - The program should obtain a copy of the most recent physical exam and review findings to identify any care coordination needs.
- Individualized recovery management plan, including identification of any issues that may compromise the patient's recovery, should be developed at the initiation of treatment in Level 1.0.
    - The plan should be developed in collaboration with the patient and reflect the patient's personal goals.
    - This plan should specify any issues in each dimension, define patient goals and objectives, and specify activities designed to meet those objectives (e.g., adherence to addiction or psychiatric pharmacotherapies, participation in mutual support, mental health counseling, etc.).
    - The recovery management plan should include a plan for contacting the program between appointments if new issues emerge that may compromise the patient's recovery.
    - Formal reassessment and recovery management plan updates should be conducted at least yearly.

Services

Level 1.0 programs should directly provide:

- Remission management checkups, including recovery capital assessment
    - Checkups may be conducted in person or through telehealth
- Mental health screening
- Patient navigation services

    - Ability to rapidly re-engage the patient in the appropriate level of SUD or mental health treatment as needed
    - Ability to rapidly refer the patient for assessment of the need for addiction or psychiatric pharmacotherapy, if not provided directly by the program (including all FDA approved medications for the treatment of SUD, currently opioid, alcohol, and tobacco use disorder).
    - Level 1.0 programs should provide regular follow up until the patient is engaged in treatment.
        - The frequency of follow-ups should be determined by the acuity of the patient needs.
- Care coordination with other providers involved in the patient's care
    - The staff member responsible for care coordination for a given patient should be clearly documented.

Level 1.0 programs should provide the following services directly or through affiliation or coordinated referral:

- Medication management services
- Medication adherence monitoring
- Functional assessment to guide intervention
- Toxicology testing
- Infectious disease screening and referral for care
- Psychosocial services including motivational interviewing and solution focused techniques to support reengagement in treatment if needed
- Health education for issues associated with the course of addiction and other potential health-related risk factors as appropriate (e.g., HIV, hepatitis C, unintended pregnancies, sexually transmitted infections, risk of exacerbating other conditions)
- Family education

All treatment services should be trauma informed responsive and delivered with cultural humility,

Psychosocial Services

Level 1.0 program should be able to provide psychotherapeutic and psychoeducational services either directly or through formal affiliation to address emerging issues that may undermine the patient's recovery. See the Universal Psychosocial Services Standards for details.

Recovery Support Services

Level 1.0 programs should also provide the following recovery support services either directly or through formal affiliation with external service providers:

- Assessment of recovery support service needs
- Development of an individualized remission management plan
    - Support accessing mutual help programs (e.g., support finding appropriate programs, identifying transportation options, etc.)
- Support accessing other community activities supportive of recovery (e.g., spiritual activities, recovery community centers, etc.)

- Assistance accessing social services for housing, nutritional assistance, health insurance, etc.
- Support coordinating with social service agencies (e.g., Children, Youth & Family Services, criminal justice agencies, etc.)
- Assistance identifying community services or supports to address potential impediments to recovery (e.g., legal services, educational services, recovery housing, childcare services, jobs training, parenting training, financial training, etc.)
- Assistance identifying community harm reduction services
- Transfer planning, including warm handoffs

Documentation

See the Universal Documentation Standards. Core documentation in Level 1.0 includes:

- Results from recovery management checkups
- Individualized remission maintenance plans

Level 1.5 – Outpatient Therapy

Level of Care Description

Level 1.5 provides outpatient psychotherapy services for patients with mild to low-moderate SUD.

Dimensional Drivers

- Dimension 3
- Dimension 4

Setting

Level 1.5 services may be offered in any appropriate setting that meets state licensure or certification criteria. For example:

- Office-based practices
- Health clinics
- Primary care clinics
- Outpatient addiction programs
- Mental health clinics
- Group homes or shelters

Staff

Level 1.5 programs are primarily staffed by appropriately credentialed and/or licensed treatment professionals, such as:

- Psychologists
- Master's level clinical social workers
- Master's level counselors
- Others credentialed to assess and treat SUD and co-occurring psychiatric disorders.

At least one clinical staff member should be qualified to assess and manage common low-acuity mental health conditions.

Role of physicians and advanced practice providers

- Level 1.5 programs typically do not have physicians or advanced practice providers on staff. However, Level 1.5 programs should have the ability to refer patients to appropriate medical providers when needed for:
    - Physical exams
    - Addiction pharmacotherapies
    - Psychiatric pharmacotherapies
    - Medication management
    - Toxicology testing
    - Laboratory testing
- When medical services are required concurrent with Level 1.5 treatment, care should be coordinated to develop an integrated treatment plan and support adherence to treatment recommendations.

Role of addiction specialist physicians

- Level 1.5 programs do not typically have addiction specialist physicians on staff.

Role of nurses

- Level 1.5 programs do not typically have nurses on staff.

Role of clinical staff

- Clinical staff:
    - Assess and treat substance use and other addictive disorders.
    - Assess and support the management of co-occurring mental health conditions.
- It is recommended that programs have dedicated staff responsible for care coordination.

Role of allied health professionals

- Level 1.5 programs may have allied health professionals on staff.
    - Care coordination staff is recommended.
    - Allied health professional staff may provide recovery support services (described below).

Support Systems

Support systems include the following:

- Biomedical
    - Ability to refer for physical examination or biomedical assessment when needed.
    - Ability to coordinate care for stable biomedical conditions as needed.
    - Ability to coordinate referral for medical assessments for addiction and psychiatric pharmacotherapies when needed (including all FDA approved medications for the treatment of SUD, currently opioid, alcohol, and tobacco use disorder).
    - Ability to refer for appropriate laboratory testing services (e.g., infectious disease screening), when needed.
    - Ability to refer for toxicology testing, when needed.
- Psychiatric
    - Established relationship with the local behavioral health crisis system, if available, to respond to urgent mental health needs.

    - Established relationships with local mental health treatment providers to support access to routine psychiatric consultation and to facilitate mental health care appointment access when needed.
    - Ability to coordinate care for stable and low-acuity psychiatric conditions as needed.
- Psychological
    - Specialized consultation for psychological and cognitive problems should be available through consultation or referral as needed.
- Level 1.5 programs should have established relationships with more and less intensive levels of care.
- Level 1.5 programs do not need to have after-hours telephonic availability.
    - Programs should educate patients at intake on what to do if urgent or emergent issues arise after hours (e.g., community resources, help lines, 911, 988, etc.)

Assessment and Treatment Planning

- Assessment and treatment planning should be sensitive to trauma and designed to prevent re-traumatization.
- A Level of Care assessment, including an addiction-focused history, should be conducted (or reviewed) at admission to determine the recommended level of care.
    - For patients who are intoxicated or experiencing withdrawal the assessment should be reviewed by a physician prior to admission.
- For patients who have not had a physical exam within the past year, the patient should be referred for a physical, ideally performed within one month of treatment initiation.
- A full biopsychosocial treatment planning assessment should be conducted (or reviewed) and used to develop an individualized treatment plan within three visits.
- Individualized treatment plans should include problem identification in each dimension and development of treatment goals and measurable treatment objectives, as well as activities designed to meet those objectives.
    - Patient treatment plans should address any mental health treatment needs identified, including:
        - Services to be delivered by the program's treatment team.
        - Services to be delivered by external providers.
    - The plan should be developed in collaboration with the patient and reflect the patient's personal goals.
- Treatment plans should reflect coordination of care with external treatment and service providers.
- Formal reassessment of the treatment plan should occur at least quarterly, with treatment plan updates incorporated as needed.
- Transition plans should address continuity of care for both SUD and mental health conditions.
    - When individuals with co-occurring disorders are transferred to another level of care, they should be transferred to a setting that can provide integrated care for their continuing SUD and mental health needs whenever possible.

Services

Level 1.5 programs should have the capacity to directly provide the following services. These services should be provided in an amount, frequency, and intensity appropriate to individual patient needs as determined by the multidimensional assessment:

- Evidence based psychosocial interventions to treat SUD, support symptom management, ensure safety, and encourage recovery (see Psychosocial Standards Section)
- All services should be designed with the expectation that many, if not most, patients will have co-occurring mental health conditions (e.g., individual and group interventions should encourage patients to address both mental health-related concerns as well as SUD-related concerns))
    - The program should provide symptom management support for co-occurring mental health conditions.
    - Patient mental health concerns should be treated concurrently by the program or through coordination with external providers.
- All treatment services should be trauma informed responsive and delivered with cultural humility,
- The program should coordinate care with any external mental health care providers involved in the patient's care, with appropriate patient consent:
    - At admission and discharge
    - As needed based to support effective care coordination for the individual patient
- The program should support access to pharmacotherapies for addiction and mental health, with appropriate medication management.
- The program's clinical services should address:
    - how to manage mental health symptoms and trauma without using substances
    - how to appropriately ask for help from peers or professionals when in distress
    - working effectively with prescribers
    - taking medications as prescribed
    - how to discuss mental illness, mental health symptoms, and mental health treatments appropriately in the context of recovery programs/mutual support groups
- The program's services should be designed to provide a welcoming environment for individuals with co-occurring mental health conditions, where patients feel safe addressing their mental health concerns and experiences.

Medical services

Level 1.5 programs are not expected to provide medical services on site. However, these programs should be able to provide referrals and care coordination services for patients with biomedical concerns including:

- Identifying appropriate medical providers
- Coordinating care with the patient's medical providers as needed
- Integrating biomedical service needs in the patient's treatment plan

Psychosocial services

Level 1.5 programs should directly provide psychotherapeutic and psychoeducational services tailored to the needs of the individual, as determined based on ASAM Criteria Assessment. See the Universal Psychosocial Services Standards for details.

Recovery support services

Level 1.5 programs should also provide the following recovery support services either directly or through formal affiliation with external service providers:

- Assessment of recovery support service needs

- Development of an individualized recovery plan
- Support accessing mutual help programs (e.g., support finding appropriate programs, identifying transportation options, etc.)
- Support accessing other community activities supportive of recovery (e.g., spiritual activities, recovery community centers, etc.)
- Assistance accessing social services for housing, nutritional assistance, health insurance, etc.
- Support coordinating with social service agencies (e.g., Children, Youth & Family Services, criminal justice agencies, etc.)
- Assistance in identifying community services or supports to address potential impediments to recovery (e.g., legal services, educational services, recovery housing, childcare services, jobs training, parenting training, financial training, etc.)
- Assistance identifying and accessing community harm reduction services
- Transfer planning, including warm handoffs

Documentation

See the Universal Documentation Standards.

Level 1.7 – Medically Managed Outpatient

Level of Care Description

Level 1.7 programs provide outpatient psychosocial interventions, biomedical interventions, and withdrawal management services for patients with SUD who can be safely and effectively treated with low intensity outpatient services.

Level 1.7 programs should provide all the services of a Level 1.5 program either directly or through formal affiliation with other providers or programs.

Dimensional Drivers

- Dimension 1
- Dimension 2

Setting

Level 1.7 services may be offered in any appropriate outpatient setting with physician oversight that meets state licensure or certification criteria.

Level 1.7 services may be offered in:

- Physician's offices
- Health clinics
- Primary care clinics
- Outpatient addiction programs
- Opioid treatment programs
- Office based addiction treatment programs
- Mobile addiction treatment programs (i.e., street medicine)

Staff

Level 1.7 programs are staffed by appropriately credentialed and/or licensed treatment professionals, including:

- Physicians with controlled substance prescribing authority and waivered to prescribe buprenorphine.
    - Advanced practice provider(s) may collaborate with physicians at this level of care and should have controlled substance prescribing authority with a waiver to prescribe buprenorphine.
- Nurses with the scopes of practice necessary to provide the services outlined in the *Assessment and Treatment Planning* and *Services* sections below.

Medical and Nursing Staff

The medical director should be a physician who is board certified or board eligible (in addiction medicine or addiction psychiatry) or who has at least 2 years of documented experience delivering specialty addiction care.

Physicians and advanced practice providers do not need to be certified as addiction specialists, and nurses do not need to be certified as addiction nurses, but training and experience in assessing and managing intoxication and withdrawal states are necessary. See competencies document.

Physicians and/or advanced practice providers are essential to Level 1.7 services, but they do not need to be on site at the treatment setting at all times. However, they should be available for patient evaluation during normal hours of operation (on-site or through telehealth).

Clinical Staff

The services of clinical staff, including counselors, psychologists, and social workers, should be available through the Level 1.7 program directly or through directly affiliated providers or programs.

- Licensed, certified, or registered clinicians should:
    - Provide a planned regimen of professionally directed evaluation, psychotherapy, psychoeducation, and coordinate the delivery of recovery support services for patients and their support systems.
    - Assess and treat substance use and other addictive disorders.
    - Assess and support the management of cooccurring mental health conditions.
    - Support coordinated treatment planning [Note: at this level of care treatment planning should be led by medical staff.]
- It is recommended that programs have dedicated staff responsible for care coordination.

Allied Health Staff

Level 1.7 programs may be staffed with appropriately certified peer support specialists.

Role of the addiction specialist physician:

- Level 1.7 programs do not need to have addiction specialist physicians on staff, but policies and procedures should define when and how to consult with an addiction specialist physician

Support Systems

Support systems include the following available on-site or through consultation:

- Biomedical

    - If primary care services are not available on site, the program should have a direct affiliation with a primary care provider and be able to arrange an appointment within 14 days of the initial evaluation.
    - The program should have established relationships with obstetricians to support coordination of care for pregnant and postpartum patients.
- Psychiatric
    - Psychiatric assessment by a psychiatrist or psychiatric nurse practitioner should be available within a time frame appropriate to the severity and urgency of the need.
        - If the initial assessment occurs via telehealth, video telehealth should be used
        - Follow up assessments may be audio only, when appropriate (as determined by the provider))
    - The program should have an established relationship with the local behavioral health crisis system, if available, to respond to urgent mental health needs.
    - The program should have established relationships with local mental health treatment providers to support access to routine psychiatric consultation and to facilitate mental health care appointment access when needed.
- Psychological
    - If psychosocial services are not available on site, they should be available through a directly affiliated provider or program.
- The program should have established relationships with more intensive levels of care.
- After hours telephonic availability
    - The program should provide after-hours access through direct connection to clinical staff or a call service, such as a nurse triage line
    - A physician or advanced practice provider should be on-call during non-business hours to respond to urgent concerns

Assessment and Treatment Planning

- Assessment and treatment planning should be sensitive to trauma and designed to prevent re-traumatization.
- An addiction-focused history should be obtained as part of the initial assessment and conducted, or reviewed, by a physician or advanced practice provider during the admission process.
- An addiction focused physical examination should be conducted by a physician or advanced practice provider within a reasonable time frame as part of the initial assessment.
- Sufficient biopsychosocial screening and assessments should be conducted to determine the appropriate level of care and to develop an individualized care plan.
- An individualized treatment plan should be developed, and should include problem identification in each dimension, treatment goals, measurable treatment objectives, and activities designed to meet those objectives. The plan should:
    - Be developed in collaboration with the patient, reflects the patient's personal goals, and incorporates the patient's strengths.
    - Address any mental health treatment needs identified, including:
        - Services to be delivered by the program's treatment team
        - Services to be delivered by external providers.
    - Reflect coordination of care with external providers as needed to address problems identified through the comprehensive biopsychosocial assessment.

- Serial medical assessments including appropriate measures of withdrawal should be conducted as needed.
- The patient facing treatment plan should include a plan for contacting the program after-hours and for accessing emergency care 24/7, including when to call 911 or 988
- Medical or nursing staff should assess patient progress at least daily (via in person or video-based check ins) during the acute phase of withdrawal management and during any treatment changes.
    - Telephone check ins may be appropriate alternatives to in person check ins depending on the acuity of the patient's signs and symptoms and concerns regarding adherence to prescribed medications.
- Treatment plan reviews should be conducted regularly with the frequency determined based on the acuity of the patient's needs.
- Transition planning, beginning at admission, addressing
    - Addiction treatment service needs
    - Physical health service needs
    - Mental health service needs
    - Recovery support service needs, including those related to SDOH
    - Continued access to medications, including medications for opioid use disorder
    - Overdose prevention and harm reduction
- Referral arrangements should be made as needed

Services

- Level 1.7 programs directly provide:
    - Nursing and medical monitoring for stabilization of withdrawal, biomedical and psychiatric conditions.
    - Psychoeducation to encourage engagement in ongoing treatment
- Such services should be provided in an amount, frequency, and intensity appropriate to the patient's individual needs and level of function as determined by the multidimensional assessment.
- All services should be designed with the expectation that many, if not most patients will have co-occurring mental health conditions
    - The program should provide symptom management support for both SUD and co-occurring MH conditions.
    - Patient mental health concerns should be treated concurrently by the program or through coordination with external providers
- The program should coordinate care with any external mental health care providers involved in the patient's care, with appropriate patient consent:
    - At admission and discharge
    - As needed based to support effective care coordination for the individual patient
- The program's services should be designed to provide a welcoming environment for individuals with co-occurring mental health conditions, where patients feel safe addressing their mental health concerns and experiences

Medical

- Outpatient withdrawal management services, including:
    - Nursing assessment upon admission, including:
        - vitals
        - history of present illness

        - baseline evaluation of withdrawal severity and risks
        - medical history including assessment of current biomedical issues and medication review.
    - Addiction focused physical examination at initial visit
    - Comprehensive physical examination (within 7 days of treatment initiation)
    - Assessment with validated scales (e.g., COWS, CIWA-Ar) to determine the severity of withdrawal when appropriate
    - Medication based methods of withdrawal management that are appropriate for the severity of withdrawal or anticipated withdrawal
    - Non-pharmacological clinical support, including but not limited to:
        - Informing patients of what to expect over the course of treatment.
        - Offering reassurance
        - Providing a quiet environment
        - Educating patients on the importance of adequate hydration and nutrition
        - Educating the family members or significant others, with patient consent, on how to support the patient during withdrawal management, including:
            - monitoring for withdrawal signs and symptoms
            - supporting medication adherence
            - supporting adequate hydration and nutrition
            - creating a low stimulation environment
            - offering encouragement and reassurance
    - Motivational interviewing
    - Coordination of psychosocial and recovery support services.
- Withdrawal management and medication initiation services should be available within 24 hours of initial call.
    - Programs should consider providing daily walk-in slots to ensure availability of services
- Medical monitoring and management of acute biomedical conditions, including:
    - Basic management of hyperglycemia and hypoglycemia support
    - Infectious disease management
        - Screening and assessment for STI and bloodborne infections
        - Initiation of treatment and/or facilitated engagement in care and coordination of care
    - Coordination of pregnancy and/or postpartum care
    - Coordination of care for biomedical conditions for which the patient is receiving treatment from an external provider, including pain
    - Initiation and management of preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP), including education regarding PrEP and PEP
- Initiation of addiction pharmacotherapies in alignment with current best practices, such as those established in the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, the APA Practice Guideline on Treatment of Alcohol Use Disorder and ASAM's clinical guidance on Integrating Tobacco Use Disorder Interventions in Addiction Treatment.
    - Low threshold initiation of addiction pharmacotherapies
- Medication initiation and management of common, low-complexity psychiatric conditions.
- Rapid initiation or continuation of medications for individuals leaving incarceration.

- Toxicology services as appropriate to the patient's individual treatment plan, following appropriate standards such as those defined in ASAM's Appropriate Use of Drug Testing in Clinical Addiction Medicine Consensus Document
    - Toxicology testing should be conducted based on patient specific orders from the responsible physician.
    - Toxicology results should be reviewed and interpreted by a physician or advanced practice provider for whom interpretation of toxicology results is in their scope of practice.
    - Program should have written policies regarding how to respond to unexpected toxicology test results, including modification of the treatment plan.
- Care coordination with other providers involved in the patient's care.
    - The staff member responsible for care coordination for a given patient should be clearly documented.
    - If psychosocial services are provided through affiliated programs there should be, at minimum, weekly touch bases regarding the care of each patient

Biomedical Capabilities

Level 1.7 programs should have the following biomedical capabilities (access to on-site during normal business hours):

- Glucose monitoring
- Pulse oximetry
- Basic wound care
- Basic first aid
- Blood pressure monitoring
- Injectable epinephrine available on site
- Naloxone available on site
- Automated external defibrillator (AED)
- Access to laboratory services during business hours
    - Access to laboratory that conducts blood cultures
- Access to toxicology services during normal business hours
    - CLIA waived point of care testing is preferred but not required.
    - Access to confirmatory testing should be available
    - Point of contact breath alcohol testing
- Point of care pregnancy testing

Psychosocial Services

Level 1.7 programs should provide psychotherapeutic and psychoeducational services either directly or through formal affiliation with Level 1.5 and/or Level 2.1. These services should be tailored to the needs of the individual as determined based on ASAM Criteria Assessment. See the Psychosocial Services Section for details.

Recovery Support Services

Level 1.7 program should also provide the following recovery support services either directly or through formal affiliation with external service providers:

- Assessment of recovery support service needs
- Development of an individualized recovery plan

- Support accessing mutual help programs (e.g., support finding appropriate programs, identifying transportation options, etc.)
- Assistance accessing social services for housing, nutritional assistance, health insurance, etc.
- Support coordinating with social service agencies (e.g., Children, Youth & Family Services, criminal justice agencies, etc.)
- Assistance identifying community services or supports to address potential impediments to recovery (e.g., legal services, educational services, recovery housing, childcare services, jobs training, parenting training, financial training, etc.)
- Assistance identifying and accessing community harm reduction services
- Transfer planning, including warm handoffs

Documentation

See the Universal Documentation Standards.

Level 2.1 – Intensive Outpatient

Level of Care Description

Level 2.1 programs provide intensive outpatient services. These programs generally provide 9-19 hours of structured programming per week consisting primarily of counseling and education about addiction and co-occurring mental health problems.

Dimensional Drivers

- Dimension 4
- Dimension 3

Setting

Level 2.1 services may be offered in any appropriate setting that meets state licensing criteria. Examples of Level 2.1 programs are:

- Day outpatient programs
- Evening outpatient programs
- Weekend intensive outpatient programs

Staff

Level 2.1 programs are staffed by an interdisciplinary team of appropriately credentialed addiction treatment professionals, typically including:

- Counselors
- Psychologists
- Clinical social Workers
- Others credentialed to assess and treat SUD and co-occurring psychiatric disorders

Clinician qualified to assess and manage mental health conditions should be on site or on call at all times during program hours of operation. [Note: management includes determining appropriate steps for addressing mental health problems including symptom management support, further assessment, referral, crisis services, transfer, etc.]

Role of physicians and advanced practice providers

- Level 2.1 programs do not typically have physicians or advanced practice providers on staff. However, Level 2.1 programs should have established relationships with physicians and/or advanced practice providers to provide the following services when needed:
    - Physical examinations
    - Addiction pharmacotherapies
    - Psychiatric pharmacotherapies
    - Toxicology testing
    - Laboratory testing
- When medical services are required concurrent with Level 2.1 treatment, care should be coordinated to develop an integrated treatment plan and support adherence to treatment recommendations.
- Physicians or advanced practice providers providing medical services to patients in this level should have at least two years of specialty training and/or experience in addiction medicine or addiction psychiatry.

Role of addiction specialist physicians

- Level 2.1 programs should have policies and procedures that define when and how to consult with an addiction specialist physician when needed.

Role of nurses

- Level 2.1 programs do not typically have nurses on staff.

Role of clinical staff

- Clinical staff:
    - Provide a planned regimen of professionally directed evaluation, psychotherapy, psychoeducation, and coordinate the delivery of recovery support services for patients and their support systems.
    - Assess and treat substance use and other addictive disorders.
    - Assess and support the management of cooccurring mental health conditions
    - Conduct and coordinate treatment planning
- Mental health treatment providers should be part of the multidisciplinary team
    - On the interdisciplinary team, staff members with more training and experience with mental health care should support their team members to provide effective, integrated co-occurring competent care
- It is recommended that programs have dedicated staff responsible for care coordination

Role of allied health professionals

- Allied health professionals (e.g., peer support specialists, patient navigators, health educators, etc.) may serve a variety of roles, including helping patients:
    - Get oriented to the setting/facility
    - Engage in the program
    - Access and engage in the recovery support services described below
- Allied health professionals may also provide health education services (e.g., HIV prevention, safe sex, overdose prevention, and reversal training, etc.)

Support Systems

The following services should be available on-site or through external service providers:

- Biomedical
  - Ability to conduct or arrange for physical examinations and medical assessments when needed.
  - Ability to conduct or arrange for medical assessments for addiction and psychiatric pharmacotherapies.
    - The program should have a direct affiliation with a physician and/or advanced practice provider waivered to prescribe buprenorphine
    - The program should have a direct affiliation with an opioid treatment program (OTP) if available within the local payment geography
  - Ability to refer for appropriate laboratory testing services (e.g., infectious disease screening), when needed.
  - Ability to refer for toxicology testing, when needed.
- Psychiatric
  - Psychiatric assessment, by a psychiatrist or psychiatric nurse practitioner, is available within a time frame appropriate to the clinical severity and urgency of the need.
  - Level 2.1 programs should have an established relationship with the local behavioral health crisis system, if available, to respond to urgent mental health needs.
  - Level 2.1 programs should have established relationships with local mental health treatment providers to support access to routine psychiatric consultation and to facilitate mental health care appointment access when needed.
- Psychological
  - Specialized consultation for psychological and cognitive problems should be available through consultation or referral when needed.
- Level 2.1 programs should have established relationships with more and less intensive levels of care.
- Level 2.1 programs do not need to have after hours telephonic availability. However, programs should educate patients at intake on what to do if urgent or emergent issues arise after hours (e.g., community resources, help lines, 911, 988, etc.)

Assessment and Treatment Planning

- Assessment and treatment planning should be sensitive to trauma and designed to prevent re-traumatization.
- A Level of Care assessment, including an addiction-focused history, should be conducted (or reviewed) at admission to determine the recommended level of care.
  - For patients who are intoxicated or experiencing withdrawal the assessment should be reviewed by a physician prior to admission.
- A full biopsychosocial treatment planning assessment should be conducted (or reviewed) and used to develop an individualized treatment plan within one week of admission.
- For patients who have not had a physical exam within the past year, a physical exam should be conducted by a physician or advanced practice provider within 14 days of admission, or sooner if needed based on the patient's medical condition.
  - Such determinations should be made according to established protocols, which should include reliance on the patient's personal physician whenever possible.
  - Protocols should be based on the program's capabilities and developed and approved by a physician or advanced practice provider.

    - For patients who have had a physical examination within the past year, the Level 2.1 clinician should obtain and review the physical examination results within 14 days of admission.
- Individualized treatment plans should include problem identification in each dimension and development of treatment goals and measurable treatment objectives, as well as activities designed to meet those objectives.
    - The plan should be developed in collaboration with the patient and reflect the patient's personal goals.
    - The patient facing treatment plan should include a plan for what to do if urgent or emergent issues arise after-hours and for accessing emergency care 24/7, including when to call 988 or 911.
- Patient treatment plans should address any mental health treatment needs identified, including:
    - Services to be delivered by the program's treatment team.
    - Services to be delivered by external providers
- Treatment plans should reflect:
    - coordination of addiction treatment, physical health care (obstetrics and gynecology, infectious disease, cardiology, etc.), mental health care, and recovery support service needs
    - coordination of care with external treatment and service providers.
- The multidisciplinary treatment team should meet at least weekly to discuss patient progress and adjust the treatment plan as needed.
- Formal reassessment and treatment plan updates should be conducted at least monthly.
- Transfer planning should begin at admission and address:
    - Addiction treatment service needs
    - Physical health service needs
    - Mental health service needs
        - When individuals with co-occurring disorders are transferred to another level of care, they should be transferred to a setting that can provide integrated care for their continuing SUD and MH needs whenever possible.
    - Recovery support service needs
    - Continued access to medications
    - Overdose prevention, including access to naloxone

Services

- Level 2.1 programs directly provide 9-19 hours per week of skilled SUD treatment services, consisting primarily of counseling and education about addiction-related and mental health problems.
- Treatment services should be provided at least 3 days per week.
- Services should be provided in an amount, frequency, and intensity appropriate to individual patient needs as determined by the multidimensional assessment.
- All treatment services should be trauma informed responsive and delivered with cultural humility,
- All services should be designed with the expectation that many if not most patients will have co-occurring mental health conditions (e.g., individual and group interventions should encourage patients to address both mental health-related concerns as well as SUD-related concerns)

    - The program should provide symptom management support for both SUD and co-occurring mental health conditions
    - Patient mental health concerns should be treated concurrently by the program or through coordination with external providers
- The program should coordinate care with any external mental health care providers involved in the patient's care, with appropriate patient consent:
    - At admission, transitions in level of care, and discharge
    - As needed based to support effective care coordination for the individual patient
- The program's services should be designed to provide a welcoming environment for individuals with co-occurring mental health conditions, where patients feel safe addressing their mental health concerns and experiences.

Medical services

- While Level 2.1 programs typically do not directly provide medical services, they should have established relationships with physicians and/or advanced practice providers to provide:
    - Physical examinations
    - Addiction pharmacotherapies
    - Psychiatric pharmacotherapies
    - Toxicology testing
    - Laboratory testing (including infectious disease testing)
- Level 2.1 programs should also:
    - Advocate with external medical providers as needed to ensure that significant patient health issues are addressed in a timely manner
    - Coordinate with prescribers of addiction and psychiatric pharmacotherapies
    - Coordinate care with other medical providers concurrently providing care for issues that may impact the patient's prognosis or recovery
- Point of contact breath alcohol testing should be available on-site.
    - A physician or advanced practice provider should develop the program's policies and procedures regarding interpretation of breath alcohol testing results, including when to contact a medical professional.
- Point of care pregnancy testing should be available

Psychosocial services

Level 2.1 program should directly provide psychotherapeutic and psychoeducational services tailored to the needs of the individual, as determined based on ASAM Criteria Assessment. See the Universal Psychosocial Services Standards for details.

Recovery support services

Level 2.1 programs should directly provide:

- Support, structure, and consistency
- Transfer planning, including warm handoffs

In addition, these programs should provide the following recovery support services either directly or through formal affiliation with external service providers:

- Assessment of recovery support service needs
- Development of an individualized recovery plan
- Peer-support specialist services, including:

    - Recovery coaching
    - Recovery plan development
    - Recovery resource navigation (i.e., supporting connection with other recovery resources)
    - Ally advocacy (i.e., advocating for the patient as needed with social service organization and professional services to address healthcare, employment, housing, education, and other needs)
- Support practicing skills of daily living, including:
    - Transportation skills
    - Health and healthcare navigation
    - Self-care (healthy living and other activities to promote personal wellbeing)
    - Support accessing services to further develop and practice core life skills building (e.g., parenting, financial management, nutrition, etc.)
- Patient navigation services for patients who need concurrent treatment with external providers
- Support accessing mutual help programs (e.g., support finding appropriate programs, identifying transportation options, etc.)
- Assistance accessing social services for housing, nutritional assistance, health insurance, etc.
- Assistance with transportation to necessary services (e.g., community rides to mutual help meetings, help identifying public transit options and obtaining passes)
- Support coordinating with social service agencies (e.g., Children, Youth & Family Services, criminal justice agencies, etc.)
- Assistance identifying and obtaining community services or supports to address potential impediments to recovery (e.g., legal services, educational services, recovery housing, childcare services, jobs training, parenting training, financial training, etc.)
- Assistance identifying and accessing community harm reduction services

Documentation

See the Universal Documentation Standards.

Level 2.5 – High Intensity Outpatient

Level of Care Description

Level 2.5 programs provide high intensity outpatient services. These programs provide at least 20 hours of structured programming per week to address addiction and co-occurring mental health problems.

Dimensional Drivers

- Dimension 3
- Dimension 4

Setting

Level 2.5 services may be offered in any appropriate setting that meets state licensing criteria. Examples include:

- Day treatment programs

- Partial hospital programs

Staff

- Level 2.5 programs are staffed by an interdisciplinary team of appropriately credentialed addiction treatment professionals, typically including:
  - Psychologists
  - Master's level clinical social workers
  - Counselors
  - Others who assess and treat SUD and co-occurring mental health conditions
- Clinician qualified to assess and manage mental health conditions should be on site or on call at all times during program hours of operation. [Note: management includes determining appropriate steps for addressing mental health problems including symptom management support, further assessment, referral, crisis services, transfer, etc.]
- Level 2.5 programs should have a medical director who is a physician or advanced practice provider with at least 2 years of addiction treatment experience.

Role of physicians and advanced practice providers

- The medical director should:
  - Develop (and regularly review) the program's policies, procedures, and pathways for making admission decisions.
  - Be available to review admission decisions as needed (i.e., when the patient presents with issues in dimensions 1, 2, or 3 may require a medical evaluation).

Role of addiction specialist physicians

- Policies and procedures should define when and how to consult with an addiction specialist physician when needed.

Role of nurses

- Level 2.5 programs do not typically provide nursing services.

Role of clinical staff

- Clinical staff:
  - Provide a planned regimen of professionally directed evaluation, psychotherapy, psychoeducation, and coordinate the delivery of recovery support services for patients and their support systems.
  - Assess and treat substance use and other addictive disorders.
  - Assess and support management of cooccurring mental health conditions.
  - Conduct and coordinate treatment planning.
- Mental health treatment providers should be part of the multidisciplinary team.
  - On the interdisciplinary team, staff members with more training and experience with mental health care should support their team members to provide effective, integrated co-occurring competent care.
- It is recommended that programs have dedicated staff responsible for care coordination.

Role of allied health professionals

- Allied health professionals (e.g., peer support specialists, patient navigators, health educators, etc.) may serve a variety of roles including helping patients:
  - Get oriented to the setting/facility

  - Engage in the program
  - Access benefits and/or social support services (e.g., health insurance, transportation assistance, nutrition benefits, etc.)
  - Attend mutual support group meetings
- Allied health professionals may also provide health education services (e.g., HIV prevention, safe sex, overdose prevention and reversal training, etc.)

Support Systems

Support systems include the following available on-site or through external service providers:

- Biomedical
  - Ability to conduct or arrange for a physical examinations and medical assessments when needed
  - Ability to conduct or arrange for medical assessments for addiction and psychiatric pharmacotherapies.
    - The program should have a direct affiliation with a physician and/or advanced practice provider waivered to prescribe buprenorphine
    - The program should have a direct affiliation with an opioid treatment program (OTP) if available within the local payment geography
  - Ability to refer for appropriate laboratory testing services (e.g., infectious disease screening), when needed.
  - Ability to refer for toxicology testing, when needed.
- Psychiatric
  - Psychiatric assessment, by a psychiatrist or psychiatric nurse practitioner, should be available within a time frame appropriate to the clinical severity and urgency of the need.
  - Level 2.5 programs should have an established relationship with the local behavioral health crisis system, if available, to respond to urgent mental health needs.
  - Level 2.5 programs should have established relationships with local mental health treatment providers to support access to routine psychiatric consultation and to facilitate mental health care appointment access when needed.
- Psychological
  - Specialized consultation for psychological and cognitive problems should be available through consultation or referral when needed.
- Level 2.5 programs should have established relationships with more and less intensive levels of care.
- Level 2.5 programs do not need to have after hours telephonic availability. However, programs should educate patients at intake on what to do if urgent or emergent issues arise after hours (e.g., community resources, help lines, 911, 988, etc.)

Assessment and Treatment Planning

- Assessment and treatment planning should be trauma informed and trauma responsive.
- A Level of Care assessment, including an addiction-focused history, should be conducted (or reviewed) at admission to determine the recommended level of care.
  - For patients who are intoxicated or experiencing withdrawal the assessment should be reviewed by a physician prior to admission.

- For patients who have not had a physical exam within the past year, a physical exam should be conducted by a physician or advanced practice provider within one week of admission or sooner if needed based on the patient's medical condition.
    - Such determinations should be made according to established protocols, which include reliance on the patient's personal physician whenever possible
    - Protocols should be based on the staff's capabilities and developed and approved by a physician or advanced practice provider.
    - For patients who have had a physical examination within the 3 months, the Level 2.5 clinician should obtain and review the physical examination results within 1 week of admission.
- A full biopsychosocial treatment planning assessment should be conducted (or reviewed) and used to develop an individualized treatment plan within 5 treatment days of admission.
- Individualized treatment plans should include problem identification in each dimension and development of treatment goals and measurable treatment objectives, as well as activities designed to meet those objectives.
    - The patient facing treatment plan should include a plan for contacting the program after-hours and for accessing emergency care 24/7, including when to call 988 or 911.
- The multidisciplinary treatment team should meet at least weekly to discuss patient progress and adjust the treatment plan as needed.
- Formal reassessment and treatment plan updates should be conducted at least every 2 weeks.
- Patient treatment plans should address any mental health treatment needs identified, including:
    - Services to be delivered by the program's treatment team.
    - Services to be delivered by external providers.
- Treatment plans should reflect:
    - coordination of addiction treatment, physical health care (obstetrics and gynecology, infectious disease, cardiology, etc.), mental health care, and recovery support service needs.
    - coordination of care with external treatment and service providers.
- Transfer planning should begin at admission and address:
    - Addiction treatment service needs
    - Physical health service needs
    - Mental health service needs
        - When individuals with co-occurring disorders are transferred to another level of care, they should be transferred to a setting that can provide integrated care for their continuing SUD and MH needs whenever possible.
    - Recovery support service needs
    - Continued access to medications
    - Overdose prevention, including access to naloxone

Services

- Level 2.5 programs should provide a minimum of 20 hours per week of clinical treatment services.
- Services should be provided in an amount, frequency, and intensity appropriate to individual patient needs as determined by the multidimensional assessment.

- All treatment services should be trauma informed responsive and delivered with cultural humility,
- All services should be designed with the expectation that many if not most patients will have co-occurring mental health conditions (e.g., individual and group interventions should encourage patients to address both mental health-related concerns as well as SUD-related concerns))
    - The program should provide symptom management support for both SUD and co-occurring MH conditions
    - Patient mental health concerns should be treated concurrently by the program or through coordination with external providers
- The program should coordinate care with any external mental health care providers involved in the patient's care, with appropriate patient consent:
    - At admission, transitions in level of care, and discharge
    - As needed based to support effective care coordination for the individual patient (at minimum monthly)
- The program's services should be designed to provide a welcoming environment for individuals with co-occurring mental health conditions, where patients feel safe addressing their mental health concerns and experiences.

Medical services

- While Level 2.5 programs typically do not directly provide medical services, they should have direct affiliations with physicians and/or advanced practice providers to provide:
    - Physical examinations
    - Medical consultation
    - Medical assessment
    - Addiction pharmacotherapies
    - Psychiatric pharmacotherapies
    - Toxicology testing
    - Laboratory testing
- Level 2.5 programs should also:
    - Arrange appointments with external medical providers when needed
    - Advocate with external medical providers as needed to ensure that significant client health issues are addressed in a timely manner
    - Coordinate with prescribers of addiction and psychiatric pharmacotherapies
    - Coordinate care with other medical providers concurrently providing care for issues that may impact the patient's prognosis or recovery
- Point of contact breath alcohol testing should be available on-site.
    - A physician or advanced practice provider should develop the program's policies and procedures regarding interpretation of breath alcohol testing results, including when to contact a medical professional.
- Point of care pregnancy testing should be available

Psychosocial services

Level 2.5 program should directly provide psychotherapeutic and psychoeducational services tailored to the needs of the individual, as determined based on ASAM Criteria Assessment. See the Universal Psychosocial Services Standards for details.

Recovery support services

Level 2.5 programs should directly provide:

- Support, structure, and consistency
- Transfer planning, including warm handoffs

In addition, these programs should provide the following recovery support services either directly or through formal affiliation with external service providers:

- Assessment of recovery support service needs
- Development of an individualized recovery plan
- Peer-support specialist services, including:
    - Recovery coaching
    - Recovery plan development
    - Recovery resource navigation (i.e., supporting connection with other recovery resources)
    - Ally advocacy (i.e., advocating for the patient as needed with social service organization and professional services to address healthcare, employment, housing, education, and other needs)
- Support practicing skills of daily living, including:
    - Transportation skills
    - Health and healthcare navigation
    - Self-care (healthy living and other activities to promote personal wellbeing)
    - Support accessing services to further develop and practice core life skills building (e.g., parenting, financial management, nutrition, etc.)
- Patient navigation services for patients who need concurrent treatment with external providers
- Support accessing mutual help programs (e.g., support finding appropriate programs, identifying transportation options, etc.)
- Assistance accessing social services for housing, nutritional assistance, health insurance, etc.
- Assistance with transportation to necessary services (e.g., community rides to mutual help meetings, help identifying public transit options and obtaining passes)
- Support coordinating with social service agencies (e.g., Children, Youth & Family Services, criminal justice agencies, etc.)
- Assistance identifying and obtaining community services or supports to address potential impediments to recovery (e.g., legal services, educational services, recovery housing, childcare services, jobs training, parenting training, financial training, etc.)
- Assistance identifying and accessing community harm reduction services

Documentation

See the Universal Documentation Standards.

Level 2.7 – Medically Managed Intensive Outpatient

Level of Care Description

Level 2.7 programs provide outpatient biomedical, medication initiation, and withdrawal management services for patients who need daily access to nursing care with medical monitoring but do not need 24-hour nursing, medical monitoring, structure, or support.

Level 2.7 programs should be able to provide all the services of a Level 2.5 program either directly or through formal affiliation with other programs.

Services should be delivered under a defined set of physician-approved policies and physician-managed procedures or medical protocols.

Dimensional Drivers

- Dimension 1
- Dimension 2

Setting

Level 2.7 services may be offered in any appropriate outpatient setting with physician oversight that meets state licensure or certification criteria.

Level 2.7 services may be offered in:

- Intensive outpatient programs
- Partial hospital programs

Staff

Level 2.7 programs are staffed by appropriately credentialed and/or licensed treatment professionals, including:

- A medical director who is an addiction specialist physician or a physician with 5+ years of documented experience in addiction specialty care.
- Physicians and/or advanced practice providers with controlled substance prescribing authority and waivered to prescribe buprenorphine
- Nurses with the scopes of practice necessary to provide the services outlined in the *Assessment and Treatment Planning* and *Services* sections below

Other than the medical director, physicians and advanced practice providers do not need to be certified as addiction specialists and nurses do not need to be certified as addiction nurses, but training and experience in assessing and managing intoxication and withdrawal syndromes is necessary. See Competencies Section.

Medical staff

- The medical director:
  - Develops the program's admission criteria
  - Develops clinical protocols
  - Directs patient care
  - Ensures the adequacy of individual treatment plans
  - Ensures daily medical coverage to meet patient needs.
  - Determines the credentials required of other physicians and advanced practice providers serving the program

    - Oversees the quality of treatment delivered by the program
    - Is ultimately responsible for the care delivered
    - Monitoring the care delivered by other physicians or advanced practice providers that serve the program
- Medical staff should be available on site or by phone during program hours of operation.
- Medical staff should be on call 24/7 to address urgent issues that arise after hours
- Physicians or advanced practice providers should be readily available to:
    - Review admission decisions and confirm that withdrawal management in this setting is safe
    - Conduct medical history and physical examinations
    - Manage appropriate medications and other treatment modalities for acute withdrawal management and other biomedical needs
    - Provide clinical consultation and supervision for biomedical, psychiatric, and cognitive problems.
- Medical staff should:
    - Have consistent, direct interactions (in person or via video-based telehealth) with patients in the acute phase of withdrawal

Nursing and Other Medical Staff (RN, LPN, paramedic, etc.)

- Appropriately licensed and credentialed nursing staff should be available during program hours of operation to:
    - Conduct nursing assessments on admission
    - Monitoring patient progress
        - Administer validated withdrawal severity assessments.
    - Administer medications and non-pharmacological interventions in accordance with provider orders.
    - Provide medication management services
    - Conduct routine daily assessments of withdrawal, biomedical comorbidities, and psychiatric comorbidities
    - Provide patient education
- The level of nursing care should be appropriate to the severity of patient needs

Clinical Staff

The services of clinical staff including counselors, psychologists, and social workers should be available through the Level 2.7 program directly or through directly affiliated providers or programs.

- Licensed, certified, or registered clinicians should:
    - Provide a planned regimen of professionally directed evaluation, psychotherapy, psychoeducation, and coordinate the delivery of recovery support services for patients and their families.
    - Assess and treat substance use and other addictive disorders.
    - Assess and support the management of cooccurring mental health conditions
    - Support treatment planning [Note: at this level of care treatment planning should be led by medical staff.]
- A clinical supervisor should be on-call 24/7 to respond to urgent situations.
- Mental health treatment providers should be part of the multidisciplinary team.

    - On the multidisciplinary team, staff members with more training and experience with mental health care should support their team members to provide effective, integrated co-occurring competent care.
- It is recommended that programs have dedicated staff responsible for care coordination.
- Clinical staff qualified to assess and manage mental health conditions should be on site or on call at all times. [Note: management includes determining appropriate steps for addressing mental health problems including symptom management support, further assessment, referral, crisis services, transfer, etc.]

Allied Health Staff

- Level 2.7 programs may be staffed with appropriately certified peer support specialists and other allied health staff

Role of the addiction specialist physician:

- If the Level 2.7 programs does not have addiction specialist physicians on staff, policies and procedures should define when and how to consult with an addiction specialist physician

Support Systems

Support systems include the following:

- Biomedical
    - The program should have a direct affiliation (e.g., MOU) with a nearby hospital to support effective coordination of care.
    - Ability to arrange for specialized clinical consultation for biomedical and cognitive problems when needed.
        - All programs should have a formal relationship with an infectious disease specialist.
        - Programs should consider local and treatment community needs when determining other need for direct affiliations. (For example, if renal failure is common in the patient population, consider a formal relationship with a nearby dialysis center to support effective coordination of care)
    - If primary care services are not available on site, the program should have a direct affiliation with a primary care provider and be able to arrange an appointment within 48 hours.
    - The program should have established relationships with obstetricians to support coordination of care for patients who are pregnant or postpartum.
- Psychiatric
    - Psychiatric assessment, by a psychiatrist or psychiatric nurse practitioner, is available within a time frame appropriate to the severity and urgency of the need.
        - If the initial assessment occurs via telehealth, video telehealth should be used
        - Follow up assessments may be audio only, when appropriate (as determined by the provider)
    - The program should have an established relationship with the local behavioral health crisis system, if available, to respond to urgent mental health needs.

    - The program should have established relationships with local mental health treatment providers to support access to routine psychiatric consultation and to facilitate mental health care appointment access when needed.
- Psychological
    - Specialized consultation for psychological and cognitive problems should be available through consultation or referral when needed.
- The program should have established relationships with more and less intensive levels of care.
- If the Level 2.7 program is not registered as an opioid treatment program (OTP), the program should have a formal affiliation with an OTP to ensure access to methadone if an OTP is available within the local payment geography.
- After hours telephonic availability
    - A physician or advanced practice provider should be on-call during non-business hours to respond to urgent concerns.

Assessment and Treatment Planning

- Assessment and treatment planning should be sensitive to trauma and designed to prevent re-traumatization.
- A nursing assessment should be performed by a registered nurse at admission.
- An addiction-focused history should be obtained as part of the initial assessment by a physician or advanced practice provider during the admission process.
- A comprehensive physical examination should be conducted by a physician or advanced practice provider performed within 36 hours as part of the initial assessment.
- Sufficient biopsychosocial screening and assessments should be conducted to determine the appropriate level of care and to develop an individualized care plan
- An individualized treatment plan should be developed, and should include problem identification in each dimension, treatment goals, measurable treatment objectives, and activities designed to meet those objectives. The plan should:
    - Be developed in collaboration with the patient, reflects the patient's personal goals, and incorporates the patient's strengths.
    - Reflect case management conducted by on-site staff
    - Address any mental health treatment needs identified, including:
        - Services to be delivered by the program's treatment team
        - Services to be delivered by external providers.
    - Reflect coordination of care with other specialty biomedical (obstetrics and gynecology, infectious disease, cardiology, etc.) and psychiatric services, as needed to address problems identified through the comprehensive biopsychosocial assessment.
- Serial medical assessments including appropriate measures of withdrawal should be conducted as needed.
- The patient facing treatment plan should include plan for contacting the program after-hours and for accessing emergency care 24/7, including when to call 911 or 988
- Medical or nursing staff should assess patient progress at least daily (via in person or video-based check ins) during the acute phase of withdrawal management and during any treatment changes.

    - Telephone check ins may be appropriate alternatives to in person check ins depending on the acuity of the patient's signs and symptoms and concerns regarding adherence to prescribed medications.
- Withdrawal management plan reviews should be conducted daily, at minimum.
- Transition planning, beginning at admission, addressing:
    - Addiction treatment service needs
    - Physical health service needs
    - Mental health service needs
        - When possible, patients with cooccurring disorders should be transferred to a setting that can provide integrated care for their continuing SUD and MH needs
    - Recovery support service needs
    - Continued access to medications, including medications for opioid use disorder
    - Overdose prevention and harm reduction
- Referral arrangements should be made as needed

Services

- Level 2.7 programs directly provide daily clinical services including:
        - Nursing and medical monitoring for stabilization of acute withdrawal, biomedical and psychiatric conditions.
        - Psychosocial services to encourage engagement in ongoing treatment
- Such services should be provided in an amount, frequency, and intensity appropriate to the patient's individual needs and level of function as determined by the multidimensional assessment.
- All treatment services should be trauma informed responsive and delivered with cultural humility,
- All services should be designed with the expectation that many if not most patients will have co-occurring mental health conditions
    - The program should provide symptom management support for both SUD and co-occurring mental health conditions
    - Patient mental health concerns should be treated concurrently by the program or through coordination with external providers
- The program should coordinate care with any external mental health care providers involved in the patient's care, with appropriate patient consent:
    - At admission and discharge
    - As needed based to support effective care coordination for the individual patient
- Care coordination with other providers involved in the patient's care
    - The staff member responsible for care coordination for a given patient should be clearly documented.
    - If psychosocial services are provided through affiliated programs, there should be daily touch bases regarding the care of each patient.
- The program's services should be designed to provide a welcoming environment for individuals with co-occurring mental health conditions, where patients feel safe addressing their mental health concerns and experiences

Medical

The following medical and nursing services should be available in Level 2.7 programs:

- Nursing assessment upon initial evaluation completed by an RN, including:
    - vitals
    - history of present illness
    - baseline evaluation of withdrawal severity and risks
    - medical history including assessment of current biomedical issues and medication review.
- Nurse monitoring
- Comprehensive medical history and physical examination performed within 36 hours of admission
- Prescribing with essential medications on site
    - A physician or advanced practice provider should be available during normal hours of operation (in person or via telehealth) to initiate or adjust medications based on the results of the nursing assessment and/or physical exam.
        - Medications may be provided based on a patient specific verbal order from the physician or APP, based on established protocols.
    - The program should have policies and procedures that define essential medicines based on current standards of clinical practice and that ensure these medications are stocked
- Medication injections (including ability to administer extended-release buprenorphine and naltrexone, and long-acting antipsychotics)
- Medication management including adherence monitoring
- Toxicology services as appropriate to the patient's individual treatment plan, following appropriate standards such as those defined in ASAM's Appropriate Use of Drug Testing in Clinical Addiction Medicine Consensus Document
    - Toxicology testing should be conducted based on patient specific orders from the responsible physician.
    - Toxicology results should be reviewed and interpreted by a physician or advanced practice provider for whom interpretation of toxicology results is in their scope of practice.
    - Program should have written policies regarding how to respond to unexpected toxicology test results, including modification of the treatment plan.
- Outpatient withdrawal management services, including:
    - Medical monitoring and management of signs and symptoms of intoxication and withdrawal
    - Assessment with validated scales (e.g., COWS, CIWA-Ar) to determine the severity of withdrawal when appropriate
    - Medication based methods of withdrawal management that are appropriate for the severity of withdrawal or anticipated withdrawal
        - Withdrawal management and medication initiation services should be available within 1 hour of arrival.
            - Programs should consider providing daily walk-in slots to ensure availability of services.
    - Non-pharmacological methods of withdrawal management including, but not limited to:
        - Informing patients of what to expect over the course of treatment.
        - Offering reassurance
        - Providing a quiet environment

        - Educating patients on the importance of adequate hydration and nutrition
        - Educating the family members or significant others on how to support the patient (with appropriate consent) including:
            - monitoring for withdrawal signs and symptoms
            - supporting medication adherence
            - supporting adequate hydration and nutrition
            - creating a low stimulation environment
            - offering encouragement and reassurance
- Medical monitoring and management of acute biomedical conditions, including:
    - Basic management of hyperglycemia and hypoglycemia support
    - Infectious disease management
        - Screening and assessment for STI and bloodborne infections
        - Initiation of treatment and/or facilitated engagement in care and coordination of care
    - Coordination of pregnancy and/or postpartum care
    - Coordination of care for biomedical conditions for which the patient is receiving treatment from an external provider, including pain
    - Direct management or coordination of psychopharmacotherapies
    - Initiation and management of preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP), including education regarding PrEP and PEP
- Medication initiation and management of common, low-complexity psychiatric conditions.
- Initiation of addiction pharmacotherapies in alignment with current best practices, such as those established in the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, the APA Practice Guideline on Treatment of Alcohol Use Disorder, and ASAM's clinical guidance on Integrating Tobacco Use Disorder Interventions in Addiction Treatment.
- Care coordination
    - The staff member responsible for care coordination for a given patient should be clearly documented.
    - If psychosocial services are provided through affiliated providers or programs, there should be daily touch bases regarding the care of each patient

Level 2.7 programs should have the following biomedical capabilities:

- ECG (at minimum with a 3-lead rhythm strip)
- Glucose monitoring
- Pulse oximetry
- Basic wound care
- Basic first aid
- Automated external defibrillator (AED)
- Blood pressure monitoring
- Injectable epinephrine available on site
- Naloxone available on site
- Ability to administer vaccines on site (including for hepatitis A and B, influenza, Covid, etc.)
- Phlebotomy services
- Laboratory services
    - Ability to conduct or arrange for appropriate laboratory testing services during normal hours of operation
    - Access to laboratory that conducts blood cultures

- Toxicology services
  - CLIA waived point of care testing is preferred but not required.
  - Ability to conduct or arrange for confirmatory testing
  - Point of care breath alcohol testing
- Point of care pregnancy testing

Psychosocial Services

- Level 2.7 programs should make available psychosocial services either directly or through affiliated providers or program(s). These services should be tailored to the needs of the individual as determined based on ASAM Criteria Assessment. See the Psychosocial Services Section for details.
- Patients should be excused from participating in psychotherapeutic, psychoeducational, and recovery support services if acute withdrawal or biomedical conditions prevent effective participation.
- Once stabilized, patients should be engaged in psychosocial treatment services.
  - Patients who need extended Level 2.7 services but can benefit from psychotherapy and otherwise meet the admission criteria for Level 2.5 should receive 20+ hours of psychosocial services per week.
  - Patients who need extended Level 2.7 services but can benefit from psychotherapy and otherwise meet the admission criteria for Level 2.1 should receive 9+ hours of psychosocial services per week.

Recovery Support Services

Level 2.7 programs should directly provide:

- Support, structure, and consistency
- Transfer planning, including warm handoffs

In addition, these programs should provide the following recovery support services either directly or through formal affiliation with external service providers:

- Assessment of recovery support service needs
- Development of an individualized recovery plan
- Peer-support specialist services, including:
  - Recovery Coaching
  - Recovery plan development
  - Recovery resource navigation (i.e., supporting connection with other recovery resources)
  - Ally advocacy (i.e., advocating for the patient as needed with social service organization and professional services to address healthcare, employment, housing, education, and other needs)
- Support practicing skills of daily living, including:
  - Transportation skills
  - Health and healthcare navigation
  - Self-care (healthy living and other activities to promote personal wellbeing)
  - Support accessing services to further develop and practice core life skills (e.g., parenting, financial management, nutrition, etc.) building
- Patient navigation services for patients who need concurrent treatment with external providers

- Support accessing mutual help programs (e.g., support finding appropriate programs, identifying transportation options, etc.)
- Assistance accessing social services for housing, nutritional assistance, health insurance, etc.
- Assistance with transportation to necessary services (e.g., community rides to mutual help meetings, help identifying public transit options and obtaining passes)
- Support coordinating with social service agencies (e.g., Children, Youth & Family Services, criminal justice agencies, etc.)
- Assistance identifying and obtaining community services or supports to address potential impediments to recovery (e.g., legal services, educational services, recovery housing, childcare services, jobs training, parenting training, financial training, etc.)
- Assistance identifying and accessing community harm reduction services

Documentation

See the Universal Documentation Standards.

Level 3.1 – Clinically Managed Low-Intensity Residential

Level of Care Description

- Level 3.1 provides clinically managed low-intensity residential services for patients who need structure and support to build and practice their recovery and coping skills.

Dimensional Drivers

- Dimension 4
- Dimension 5

Setting

- Level 3.1 services are offered in appropriately licensed facilities located in residential settings with 24-hour staff and integrated clinical services.
- The facility should incorporate space for:
    - Counseling services
    - Group meetings
    - Therapeutic activities
    - Patient rest
    - Patient privacy
    - Meals
    - Hygiene
- The living space should be within reasonable proximity of the space for clinical services, allowing staff to maintain adequate supervision of patients to rapidly address emerging clinical issues.
    - If any treatment services are offered off-site, programs should provide access to safe and reliable transportation.
- The layout of the facility should enable adequate supervision and management of patients at all times, ensuring staff can respond to instability in a safe and timely manner.
    - Patients should be able to alert staff to an issue immediately, and staff should be able to respond immediately (within minutes) to assess how to respond.

- The facility should provide a supportive living environment that provides the needs of daily living.
- The setting should provide an environment that:
  - Is safe from substances, paraphernalia, and weapons.
    - Searches of patients, visitors, and their belongings that are necessary to provide an environment free from substances, paraphernalia, and weapons should utilize trauma-informed practices and preserve patient dignity and privacy
  - Provides privacy and security of personal belongings

Patient Supervision

- Level 3.1 programs should provide 24-hour structure and support.
  - The whereabouts of each patient who is on-site should be monitored and documented at least once per hour.
  - At the start of treatment in Level 3.1 some patients may benefit from staff monitoring or peer support when they are off-site. Programs should have policies and procedures in place for providing monitoring or support when patients are off-site. For example, allowing patients who need additional support to go off-site in groups of 3 or more.
  - As patients progress clinically in treatment (as determined by their primary counselor), they should be able to leave the program independently as they prepare to reintegrate into their community.

Staff

- Level 3.1 programs should be staffed by a multidisciplinary team of appropriately trained and credentialed and/or licensed treatment professionals, including:
  - Licensed or credentialed clinical staff such as counselors, social workers, and psychologists
- Programs should also be staffed by allied health professional staff (e.g., peer support specialists, patient navigators, health educators, counselor aides or group living workers).
- The program director should have a master's degree and at least five years of addiction treatment experience.

Role of physicians and advanced practice providers

- Level 3.1 programs do not typically have medical personnel on staff; however, a physician should review admission decisions to confirm the appropriateness of treatment at this level of care.
- Level 3.1 programs should have a direct affiliation with a physician or advanced practice provider who is waivered to prescribe buprenorphine, who can provide physical examinations, prescribe addiction and psychiatric medications, and provide medication management and laboratory testing as needed.

Role of addiction specialist physicians

- Level 3.1 programs do not need to have addiction specialist physicians on staff, but policies and procedures should define when and how to consult with, or refer to, an addiction specialist physician when needed.

Role of nurses

- Level 3.1 programs are not required to be staffed by nursing professionals.

Role of clinical staff

- Clinical staff:
  - Provide a planned regimen of professionally directed evaluation, psychotherapy, psychoeducation, and coordinate the delivery of recovery support services for patients and their support systems.
  - Assess and treat substance use disorders.
  - Assess and support management of common, low severity cooccurring mental health conditions.
- Mental health treatment providers should be part of the multidisciplinary team.
- It is recommended that programs have dedicated staff responsible for care coordination
- Supervisory clinical staff should be available 24/7 to respond to urgent situations
- A clinician qualified to assess and manage mental health conditions should be on site or on call 24 hours per day. [Note: management includes determining appropriate steps for addressing mental health problems including symptom management support, further assessment, referral, crisis services, transfer, etc.]

Role of allied health professionals

- Allied health professionals (e.g., peer support specialists, patient navigators, health educators, etc.) should be awake, on-site 24 hours a day.
- Allied health professionals provide recovery support services including:
  - Peer support services
  - Health education
  - Social milieu
  - Patient navigation services
  - Transition support
- Allied health professionals may also provide health education services (e.g., HIV prevention, safe sex, overdose prevention and reversal training, etc.)
- Level 3.1 programs should have policies and procedures that define activities to be performed during the night shift (e.g., hourly monitoring and documentation of patient whereabouts, coordinating response to urgent patient issues).

Support Systems

Support systems include the following:

- Biomedical
  - Ability to conduct or arrange for physical examination or medical assessment when needed.
  - Ability to conduct or arrange medical evaluations for pharmacotherapy for psychiatric and addiction medications.
    - The program should have a direct affiliation with a physician and/or advanced practice provider with waivered to prescribe buprenorphine
    - The program should have a direct affiliation with an opioid treatment program (OTP) if available within the local payment geography
  - Ability to refer for appropriate laboratory testing services (e.g., infectious disease screening), when needed.
  - Ability to refer for toxicology testing, when needed.
- Psychiatric

  - Psychiatric assessment, by a psychiatrist or psychiatric nurse practitioner, should be available within a time frame appropriate to the clinical severity and urgency of the need.
  - Level 3.1 programs should have an established relationship with the local behavioral health crisis system, if available, to respond to urgent mental health needs.
  - Level 3.1 programs should have established relationships with local mental health treatment providers to support access to routine psychiatric consultation and to facilitate mental health care appointment access when needed.
- Psychological
  - Specialized consultation for psychological and cognitive problems should be available through consultation or referral when needed.
- Level 3.1 programs should have established relationships with more and less intensive levels of care.
- Level 3.1 programs should have established policies and procedures for responding to urgent medical and psychiatric needs 24 hours a day, 7 days a week, including:
  - Access to medical consultation
  - When to call 911
  - When to call 988

Assessment and Treatment Planning

In Level 3.1 programs:

- Assessment and treatment planning should be sensitive to trauma and designed to prevent re-traumatization.
- A multidimensional level of care assessment should be conducted at admission to determine the recommended level of care
  - For patients who are intoxicated or experiencing withdrawal the assessment should be reviewed by a physician prior to admission
- A physical examination should be conducted by a physician or advanced practice provider within 7 days of admission or sooner if needed based on the patient's medical condition.
  - Such determinations should be made according to established protocols, which should include reliance on the patient's personal physician whenever possible.
  - Protocols should be based on the program's capabilities and developed and approved by a physician or advanced practice provider.
  - Alternatively, records from a physical examination conducted within 30 days of admission should be evaluated by a physician or advanced practice provider within 7 days of admission
- A full biopsychosocial treatment planning assessment should be conducted and used to develop an initial individualized treatment plan within 3 days of admission.
- An addiction-focused history should be obtained as part of the initial treatment planning assessment.
- Individualized treatment plans should include problem identification in each dimension and development of treatment goals and measurable treatment objectives, as well as activities designed to meet those objectives. The plan should:
  - Reflect case management conducted by on-site staff
  - Reflect:

        - coordination of addiction treatment, physical health care (obstetrics and gynecology, infectious disease, cardiology, etc.), mental health care, and recovery support service needs
        - coordination of care with external treatment and service providers.
- Patient treatment plans should address any mental health treatment needs identified, including:
    - Services to be delivered by the program's treatment team.
    - Services to be delivered by external providers
- The multidisciplinary treatment team should meet at least weekly to discuss patient progress and adjust the treatment plan as needed.
    - A progress note should be added to the clinical record weekly that outlines progress, concerns, and any planned changes to clinical care
- Formal reassessment and treatment plan updates should occur at least monthly, including:
    - Determination of whether the patient is progressing appropriately and if a higher or lower intensity of treatment may be needed
    - Signatures from key clinical staff
- Transfer planning should begin at admission and address:
    - Addiction treatment service needs
    - Physical health service needs
    - Mental health service needs
        - When individuals with co-occurring disorders are transferred to another level of care, they should be transferred to a setting that can provide integrated care for their continuing SUD and MH needs whenever possible.
    - Recovery support service needs
    - Continued access to medications
    - Overdose prevention, including access to naloxone
    - For out of state patients, transfer planning should plan for appropriate care in the patient's local community

Services

- Level 3.1 programs should directly provide:
    - 9-19 hours of clinical services per week including:
        - Daily clinical services designed to improve the patient's ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance, and punctuality.
        - Clinical program activities designed to stabilize and maintain the stability of the patient's substance use disorder symptoms, and to help him or her develop and apply recovery skills, such as:
            - relapse prevention
            - exploring interpersonal choices
            - development of a social network supportive of recovery.
    - These services should be provided in an amount, frequency, and intensity appropriate to individual patient needs as determined by the multidimensional assessment.
- Structured services should be available 7 days per week
- Daily activities should be designed to allow patients to learn and practice prosocial behaviors
- Coordination of patient referrals and transfers to other levels of care when needed

    - For patients who are from another region or state, coordination of transfer to a program in their local community
- Care coordination to manage engagement and track progress when a patient is receiving concurrent services from an external treatment or service provider, including
    - Data sharing as needed to support effective coordination of care (at minimum monthly, to support the formal treatment plan review)
    - Monitoring of the patient's adherence in taking any prescribed medications, and/or any permitted over the counter (OTC) medications or supplements.
- Staff supervision and monitoring as outlined in the Patient Supervision section above
- All treatment services should be trauma responsive and delivered with cultural humility,
- All services should be designed with the expectation that many if not most patients will have co-occurring mental health conditions (e.g., individual and group interventions should encourage patients to address common mental health-related concerns as well as SUD-related concerns)
    - The program should provide symptom management support for both SUD and co-occurring mental health conditions
    - Patient mental health concerns should be treated concurrently by the program or through coordination with external providers
- The program should coordinate care with any external mental health care providers involved in the patient's care, with appropriate patient consent:
    - At admission and discharge
    - As needed based to support effective care coordination for the individual patient
- The program's services should be designed to provide a welcoming environment for individuals with co-occurring mental health conditions, where patients feel safe addressing their mental health concerns and experiences.

Medical

- As discussed in the Staff Section, Level 3.1 programs do not need to have medical staff. However, Level 3.1 programs should have established relationships with physician(s) and/or advanced practice providers to coordinate access to:
    - Physical examinations
    - Laboratory testing
    - Addiction pharmacotherapy
    - Psychiatric pharmacotherapy
    - Toxicology services
        - CLIA waived point of care testing should be available on site.
        - Access to confirmatory testing should be available when needed (see ASAM Drug Testing Guideline)
- Level 3.1 programs should also:
    - Advocate with external medical providers as needed to ensure that significant client health issues are addressed in a timely manner
    - Coordinate with prescribers of addiction and psychiatric pharmacotherapies
    - Coordinate care with other medical providers concurrently providing care for issues that may impact the patient's prognosis or recovery
- Point of contact breath alcohol testing should be available on-site.

    - A physician or advanced practice provider should develop the program's policies and procedures regarding interpretation of breath alcohol testing results, including when to contact a medical professional.
- Point of care pregnancy testing should be available on site

Psychosocial services

Level 3.1 program should directly provide psychotherapeutic and psychoeducational services tailored to the needs of the individual, as determined based on ASAM Criteria Assessment. See the Psychosocial Services Section for details.

Recovery support services

Level 3.1 programs should directly provide:

- Planned community reinforcement designed to foster prosocial values and milieu or community living skills
- A therapeutic milieu including support, structure, and consistency
- Transfer planning, including warm handoffs

In addition, these programs should provide the following recovery support services either directly or through formal affiliation with external service providers:

- Assessment of recovery support service needs
- Development of an individualized recovery plan
- Peer-support specialist services, including:
    - Recovery coaching
    - Recovery plan development
    - Recovery resource navigation (i.e., supporting connection with other recovery resources)
    - Ally advocacy (i.e., advocating for the patient as needed with social service organization and professional services to address healthcare, employment, housing, education, and other needs)
- Support developing and practicing skills of daily living, including:
    - Transportation skills
    - Health and healthcare navigation
    - Self-care (healthy living and other activities to promote personal wellbeing)
    - Parenting
    - Financial management
    - Nutrition
- Patient navigation services for patients who need concurrent treatment with external providers
- Support accessing mutual help programs (e.g., support finding appropriate programs, identifying transportation options, etc.)
- Assistance accessing social services for housing, nutritional assistance, health insurance, etc.
- Assistance with transportation to necessary services (e.g., community rides to mutual help meetings, help identifying public transit options and obtaining passes)
- Support coordinating with social service agencies (e.g., Children, Youth & Family Services, criminal justice agencies, etc.)

- Assistance identifying and obtaining community services or supports to address potential impediments to recovery (e.g., legal services, educational services, recovery housing, childcare services, jobs training, parenting training, financial training, etc.)
- Assistance identifying and accessing community harm reduction services

Documentation

See the Universal Documentation Standards.

Level 3.5 – Clinically Managed High-Intensity Residential

Level of Care Description

- Level 3.5 provides clinically managed high-intensity residential services for patients who need a safe and stable living environment to develop sufficient recovery skills so that they do not immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care.

Dimensional Drivers

- Dimension 4
- Dimension 5
- Dimension 3

Setting

- Level 3.5 services are offered in appropriately licensed facilities located in residential settings (e.g., a therapeutic community or residential treatment center). Level 3.5 program services may be offered in an appropriately licensed facility located in a community setting or a specialty unit within a licensed health care facility.
- The facility should incorporate space for:
    - Counseling services
    - Group meetings
    - Therapeutic activities
    - Patient rest
    - Patient privacy
    - Meals
    - Hygiene
- The facility should provide a supportive living environment that provides the needs of daily living.
- The setting should provide an environment that:
    - Is safe from substances, paraphernalia, and weapons.
        - Searches of patients, visitors, and their belongings that are necessary to provide an environment free from substances, paraphernalia, and weapons should utilize trauma-informed practices and preserve patient dignity and privacy
    - Provides privacy and security of personal belongings

Patient Supervision

- Level 3.5 programs should provide 24-hour supervision of patients.
    - Patients should be monitored at least once per hour.

    - Programs should have policies and procedures in place that address when patients may need to be monitored more frequently (e.g., when the patient is at risk for self-harm).
- At the start of treatment in Level 3.5:
    - Patients should not leave the program premises except under limited circumstances, such as specialty medical or diagnostic appointments, or medical or psychiatric emergencies.
    - Program staff should provide continuous monitoring of patients when they are off-site to prevent risky behaviors and address any instability or other issues that may arise in a safe and timely manner.
- As patients progress in Level 3.5, they may be given opportunities to practice skills for community reintegration before transitioning to a less intensive level of care.
    - It may be appropriate for patients to leave the premises, with staff supervision, to participate in services in the community such as a mutual support meeting.
    - The degree of staff monitoring when patients participate in services in the community may vary from continuous monitoring of patients when they are off-site to a lower level of staff supervision (e.g., 1 staff member taking a group to a mutual support meeting) based on patient readiness/progress in treatment).
        - The degree of staff monitoring provided should be determined by the patient's primary therapist and documented in the patient record.

Staff

- Level 3.5 programs should be staffed by a multidisciplinary team of appropriately trained and credentialed and/or licensed treatment professionals, including:
    - Psychologists
    - Master's level social workers
    - Counselors
- Programs should also be staffed by allied health professional staff (e.g., peer support specialists, patient navigators, health educators, counselor aides or group living workers).
- A clinician with competence in the treatment of substance use disorders should be available on-site or on-call at all times.
- A clinician qualified to assess and manage mental health conditions should be on site or on call at all times. [Note: management includes determining appropriate steps for addressing mental health problems including symptom management support, further assessment, referral, crisis services, transfer, etc.]
- A program director with a master's degree and at least five years of addiction treatment experience.
- Level 3.5 programs should have a medical director who is a physician or advanced practice provider with at least 2 years of addiction treatment experience.

Role of physicians and advanced practice providers

- The medical director should:
    - Develop (and regularly review) the program's policies, procedures, and pathways for making admission decisions.
    - Be available to review admission decisions as needed (i.e., when the patient presents with issues in dimensions 1, 2, or 3 may require a medical evaluation).

Role of addiction specialist physicians

- Level 3.5 programs do not typically have addiction specialist physicians on staff, but policies and procedures should define when and how to consult with an addiction specialist physician when needed.

Role of nurses

- Nursing staff are not required in Level 3.5 programs.

Role of clinical staff

- Clinical staff:
  - Provide a planned regimen of professionally directed evaluation, psychotherapy, psychoeducation, and coordinate the delivery of recovery support services for patients and their support systems.
  - Assess and treat substance use and other addictive disorders.
  - Assess and support management of cooccurring mental health conditions.
- Mental health treatment providers should be part of the multidisciplinary team.
  - On the multidisciplinary team, staff members with more training and experience with mental health care should support their team members to provide effective, integrated co-occurring competent care.
- It is recommended that programs have dedicated staff responsible for care coordination.
- Supervisory clinical staff should be available 24/7 to respond to urgent situations

Role of allied health professionals

- Allied health professional staff should be available on-site 24 hours a day
- Allied health professionals provide recovery support services including:
  - Peer support services
  - Health education
  - Social milieu
  - Patient navigation services
  - Transition support
- Allied health professionals may also provide health education services (e.g., HIV prevention, safe sex, overdose prevention and reversal training, etc.)
- Level 3.5 programs should have policies and procedures that define activities to be performed during the night shift (e.g., hourly monitoring and documentation of patient whereabouts, coordinating response to urgent patient issues).

Supports Systems

Support systems include the following:

- Biomedical
  - A physician, or advanced practice provider, is available on-call 24/7.
  - Ability to conduct or arrange for a physical examination
  - Medical evaluation and consultation should be available 24 hours a day to support management of patients who are intoxicated or experiencing withdrawal, in accordance with treatment/transfer practice protocols and guidelines
  - Ability to conduct or arrange medical evaluations for pharmacotherapy for psychiatric and addiction medications.

        - The program should have a direct affiliation with a physician and/or advanced practice provider waivered to prescribe buprenorphine
        - The program should have a direct affiliation with an opioid treatment program (OTP)
    - Programs should seek to establish a relationship (e.g., formal MOU or informal connection) with nearby hospital(s) for coordination of care.
    - Ability to conduct or arrange for appropriate laboratory testing services.
    - Access to conduct or arrange for toxicology testing when needed (see ASAM Drug Testing Guideline)
    -
- Psychiatric
    - Psychiatric assessment, by a psychiatrist or psychiatric nurse practitioner, should be available within a time frame appropriate to the clinical severity and urgency of the need.
    - Level 3.5 programs should have an established relationship with the local behavioral health crisis system, if available, to respond to urgent mental health needs.
    - Level 3.5 programs should have established relationships with local mental health treatment providers to support access to routine psychiatric consultation and to facilitate mental health care appointment access when needed. A psychiatric assessment is available within 7 days.
- Psychological
    - Specialized consultation for psychological and cognitive problems should be available through consultation or referral when needed.
- Level 3.5 programs should have established relationships with more and less intensive levels of care.
- Ability to provide transportation for off-site clinical or recovery support services when needed
- Level 3.5 programs should have established policies and procedures for responding to urgent medical and psychiatric needs 24 hours a day, 7 days a week, including:
    - When to engage the on-call medical provider
    - When to call 911
    - When to call 988

Assessment and Treatment Planning

- Assessment and treatment planning should be sensitive to trauma and designed to prevent re-traumatization.
- A multidimensional level of care assessment should be conducted at admission to determine the recommended level of care
    - For patients who are intoxicated or experiencing withdrawal the assessment should be reviewed by a physician prior to admission.
- A physical examination should be conducted or reviewed by a physician or advanced practice provider within 72 hours of admission.
    - If self-administered withdrawal management medications are to be used, the patient should have a physical examination prior to admission.
- A full biopsychosocial treatment planning assessment should be conducted and used to develop an initial individualized treatment plan within 3 days of admission.
- An addiction-focused history should be obtained as part of the initial treatment planning assessment.

- Individualized treatment plans should include problem identification in each dimension and development of treatment goals and measurable treatment objectives, as well as activities designed to meet those objectives.
    - Be developed in collaboration with the patient, reflects the patient's personal goals, and incorporates the patient's strengths.
    - Reflect case management conducted by on-site staff
    - Address any mental health treatment needs identified, including:
        - Services to be delivered by the program's treatment team
        - Services to be delivered by external providers.
    - Reflect coordination of:
        - coordination of addiction treatment, physical health care (obstetrics and gynecology, infectious disease, cardiology, etc.), mental health care, and recovery support service needs
        - coordination of care with external treatment and service providers.
- The multidisciplinary treatment team should meet at least weekly to discuss patient progress and adjust the treatment plan as needed.
    - A progress note should be added to the clinical record weekly that outlines progress, concerns, and any planned changes to clinical care
- Formal reassessment and treatment plan updates should occur at least monthly, including:
    - Determination of whether the patient is progressing appropriately and if a higher or lower intensity of treatment may be needed
    - Signatures from key clinical staff
- Transfer planning should begin at admission and address:
    - Addiction treatment service needs
    - Physical health service needs
    - Mental health service needs
        - When individuals with co-occurring disorders are transferred to another level of care, they should be transferred to a setting that can provide integrated care for their continuing SUD and MH needs whenever possible.
    - Recovery support service needs
    - Continued access to medications
    - Overdose prevention, including access to naloxone
    - For out of state patients, transfer planning should plan for appropriate care in the patient's local community

Services

Level 3.5 programs directly provide the following services:

- 20 or more hours of clinical services per week including:
    - Daily clinical services designed to improve the patient's ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance, and punctuality.
    - Clinical program activities designed to stabilize and maintain the stability of the patient's substance use disorder symptoms, and to help him or her develop and apply recovery skills, such as:
        - relapse prevention
        - exploring interpersonal choices
        - development of a social network supportive of recovery.

    - These services should be provided in an amount, frequency, and intensity appropriate to individual patient needs as determined by the multidimensional assessment
- Clinically managed residential withdrawal management [Note: this is equivalent to the services provided by Level 3.2 WM in the 3rd edition of *The ASAM Criteria.*]. Level 3.5 programs should be able to provide:
    - 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, who do not need medically monitored or managed care (as determined through a medical evaluation).
    - Supervision of self-administered medications for the management of withdrawal in accordance with a physician prescription
    - Use of established clinical protocols to determine if a patient requires medically monitored or managed care and transfer to a more appropriate level of care.
    - Psychosocial services designed to support completion of the withdrawal management process
- Structured services should be available 7 days per week, including daily activities designed to allow patients to learn and practice prosocial behaviors
- Care coordination to manage engagement and track progress when a patient is receiving concurrent services from another medical provider
- Management of patient referrals and transfers to other levels of care when needed
    - For patients who are from another region or state, management of transfer to a program in their local community
- Care coordination to manage engagement and track progress when a patient is receiving concurrent services from an external treatment or service provider, including
    - Data sharing as needed to support effective coordination of care (at minimum monthly, to support the formal treatment plan review)
    - Monitoring of the patient's adherence in taking any prescribed medications, and/or any permitted over the counter (OTC) medications or supplements.
- Staff supervision and monitoring as outlined in the Patient Supervision section above
- All treatment services should be trauma informed responsive and delivered with cultural humility,
- All services should be designed with the expectation that many if not most patients will have co-occurring mental health conditions (e.g., individual and group interventions should encourage patients to address both mental health-related concerns as well as SUD-related concerns)
    - The program should provide symptom management support for both SUD and co-occurring mental health conditions
    - Patient mental health concerns should be treated concurrently by the program or through coordination with external providers
- The program should coordinate care with any external mental health care providers involved in the patient's care, with appropriate patient consent:
    - At admission, transitions in level of care, and discharge
    - As needed based to support effective care coordination for the individual patient (at minimum monthly)
- The program's services should be designed to provide a welcoming environment for individuals with co-occurring mental health conditions, where patients feel safe addressing their mental health concerns and experiences.

Medical

- As discussed in the Staff Section, Level 3.5 programs do not need to have medical staff. However, the program should provide coordinated access to physician(s) and/or advanced practice providers with the scope of practice to provide the following services:
    - physical examination
    - laboratory testing
    - Addiction pharmacotherapy
    - Psychiatric pharmacotherapy
    - Medication management
    - Toxicology services (Random drug screening to shape behavior and reinforce treatment gains, as appropriate to the patient's individual treatment plan).
        - CLIA waived point of care testing is available on site.
        - Access to confirmatory testing should be available when needed (see ASAM Drug Testing Guideline)
- Level 3.5 programs should also:
    - Arrange appointments with external medical providers when needed
    - Advocate with external medical providers as needed to ensure that significant client health issues are addressed in a timely manner
    - Coordinate with prescribers of addiction and psychiatric pharmacotherapies
    - Coordinate care with other medical providers concurrently providing care for issues that may impact the patient's prognosis or recovery
- Point of contact breath alcohol testing should be available on site
    - A physician or advanced practice provider should develop the program's policies and procedures regarding interpretation of breath alcohol testing results, including when to contact a medical professional.
- Point of care pregnancy testing should be available on site

Psychosocial services

Level 3.5 programs should directly provide psychotherapeutic and psychoeducational services tailored to the needs of the individual, as determined based on ASAM Criteria Treatment Planning Assessment. See the Psychosocial Services Section for details.

Recovery support services

Level 3.5 programs should directly provide:

- Planned community reinforcement designed to foster prosocial values and milieu or community living skills
- A therapeutic milieu including support, structure, and consistency
- Transfer planning, including warm handoffs

In addition, these programs should provide the following recovery support services either directly or through formal affiliation with external service providers:

- Assessment of recovery support service needs
- Development of an individualized recovery plan
- Peer-support specialist services, including:
    - Recovery coaching

    - Recovery plan development
    - Recovery resource navigation (i.e., supporting connection with other recovery resources)
    - Ally advocacy (i.e., advocating for the patient as needed with social service organization and professional services to address healthcare, employment, housing, education, and other needs)
- Support developing and practicing skills of daily living, including:
    - Transportation skills
    - Health and healthcare navigation
    - Self-care (healthy living and other activities to promote personal wellbeing)
    - Parenting
    - Financial management
    - Nutrition
- Patient navigation services for patients who need concurrent treatment with external providers
- Support accessing mutual help programs (e.g., support finding appropriate programs, identifying transportation options, etc.)
- Assistance accessing social services for housing, nutritional assistance, health insurance, etc.
- Assistance with transportation to necessary services (e.g., community rides to mutual help meetings, help identifying public transit options and obtaining passes)
- Support coordinating with social service agencies (e.g., Children, Youth & Family Services, criminal justice agencies, etc.)
- Assistance identifying and obtaining community services or supports to address potential impediments to recovery (e.g., legal services, educational services, recovery housing, childcare services, jobs training, parenting training, financial training, etc.)
- Assistance identifying and accessing community harm reduction services

Documentation

See the Universal Documentation Standards.

Level 3.7 – Medically Managed Intensive Residential

Level of Care Description

Level 3.7 programs provide medically managed intensive residential treatment focused on the management of withdrawal and biomedical comorbidities for patients who need 24-hour observation, monitoring, and treatment, but do not require the full resources of an acute care hospital.

Level 3.7 programs provide coordinated services delivered by medical, nursing, and clinical professionals in a permanent residential facility. Medical services are delivered under a defined set of physician-approved policies and physician-managed procedures or medical protocols.

Level 3.7 programs should also be able to provide all the services of a Level 3.5 program either directly or through formal affiliations with other programs.

Dimensional Drivers

- Dimension 1
- Dimension 2
- Dimension 5

Setting

Level 3.7 program services are offered in appropriately licensed facilities located in community settings.

The facility should incorporate space for:

- Medical and nursing services
- Counseling services
- Group meetings
- Therapeutic activities
- Patient rest
- Patient privacy
- Meals
- Hygiene

The nursing station should be in close proximity to the patient area to allow nursing staff to respond to medical needs or instability in a safe and timely manner.

- Patients should be able to immediately alert staff to an emerging issue

The setting should provide an environment that:

- Is safe from substances, paraphernalia, and weapons.
    - Searches of patients and their belongings that are necessary to provide an environment free from substances, paraphernalia, and weapons should utilize trauma-informed practices and preserve patient dignity and privacy
- Provides privacy and security of personal belongings

Patient Supervision

- Level 3.7 programs should provide 24-hour supervision of patients.
    - Staff should verify the location/wellness of each patient at least once every hour.
    - Programs should have policies and procedures in place that address when patients may need to be monitored more frequently (e.g., when the patient is at risk for self-harm).
- At this level of care, patients should not leave the program premises except under limited circumstances, such as specialty medical or diagnostic appointments, or medical or psychiatric emergencies.
- Program staff should provide continuous monitoring of patients when they are off-site to prevent risky behaviors and address any instability or other issues that may arise in a safe and timely manner

Staff

Level 3.7 programs are staffed by an interdisciplinary team of appropriately trained and credentialed and/or licensed medical and clinical professionals, including:

- A medical director.
    - The medical director for a Level 3.7 program should ideally be board certified or board eligible in addiction medicine or addiction psychiatry.
        - If a qualified board certified or board eligible physician cannot be found, a physician with at least 5 years of experience in addiction treatment who meets the competencies described in [section x] may serve as medical director. In these instances, the medical director should have:
            - An established mentor who is board certified in addiction medicine or addiction psychiatry
            - A written plan to obtain board certification within 5 years.
- Physician(s) and/or advanced practice provider(s) with controlled substance prescribing authority and waivered to prescribe buprenorphine
- Nurses with the scopes of practice necessary to provide the services outlined in the *Assessment and Treatment Planning* and *Services* sections below.
- Clinical professionals such as counselors, social workers, and psychologists
- A Program Director with, at minimum, a master's degree, and 5 years of experience in addiction treatment

Staffing Levels

Programs should maintain sufficient staff to maintain integrity of care for the range and severity of problems that may be addressed at Level 3.7.

- The program should identify the positions that are critical for running the program and the level of staffing needed to safely operate the program.
    - Level 3.7 programs must be able to provide 24-hour nursing care.
    - Critical positions include nurse supervisors and sufficient nursing staff to provide 24-hour coverage with the minimum staff to patient ratio needed to safely manage the patient population of the program.
    - The program director and medical director are also critical positions in a Level 3.7 program.
    - Programs also need sufficient clinical staff to meet patient psychosocial treatment needs.
    - Supervisory staff should be available 24/7 to respond to urgent situations
- Level 3.7 programs should have at least one nurse for every 7 patients.
- Staff trained in de-escalation should be awake and available on site 24/7

Role of the addiction specialist physician:

As discussed above, the medical director for a Level 3.7 program should ideally be an addiction specialist physician or eligible for specialty board certification.

Medical staff

- The medical director:
    - Develops the program's admission criteria
    - Develops clinical protocols

    - Directs patient care
    - Ensures the adequacy of individual treatment plans
    - Ensures daily medical coverage to meet patient needs.
    - Determines the credentials required of other physicians and advanced practice providers serving the program
    - Oversees the quality of treatment delivered by the program
    - Is ultimately responsible for the care delivered
    - Monitoring the care delivered by other physicians or advanced practice providers that serve the program
- Medical staff should be available on site or via telehealth 24/7.
- Physicians or advanced practice providers should be readily available to:
    - Review admission decisions within 24 hours of admission to confirm the appropriateness of the LOC placement.
    - Assess and treat substance withdrawal and co-occurring biomedical conditions
    - Monitor patient response to treatment
    - Perform physical examinations for all patients admitted to this level of care within 24 hours of admission (or earlier, if medically necessary).
    - Provide on-site monitoring of care and further evaluation on a daily basis.
    - Provide clinical consultation and supervision for biomedical, psychiatric, and cognitive problems.
- Medical staff are responsible for:
    - Coordinate care with external prescribers of controlled substances
    - Assume management of all controlled substance prescriptions from external prescribers
    - Make final determinations regarding the medication treatment plan, including when to taper or discontinue medications prescribed prior to admission
- Other than the medical director, physicians and advanced practice providers do not need to be certified as addiction specialist physicians and nurses do not need to be certified as addiction nurses, but training and experience in assessing and managing intoxication and withdrawal syndromes are necessary
- Advanced practice providers should have ready access to the medical director or another addiction specialist physician at all times.

Nursing and Other Medical Staff (RN, LPN, paramedic, etc.)

- A registered nurse or other licensed and credentialed nurse is available to:
    - Conduct a nursing assessment on admission.
    - Monitor patient progress and administer medication
    - Administer validated withdrawal severity assessments.
    - Provide medication management services
    - Administer medications in accordance with physician orders, on an hourly basis, if needed
- The level of nursing care is appropriate to the severity of patient needs.
- A nursing supervisor is available 24/7 to respond to urgent situations.

Clinical staff

Psychosocial services, delivered by counselors, psychologists, and/or social workers, should be available through the Level 3.7 program directly or through directly affiliated providers or programs.

- Clinical staff:
  - Provide a planned regimen of professionally directed evaluation, psychotherapy, psychoeducation, and coordinate the delivery of recovery support services for patients and their support systems.
  - Assess and treat substance use and other addictive disorders.
  - Assess and support management of cooccurring mental health conditions.
  - Support for treatment planning [Note: at this level of care treatment planning should be led by medical staff.]
- A clinical supervisor should be on-call 24/7 to respond to urgent situations.
- Mental health treatment providers should be part of the multidisciplinary team.
  - On the multidisciplinary team, staff members with more training and experience with mental health care should support their team members to provide effective, integrated co-occurring competent care.
- It is recommended that programs have dedicated staff responsible for care coordination.
- Clinical staff qualified to assess and manage mental health conditions should be on site or on call at all times. [Note: management includes determining appropriate steps for addressing mental health problems including symptom management support, further assessment, referral, crisis services, transfer, etc.]

Allied Health Staff

- Level 3.7 programs may be staffed with appropriately licensed peer support specialists and other allied health staff

Support Systems

Support systems include the following:

- Biomedical
  - Direct affiliation (e.g., MOU) with a nearby hospital to support effective coordination of care
  - Ability to arrange for specialized clinical consultation for biomedical and cognitive problems when needed.
    - All programs should have a formal relationship with an infectious disease specialist.
    - Programs should consider local and treatment community needs when determining other need for direct affiliations. (For example, if renal failure is common in the patient population, consider a formal relationship with a nearby dialysis center to support effective coordination of care)
  - The program should have established relationships with obstetricians to support coordination of care for patients who are pregnant or postpartum.
- Psychiatric
  - Psychiatric assessment, by a psychiatrist or psychiatric nurse practitioner, is available by telephone within a time frame appropriate to the severity and urgency of the need.
    - If the initial assessment occurs via telehealth, video telehealth should be used
    - Follow up assessments may be audio only, when appropriate (as determined by the provider)
  - The program should have an established relationship with the local behavioral health crisis system, if available, to respond to urgent mental health needs.

    - The program should have established relationships with local mental health treatment providers to support access to routine psychiatric consultation and to facilitate mental health care appointment access when needed.
- Psychological
    - If psychotherapeutic services are not provided by program staff, they should be available on-site through a directly affiliated treatment providers or programs.
    - Specialized consultation for psychological and cognitive problems should be available through consultation or referral when needed.
- Established relationships with more and less intensive levels of care.
- Direct affiliation with OTP(s), if available within the local payment geography
- Level 3.7 programs should be able to provide transportation services for patients who need to access specialty healthcare services that are not available in the 3.7 program.

Assessment and Treatment Planning

In Level 3.7 programs:

- Assessment and treatment planning should be sensitive to trauma and designed to prevent re-traumatization.
- A comprehensive nursing assessment should be performed at the time of admission.
- An addiction-focused history should be obtained as part of the initial assessment and conducted or reviewed by a physician or advanced practice provider during the admission process.
- A comprehensive physical examination should be conducted by a physician or advanced practice provider within 24 hours of admission.
    - If Level 3.7 services are step-down services from Level 4-WM, records of a physical examination within the preceding 7 days should be evaluated by a physician or advanced practice provider within 24 hours of admission.
- Sufficient biopsychosocial screening and assessments of the patient's substance use disorder(s) and co-occurring disorder(s), should be conducted to determine the appropriate recommended level of care and to develop an individualized care plan.
- An individualized treatment plan should be developed, and should include problem identification in each dimension, treatment goals, measurable treatment objectives, and activities designed to meet those objectives. The plan should:
    - Be developed in collaboration with the patient, reflects the patient's personal goals, and incorporates the patient's strengths.
    - Reflect case management conducted by on-site staff
    - Address any mental health treatment needs identified, including:
        - Services to be delivered by the program's treatment team
        - Services to be delivered by external providers.
    - Reflect coordination of:
        - addiction treatment, physical health care (obstetrics and gynecology, infectious disease, cardiology, etc.), mental health care, and recovery support service needs
        - coordination of care with external treatment and service providers.
- Serial medical assessments including appropriate measures of withdrawal should be conducted as needed.
- A physician or advanced practice provider should assess patient progress at least daily

- Treatment plan reviews should be conducted daily, at minimum.
- Transfer planning should begin at admission and address
    - Addiction treatment service needs
    - Physical health service needs
    - Mental health service needs
        - When possible, patients with cooccurring disorders should be transferred to a setting that can provide integrated care for their continuing SUD and MH needs
    - Recovery support service needs
    - Continued access to medications
    - Overdose prevention and harm reduction
    - For out of state patients, transfer planning should plan for appropriate care in the patient's local community
- Referral arrangements should be made as needed.

Services

- Level 3.7 programs directly provide:
    - Daily medical interventions including:
        - Nursing and medical monitoring for stabilization of acute withdrawal, biomedical and psychiatric conditions.
        - Psychosocial services to encourage engagement in ongoing treatment
- Such services should be provided in an amount, frequency, and intensity appropriate to the patient's individual needs and level of function as determined by the multidimensional assessment.
- All treatment services should be trauma informed responsive and delivered with cultural humility,
- All services should be designed with the expectation that many if not most patients will have co-occurring mental health conditions
    - Patient mental health concerns should be treated concurrently by the program or through coordination with external providers
    - The program should provide symptom management support for both SUD and co-occurring mental health conditions
- The program should coordinate care with any external mental health care providers involved in the patient's care, with appropriate patient consent:
    - At admission and discharge
    - As needed based to support effective care coordination for the individual patient
- Care coordination with other providers involved in the patient's care
    - The staff member responsible for care coordination for a given patient should be clearly documented.
    - If psychosocial services are provided through affiliated programs, there should be daily touch bases regarding the care of each patient.
- Management of patient transfers to other levels of care when needed, including:
    - Care coordination
    - Data sharing
    - For patients who are from another region or state, management of transfer to a program in their local community

- The program's services should be designed to provide a welcoming environment for individuals with co-occurring mental health conditions, where patients feel safe addressing their mental health concerns and experiences.

Medical and Nursing

The following medical and nursing services should be available in Level 3.7 programs:

- Nursing assessment conducted at admission, including:
  - vitals
  - history of present illness
  - baseline evaluation of withdrawal severity and risks
  - medical history including assessment of current biomedical issues and medication review.
- Comprehensive medical history and physical examination performed within 24 hours of admission
- Medication management, including regular monitoring of the patient's adherence to prescribed medications.
- Hourly nurse monitoring of the patient's progress and medication administration are available, if needed.
- Daily treatment services to manage acute symptoms of the patient's biomedical, substance use, or mental disorder(s).
- Management of chronic physical and mental health conditions
- Prescribing, with essential medications on site.
  - The program should have policies and procedures that define essential medicines based on current standards of clinical practice and that ensure these medications are stocked
- Residential intoxication and withdrawal management services, including:
  - Medical monitoring and management of signs and symptoms of intoxication and withdrawal
  - Assessment with validated scales (e.g., COWS, CIWA-Ar, RASS) to determine the severity of withdrawal when appropriate
  - Medication based methods of withdrawal management that are appropriate for the severity of withdrawal or anticipated withdrawal
  - Non-medication-based methods of withdrawal management, when indicated, including but not limited to:
    - Informing patients of what to expect over the course of treatment.
    - Offering reassurance
    - Providing a quiet environment
    - Educating patients on the importance of adequate hydration and nutrition
- Toxicology services as appropriate to the patient's individual treatment plan, following appropriate standards such as those defined in ASAM's Appropriate Use of Drug Testing in Clinical Addiction Medicine Consensus Document
  - Toxicology testing should be conducted based on patient specific orders from the responsible physician.
  - Toxicology results should be reviewed and interpreted by a physician or advanced practice provider for whom interpretation of toxicology results is in their scope of practice.

    - Program should have written policies regarding how to respond to unexpected toxicology test results, including modification of the treatment plan.
- Addiction pharmacotherapies
    - Patient education regarding available pharmacotherapies, currently including those available to treat opioid use disorder, alcohol use disorder, and tobacco use disorder
    - Access to all FDA approved medications for the treatment of SUDs
        - Access to methadone is not required if there are no OTPs in the local payment geography
    - Initiation of addiction pharmacotherapies in alignment with current best practices, such as those established in the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, the APA Practice Guideline on Treatment of Alcohol Use Disorder, and ASAM's clinical guidance on Integrating Tobacco Use Disorder Interventions in Addiction Treatment.
- Residential management of biomedical conditions, including:
    - Sliding scale diabetes management
    - Basic wound care
    - Infectious disease management
        - Screening and assessment for STI and bloodborne infections
        - Initiation of treatment or coordinated referral to treatment with care coordination
    - Coordination of pregnancy or postpartum care
    - Coordination of care for biomedical conditions for which the patient is receiving treatment from an external provider, including pain

Biomedical capabilities:

- Intravenous (IV) and injectable medications
    - Ability to use PICC lines
- IV fluids
- Electrocardiogram (ECG) (with a 3-lead rhythm strip at minimum) [Note: The rationale for ECG capacity is to determine the level of risk and need for Level 4, not for diagnosis or disease management. It is also important for monitoring for QTC prolongation in patients on methadone.]
- Pulse oximetry
- Bottle oxygen
- Vacuum assisted wound closure
- Basic first aid
- Automated external defibrillator (AED)
- Assistance with mobility
- Blood pressure monitor
- Injectable epinephrine available on site
- Naloxone available on site
- Phlebotomy
- Laboratory services
    - Access to laboratory services 5 days per week
    - Access to laboratory that conducts blood cultures
- Toxicology services
    - CLIA waived point of care testing is available on-site.

    - Access to confirmatory testing should be available
    - Point of contact breath alcohol testing
- Point of care pregnancy testing
- Ability to administer vaccines on site, including for hepatitis A and B, influenza, Covid, etc.
- Initiation and management of preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP), including education regarding PrEP and PEP

Psychosocial Services

- Level 3.7 programs should make available psychosocial services either directly or through affiliated providers or program(s). These services should be tailored to the needs of the individual as determined based on ASAM Criteria Assessment. See the Psychosocial Services Section for details.
- Patients should be excused from participating in psychotherapeutic, psychoeducational, and recovery support services if acute withdrawal or biomedical conditions prevent effective participation.
- Once stabilized, patients should be seamlessly enrolled in ongoing treatment services.
    - Patients who need extended Level 3.7 services but can benefit from psychotherapy and meet the admission criteria for Level 2.5 or 3.5 should receive 20+ hours of intervention services per week with a focus on psychotherapy
    - Patients who need extended Level 3.7 services but can benefit from psychotherapy and meet the admission criteria for Level 2.1 or 3.1 should receive 9+ hours of intervention services per week with a focus on psychotherapy

Recovery Support Services

Level 3.7 programs should directly provide:

- Transfer planning, including warm handoffs

In addition, these programs should provide the following recovery support services either directly or through formal affiliation with external service providers:

- Assessment of recovery support service needs
- Development of an individualized recovery plan
- Introduction to the concepts of planned community reinforcement, therapeutic milieu, and social milieu in preparation for treatment in less intensive levels of care
- Peer-support specialist services, including:
    - Recovery coaching
    - Recovery plan development
    - Recovery resource navigation (i.e., supporting connection with other recovery resources)
    - Ally advocacy (i.e., advocating for the patient as needed with social service organization and professional services to address healthcare, employment, housing, education, and other needs)
- Support developing and practicing skills of daily living, including:
    - Transportation skills
    - Health and healthcare navigation
    - Self-care (healthy living and other activities to promote personal wellbeing)
    - Parenting
    - Financial management

    - Nutrition
- Patient navigation services for patients who need concurrent treatment with external providers
- Support accessing mutual help programs (e.g., support finding appropriate programs (including online), identifying transportation options, etc.)
- Assistance accessing social services for housing, nutritional assistance, health insurance, etc.
- Assistance with transportation to necessary services (e.g., community rides to mutual help meetings, help identifying public transit options and obtaining passes)
- Support coordinating with social service agencies (e.g., Children, Youth & Family Services, criminal justice agencies, etc.)
- Assistance identifying and obtaining community services or supports to address potential impediments to recovery (e.g., legal services, educational services, recovery housing, childcare services, jobs training, parenting training, financial training, etc.)
- Assistance identifying and accessing community harm reduction services

Documentation

See the Universal Documentation Standards

Level 4.0 – Medically Managed Intensive Inpatient

Level of Care Description

Level 4 services are appropriate for patients whose acute intoxication, withdrawal, biomedical, psychiatric and/or cognitive conditions are so severe that they require 24-hour medically directed evaluation and treatment in an acute care inpatient setting.

Because Level 4 program services are the most intensive in the continuum of care, their principal focus is the stabilization of the patient and preparation for his or her transfer to a less intensive setting for continuing care.

Level 4 services may be offered in an acute care general hospital (Level 4 – General Hospital) or in an addiction treatment unit within an acute care general hospital with critical care services available on premises (Level 4 – Specialty Addiction Unit).

This section will separately outline the standards for the Level 4 – General Hospitals and Level 4 – Specialty Addiction Units

Dimensional Drivers

- Dimension 1
- Dimension 2
- Dimension 3

Setting

Level 4 program services may be offered in any appropriately licensed acute care setting. Level 4 treatment typically occurs in two types of settings:

- an acute care general hospital

- an addiction treatment unit within an acute care general hospital with critical care services available on premises

Such a program must offer medically directed acute withdrawal management and related treatment designed to alleviate acute psychiatric, cognitive, and/or biomedical conditions resulting from, or co-occurring with, a patient's substance use disorder.

Level 4 – General Hospitals

Staff

Level 4 programs should be staffed by an interdisciplinary team of appropriately trained and credentialed and/or licensed treatment professionals, available to assess and treat patients with acute needs related to substance use disorder and any cooccurring biomedical, psychiatric, or cognitive conditions. Level 4 programs provide medical management by physicians and primary nursing care 24 hours a day. Staff include:

- Physician(s) with controlled substance prescribing authority and waivered to prescribe buprenorphine
    - Advanced practice provider(s) may collaborate with physicians at this level of care and should have controlled substance prescribing authority with a waiver to prescribe buprenorphine.
- Nurses with the scopes of practice necessary to provide the services outlined in the *Assessment and Treatment Planning* and *Services* sections below.
- Clinical professionals such as counselors, social workers, and/or psychologists

Medical Staff

In all Level 4 programs:

- Physicians:
    - Should be available onsite 24 hours a day
    - Serve as active members of the care team
    - Medically manage the care of the patient and assure the quality of care
    - Are responsible for diagnosis, treatment, and treatment plan decisions (in collaboration with the patient)
    - Are responsible for determining:
        - whether and when to admit the patient
        - continuation of patient care
        - when a patient should be transferred to an intensive care unit or relevant specialty unit
        - when to transfer the patient to a less intensive level of care
- Physicians do not need to be certified as addiction specialist physicians and nurses do not need to be certified as addiction nurses, but training and experience in assessing and managing intoxication and withdrawal syndromes is necessary
- Nurses
    - A registered nurse or other licensed and credentialed nurse should be available to conduct a nursing assessment on admission and to provide primary nursing care and observation 24 hours per day.
    - The level of nursing care should be appropriate to the severity of patient needs.
    - A nursing supervisor should available 24/7 to respond to urgent situations.

Role of the addiction specialist physician:

- Level 4 programs should have an addiction specialist physician on call for consultation 24/7
- Written protocols related to the treatment of intoxication, withdrawal, and or substance use disorder should be reviewed by a physician who is board certified in addiction medicine or addiction psychiatry.

Clinical staff

- Licensed, certified, or registered clinicians should be available daily to provide assessment and case management services according to the assessed needs of the patient.
- All clinicians involved in the assessment or treatment of patients should be trained to administer and interpret validated screening tools and multidimensional assessments to determine individual patient needs.
- Clinicians who make level of care recommendations (master's level and above) should:
    - be trained to conduct and interpret a multidimensional assessment according to *The ASAM Criteria*.
    - be knowledgeable about the biological and psychosocial dimensions of addiction and other behavioral health disorders
- Clinical staff should be trained in de-escalation and other behavior management strategies for managing patients with intoxication, withdrawal, and SUD.
- Some, if not all, program staff should have sufficient cross-training to understand the signs and symptoms of psychiatric disorders and to understand and explain the uses of medications for addiction treatment and their efficacy in treating SUDs.
- A clinical supervisor should be available 24/7 to respond to urgent situations

Allied Health Staff

Level 4 programs may also be staffed with appropriately licensed peer support specialists and other allied health staff

Support Systems

Support systems include a full range of acute care services, specialty consultation, and intensive care services. The following support systems should be available in a Level 4 program:

- Psychiatric assessment should be available within a time frame appropriate to the severity and urgency of the need.
- Laboratory services should be available on site
- Toxicology services
    - CLIA waived point of care testing should be available on-site
    - Laboratory-based immunoassay testing for common drugs and drug metabolites should be available on-site.
    - Ability to conduct confirmatory testing for specialty metabolites should be available on site or through affiliation with an external laboratory
- Specialized consultation for psychological and cognitive problems should be available through consultation or referral when needed.
- Relationships with less intensive levels of care, including opioid treatment programs if available in the local payment geography, to support effective engagement in SUD treatment and care coordination upon discharge.

Assessment and Treatment Planning

In Level 4 programs, the assessment and treatment plan review include:

- A nursing assessment performed at the time of admission.
- A history and physical examination performed within 24 hours of admission
    - The extent of the exam should be determined by the treating physician based on the clinical presentation
- Appropriate laboratory and toxicology testing.
- Approval of the admission by a physician.
- Sufficient biopsychosocial screening and assessments to determine placement, and for the individualized care plan to address treatment priorities identified in each dimension.
    - Although Level 4 is specifically designed for acute conditions in Dimensions 1, 2 or 3, it also is important to assess the patient and develop a care plan for any treatment priorities identified in Dimensions 4 through 6.
    - The results of all biopsychosocial screening and assessments should be clearly communicated to the next level of care, ideally through a direct conversation between clinicians and written documentation of assessment results and treatment plans (with appropriate patient consent as required)
    - Assessment and treatment planning should be sensitive to trauma and designed to prevent re-traumatization.
    - Referral arrangements should be made as needed
- Regular re-assessments, at a frequency appropriate to the patient's level of stability and severity of illness (at minimum daily), to determine if the patient is progressing appropriately
    - Progress notes and treatment changes recorded in the treatment plan
- Skilled assessment and monitoring of any co-occurring psychiatric or cognitive disorders.
- Patient treatment plans should reflect:
    - coordination of addiction, biomedical, and mental health care
    - case management services
- Serial medical assessments including appropriate measures of withdrawal when applicable.
- Transfer planning, beginning at admission and addressing:
    - Addiction treatment service needs
    - Physical health service needs
    - Mental health service needs
        - When individuals with co-occurring disorders are transferred to another level of care, they should be transferred to a setting that can provide integrated care for their continuing SUD and MH needs whenever possible.
    - Recovery support service needs
    - Continued access to medications, including addiction pharmacotherapies
    - Overdose prevention, including access to naloxone

Services

Level 4 programs directly provide:

- Daily clinical services (provided by an interdisciplinary treatment team) to assess and address the patient's individual needs, including.
    - Nursing services
    - Medical services, including critical care services
    - Case management services

- Integrated care delivery including:
  - Coordination between relevant specialty units within the hospital
  - Care coordination with external providers involved in the patient's care
- Management of transfer to other levels of care
- For the patient with a severe comorbid psychiatric disorder, psychiatric interventions should be coordinated with intoxication, withdrawal, and/or SUD treatment services.
- For the patient with a severe comorbid biomedical disorder, biomedical interventions should be coordinated with intoxication, withdrawal, and/or SUD treatment services

Medical

Level 4 programs provide:

- Full medical acute care services
- Intensive care, as needed
- Psychiatric services
- Individualized management of all acute biomedical, psychiatric, and cognitive conditions delivered by an interdisciplinary treatment team.
- Hourly or more frequent nurse monitoring of the patient's progress and medication administration, if needed.
- Medical history and physical examination
- Diagnostic assessments
- Prescribing and medication management
- Nursing assessments conducted at admission
- Continuation of addiction pharmacotherapies, including all FDA approved medications for SUD
- Initiation of buprenorphine for opioid use disorder and other medications indicated for substance use disorders
- Inpatient intoxication and withdrawal management services, including:
  - Physician and/or nurse monitoring and management of signs and symptoms of intoxication and withdrawal
  - Assessment with validated scales (e.g., COWS, CIWA-Ar) to determine the severity of withdrawal and inform appropriate interventions
  - Medication based methods of withdrawal management that are appropriate for the severity of withdrawal or anticipated withdrawal
  - Non-pharmacological clinical support, including, but not limited to:
    - Informing patients of what to expect over the course of treatment.
    - Offering reassurance
    - Providing a quiet environment when feasible
    - Educating patients on the importance of adequate hydration and nutrition

Psychosocial Services

All Level 4 programs should provide basic psychotherapeutic and psychoeducational services including:

- Interventions designed to enhance the patient's understanding of addiction, completion of treatment at Level 4, and engagement in an appropriate level of care for continuing treatment.
- Patient and family education on withdrawal management and SUD treatment
- Coordination of engagement in psychosocial and recovery support services

Recovery Support Services

All Level 4 programs are encouraged to provide peer support services to facilitate engagement in ongoing care.

Documentation

Documentation should include:

- Scoring for withdrawal rating scale tables and flow sheets (which may include tabulation of vital signs) as needed
- Standardized SUD screening and assessment results
- Standardized mental health screening and assessment results
- Transfer plan that ideally addresses:
  - Review of the ASAM Criteria dimensions
  - Recommendations for follow-up care
  - Reasons for departures from recommendations if applicable
  - Program(s) that the patient will transfer to
  - Required medications and how patients will maintain access to medications during the transfer
  - Follow up plan to ensure engagement in care and documentation of follow ups

Level 4 – Addiction Specialty Unit

Level of Care Description

Level 4 services can also be provided by an addiction treatment unit within an acute care general hospital with critical care services available on premises.

Since many hospitals around the country do not have addiction specialty units or addiction medicine specialists on staff these programs should ideally provide addiction specialist consulting services to community and critical access hospitals, when needed.

Dimensional Drivers

- Dimension 1
- Dimension 2
- Dimension 3

Staff

Level 4 specialty programs are staffed by an interdisciplinary team of appropriately trained and credentialed and/or licensed treatment professionals, available to assess and treat patients with acute needs related to substance use disorder and any cooccurring biomedical, psychiatric, or cognitive conditions.

- Level 4 programs provide medical management by physicians and primary nursing care 24 hours a day.
- The medical director should be board certified in addiction medicine or addiction psychiatry
- Staff should be knowledgeable about the biopsychosocial dimensions of addiction as well as biomedical, psychiatric, and cognitive disorders

Although treatment in Level 4 is focused on substance use and other addictive disorders, the skills of the interdisciplinary team and the availability of support services, including medical and psychiatric consultation services, allow the joint treatment of any co-occurring biomedical or psychiatric conditions that need to be addressed.

Staff includes:

- A Medical Director who is Board certified in addiction medicine or addiction psychiatry
- Physician(s) with controlled substance prescribing authority and waivered to prescribe buprenorphine
    - Advanced practice provider(s) may support physicians at this level of care and should have controlled substance prescribing authority with a waiver to prescribe buprenorphine.
- Nurses with the scopes of practice necessary to provide the services outlined in the Treatment section below.
- Clinical professionals such as counselors, social workers, and/or psychologists with the scopes of practice necessary to provide the services outlined in the Treatment section below

Staff trained in de-escalation should be awake and available on site 24/7.

Staff qualified to assess and manage mental health conditions should be on site or on call 24/7. [Note: management includes determining appropriate steps for addressing mental health problems including symptom management support, further assessment, referral, crisis services, transfer, etc.]

Medical staff

In Level 4 specialty programs:

- The medical director:
    - Develops the program's admission criteria
    - Develops clinical protocols
    - Directs patient care
    - Ensures the adequacy of individual treatment plans
    - Ensures daily medical coverage to meet patient needs.
    - Determines the credentials required of other physicians and advanced practice providers serving the program
    - Oversees the quality of treatment delivered by the program
    - Is ultimately responsible for the care delivered
- Physicians other than the medical director do not need to be certified as addiction specialist physicians and nurses do not need to be certified as addiction nurses, but training and experience in assessing and managing intoxication and withdrawal syndromes is necessary
- Advanced practice providers should have ready access to the medical director or another addiction specialist physician at all times.
- Nursing staff

  - Should meet the core competencies outlined in the *Addiction Nursing Competencies: A Comprehensive Toolkit for the Addictions Nurse*
  - A registered nurse or other licensed and credentialed nurse should be available to conduct a nursing assessment on admission and to provide primary nursing care and observation 24 hours per day.
  - The level of nursing care should be appropriate to the severity of patient needs.
  - A nursing supervisor should be available 24/7 to respond to urgent situations
- Physicians and advanced practice providers should:
  - Be available onsite 24 hours a day
  - Serve as active members of the care team
  - Medically manage the care of the patient and assure the quality of care
  - Be responsible for diagnosis, treatment, and treatment plan decisions (in collaboration with the patient) for acute intoxication, withdrawal, SUD, and co-occurring biomedical, psychiatric, and cognitive conditions
  - Determine:
    - whether and when to admit the patient
    - continuation of patient care
    - when to transfer the patient to a less intensive level of care

Role of the addiction specialist physician:

If Level 4 is a specialty addiction unit:

- An addiction specialist physician should serve as the medical director.
- An addiction specialist physician should oversee and deliver direct care of patients.
  - Other physicians and advanced practice providers can support and extend the capabilities of the addiction specialist physician; however, they should not replace the role of the addiction specialist physician in direct patient care.
- Written protocols related to the treatment of intoxication, withdrawal, and or substance use disorder should be reviewed and approved by the medical director.

Clinical staff

In Level 4 specialty programs:

- Appropriately credentialed clinical staff (i.e., counselors, social workers, and/or psychologists) should be available at least 12 hours per day to provide:
  - Assessment
  - Support for treatment planning [Note: at this level of care treatment planning should be led by medical staff.]
  - A planned regimen of professionally directed psychosocial services
  - Case management
  - Coordination of recovery support services for patients and their families.
  - Assessment and support for management of cooccurring mental health conditions
- Mental health treatment providers should be part of the multidisciplinary team.
  - On the multidisciplinary team, staff members with more training and experience with mental health care should support their team members to provide effective, integrated co-occurring competent care
- Clinical staff should have specialized training in behavior management techniques and evidence-based psychotherapeutic and psychoeducational practices aligned with their scope of practice.

- A clinical supervisor should be on-call 24/7 to respond to urgent situations.
- All clinicians involved in the assessment or treatment of patients should be trained to administer and interpret validated screening tools and multidimensional assessments to determine individual patient needs.
- Clinicians (master's level and above) who make level of care recommendations should be trained to conduct and interpret the multidimensional assessment according to *The ASAM Criteria*.
- Some, if not all, program staff should have sufficient cross-training to understand the signs and symptoms of psychiatric disorders and to understand and explain the uses of medications for addiction treatment and their efficacy in treating SUDs.
- A clinical supervisor is available 24/7 to respond to urgent situations
- It is recommended that programs have dedicated staff responsible for care coordination

Allied Health Staff

Level 4 programs may also be staffed with appropriately licensed peer support specialists and other allied health staff.

Support Systems

Support systems include a full range of acute care services, specialty consultation, and intensive care services. The following support systems should be available in a Level 4 specialty program:

- Psychiatric assessment should be available by within a time frame appropriate to the severity and urgency of the need.
- Laboratory services available on site
- Toxicology services
    - CLIA waived point of care testing available on-site
    - Laboratory-based immunoassay testing for common drugs and drug metabolites available on-site.
    - Ability to conduct confirmatory testing for specialty metabolites available on site or through affiliation with an external laboratory
- Specialized consultation for psychological and cognitive problems available through consultation or referral when needed.
- Established relationships with less intensive levels of care, including opioid treatment programs if available in the community, to support effective engagement in SUD treatment and care coordination upon discharge.
- Established relationships with less intensive levels of care

Assessment and Treatment Planning

In Level 4 specialty programs:

- A nursing assessment should be performed at the time of admission.
- A history and physical examination should be performed within 24 hours of admission
    - The extent of the exam should be determined by the treating physician based on the clinical presentation
- A physician should review and approve the admission.
- Sufficient biopsychosocial screening and assessments should be conducted to determine placement, and for the individualized care plan to address treatment priorities identified in each dimension.

  - Although Level 4 is specifically designed for acute issues in Dimensions 1, 2 or 3, it also is important to assess the patient and develop a care plan for any treatment priorities identified in Dimensions 4 through 6.
  - The results of all biopsychosocial screening and assessments should be clearly communicated to the next level of care, ideally through a direct conversation between clinicians and written documentation of assessment results and treatment plans (with appropriate patient consent as required)
  - Referral arrangements should be made as needed.
- Assessment and treatment planning should be sensitive to trauma and designed to prevent re-traumatization.
- Individualized treatment plans should include problem identification in each dimension and development of treatment goals and measurable treatment objectives, as well as activities designed to meet those objectives. The plan should:
  - Be developed in collaboration with the patient, reflects the patient's personal goals, and incorporates the patient's strengths.
  - Reflect case management conducted by on-site staff
  - Reflect:
    - coordination of addiction treatment, physical health care (obstetrics and gynecology, infectious disease, cardiology, etc.), mental health care, and recovery support service needs
    - coordination of care with external treatment and service providers.
- Patient treatment plans should address any mental health treatment needs identified, including:
  - Services to be delivered by the program's treatment team.
  - Services to be delivered by external providers
- Regular re-assessments, at a frequency appropriate to the patient's level of stability and severity of illness (at minimum daily), to determine if the patient is progressing appropriately
  - Progress notes and treatment changes recorded in the patient record
  - Serial reassessments should include appropriate measures of withdrawal when applicable.
- Skilled assessment and monitoring should be available for any co-occurring psychiatric or cognitive disorders.
- Transfer planning should begin at admission and address:
  - Addiction treatment service needs
  - Physical health service needs
  - Mental health service needs
    - When individuals with co-occurring disorders are transferred to another level of care, they should be transferred to a setting that can provide integrated care for their continuing SUD and MH needs whenever possible.
  - Recovery support service needs
  - Continued access to medications
  - Overdose prevention, including access to naloxone

Services

Level 4 specialty programs directly provide:

- Daily clinical services (provided by an interdisciplinary treatment team) to assess and address the patient's individual needs, including:

    - Nursing services
    - Medical services
        - Access to critical care services when needed
    - Psychiatric services
    - Case management services
    - Psychotherapy
    - Psychoeducation
    - Health education
    - Services integrating family/significant others
- Integrated care delivery
- Care coordination with other providers involved in the patient's care
    - The staff member responsible for care coordination for a given patient should be clearly documented.
- Management of transfers to other levels of care
- For the patient with a severe comorbid psychiatric disorder, psychiatric interventions should be coordinated with intoxication, withdrawal, and/or SUD treatment services.
- For the patient with a severe comorbid biomedical disorder, biomedical interventions should be coordinated with intoxication, withdrawal, and/or SUD treatment services.
- All treatment services should be trauma responsive and delivered with cultural humility,
- All services should be designed with the expectation that many if not most patients will have co-occurring mental health conditions (e.g., individual and group interventions should encourage patients to address both mental health-related concerns as well as SUD-related concerns)
    - The program should provide symptom management support for both SUD and co-occurring mental health conditions
    - Patient mental health concerns should be treated concurrently by the program or through coordination with external providers
- The program should coordinate care with any external mental health care providers involved in the patient's care, with appropriate patient consent:
    - At admission and discharge
    - As needed based to support effective care coordination for the individual patient
- The program's services should be designed to provide a welcoming environment for individuals with co-occurring mental health conditions, where patients feel safe addressing their mental health concerns and experiences

Medical

Level 4 specialty programs should be able to provide:

- Full medical acute care services
- Intensive care, as needed
- Individualized management of all acute biomedical, psychiatric, and cognitive conditions delivered by an interdisciplinary treatment team.
- Hourly or more frequent nurse monitoring of the patient's progress and medication administration is available, if needed.
- Medical history and physical examination
- Medication management
- A nursing assessment conducted at admission

- Inpatient intoxication and withdrawal management services, including:
    - Physician and/or nurse monitoring and management of signs and symptoms of intoxication and withdrawal
    - Assessment with validated scales (e.g., COWS, CIWA-Ar) to determine the severity of withdrawal when appropriate
    - Medication based methods of withdrawal management that are appropriate for the severity of withdrawal or anticipated withdrawal
    - Non-pharmacological clinical support, including:
        - Informing patients of what to expect over the course of treatment.
        - Offering reassurance
        - Providing a quiet environment when feasible
        - Educating patients on the importance of adequate hydration and nutrition
- Initiation of addiction pharmacotherapies, including all FDA approved medications for SUD, in alignment with current best practices, such as those established in the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, the APA Practice Guideline on Treatment of Alcohol Use Disorder, and ASAM's clinical guidance on Integrating Tobacco Use Disorder Interventions in Addiction Treatment.
    - Protocols should address care coordination with prescribers in the community
- Continuation of addiction pharmacotherapies, including all FDA approved medications for SUD
- Patient education regarding available pharmacotherapies
- Infectious disease screening, management, and monitoring
- Education, initiation, and management of preexposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)

Psychosocial Services

In Level 4 specialty programs psychosocial services should be available at least 12 hours per day. These services should be tailored to the needs of the individual as determined based on ASAM Criteria Assessment. See the Universal Psychosocial Service Standards Section for details.

Many patients in Level 4 programs may not be ready to engage in psychosocial support services while acute problems in Dimensions 1, 2, or 3 are stabilized; However, once stabilized patients should be engaged in psychosocial treatment services.

Recovery Support Services

Level 4 specialty programs should provide peer support services to facilitate engagement in ongoing care. Recovery support services should include:

- Support for engagement in ongoing care
- Transition planning, including warm handoffs
- Harm reduction (e.g., naloxone training and access)
- Connection to appropriate community resources

Documentation

See the Universal Documentation Standards Section

Co-Occurring Enhanced Levels of Care

Co-occurring Enhanced (COE) Programs should meet all of the standards for the base level of care plus the COE standards defined below. For example, Level 3.1 COE programs should meet the standards for Level 3.1, plus the standards defined below for Level 3.1 COE.

All COE programs should routinely admit patients who have co-occurring psychiatric disorders with significant active and/or unstable symptoms or who experience significant functional impairment or disability.

In COE programs, the Treatment Planning Assessment should be an "Integrated Assessment" that integrates the ASAM Criteria Treatment Planning Assessment and a comprehensive assessment of mental health (including current status and baseline functioning) and related treatment needs including collection of information from outside sources as needed.

Level 1.5 COE

Setting

- The program should provide a welcoming and supportive environment for individuals with serious mental health conditions, including those who may experience significant active and/or unstable symptoms or significant functional impairment or disability.

Staff

- Level 1.5 COE programs should have sufficient staff with the scope of practice to assess, diagnose, and treat mental health conditions on-site during program hours of operation.
    - COE programs should generally have a higher staff to patient ratio than non-COE programs in order to provide additional flexibility and support.
- All professional and paraprofessional staff should have the competency to work with individuals who have active co-occurring psychiatric symptoms and/or psychiatric disabilities.

Support Systems

- Level 1.5 COE programs should have an established relationship with a psychiatrist or psychiatric nurse practitioner to provide:
    - Psychiatric assessments
    - Psychiatric medications and medication management
- Level 1.5 COE programs should ideally have established relationships with more intensive levels of COE care, as well as mental health treatment programs and service providers such as:
    - Intensive case management services
    - Psychosocial rehab programs
    - Mental health group residential settings
    - Mobile crisis intervention services
    - Mental health treatment centers

Assessment and Treatment Planning

- The Level 1.5 COE program's admission criteria should welcome individuals with any type of co-occurring mental illness diagnosis or symptoms, provided they meet criteria based on their level of acuity or disability as defined in the ASAM Criteria dimensional admission criteria.
- An Integrated Assessment should typically be conducted or reviewed within the first 3 visits.
- The treatment planning assessment should address:

    - Anticipated baseline acuity of psychiatric conditions and related disability based on history and current presentation
    - Symptom management and disability supports
    - Medical management of psychiatric conditions
    - Psychosocial treatment services for psychiatric conditions
- If an individual is engaged in ongoing mental health treatment by an external provider, the treatment team should share information and coordinate care with the external provider(s):
    - At admission
    - regularly during treatment (not less than monthly)
    - At discharge

Services

- If group programming is offered, it should:
    - Be flexibly designed to accommodate those who have symptoms or functional impairments/disabilities that preclude full attendance and participation.
    - Have the flexibility to provide smaller group size compared to groups in a non-COE program, when needed.
    - Deliver content in a format appropriate for individuals with challenges due to psychiatric disabilities.
- Level 1.5 COE programs should have flexibility to provide individual support to:
    - Patients who need de-escalation or reduction of stimulation (e.g., due to panic attacks or feeling overwhelmed) during program hours.
    - Patients who need additional assistance due to functional impairment.
- Level 1.5 COE programs should have educational materials available that address common serious mental health concerns. [Note that, compared to non-COE programs, COE programs should provide more guidance for managing significant acute symptoms (e.g., panic attacks, psychosis), cognitive challenge, functional disability]. Educational materials should:
    - Provide guidance for management of severe mental health symptom (e.g., psychosis)
    - Be accessible for individuals with severe cognitive disabilities or challenges due to psychiatric disabilities
    - Address how to discuss severe mental illness, mental health symptoms, and mental health treatments appropriately in the context of mutual-support and other recovery support programs.
- Level 1.5 COE programs should provide gender sensitive and responsive care.

Level 1.7 COE

Setting

- The program should provide a welcoming and supportive environment for individuals with serious mental health conditions, including those who may experience significant active and/or unstable symptom or significant functional impairment or disability

Staff

- Level 1.7 COE programs should have a psychiatrist or psychiatric nurse practitioner available during program hours of operation (on-site or via telehealth)
- All professional and paraprofessional staff should have competency to work with individuals who have active co-occurring psychiatric symptoms and/or psychiatric disabilities.
- COE programs should generally have a higher staff to client ratios than non-COE programs in order to provide additional flexibility and support.

Support Systems

- Level 1.7 COE programs should have direct affiliations with mental health treatment programs and service providers to support access to routine psychiatric consultation and to facilitate mental health care appointment access when needed, including:
    - Intensive case management services
    - Psychosocial rehab programs
    - Mental health group residential settings
    - Mobile crisis intervention services
    - Mental health treatment centers

Assessment and Treatment Planning

- The Level 1.7 COE program's admission criteria should welcome individuals with any type of co-occurring mental illness diagnosis or symptoms, provided they meet criteria based on their level of acuity or disability as defined in the ASAM Criteria dimensional admission criteria.
- An Integrated Assessment should be conducted or reviewed within the first 3 visits.
- The treatment planning assessment should address:
    - Anticipated baseline acuity of psychiatric conditions and related disability based on history and current presentation
    - Symptom management and disability supports
    - Medical management of psychiatric conditions
    - Psychosocial treatment services for psychiatric conditions
- In a COE program, if an individual is engaged in ongoing mental health treatment by an external provider the treatment team should share information and coordinate care with the external provider(s):
    - At admission
    - Regularly during treatment (not less than monthly)
    - At discharge

Services

- Medical management of psychiatric conditions
    - In Level 1.7 COE programs, a psychiatrist or psychiatric nurse practitioner should be available to make medication adjustments weekly (on-site or via telehealth).
- If any group programming is offered, it should:
    - Be flexibly designed to accommodate those who have symptoms or functional impairments/disabilities that preclude full attendance and participation
    - Have the flexibility to provide smaller group size compared to groups in a non-COE program, when needed.
    - Deliver content in a format appropriate for individuals with challenges due to psychiatric disabilities.
- Level 1.7 COE programs should have flexibility to provide individual support to:
    - Patients who need de-escalation or reduction of stimulation (e.g., due to panic attacks or feeling overwhelmed) during program hours.
    - Patients who need additional assistance due to functional impairment.
- Level 1.7 COE programs should have educational materials available that address common serious mental health concerns. [Note that, compared to non-COE programs, COE programs

should provide more guidance for managing significant acute symptoms (e.g., panic attacks, psychosis), cognitive challenge, functional disability]. Educational materials should:
    - Provide guidance for management of severe mental health symptoms
    - Be accessible for individuals with severe cognitive disabilities or challenges due to psychiatric disabilities
    - Address how to discuss severe mental illness, mental health symptoms, and mental health treatments appropriately in the context of mutual-support and other recovery support programs.
- Level 1.7 COE programs should provide gender sensitive and responsive care.

Level 2.1 COE

Setting

- The program should provide a welcoming and supportive environment for individuals with serious mental health conditions, including those who may experience significant active and/or unstable symptom or significant functional impairment or disability.

Staff

- A clinical supervisor qualified to assess and treat mental health problems should be on-site or on-call during program hours of operation.
- Level 2.1 COE programs should have sufficient staff with the scope of practice to assess, diagnose, and treat mental health conditions on site during hours of operation
- All professional and paraprofessional staff should have competency to work with individuals who have active, unstable co-occurring psychiatric symptoms and/or severe psychiatric disabilities.
- COE programs should generally have a higher staff to patient ratio than non-COE programs in order to provide additional flexibility and support.

Support Systems

- Level 2.1 COE programs should have direct affiliations with mental health treatment programs and service providers including:
    - Intensive case management services
    - Psychosocial rehab programs
    - Mental health group residential settings
    - Mobile crisis intervention services
    - Mental health treatment centers

Assessment and Treatment Planning

- The Level 2.1 COE program's admission criteria should welcome individuals with any type of co-occurring mental illness diagnosis or symptoms, provided they meet criteria based on their level of acuity or disability as defined in the ASAM Criteria dimensional admission criteria.
- An Integrated Assessment should be conducted or reviewed within 5 days of admission.
- The treatment planning assessment should address:
    - Anticipated baseline acuity of psychiatric conditions and related disability based on history and current presentation
    - Symptom management and disability supports

- Medical management of psychiatric conditions
- Psychosocial treatment services for psychiatric conditions

- In a COE program, if an individual is engaged in ongoing mental health treatment by an external provider the treatment team should share information and coordinate care with the external provider(s):
  - at admission
  - regularly during treatment (not less than monthly)
  - as needed during treatment

Services

- In COE programs, group programming should:
  - Be flexibly designed to accommodate those who have symptoms or functional impairments/disabilities that preclude full attendance and participation.
  - Typically have a smaller group size compared to groups in a non-COE program. For example, while groups programing in non-COE programs should typically include 6-12 patient[1]; COE programs may typically include 4-8 patients.
  - Deliver content in a format appropriate for individuals with challenges due to psychiatric disabilities.
- Level 2.1 COE programs should have the flexibility to provide individual support to:
  - Patients who need de-escalation or reduction of stimulation (e.g., due to panic attacks or feeling overwhelmed) during program hours.
  - Patients who need additional assistance due to functional impairment
- Level 2.1 programs should have educational materials available that address common serious mental health concerns. [Note that, compared to non-COE programs, COE programs should provide more guidance for managing significant acute symptoms (e.g., panic attacks, psychosis), cognitive challenge, functional disability]. Educational materials should:
  - Provide guidance for acute mental health symptom management
  - Be accessible for individuals with cognitive challenges due to psychiatric disabilities
  - Address how to discuss mental illness, mental health symptoms, and mental health treatments appropriately in the context of mutual-support and other recovery support programs.
- Level 2.1 COE programs should provide gender sensitive and responsive care.

Level 2.5 COE

Setting

- The program should provide a welcoming and supportive environment for individuals with serious mental health conditions, including those who may experience significant active and/or unstable symptom or significant functional impairment or disability.

Staff

- Level 2.5 COE programs should have sufficient staff with the scope of practice to assess, diagnose, and treat mental health conditions on site during hours of operation.

[1] Substance Abuse and Mental Health Services Administration. (2021). Group Therapy in Substance Use Treatment. Advisory. Publication No. PEP20-02-01-020 (2021)

- Staff with the competency to supervise mental health treatment should be on site during program hours of operation.
- All professional and paraprofessional staff should have competency to work with individuals who have active, unstable co-occurring psychiatric symptoms and/or severe psychiatric disabilities.
- COE programs should generally have a higher staff to patient ratio than non-COE programs in order to provide additional flexibility and support.

Support Systems

- Level 2.5 COE programs have direct affiliations with psychiatrist(s) or psychiatric nurse practitioner(s) to provide on call services 24/7 (on-site or via telehealth).
- Level 2.5 COE programs should have direct affiliations with mental health treatment programs and service providers including:
    - Intensive case management services
    - Psychosocial rehab programs
    - Mental health group residential settings
    - Mobile crisis intervention services
    - Mental health treatment centers

Assessment and Treatment Planning

- The Level 2.5 COE program's admission criteria should welcome individuals with any type of co-occurring mental illness diagnosis or symptoms, provided they meet criteria based on their level of acuity or disability as defined in the ASAM Criteria dimensional admission criteria.
- An Integrated Assessment should be conducted or reviewed within 3 days of admission.
- The treatment planning assessment should address:
    - Anticipated baseline acuity of psychiatric conditions and related disability based on history and current presentation
    - Symptom management and disability supports
    - Medical management of psychiatric conditions
    - Psychosocial treatment services for psychiatric conditions
- In a COE program, if an individual is engaged in ongoing mental health treatment by an external provider the treatment team should share information and coordinate care with the external provider(s):
    - at admission
    - regularly during treatment (not less than weekly)
    - at discharge

Services

- In COE programs, any group programming should:
    - Be flexibly designed to accommodate those who have symptoms or functional impairments/disabilities that preclude full attendance and participation.
    - Typically have a smaller group size compared to groups in a non-COE program.
    - Deliver content in a format appropriate for individuals with challenges due to psychiatric disabilities.
- Level 2.5 COE programs should have flexibility to provide individual support to:
    - Patients who need de-escalation or reduction of stimulation (e.g., due to panic attacks or feeling overwhelmed) during program hours.

- Patients who need additional assistance due to functional impairment.
- Level 2.5 programs should have educational materials available that address common serious mental health concerns. [Note that, compared to non-COE programs, COE programs should provide more guidance for managing significant acute symptoms (e.g., panic attacks, psychosis), cognitive challenge, functional disability]. Educational materials should:
  - Provide guidance for acute mental health symptom management.
  - Be accessible for individuals with cognitive challenges due to psychiatric disabilities.
  - Address how to discuss mental illness, mental health symptoms, and mental health treatments appropriately in the context of mutual-support and other recovery support programs.
- Level 2.5 COE programs should provide gender sensitive and responsive care.

Level 2.7 COE

Setting

- The program should provide a welcoming and supportive environment for individuals with serious mental health conditions, including those who may experience significant active and/or unstable symptom or significant functional impairment or disability.

Staff

- Level 2.7 COE programs should have a psychiatrist or psychiatric nurse practitioner on staff.
- A psychiatrist or psychiatric nurse practitioner should be on call 24/7.
- Level 2.7 COE programs should have sufficient staff with the scope of practice to assess, diagnose, and treat mental health conditions on site and available on every shift.
- Staff with the competency to supervise mental health treatment should be on site on every shift.
- All professional and paraprofessional staff should have competency to work with individuals who have active, unstable co-occurring psychiatric symptoms and/or severe psychiatric disabilities.
- COE programs should generally have a higher staff to patient ratio than non-COE programs in order to provide additional flexibility and support.

Support Systems

- Level 2.7 COE programs should have direct affiliations with mental health treatment programs and service providers including:
  - Intensive case management services
  - Psychosocial rehab programs
  - Mental health group residential settings
  - Mobile crisis intervention services
  - Mental health treatment centers

Assessment and Treatment Planning

- Level 2.7 COE programs' admission criteria should welcome individuals with any type of co-occurring mental illness diagnosis or symptoms, provided they meet criteria based on their level of acuity or disability as defined in the ASAM Criteria dimensional admission criteria.
- A psychiatric assessment should be conducted within 24 hours of admission.
- An Integrated Assessment should be conducted or reviewed within 48 hours of admission (or initial psychiatric stabilization).

- The treatment planning assessment should address:
  - Anticipated baseline acuity of psychiatric conditions and related disability based on history and current presentation
  - Symptom management and disability supports
  - Medical management of psychiatric conditions
  - Psychosocial treatment services for psychiatric conditions
- In a COE program, if an individual is engaged in ongoing mental health treatment by an external provider the treatment team should share information and coordinate care with the external provider(s):
  - At admission
  - Regularly during treatment (not less than weekly)
  - At discharge

Services

- Medical management of psychiatric conditions
- Consultation with a psychiatrist or psychiatric nurse practitioner should be available24/7 (on-site or via telehealth) to respond to psychiatric emergencies and adjust medications as needed.
- Psychosocial treatment services for psychiatric conditions, including:
  - Symptom management supports
  - Disability management supports (e.g., for ADLs, assignments, etc.)
- Psychoeducation to help patients:
  - understand medication changes
  - report medication effects and side effects
  - report on symptoms and disabilities
- In COE programs, group programming should:
  - Be flexibly designed to accommodate those who have symptoms or functional impairments/disabilities that preclude full attendance and participation
  - Typically have a smaller group size compared to groups in a non-COE program.
  - Deliver content in a format appropriate for individuals with challenges due to psychiatric disabilities.
- Level 2.7 COE programs should have flexibility to provide individual support to:
  - Patients who need de-escalation or reduction of stimulation (e.g., due to panic attacks or feeling overwhelmed) during program hours.
  - Patients who need additional assistance due to functional impairment.
- Level 2.7 COE programs should have educational materials available that address common serious mental health concerns. [Note that, compared to non-COE programs, COE programs should provide more guidance for managing significant acute symptoms (e.g., panic attacks, psychosis), cognitive challenge, functional disability]. Educational materials should:
  - Provide guidance for acute mental health symptom management
  - Be accessible for individuals with cognitive challenges due to psychiatric disabilities
  - Address how to discuss mental illness, mental health symptoms, and mental health treatments appropriately in the context of mutual-support and other recovery support programs.
- Level 2.7 COE programs should provide gender sensitive and responsive care.

Level 3.1 COE

Setting

- The program should provide a welcoming and supportive environment for individuals with serious mental health conditions, including those who may experience significant active and/or unstable symptom or significant functional impairment or disability.
- Level 3.1 COE programs should have quiet space for de-escalation.

Staff

- A clinical supervisor qualified to assess and treat mental health problems should be on-site or on-call during program hours of operation.
- Level 3.1 COE programs should have sufficient clinical staff with the scope of practice to assess, diagnose, and treat mental health conditions on-site during business hours and on-call overnight.
- Staff with the competency to supervise mental health treatment should be on site or on-call 24/7.
- All professional and paraprofessional staff should have competency to work with individuals who have active, unstable co-occurring psychiatric symptoms and/or severe psychiatric disabilities.
- COE programs should generally have a higher staff to patient ratio than non-COE programs in order to provide additional flexibility and support.

Support Systems

- Level 3.1 COE programs should have direct affiliations with mental health treatment programs and service providers including:
    - Intensive case management services
    - Psychosocial rehab programs
    - Mental health group residential settings
    - Mobile crisis intervention services
    - Mental health treatment centers

Assessment and Treatment Planning

- The Level 3.1 COE program's admission criteria should welcome individuals with any type of co-occurring mental illness diagnosis or symptoms, provided they meet criteria based on their level of acuity or disability as defined in the ASAM Criteria dimensional admission criteria.
- An Integrated Assessment should be conducted or reviewed within 3 days of admission.
- The treatment planning assessment should address:
    - Anticipated baseline acuity of psychiatric conditions and related disability based on history and current presentation
    - Symptom management and disability supports
    - Medical management of psychiatric conditions
    - Psychosocial treatment services for psychiatric conditions
- In a COE program, if an individual is engaged in ongoing mental health treatment by an external provider the treatment team should share information and coordinate care with the external provider(s):
    - At admission
    - Regularly during treatment (not less than monthly)

- At discharge

Services

- In COE programs, any group programming should:
  - Be flexibly designed to accommodate those who have symptoms or functional impairments/disabilities that preclude full attendance and participation.
  - Typically have a smaller group size compared to groups in a non-COE program.
  - Deliver content in a format appropriate for individuals with challenges due to psychiatric disabilities.
- Level 3.1 COE programs should have flexibility to provide individual support to:
  - Patients who need de-escalation or reduction of stimulation (e.g., due to panic attacks or feeling overwhelmed) during program hours.
  - Patients who need additional assistance due to functional impairment.
- Level 3.1 programs should have educational materials available that address common serious mental health concerns. [Note that, compared to non-COE programs, COE programs should provide more guidance for managing significant acute symptoms (e.g., panic attacks, psychosis), cognitive challenge, functional disability]. Educational materials should:
  - Provide guidance for acute mental health symptom management
  - Be accessible for individuals with cognitive challenges due to psychiatric disabilities
  - Address how to discuss mental illness, mental health symptoms, and mental health treatments appropriately in the context of mutual-support and other recovery support programs.
- Level 3.1 COE programs should provide gender sensitive and responsive care.

Level 3.5 COE

Setting

- The program should provide a welcoming and supportive environment for individuals with serious mental health conditions, including those who may experience significant active and/or unstable symptom or significant functional impairment or disability Level 3.5 COE programs should have quiet space for de-escalation.

Staff

- A psychiatrist or psychiatric nurse practitioner should be on call 24/7.
- Level 3.5 COE programs should have sufficient staff with the scope of practice to assess, diagnose, and treat mental health conditions on site 24/7.
- Staff with the competency to supervise mental health treatment should be on site or on-call 24/7.
- All professional and paraprofessional staff should have competency to work with individuals who have active, unstable co-occurring psychiatric symptoms and/or severe psychiatric disabilities.
- COE programs should generally have a higher staff to patient ratio than non-COE programs in order to provide additional flexibility and support.

Support Systems

- Level 3.5 COE programs should have direct affiliations with mental health treatment programs and service providers including:

- Intensive case management services
- Psychosocial rehab programs
- Mental health group residential settings
- Mobile crisis intervention services
- Mental health treatment centers

Assessment and Treatment Planning

- Level 3.5 COE programs' admission criteria should welcome individuals with any type of co-occurring mental illness diagnosis or symptoms, provided they meet criteria based on their level of acuity or disability as defined in the ASAM Criteria dimensional admission criteria.
- An Integrated Assessment should be conducted or reviewed within 3 days of admission.
- The treatment planning assessment should address:
  - Anticipated baseline acuity of psychiatric conditions and related disability based on history and current presentation
  - Symptom management and disability supports
  - Medical management of psychiatric conditions
  - Psychosocial treatment services for psychiatric conditions
- In a COE program, if an individual is engaged in ongoing mental health treatment by an external provider the treatment team should share information and coordinate care with the external provider(s):
  - At admission
  - Regularly during treatment (not less than monthly)
  - At discharge

Services

- In Level 3.5 COE programs, a psychiatrist or psychiatric nurse practitioner should be available (on-site or via telehealth) to make medication adjustments.
- In COE programs, any group programming should:
  - Be flexibly designed to accommodate those who have symptoms or functional impairments/disabilities that preclude full attendance and participation.
  - Typically have a smaller group size compared to groups in a non-COE program.
  - Deliver content in a format appropriate for individuals with challenges due to psychiatric disabilities.
- Level 3.5 COE programs should have flexibility to provide individual support to:
  - Patients who need de-escalation or reduction of stimulation (e.g., due to panic attacks or feeling overwhelmed) during program hours.
  - Patients who need additional assistance due to functional impairment.
- Level 3.5 programs should have educational materials available that address common serious mental health concerns. [Note that, compared to non-COE programs, COE programs should provide more guidance for managing significant acute symptoms (e.g., panic attacks, psychosis), cognitive challenge, functional disability]. Educational materials should:
  - Provide guidance for acute mental health symptom management
  - Be accessible for individuals with cognitive challenges due to psychiatric disabilities
  - Address how to discuss mental illness, mental health symptoms, and mental health treatments appropriately in the context of mutual-support and other recovery support programs.
- Level 3.5 COE programs should provide gender sensitive and responsive care.

Level 3.7 COE

Setting

- The program should provide a welcoming and supportive environment for individuals with serious mental health conditions, including those who may experience significant active and/or unstable symptom or significant functional impairment or disability.
- Level 3.7 COE programs should have quiet space for de-escalation.

Staff

- Level 3.7 COE programs should have a psychiatrist or psychiatric nurse practitioner on staff.
- A psychiatrist or psychiatric nurse practitioner should be on call 24/7.
- Level 3.7 COE programs should have sufficient staff with the scope of practice to assess, diagnose, and treat mental health conditions on site and available on every shift.
- Staff with the competency to supervise mental health treatment should be on site on every shift.
- All professional and paraprofessional staff should have competency to work with individuals who have active, unstable co-occurring psychiatric symptoms and/or severe psychiatric disabilities.
- COE programs should generally have a higher staff to patient ratio than non-COE programs in order to provide additional flexibility and support.

Support Systems

- Level 3.7 COE programs should have direct affiliations with mental health treatment programs and service providers including:
    - Intensive case management services
    - Psychosocial rehab programs
    - Mental health group residential settings
    - Mobile crisis intervention services
    - Mental health treatment centers

Assessment and Treatment Planning

- Level 3.7 COE programs' admission criteria should welcome individuals with any type of co-occurring mental illness diagnosis or symptoms, provided they meet criteria based on their level of acuity or disability as defined in the ASAM Criteria dimensional admission criteria.
- A psychiatric assessment should be conducted within 24 hours of admission.
- An Integrated Assessment should be conducted or reviewed within 48 hours of admission (or initial psychiatric stabilization).
- The treatment planning assessment should address:
    - Anticipated baseline acuity of psychiatric conditions and related disability based on history and current presentation
    - Symptom management and disability supports
    - Medical management of psychiatric conditions
    - Psychosocial treatment services for psychiatric conditions
- In a COE program, if an individual is engaged in ongoing mental health treatment by an external provider the treatment team should share information and coordinate care with the external provider(s):
    - At admission

- Regularly during treatment (not less than weekly)
- At discharge

Services

- Medical management of psychiatric conditions
- Consultation with a psychiatrist or psychiatric nurse practitioner should be available 24/7 (on-site or via telehealth) to respond to psychiatric emergencies and adjust medications as needed.
- Psychosocial treatment services for psychiatric conditions, including:
  - Symptom management supports
  - Disability management supports (e.g., for ADLs, assignments, etc.)
- Psychoeducation to help patients:
  - understand medication changes
  - report medication effects and side effects
  - report on symptoms and disabilities
- In COE programs, group programming should:
  - Be flexibly designed to accommodate those who have symptoms or functional impairments/disabilities that preclude full attendance and participation
  - Typically have a smaller group size compared to groups in a non-COE program.
  - Deliver content in a format appropriate for individuals with challenges due to psychiatric disabilities.
- Level 3.7 COE programs should have flexibility to provide individual support to:
  - Patients who need de-escalation or reduction of stimulation (e.g., due to panic attacks or feeling overwhelmed) during program hours.
  - Patients who need additional assistance due to functional impairment.
- Level 3.7 COE programs should have educational materials available that address common serious mental health concerns. [Note that, compared to non-COE programs, COE programs should provide more guidance for managing significant acute symptoms (e.g., panic attacks, psychosis), cognitive challenge, functional disability]. Educational materials should:
  - Provide guidance for acute mental health symptom management
  - Be accessible for individuals with cognitive challenges due to psychiatric disabilities
  - Address how to discuss mental illness, mental health symptoms, and mental health treatments appropriately in the context of mutual-support and other recovery support programs.
- Level 3.7 COE programs should provide gender sensitive and responsive care.

Level 4 COE

Level of Care Description

In this edition of *The ASAM Criteria*, we are recommending that all SUD treatment programs achieve, at minimum, co-occurring capability. As outlined above, we also describe standards for a continuum of co-occurring enhanced treatment programs. ASAM similarly recommends that the mental health treatment field adopt commensurate standards such that all mental health programs are expected to have the capacity to provide co-occurring capable care for individuals with comorbid SUD. Further, it is critical that standards developed by the SUD and mental health treatment fields for co-occurring enhanced, or dual diagnosis care, are well aligned. In the longer term, standards for COE care

developed by the SUD and mental health treatment fields should converge into one set of "Dual Diagnosis" standards of care.

While ASAM does not have a role in setting mental health treatment program standards, we are including psychiatric inpatient units or hospitals as part of the SUD continuum. We are labelling those programs as Level 4 COE to contrast with biomedical units which are labeled as non-specialty Level 4 programs.

The following standards are recommended for consideration to help psychiatric inpatient units be effective, co-occurring capable partners in serving individuals with SUD and severe acute co-occurring psychiatric needs:

Setting

- Program's services should be designed to provide a welcoming environment for individuals with co-occurring SUD, where patients feel safe addressing their SUD related concerns and experiences.

Staff

- In each program, at least one clinical staff member who is qualified by training and/or licensure to assess and treat SUD should be part of the clinical team.
- All professional and paraprofessional staff should be trained to provide support to individuals with SUD.
- Physicians or advanced practice providers waivered to prescribe buprenorphine.

Support Systems

- Programs should have established relationships with more and less intensive levels of care, including both COE and non-COE SUD treatment providers, to:
    - Support access to specialty SUD assessment and consultation
    - Facilitate coordinated transitions in care
- Established relationships with physicians and/or advanced practice providers who can prescribe medications for SUD, including buprenorphine.
- Ability to coordinate care for SUD as needed.

Assessment and Treatment Planning

- The initial nursing assessment should screen for and assess withdrawal risks and SUD treatment needs.
- A physical examination should be conducted by a physician or advanced practice provider within 24 hours of admission.
- An integrated history (mental health and addiction) should be conducted (or reviewed) by a physician or advanced practice provider as part of the initial assessment.
- Assessment and treatment planning should be sensitive to trauma and designed to prevent re-traumatization.
- Patient treatment plans should address any SUD treatment needs identified, including:
    - Services to be delivered by the program's treatment team.
    - Services to be delivered by external providers.
- Transfer/discharge plans should address continuity of care for both SUD and mental health conditions.

Services

- Inpatient mental health programs should be able to provide the equivalent of Level 3.7 withdrawal management and SUD treatment services, including:
    - Nursing and medical monitoring for stabilization of acute withdrawal, biomedical and psychiatric conditions.
    - Psychosocial services to encourage engagement in ongoing treatment
    - Hourly nurse monitoring of the patient's progress and medication administration
    - Medical monitoring and management of signs and symptoms of intoxication and withdrawal
    - Assessment with validated scales (e.g., COWS, CIWA-Ar, RASS) to determine the severity of withdrawal when appropriate
    - Medication based methods of withdrawal management that are appropriate for the severity of withdrawal or anticipated withdrawal
    - Non-medication-based methods of withdrawal management, when indicated, including but not limited to:
        - Informing patients of what to expect over the course of treatment.
        - Offering reassurance
        - Providing a quiet environment
        - Educating patients on the importance of adequate hydration and nutrition
- Biomedical capabilities equivalent to a Level 3.7 program.
- Addiction pharmacotherapies
    - Patient education regarding available pharmacotherapies, currently including those available to treat opioid use disorder, alcohol use disorder, and tobacco use disorder
    - Initiation and continuation of addiction pharmacotherapies in alignment with current best practices, such as those established in the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, the APA Practice Guideline on Treatment of Alcohol Use Disorder, and ASAM's clinical guidance on Integrating Tobacco Use Disorder Interventions in Addiction Treatment.
- Services should be designed with the expectation that many if not most patients will have co-occurring mental health conditions (e.g., individual and group interventions should encourage patients to address both mental health-related concerns as well as SUD-related concerns)
    - Programs should support patients to manage SUD related symptoms
    - Patient SUD should be addressed concurrently by the program and through coordination with external providers as needed
- Programs should coordinate care with any external SUD care providers involved in the patient's care, with appropriate patient consent:
    - At admission and discharge
    - As needed based to support effective care coordination for the individual patient
- The program should support access to pharmacotherapies for addiction, with appropriate medication management.
- The program's clinical services should include:
    - Individual and group interventions for SUD
    - Interventions designed to address:
        - how to manage mental health symptoms and trauma without using substances

    - how to discuss SUD, SUD symptoms, and SUD treatments (including medications) appropriately in the context of mental health treatment and recovery support services
    - [Note: Patients should be excused from participating in psychotherapeutic, psychoeducational, and recovery support services if acute psychiatric, withdrawal or biomedical conditions prevent effective participation.]
- Level 4 COE programs should be able to admit individuals who are currently in methadone treatment who require psychiatric hospital level of care.

Dual Diagnosis Level 4 COE Programs

Dual Diagnosis Level 4 COE Programs should have enhanced capabilities for treating both psychiatric disorders and SUD. These SUD enhanced psychiatric inpatient units (or tracks) should meet all of the Level 4 COE program standards above and have enhanced capabilities for treating both psychiatric disorders and SUD. ASAM suggests the following additional SUD related standards for these specialized units (or tracks) in inpatient psychiatric hospitals or psychiatric units within an acute care hospital:

Staff

- Programs should have sufficient staff with the scope of practice to assess, diagnose, and treat SUD on site during program hours of operation.
- All professional and paraprofessional staff should have competency to work with individuals who have active co-occurring SUD, intoxication, and withdrawal syndromes.
- Programs should have an addiction specialist physician on staff (or directly affiliated) to provide specialized clinical consultation for intoxication, withdrawal syndromes, and/or SUD.

Support Systems

- Established relationships with OTP(s), if available within the local payment geography

Assessment and Treatment Planning

- The initial nursing assessment should include:
    - Integrated SUD history, including evaluation of baseline periods of remission and reduced use, mental health status during those periods, and factors that contributed to previous success.
    - Baseline evaluation of withdrawal severity and risks
    - Assessment of current biomedical issues and medication review
- The initial physical exam, conducted by a physician or advanced practice provider within 24 hours of admission, should include the components of an addiction focused physical examination.
- The initial history, obtained as part of the initial assessment, should include an addiction-focused history, and should be conducted or reviewed by a physician or advanced practice provider during the admission process.
- Serial medical assessments including appropriate measures of withdrawal should be conducted as needed.
- An Integrated Assessment should be conducted (or reviewed) to determine SUD treatment needs.
- The patient's individualized treatment plan should include problem identification in each of the ASAM Criteria dimensions, treatment goals, measurable treatment objectives, and activities designed to meet those objectives.

- The plan should reflect coordination of SUD treatment needs and coordination of care with external SUD treatment providers.
- Transfer planning should begin at admission and address:
  - SUD treatment needs
  - SUD recovery support service needs
  - Continued access to medications for SUD treatment
  - Overdose prevention and harm reduction

Services

- Level 4 COE programs should be able to provide:
  - Toxicology services, following appropriate standards such as those defined in ASAM's Appropriate Use of Drug Testing in Clinical Addiction Medicine Consensus Document
  - Access to all FDA approved medications for the treatment of SUDs
  - Psychosocial treatment services for SUD tailored to the needs of the individual as determined based on ASAM Criteria Assessment. See the Psychosocial Services Section for details.
    - Patients should be excused from participating in psychotherapeutic, psychoeducational, and recovery support services if acute psychiatric, withdrawal or biomedical conditions prevent effective participation.
- Level 4 COE programs should provide gender sensitive and responsive care.

Universal Psychosocial Service Standards – 4th Edition

SUD treatment programs should offer a range of psychotherapeutic and psychoeducational services. Specific services offered to a given patient should be tailored to their individual needs, as determined based on ASAM Criteria Assessment.

Psychosocial services should be designed with the expectation that many if not most patients will have co-occurring mental health conditions. Individual and group interventions should encourage patients to address both mental health-related concerns as well as SUD-related concerns.

Translation services should be available to make psychotherapeutic and psychoeducational content available in the patient's preferred language.

Psychotherapy

Psychotherapy is the use of evidence-based psychological methods to help a person change behavior, increase happiness, and overcome problems. Psychotherapy aims to improve an individual's well-being and mental health, to resolve or mitigate troublesome behaviors, beliefs, compulsions, thoughts, or emotions, and to improve relationships and social skills.

Psychotherapy services should be delivered by an appropriately credentialed master's level psychologists, social workers, and other master's level behavioral health professionals (e.g., licensed professional clinical counselors (LPCC), licensed marriage and family therapist (LMFT)) and include:

- Individual and group counseling that actively addresses and monitors:
  - SUD
  - Sequalae of SUD
  - Cooccurring mental health concerns
  - The interaction between SUD and mental health symptoms

    - How to manage mental health symptoms and trauma without using substances
    - Relapse prevention
- Motivational interviewing and enhancement interventions appropriate to the patient's stage of readiness to change, designed to facilitate the patient's understanding of the relationship between his or her substance use disorder and attendant life issues.
- Occupational and recreational therapies adapted to the patient's developmental stage and level of comprehension, understanding, and physical abilities
- Recovery support group facilitation
- Contingency management
- Community reinforcement approach (CRA)
- Family therapy
- Cognitive behavioral therapy
- Eye Movement Desensitization and Reprocessing (EMDR)
- Solution focused therapy
- Dialectical behavioral therapy
- Other evidence-based therapies.

Psychoeducation

Psychoeducation (PE) is defined as an intervention with systematic, structured, and didactic knowledge transfer for an illness and its treatment, integrating emotional and motivational aspects to enable patients to cope with the illness and to improve its treatment adherence and efficacy. Psychoeducation involves structured programming delivered by licensed clinical professionals, and includes:

- Interventions designed to:
    - Enhance the patient's understanding of addiction, completion of treatment, and engagement in an appropriate level of care for continuing treatment.
    - Educate patients on what to expect over the course of treatment
    - Enhance the patient's understanding of co-occurring mental health concerns and how they interact with addiction, including:
        - how to discuss mental illness, mental health symptoms, and mental health treatments appropriately in the context of recovery programs/mutual support groups
        - how to appropriately ask for help for mental health concerns from peers or professionals when needed
    - Support adherence to medications prescribed for addiction and mental health concerns, including:
        - How to work honestly and effectively with prescribers
        - The importance of taking meds as prescribed
    - Support successful initial involvement or reinvolvement in regular, productive daily activity (such as work or school) and, as indicated, successful reintegration into family living
    - Support patients to develop and apply recovery skills, through:
        - relapse prevention
        - exploring interpersonal choices
        - development of a social network supportive of recovery
        - educational and skill building groups

        - vocational rehabilitation activities
        - occupational and recreational therapies
        - art, music, or movement therapies
        - physical therapy
    - Encourage the patient's motivation to address SUD and co-occurring conditions
    - Support integrated treatment for tobacco use disorders, including:
        - The benefits of treating tobacco use disorder at the same time as other SUDs
        - Evidence-based tobacco use disorder treatments (e.g., pharmacotherapy, counseling)
        - Relative risk nicotine/tobacco products
        - Motivational and harm reduction strategies for patients who are ambivalent about quitting
- Health education services regarding:
    - The causes of addiction
    - Factors that influence the progression of addiction
    - Pharmacotherapies for SUD
    - Pharmacotherapies for psychiatric disorders
    - Harm reduction strategies including overdose recognition and response training
    - Health-related risk factors associated with SUD (for example: HIV, hepatitis C, sexually transmitted infections, skin and soft tissue infections, unintended pregnancy).
    - The importance of taking care of physical and mental health
        - All programs should have educational materials routinely available that address common physical and mental health concerns, including trauma.
- Psychoeducational services for the patient's family and significant others (with appropriate patient consent), including:
    - What to expect during treatment
    - How to support loved ones during treatment
    - The importance of self-care
    - Overdose recognition and response training
- Other evidence-based psychoeducation.

Universal Documentation Standards

Program documentation should include:

- The level(s) of care that the patient is receiving treatment from
    - Current
    - Past 12 months
- Summary of the results of the biopsychosocial assessment including:
    - Overview and analysis of problems within each of the six dimensions
        - Prioritization of the problems identified
        - The relationship between the problems identified and substance-related and addictive disorders
        - The patient's current level of functioning (e.g., skills of daily living)
    - Level of care recommendation(s)
    - Final disposition and reason for any discrepancies
- Summary of physical examination

- Standardized mental health screening and assessment results (dated), with comparison to past results
- Nicotine/tobacco use status including:
    - Duration
    - Frequency
    - Pack years if applicable (i.e., number of packs of cigarettes smoked per day multiplied by the number of years the person has smoked
    - Type(s) of products used (e.g., combustible cigarettes, oral tobacco, e-cigarettes, snus, etc.).
- Review of admission decision
- The patient's individualized treatment plan (or remission management plan for Level 1.0) including:
    - Problem identification in each dimension
    - Treatment goals
    - Measurable treatment objectives
    - Patient strengths
    - Services to address problems identified designed to meet stated objectives
    - Medications and medication management plan
    - The plan for after-hours medical advice and emergencies, if applicable
- The treatment plans for patients with co-occurring psychiatric conditions should have specific documentation of:
    - Patient mental health concerns
    - Mental health screening and assessment results if applicable
    - Services provided by the program to address mental health concerns, including symptom management strategies
    - Services to address mental health concerns provided by external providers
        - Care coordination with external providers
    - individual strengths that support effective management of mental health symptoms without using substances
- The treatment plans for patients with biomedical conditions should have specific documentation of:
    - Patient biomedical concerns (including pain)
    - Biomedical assessment results if applicable
    - Services provided by the program to address biomedical concerns
    - Services provided by external providers to address biomedical concerns
        - Care coordination with external providers
- The treatment plans for patients with co-occurring pain conditions should have specific documentation of:
    - Screening and assessment results, if applicable
    - Services provided by the program to address pain, including symptom management strategies
    - Services to address pain provided by external providers
        - Care coordination with external providers
    - Continuing care plan post discharge from program.
- Individualized progress notes in the patient's record that clearly reflect implementation of the treatment plan, the patient's response to therapeutic interventions for all disorders treated, and capture:
    - Significant events that may alter course of treatment

    - Changes in frequency or types of services
    - Changes in LOC
    - Subsequent amendments to the plan.
    - Signature of the clinician with date
    - Signature of the supervisor if the clinician is a trainee, with date
- Documentation should allow for each clinician involved in a patient's care to see relevant medical and psychosocial information
- A copy of the treatment plan should be provided to the client at the initiation of the plan and subsequently when updated.
- Laboratory and toxicology order sets and notes regarding how the treatment plan was modified based on results
- Documentation of patient consent, or refusal to consent, for care coordination and information sharing with external providers or program.
- Documentation of consent, or decline of consent, to involve family members, significant others, or other support persons
- Documentation of case management services
- Documentation of referral to other service providers should include:
    - Recommendations for care
    - Reasons for departures from clinical recommendations if applicable
    - Incorporation of treatment/services in the patient's treatment plan
    - Care coordination
    - Follow up plan to ensure engagement in care and documentation of follow ups
- Transfer plan that addresses:
    - Review of the ASAM Criteria dimensions
    - Recommendations for follow-up care
    - Reasons for departures from recommendations if applicable
    - Program(s) that the patient will transfer to
    - Required medications and how patients will maintain access to medications during the transfer
    - Access to naloxone if applicable
    - Follow up plan to ensure engagement in care and documentation of follow ups
- Documentation of unplanned discharge, including:
    - status at discharge
    - reason for discharge
    - care recommendations provided to the patient
    - access to medications after discharge
    - notifications made (signed and dated)
    - plan for follow up with the patient and documentation of follow ups (signed and dated)
- Medically monitored or managed programs should additionally document:
    - Results of the nursing assessment
    - Results of the physical examinations and medical assessments
    - Toxicology and laboratory orders and results
    - Scoring for withdrawal rating scale tables and flow sheets (which may include tabulation of vital signs) as needed.

Other program documentation

- Business associate agreement and qualified service organization agreement with affiliated programs, where applicable
    - Safe staffing levels including:
        - How many physicians and advanced practice providers the medical director can safely manage.
        - Maximum patient to staff ratios for each staff type.
            - The actual number of patients that an individual staff member can manage should consider any responsibilities of the staff member other than patient care (e.g., administrative, educational, etc.)
            - Nurse to patient ratios:
                - At Level 3.7 patient a minimum nurse-to-patient ratio of 1:7 is recommended.
    - Essential medicines based on current standards of clinical practice and that ensure these medications are stocked or readily accessible when needed

Program policies and procedures

- Policies and procedures related to Dimension 1 and 2 concerns should be reviewed approved by the medical director, or, for programs without a medical director, a physician with at least 5 years of experience in specialty addiction treatment. Policies include:
    - Admission criteria and transfer criteria related to intoxication, withdrawal, and biomedical concerns
    - Determining when medical evaluation is needed for intoxication, withdrawal risk, or other medical concerns
    - Responding to medical emergencies (including those that occur on-site)
    - Toxicology testing including:
        - When point of care tests should be used
        - When confirmatory tests should be used
        - Who has the scope of practice to order and interpret test results
        - How results will be communicated to patients
        - How to address positive drug test results
        - Breath alcohol testing
            - When breath alcohol testing should be conducted
            - Interpretation of results
            - When to contact a medical professional
    - Access to all FDA approved medications for addiction treatment
    - Infectious disease screening
    - Infection control and mitigation (e.g., for hepatitis C, HIV, TB, COVID, monkeypox, etc.), including identification of the responsible infection control officer and the responsibilities of this role
    - Managing patients with chronic conditions (e.g., renal failure, bleeding disorders, etc.)
    - Managing patients with pain, including:
        - When to refer patients for evaluation for, pain specialist evaluation
        - When to refer patients for pain psychology evaluation
        - How to modify their current treatment regimen to accommodate pain as a significant trigger for relapse.

        - Appropriate training for assessment of pain and the interrelationship between the patient's pain and addiction.
- Policies and procedures related to Dimension 3 concerns should be reviewed and approved by qualified master's level mental health professionals. Policies include:
    - Screening for mental health concerns
    - Admission criteria and transfer criteria related to psychiatric and cognitive concerns
    - Determining when a mental health assessment is needed for psychiatric concerns including:
        - Determining what level of assessment is needed (e.g., assessment by a master's level clinician vs. assessment by a psychiatrist or psychiatric nurse practitioner)
    - Accommodating patients affected by changes in mental health status that interferes with their treatment participation.
        - Educating patients on how to ask for accommodation when needed and how to provide appropriate accommodations in a way that is transparent and fair for all clients
    - Access to medications for psychiatric disorders
        - Oversight and monitoring of controlled medications
    - Managing mental health advanced directives
- All other clinical policies and procedures should be reviewed and approved by a master's level clinical professional with at least 5 years of experience in addiction treatment.
- All programs should have policies and procedures that address:
    - Admission criteria and transfer criteria, in alignment with *The ASAM Criteria* Dimensional Admission Criteria
    - Coordination of referrals to alternate levels of care
        - What to do if a higher LOC is needed but not available
    - Coordination of care with external providers
    - Medication reconciliation, including:
        - Responsibility for conducting a complete medication reconciliation
        - Oversight of controlled substance prescriptions
        - Checking the prescription drug management program (PDMP) upon admission
        - Requirements for patients to authorize release of information to coordinate care with external prescribers
        - For outpatient programs, managing access to controlled prescriptions while patients are on site
        - Coordination of care with external prescribers
            - Upon admission
            - Upon discharge
            - As needed throughout treatment
    - Treatment of tobacco use disorder, including:
        - Screening for tobacco/nicotine use
        - Barrier-free access to evidence-based treatments for tobacco use disorder, including pharmacotherapy and behavioral therapy
        - Supporting integrated treatment

        - Restricting consumer tobacco and nicotine products for staff and patients (e.g., combustible cigarettes, smokeless tobacco, e-cigarettes, etc.), including smoke free policies
        - Organizational support for staff access to treatment
    - Patient code of conduct, including:
        - Patient review and signature at admission
        - Response to conduct that presents risk for harm to self or others
    - Harm reduction including:
        - Access to naloxone in the facility
        - Access to naloxone when patients are off site
        - Overdose reversal training for staff and patients
        - Patient and family access to naloxone after transfer/discharge
    - Staffing, including:
        - Supervision and monitoring of staff competencies
        - Training of professional and para-professional staff
        - Mental health training and competencies
        - Determining appropriate staff to patient ratios
    - Responding to current public health alerts
    - How and when to consult a supervisor
        - Chain of command for urgent and emergent situations
    - After-hours urgent needs or questions
    - Formal grievance procedures
    - Responding to requests to change treating clinicians
    - Managing violent or threatening behaviors
    - Confidentiality, including:
        - Consent
        - Access to health records
        - Storage of records
        - Client rights
        - Mandated reporting and communication with criminal justice entities
    - Emergency preparedness addressing:
        - Emergency evacuation planning
        - Patient relocation (for residential and inpatient programs)
        - Considerations for patient discharge or transfers (pre- or post-disaster evacuation)
        - Ensuring continued access to critical medications
        - Communications and coordination in an emergency
        - Identification of staff leads and emergency points of contact
        - Utilizing back-up strategies (cell, radio, internet) if telephone or electrical power are inoperable.
        - Patient Education
        - Staff Training
        - Standards regarding reporting patient safety events
        - Accessing local, state, and/or federal services and support before, during, and after a disaster
    - Considerations regarding safe staffing levels, including:
        - Strategies for addressing staff shortages and procedures for when critical positions cannot be filled.

        - This may include interim appointments, hiring temporary staff, or transitioning patients to other programs if care cannot be safely and effectively provided by the program.
    - Programs that house multiple levels of care should consider delineating which beds may be filled by patients at level 3.7 to ensure that staffing is sufficient to meet the needs of patients placed at this level of care.
        - If beds are used flexibly the program must be able to expand staffing to meet the needs of all patients accepted to this level of care.
    - Competency-based training for all direct service personnel as appropriate to their discipline and scope of practice.
- Residential programs should have policies and procedures that:
    - Define activities to be performed during the night shift (e.g., hourly monitoring and documentation of patient whereabouts, coordinating response to urgent patient issues).
    - Address the safety of patients and personnel, including searches of patients and belongings that preserve privacy and dignity, and are sensitive to potential trauma of patients.
    - Handling of items brought into the program, including addictive substances, tobacco products, prescription medications, over-the-counter products, weapons, paraphernalia related to addiction, and pornography.
    - Address medication reconciliation, including:
        - In Level 3.7, assuming management of all controlled substance prescriptions

The ASAM Criteria Dimensional Admission Criteria

Integrating the Risk Ratings and Dimensional Admission Criteria

The 3rd edition of *The ASAM Criteria* includes a framework for rating risks in each dimension as well as dimensional admission criteria for each level of care. However, the dimensional admission criteria do not reference the risk ratings. The 4th edition will integrate risk ratings into the admission criteria and will incorporate a written algorithm/decision tree with a goal of making the decision rules easier to understand and follow reproducibly.

How to use the Dimensional Admission Criteria

For each subdimension, determine the risk rating based on the associated descriptions of clinical presentation. Each risk rating is aligned with either (1) the minimum level of care at which a patient with the described presentation should be placed to be safely and effectively treated, or (2) services that should be provided in addition to, or within, the recommended level of care (e.g., recovery residence, supportive housing, continuation of medications for OUD treatment).

The dimensional admission criteria assume that:

- The clinician has determined that the patient's primary treatment need is for SUD.
- The severity of the patient's SUD is not significantly less severe than co-occurring issues in Dimensions 2 or 3.
    - If the patient has a mild SUD (as defined by DSM5) and severe psychiatric concerns, the patient's Dimension 3 issues may be treated primarily in the mental health system.

- If the patient has a mild SUD and severe physical health concerns, the patient's Dimension 2 issues may be treated primarily in the medical/surgical healthcare system.

The dimensional admission criteria are designed to identify the least intensive level of care where a patient can be safely and effectively treated. To make the initial recommendation, the assessor will first consider specific subdimensions, then dimensional interactions (See Level of Care Determination Rules). After the initial level of care recommendation is determined, issues in Dimension 6 (Readiness and Resources), should be considered to determine where the patient is willing and able to engage in treatment (See Assessment Standards).

It is important to note that the examples described in the dimensional admission criteria do not articulate all possible clinical scenarios. The examples are illustrative, rather than a comprehensive list of clinical presentations that would be served appropriately at each level of care.

Each subdimension should be considered independently. The "minimum level of care" criteria within each subdimension articulate the issues that would be appropriately treated at that level of care based on the described clinical presentation alone. When making the initial risk rating determinations, the assessor should isolate the specific subdimension to determine the minimum level of care at which the patient should be placed (based on clinical presentation in that subdimension alone) to maximize safety/function and minimize distractions to SUD recovery. The patient's needs in other dimensions and subdimensions should NOT be considered when rating, except where otherwise specified (e.g., criteria that consider how issues in Dimensions 1 or 2 may exacerbate Dimension 3 severity).

The program's admission criteria should not exclude patients on the basis of a current or past diagnoses alone; the appropriateness of admission should be determined based on the severity and acuity of concerns, and associated risks, across the dimensions as outlined in the dimensional admission criteria. If a condition can be self-managed by the patient (e.g., a blood clotting disorder) or managed effectively by an external provider, it should not be used as a reason for exclusion from any level of care.

If a patient does NOT meet the level of active symptomatology or functional impairment specified for a certain level of care, that individual can be served at any level of care that meets their needs in other dimensions. For example, a patient with bipolar disorder that is well managed with current treatment should be able to receive care at any level, with the level determined by the individual's clinical presentation across the six dimensions.

The dimensional admission criteria are defined based on the core service characteristic standards for each level of care. If a program has enhanced capabilities that allow it to meet a given patient's additional needs (beyond what is defined in the service characteristic standards for that level of care), it may be appropriate to do so, as determined by the clinical judgement of a qualified healthcare professional.

Subdimensions that contribute to the initial level of care recommendation:

Dimension 1

- Intoxication and associated risks (including overdose)
- Acute withdrawal and associated risks
- MOUD needs

Dimension 2 – Biomedical conditions

- Physical health concerns
- Pregnancy-related concerns

Dimension 3 - Psychiatric and cognitive conditions

- Active psychiatric concerns
- Persistent Disability

Dimension 4 – Substance use related risks

- Likelihood of engaging in risky substance use
- Likelihood of engaging in other harmful SUD related behaviors

Dimension 5 – Recovery environment

- Ability to interact productively with current environment
- Safety in current environment
- Support in current environment

Note that Dimension 6 – Readiness and Resources, does not contribute to the initial recommendation but will be discussed with the patient to determine what type of treatment the patient is willing and able to participate in.

Dimension 1 – Acute intoxication and withdrawal potential

Risks associated with acute intoxication or withdrawal should be assessed using policies, procedures, and pathways developed (and regularly reviewed) by a physician or advanced practice provider with at least two years of addiction treatment experience. Note that specific parameters or thresholds for vital signs are not included as there can be significant variability across patients in the significance of these findings due to co-morbidities, medications, etc. As such, it is important that programs have policies and procedures for determining when a medical evaluation is necessary before admission.

Intoxication and associated risks (including overdose)

Intoxication alone is not a reason to admit a patient to a higher level of care. However, concerning biomedical or psychiatric signs or symptoms presenting in a patient who is intoxicated should be considered as outlined below.

Level 4 = Risk Rating 4

1. The patient is incapacitated, with very severe signs and symptoms who require the resources of an acute care hospital. *Examples include, but are not limited to*:
   - Very severe neurological signs or symptoms due to intoxication. *For example*:
     - Profound decrease in consciousness, including coma
     - Intoxication related seizure within the past 6 hours
   - Uncontrollable[2] or unexplained generalized tonic clonic seizures (e.g., stimulant-related seizures).

[2] Uncontrollable is defined as: Not controlled by standard interventions available at a lower LOC.

- Very severe cardiovascular signs or symptoms due to intoxication. *For example*:
  - Malignant dysrhythmias
  - Hypertensive emergency
  - Concern for syncope of cardiac origin
- Very severe respiratory signs or symptoms due to intoxication. *For example*:
  - Profound respiratory depression (i.e., where mechanical ventilation or other invasive respiratory support may be needed)
- Very severe gastrointestinal signs or symptoms due to intoxication. *For example*:
  - Persistent vomiting or diarrhea that is not responsive to medications
- Very severe psychiatric signs or symptoms due to intoxication. *For example*:
  - Severe agitation refractory to medication
  - Unexplained or unmanageable psychosis
  - Imminent threat to self or others
  - Other signs or symptoms that may require a secure unit
- Other very severe signs or symptoms due to intoxication that meet med-surg criteria for hospitalization. *For example*:
  - Unstable or abnormal vital signs that are unexplained and/or not responsive to standard treatment (e.g., hypotension, hyperthermia, hypothermia)
  - Concern for sepsis
- Patients who need services only available in an acute care setting due to intoxication. *For example*:
  - Patients who need continuous cardiac monitoring
  - Patients who need titratable infusions for conditions related to D1/D2/D3

OR

2. Issues of intoxication are exacerbating biomedical or mental health conditions that would otherwise meet the Dimension 2 or Dimension 3 criteria for Level 3.7 program

Minimum Level 3.7 = Risk Rating 3

The patient is experiencing moderately severe to severe signs or symptoms of intoxication that may pose an imminent risk of danger to self or others, and needs after-hours medical monitoring, but does not require the full resources of an acute care hospital. *Examples include, but are not limited to*:

- Moderately severe to severe neurological signs or symptoms due to intoxication. *For example*:
  - Controllable and explainable (i.e., known seizure disorder) intoxication-related seizures more than 6 hours ago
  - Controllable and explainable somnolence
  - Moderate ambulatory difficulty
- Moderately severe to severe cardiovascular signs or symptoms due to intoxication. *For example*:
  - Controllable and explainable hypertension
  - Controllable and explainable bradycardia or tachycardia
- Moderately severe to severe respiratory signs or symptoms due to intoxication. *For example*:
  - Controllable and explainable moderately severe to severe respiratory depression (where mechanical ventilation is not anticipated to be needed)

- Moderately severe to severe gastrointestinal signs or symptoms. *For example*:
  - Persistent vomiting or diarrhea that is responsive to medication
- Moderately severe to severe psychiatric signs or symptoms due to intoxication. *For example*:
  - Moderately severe to severe agitation responsive to medications
  - Moderate to severe psychosis, responsive to medications, without immediate risk of harm to self or others
  - Acute suicidal or homicidal ideation without imminent risk to self or others (as determined by a qualified healthcare professional using a validated assessment)
- Controllable and explainable, moderately severe to severe abnormalities of vital signs (e.g., hypotension, hypothermia, hyperthermia)
- Patients who need services only available in a sub-acute care setting due to intoxication. *For example*:
  - Patients who need IV medications
  - Patients who need medical services outside of normal business hours (e.g., post-operative patients with pain adequately controlled with oral medications who need ongoing medical support such as wound care)

Minimum Level 2.7 = Risk Rating 2

The patient is experiencing moderately severe to severe signs or symptoms of intoxication that respond to support and treatment sufficiently that the patient does not pose an imminent danger to self or others AND the patient does not need after-hours medical monitoring. *Examples include, but are not limited to*:

- Moderately severe to severe neurological signs or symptoms due to intoxication AND the patient does not need after-hours medical monitoring. *For example*:
  - Controllable and explainable (i.e., known seizure disorder) intoxication related seizures AND the patient has sufficient monitoring and support at home
  - Controllable and explainable somnolence
  - Moderate ambulatory difficulty
- Moderately severe to severe cardiovascular signs or symptoms due to intoxication AND the patient does not need after-hours medical monitoring. *For example*:
  - Controllable and explainable hypertension
  - Controllable and explainable bradycardia or tachycardia
- Moderately severe to severe respiratory signs or symptoms due to intoxication AND the patient does not need after-hours medical monitoring. *For example*:
  - Controllable and explainable moderately severe to severe respiratory depression
- Moderately severe to severe gastrointestinal signs or symptoms due to intoxication AND the patient does not need after-hours medical monitoring. *For example*:
  - Persistent vomiting or diarrhea that is responsive to oral medication
- Moderately severe to severe psychiatric signs or symptoms due to intoxication AND the patient does not need after-hours medical monitoring. *For example*:
  - Moderate to severe agitation responsive to oral medication
  - Moderate to severe psychosis responsive to oral medication without immediate risk of harm to self or others
- Controllable and explainable, moderately severe to severe abnormalities of vital signs (e.g., hypotension, hypothermia, hyperthermia)
- Patients who need services due to intoxication that are not available in a lower level of care AND the patient does not need after-hours medical monitoring. *For example:*

- The patient needs observation or monitoring during normal business hours

Minimum Level 1.7 = Risk Rating 1

The patient is experiencing mild to moderate signs or symptoms of intoxication that interfere with functioning but do not pose imminent danger to self or others. *Examples include, but are not limited to*:

- Mild-Moderate neurological signs or symptoms due to intoxication that are expected to predictably resolve
- Mild-Moderate abnormalities of vital signs due to intoxication that are expected to predictably resolve
- Mild-Moderate gastrointestinal signs and symptoms due to intoxication that are expected to predictably resolve. *For example*:
  - Vomiting and diarrhea easily controlled with oral medication
- Mild-Moderate psychiatric signs and symptoms due to intoxication that is expected to predictably resolve

No specific needs = Risk Rating 0

Acute Withdrawal and Associated Risks

The withdrawal risk Criteria are not specific to substance. When applying the Withdrawal Risk Criteria, the medical provider should consider potential interactions between withdrawal syndromes when the patient has risks associated with multiple substances that elicit physiologic withdrawal. In addition, the assessment of risks should consider the likely response to treatment (e.g., initiation of methadone or buprenorphine).

Level 4 = Risk Rating 4

1. The patient is experiencing very severe withdrawal, or evidence suggests that very severe withdrawal is imminent, that requires the resources of an acute care setting. *Examples include, but are not limited to*:
   - Very severe neurological signs or symptoms. *For example:*
     - Uncontrollable or unexplained generalized tonic clonic seizures
     - New onset seizures
     - Delirium tremens
     - Meets criteria for Wernicke's or Korsakoff's
   - Very severe cardiovascular signs and symptoms. *For example:*
     - Malignant dysrhythmias
     - Hypertensive emergency
     - Concern for syncope of cardiac origin
   - Very severe gastrointestinal signs and symptoms. *For example*:
     - Intractable vomiting and/or diarrhea (not controlled by medication)
   - Very severe psychiatric signs and symptoms. *For example*:
     - Violent and impulsive behavior
     - Unexplained or unmanageable psychosis
     - Imminent threat to self or others
     - Severe agitation refractory to medications

    - Other signs or symptoms that may require a secure unit
- Other very severe signs or symptoms due to withdrawal that meet med-surg criteria for hospitalization. *For example*:
    - Unstable or abnormal vital signs that are unexplained and/or not responsive to standard treatment (e.g., hypotension, hyperthermia, hypothermia)
    - Concern for sepsis
- Patients who need services only available in an acute care setting. *For example*:
    - Patients who need continuous cardiac monitoring
    - Patients who need titratable infusions

OR

2. The patient is experiencing severe withdrawal, or evidence suggests that severe withdrawal is imminent, AND the patient is not responding to standard medications

OR

3. The patient is experiencing severe withdrawal, or evidence suggests that severe withdrawal is imminent, AND the patient has a co-occurring physical or mental disorder that is expected to be exacerbated during withdrawal and requires medical management. *For example:*
    - Alcohol or sedative withdrawal and poorly controlled seizure disorder
    - Unstable coronary artery disease and otherwise meets the Withdrawal Risks criteria for 3.7
    - Dysrhythmia and otherwise meets the Withdrawal Risks criteria for 3.7
    - Dialysis dependent patient who otherwise meets the Withdrawal Risks criteria for 3.7
    - Patient with acute liver failure (acute hepatitis) or acute renal failure who otherwise meets the Withdrawal Risks criteria for 3.7
    - Patient with <u>persistent</u> hyperglycemia (>300 glucose) or <u>persistent</u> hypoglycemia (<60) despite treatment who otherwise meets the Withdrawal Risks criteria for 3.7
    - Unstable psychiatric disorder and otherwise meets the Withdrawal Risk criteria for 3.7

OR

4. The patient is experiencing severe withdrawal from alcohol and/or sedative/hypnotics, or evidence suggests that severe withdrawal is imminent AND the patient has a history of very severe uncontrollable withdrawal syndrome.

Minimum Level 3.7 = Risk Rating 3B

1. The patient is experiencing, or expected to imminently experience, moderately severe to severe signs and symptoms of withdrawal, <u>WITH</u> the need for after-hours medical monitoring, but not the full resources of an acute care hospital. *<u>Examples include, but are not limited to</u>*:

    - Moderately severe to severe neurological signs or symptoms. *For example*:
        - Controllable and explainable generalized tonic clonic seizures

- Moderately severe to severe cardiovascular signs and symptoms. *For example*:
  - Controllable and explainable moderately severe to severe hypotension or hypertension
  - Controllable and explainable moderately severe to severe hypothermia or hyperthermia
  - Controllable and explainable moderately severe to severe bradycardia or tachycardia
- Moderately severe to severe gastrointestinal signs and symptoms. *For example*:
  - Persistent vomiting or diarrhea that is responsive to medications
- Moderately severe to severe psychiatric signs and symptoms. *For example*:
  - Moderately severe to severe agitation that is responsive to medications
  - Moderate to severe psychosis, responsive to IV or PO medications, without immediate risk of harm to self or others
- Patients who need services not available in a less intensive level of care. *For example*:
  - Patients who need IV medications or other medical services outside of normal business hours (e.g., post operative patients with pain adequately controlled with oral medications who need ongoing medical support (e.g., wound care needs)
  - The patient or available support system are unable to follow instructions necessary for withdrawal management in an intensive outpatient care setting

OR

2. The patient is experiencing moderate signs and symptoms of withdrawal AND has a co-occurring physical or mental disorder that complicates withdrawal and requires medical monitoring. *For example*:

   - Poorly controlled diabetes and the patient otherwise meets the Withdrawal Risks criteria for 2.7
   - Poorly controlled hypertension and the patient otherwise meets the Withdrawal Risks criteria for 2.7
   - Unstable psychiatric disorder and the patient otherwise meets the Withdrawal Risks criteria for 2.7
   - Significant impairment in ability to manage activities of daily living and the patient otherwise meets the Withdrawal Risks criteria for 2.7
   - Suicidal or homicidal ideation without an immediate threat to self or others and the patient otherwise meets the Withdrawal Risks criteria for 2.7

OR

3. The patient is experiencing moderate withdrawal from alcohol and/or sedative-hypnotics, AND the patient has a history of severe withdrawal syndrome (e.g., delirium tremens, seizures) that was controllable with treatment.

Minimum Level 3.5 = Risk Rating 3A

The patient is experiencing mild withdrawal or post-acute withdrawal symptoms, and needs residential care to monitor for any changes in status; and/or to assist with medication adherence. A physician or advanced practice provider has determined that the patient is not at risk for severe withdrawal, and does not require medical management or monitoring. The patient

lacks sufficient support and monitoring at home to ensure safety and continued engagement in care during the post-acute phase of withdrawal. *Examples may include but are not limited to:*

- The patient has been receiving treatment in Level 3.7 or Level 4 for benzodiazepine withdrawal, and no longer requires 24-hour nursing care/medical management or monitoring, but needs residential care to support medication adherence and monitor for changes in status; AND the patient lacks sufficient support and monitoring at home.
- The patient is in stimulant withdrawal and is experiencing mild lethargy or paranoia. The patient does not require medical management or monitoring but needs 24-hour clinical monitoring to monitor for changes in status and support continued engagement in care; AND the patient lacks sufficient support and monitoring at home.

Minimum Level 2.7 = Risk Rating 2

1. The patient is experiencing, or expected to imminently experience, moderately severe to severe signs and symptoms of withdrawal, WITHOUT the need for after-hours medical monitoring. *Examples include, but are not limited to*:

    - Moderately severe to severe neurological signs or symptoms AND the patient does not need after-hours medical monitoring. *For example:*
        - Controllable and explainable (i.e., known seizure disorder) generalized tonic clonic seizures AND the patient has sufficient monitoring and support at home
        - Controllable and explainable somnolence
    - Moderately severe to severe cardiovascular signs or symptoms AND the patient does not need after-hours medical monitoring. *For example:*
        - Controllable and explainable hypotension or hypertension
        - Controllable and explainable hypothermia or hyperthermia
        - Controllable and explainable bradycardia or tachycardia
    - Moderately severe to severe gastrointestinal signs or symptoms AND the patient does not need after-hours medical monitoring. *For example:*
        - Persistent vomiting or diarrhea that is responsive to oral meds
    - Moderately severe to severe psychiatric signs or symptoms with minimal risk of hallucinations, dissociation, or severe affective disorder during unobserved periods outside the program AND the patient does not need after-hours medical monitoring. *For example:*
        - Moderate to severe agitation responsive to oral medication
        - Moderate to severe psychosis responsive to oral medication without immediate risk of harm to self or others
        - Moderately severe paranoia
        - Moderately severe depression or anxiety

OR

2. The patient is experiencing, or expected to imminently experience, moderately severe to severe signs and symptoms of withdrawal AND needs services that are not available in a lower level of care (e.g., patients who need IV medications during normal business hours)

OR

3. The patient meets the Withdrawal Risk criteria for Level 1.7 AND the patient or available support system are unable to follow instructions necessary for withdrawal management AND the patient has sufficient support to enable them to engage in Level 2.7 services

Minimum Level 1.7 = Risk Rating 1

The patient is experiencing, or expected to experience, mild to moderate signs and symptoms of withdrawal that interfere with daily functioning but do not pose imminent danger. Minimal risk of severe withdrawal. The patient/support persons can clearly understand and follow instructions necessary for care at this level. *Examples include, but are not limited to*:

- Mild-Moderate neurological signs or symptoms due to withdrawal that are expected to predictably resolve
- Mild-Moderate abnormalities of vital signs due to withdrawal that are expected to predictably resolve
- Mild-Moderate gastrointestinal signs and symptoms due to withdrawal that are expected to predictably resolve. *For example*:
    - Vomiting and diarrhea controlled with oral medication
- Mild-Moderate psychiatric signs and symptoms due to withdrawal that are expected to predictably resolve

No specific needs = Risk Rating 0

MOUD needs

Minimum 3.7 for MOUD initiation or transition = Risk Rating D

1. The patient is experiencing or at risk for opioid withdrawal AND another withdrawal syndrome (e.g., recent polysubstance use with risk factors for withdrawal)

OR

2. The patient has an OUD and is not currently on MOUD AND has a history of difficulty with initiation of MOUD.

OR

3. The patient will be transitioned from methadone or buprenorphine to naltrexone

OR

4. The patient is experiencing or at risk for opioid withdrawal and wants to initiate naltrexone

OR

5. The patient is pregnant and has a severe OUD with frequent use of synthetic opioids (e.g., fentanyl)

Minimum 2.7 for MOUD initiation = Risk Rating C

1. The patient has a severe OUD with frequent use of synthetic opioids (e.g., fentanyl)

OR

2. The patient is transitioning from methadone to buprenorphine

Minimum 1.7 MOUD initiation or transition = Risk Rating B

1. The patient has an opioid use disorder and is not currently on MOUD (and uncomplicated MOUD initiation is anticipated)

MOUD continuation (minimum 1.5, or program with ability to coordinate care with an OTP if patient is on methadone) = Risk Rating A

While all ASAM levels of care will require access to MOUD, some programs may not be able to support continuation of methadone due to logistical challenges (e.g., nearest OTP is more than 30 miles away). Until all programs can support continuation of methadone treatment, the algorithm will flag the need for continuation of MOUD to ensure that this is considered during placement.

1. The patient is currently taking medication for opioid use disorder and needs to continue this medication

No specific needs = Risk Rating 0

Dimension 2 – Biomedical Conditions

When applying the Dimension 2 admission criteria the medical provider should determine whether the physical health issues interact with the SUD. Chronic biomedical conditions that are poorly controlled, but not influenced by intoxication, withdrawal, or SUD, should not determine admission, and should be referred to general medical treatment system.

The program's admission criteria should not exclude patients on the basis of a current or past biomedical conditions alone; the appropriateness of admission should be determined based on the severity and acuity of the patient's biomedical conditions as outlined in The ASAM Criteria dimensional admission rules. Similarly, pregnancy alone is not a reason to exclude patients from being admitted to any Level of Care.

Physical health concerns

Level 4 = Risk Rating 4

1. The patient is experiencing unstable physical health problems that require 24-hour medical management and/or the full resources of an acute care hospital. *Examples include, but are not limited to*:
    - Very severe neurological signs or symptoms. *For example*:
        - Uncontrollable generalized tonic clonic seizures

- New onset seizure
- Signs or symptoms of stroke
- Meets criteria for Wernicke's or Korsakoff's
- Sudden, significant deficits in balance, gait, sensory, or motor abilities (not related to intoxication)
- Significant head trauma or injury in the past 48 hours
- Loss of consciousness from physical trauma in the past 48 hours

- Very severe cardiovascular signs and symptoms. *For example*:
  - Malignant arrhythmias
  - Hypertensive emergency
  - Signs or symptoms of acute myocardial infarction
  - Concern for syncope of cardiac origin
- Very severe respiratory signs and symptoms. *For example*:
  - Asthma not controlled by medications
  - COPD exacerbation requiring monitoring, medication, and airway management
  - Serious respiratory depression
- Very severe gastrointestinal signs and symptoms. *For example*:
  - Intractable vomiting and diarrhea (not controlled by medication)
  - Vomiting blood (hematemesis)/concerns for gastrointestinal bleeding
  - Concern for acute pancreatitis
- Very severe hepatic or renal signs or symptoms. *For example*:
  - Acute jaundice or other signs or symptoms consistent with acute liver failure
  - Signs or symptoms consistent with acute renal failure
- Very severe hematological signs and symptoms. *For example*:
  - Uncontrolled bleeding
  - Concern for pancytopenia
- Very severe infectious signs or symptoms. *For example*:
  - Concern for endocarditis or associated infection
  - Concern for sepsis
  - Skin infections not controlled by current antibiotic regimen
  - Other severe infection requiring intravenous antibiotics
- Very severe endocrine signs or symptoms. *For example*:
  - Diabetic emergency (e.g., diabetic ketoacidosis (DKA); extreme hypo- or hyperglycemia)
  - Signs or symptoms consistent with new onset Addison's
- New onset severe acute pain
- Other very severe signs and symptoms that meet med-surg criteria for hospitalization. *For example*:
  - Unstable or abnormal vital signs that are unexplained and/or not responsive to standard treatment
- Patients who need services only available in an acute care setting. *For example*:
  - Patients who need continuous cardiac monitoring
  - Patients who need titratable infusions
  - Patients who need rapid and/or frequent access to laboratory and/or imaging studies

OR

2. The patient has moderately severe to severe acute physical health problems that may be exacerbated by intoxication or withdrawal and require monitoring in an acute care setting (e.g., poorly controlled seizure disorder, poorly controlled hypertension)

Minimum Level 3.7 = Risk Rating 3B

1. The patient has explainable and controllable, moderately severe to severe acute physical health problems that require 24-hour nursing and/or medical monitoring, but do not require the full resources of an acute care hospital. *Examples include, but are not limited to*:

    - Moderately severe to severe neurological signs or symptoms. *For example:*
        - Poorly controlled seizure disorder but no recurrent seizures in past 24 hours
        - Active neurological disorder (e.g., multiple sclerosis, Parkinson's disease) that requires mobility assistance and/or medication monitoring, without sufficient home support to enable access to daily care in a Level 2.7 program
    - Moderately severe to severe cardiovascular signs and symptoms. *For example:*
        - Controllable and explainable hypotension or hypertension
        - Controllable and explainable bradycardia or tachycardia
    - Moderately severe to severe respiratory signs and symptoms (without anticipated need for mechanical ventilation)
    - Moderately severe to severe gastrointestinal signs and symptoms
    - Moderately severe to severe hematological signs and symptoms
    - Moderately severe to severe infectious signs or symptoms. *For example:*
        - Infections under treatment that require medication monitoring due to severity of illness or medication adherence challenges (e.g., tuberculosis, hepatitis C, significant injection site abscess, bacterial pneumonia)
    - Moderately severe to severe endocrine signs or symptoms. *For example:*
        - Diabetic urgency (e.g., severe hypo- or hyperglycemia that responds to medication) without signs of active organ damage
    - Moderately severe to severe immunological signs or symptoms. *For example:*
        - Autoimmune disorder flareup requiring intensive symptom management but not hospitalization
    - Moderately severe to severe hepatic or renal signs or symptoms. *For example:*
        - Active hepatitis from known cause with mild-moderately impaired liver function but not liver failure
        - Dialysis-dependent renal failure that requires mobility assistance and/or medication monitoring, without sufficient home support to enable access to daily care in a Level 2.7 program
    - Other moderately severe to severe abnormalities in vital signs. *For example:*
        - Controllable and explainable hypothermia or hyperthermia
    - Patients who need services not available in a less intensive level of care. *For example:*
        - Need for wound care (e.g., for severe injection site abscess requiring debridement)
        - Need for ostomy care (e.g., for new ostomy or ostomy site infection)
        - IV medications
        - Overnight nursing care

OR

2. The patient has moderate to severe acute physical health problems that may be exacerbated by intoxication or withdrawal and require 24-hour observation or monitoring but do not require the full resources of an acute care hospital.

OR

3. The patient meets the Dimension 2 admission criteria for Level 2.7 AND cannot reliably access daily care at Level 2.7.

Minimum Level 3.5 = Risk Rating 3A

The patient recently received treatment at Level 3.7 or Level 4 for acute issues in Dimension 2, and these issues no longer require 24-hour nursing or medical monitoring, but still require 24-hour residential care to monitor for any changes in status; AND the patient does not have adequate home monitoring to ensure safety.

Minimum Level 2.7 = Risk Rating 2

1. The patient has explainable and controllable moderately severe to severe acute but non-life-threatening physical health problems that impact daily functioning and may interfere with SUD treatment and recovery and do not require after-hours medical monitoring. AND the patient CAN reliably access daily care at Level 2.7. *Examples include, but are not limited to*:

    - Moderately severe to severe neurological signs or symptoms AND the patient does not need after-hours medical monitoring. *For example:*
        - Active neurological disorder that requires mobility assistance and/or medication monitoring, with sufficient home support to enable access to daily care in a Level 2.7 program
    - Moderately severe to severe cardiovascular signs and symptoms AND the patient does not need after-hours medical monitoring. *For example:*
        - Controllable and explainable hypotension or hypertension
        - Controllable and explainable bradycardia or tachycardia
    - Moderately severe to severe respiratory signs and symptoms AND the patient does not need after-hours medical monitoring.
    - Moderately severe to severe gastrointestinal signs and symptoms AND the patient does not need after-hours medical monitoring
    - Moderately severe to severe hematological signs and symptoms AND the patient does not need after-hours medical monitoring
    - Moderately severe to severe infectious signs or symptoms AND the patient does not need after-hours medical monitoring. *For example:*
        - Infections under treatment that require medication monitoring due to severity of illness or medication adherence challenges (e.g., tuberculosis, hepatitis C, significant injection site abscess, bacterial pneumonia)
    - Moderately severe to severe endocrine signs or symptoms AND the patient does not need after-hours medical monitoring. *For example:*
        - Poorly controlled diabetes (may be associated with HbA1C <10%)
        - Diabetes requiring sliding scale management for insulin control (e.g., severe swings in blood glucose; frequent episodes of hypo- or hyperglycemia)
    - Moderately severe to severe immunological signs or symptoms AND the patient does not need after-hours medical monitoring. *For example:*

- Autoimmune disorder flareup requiring intensive symptom management but not after-hours observation or monitoring

- Moderately severe to severe hepatic or renal signs or symptoms AND the patient does not need after-hours medical monitoring. *For example:*
  - Active hepatitis causing impaired liver function (but not liver failure)
  - Dialysis-dependent renal failure that requires mobility assistance and/or medication monitoring, WITH sufficient home support to enable access to daily care in a Level 2.7 program
- Other moderately severe to severe abnormalities in vital signs AND the patient does not need after-hours medical monitoring. *For example:*
  - Controllable and explainable hypothermia or hyperthermia
- Patients who need services not available in a less intensive level of care AND the patient does not need after-hours medical monitoring. *For example:*
  - Patients requiring frequent laboratory monitoring

OR

2. The patient has moderate to severe acute physical health problems (e.g., complex partial seizure disorder, hypertension, diabetes) that may be exacerbated by intoxication or withdrawal and require observation but do not require after-hours observation or monitoring.

Minimum Level 1.7 = Risk Rating 1

The patient has mild to moderate acute health problems that impact daily functioning but will not interfere with SUD treatment and recovery. *Examples include, but are not limited to*:

a. Medication initiation for mild to moderate infection
b. Medication initiation/adjustment for other acute mild to moderate physical health concerns

No specific needs = Risk Rating 0

Pregnancy-related concerns

Level 4 = Risk Rating 4

The patient's pregnancy is immediately unstable (e.g., acute vaginal bleeding, contractions, or cessation of fetal movement, concern for preeclampsia (e.g., new hypertension), leakage of fluid unstable fetal heartbeat, cardiomyopathy) and requires fetal monitoring, 24-hour medical management, and/or the full resources of an acute care hospital.

Minimum Level 3.7 = Risk Rating 3

The patient is pregnant and requires frequent medical monitoring for non-life-threatening pregnancy complications (e.g., stable gestational diabetes or chronic hypertension), including after-hours medical monitoring, but does not require fetal monitoring or 24-hour medical management

Minimum Level 2.7 = Risk Rating 2

The patient is pregnant and requires frequent outpatient medical monitoring for non-life-threatening pregnancy complications (e.g., stable gestational diabetes or chronic hypertension) but does not require fetal monitoring or after-hours medical monitoring.

Minimum Level 1.7 = Risk Rating 1

The patient is pregnant, is at low or average risk of pregnancy complications, and requires assistance with coordination of prenatal care.

No specific needs = Risk Rating 0

Dimension 3 – Psychiatric and Cognitive Conditions

The program's admission criteria should not exclude patients on the basis of a current or past mental health disorder diagnosis alone; the appropriateness of admission should be determined based on the severity and acuity of the patient's psychiatric concerns as outlined in The ASAM Criteria dimensional admission rules.

Suicidal ideations alone are not a reason to deny admission. All programs should be co-occurring capable, including being able to assess and triage patients to who report suicidal ideations to determine if they need a psychiatric assessment/higher LOC.

Active Psychiatric Symptoms

Level 4 COE = Risk Rating 4 (inpatient psychiatric hospital or inpatient psychiatric unit within an acute care hospital)

1. The patient has psychiatric concerns that pose an acute risk of serious harm to self or others or deterioration without daily psychiatric management, 24-hour psychiatric nursing, and/or the level of programming and structure, secure staffing and support provided by a psychiatric inpatient setting. The patient does NOT require inpatient medical management for very severe withdrawal or life-threatening biomedical problems (otherwise, the patient should be treated in a Level 4 acute care hospital, then transferred to inpatient psychiatric once their withdrawal and/or biomedical conditions are stabilized). *Examples include, but are not limited to*:
    - Immediate risk of suicide, homicide, or very severe self-harm
    - Active, uncontrolled violent impulses
    - Acute mental status changes (e.g., psychosis or mania) with unpredictable, disorganized, or violent behavior
    - Severe treatment resistant depression with need for complex management, including consideration for interventional psychiatry (e.g., electroconvulsive therapy, transcranial magnetic stimulation)
    - Need for high-intensity monitoring, along with need for daily medication adjustments based on potential for significant side effects, metabolic risk, or other factors
    - Acute, severe psychiatric symptoms that require medication AND the patient actively resists medication assistance.
    - Other signs or symptoms which may require a secure unit

OR

2. The patient has psychiatric concerns that otherwise meet criteria for psychiatric inpatient hospitalization.

OR

3. The patient meets Dimension 3 Criteria for Level 3.7 COE, but psychiatric concerns are exacerbated by intoxication, withdrawal, or co-occurring Dimension 2 concerns and require monitoring in an acute psychiatric care setting.

Minimum Level 3.7 COE = Risk Rating 3F

1. The patient has psychiatric concerns at a level of acuity that requires active medical treatment, symptom management, and/or support in a 24 hour medically managed setting, but does NOT require the full resources of a psychiatric inpatient unit. *Examples include, but are not limited to*:

    - Active suicidal and/or homicidal ideation with some intent to act without a specific plan[3], AND patient demonstrates ability to seek help before acting and secured setting is not required (as determined by a qualified mental health professional).
    - Active, frequent impulses to harm self or others, but patient has ability to maintain control with 24-hour access to staff support
    - Acute mental status changes (e.g., psychosis or mania) without unpredictable or violent behavior
    - Active psychiatric concerns that require frequent but not daily management of complex psychiatric medication regimen (e.g., initiation or adjustment of multiple psychiatric medications, with need for residential medical monitoring during medication changes due to psychiatric instability and/or potential for severe but non-life-threatening side effects), AND patient is willing to take medications

OR

2. The patient seeking SUD treatment has other psychiatric concerns that otherwise meet criteria for a sub-acute psychiatric residential setting (e.g., Level 5 in LOCUS).

OR

3. The patient otherwise meets Dimension 3 Criteria for Level 2.7 COE, and psychiatric concerns may be exacerbated by intoxication, withdrawal, or co-occurring Dimension 2 concerns and require monitoring in a sub-acute residential care setting.

Minimum Level 3.7 = Risk Rating 3E

The patient has psychiatric concerns at a level of acuity requiring medication initiation, adjustment, or adherence support with after-hours medical monitoring (e.g., due to non-life-threatening metabolic risk or side effects of psychiatric medications), but does not require specialty psychiatric assessment or management or high intensity staff support (i.e., higher staff-to-patient ratios as in Level 3.7 COE). *Examples include, but are not limited to*:

[3] Note: Language is aligned with the Columbia Suicide Severity Ratings Scale.

- Psychiatric concerns (e.g., depression or anxiety) that require medical intervention, and medication can be managed by a non-specialist physician (e.g., patient requires initiation of, or dose titration for, a single psychiatric medication), but potential interactions with Dimension 1 or 2 (e.g., medication interactions) require 24/7 medical monitoring.
- Moderately severe psychiatric disorder (e.g., panic disorder, PTSD) that requires additional doses of controlled psychiatric medication as needed (prn), but patient cannot safely and reliably self-administer the medication, AND lacks sufficient supports or monitoring at home.

Minimum Level 3.5 COE = Risk Rating 3D

1. The patient has psychiatric concerns at a level of acuity that impacts safety and/or function to the point of requiring intensive mental health focused psychotherapy or 24/7 on-call psychiatric support; AND 24-hour residential supervision to monitor for changes in status and rapidly respond to medical concerns that may arise; but the patient has sufficient control so as not to require an acute or sub-acute psychiatric setting. *Examples include, but are not limited to*:

    - Recurrent suicidal and/or homicidal ideation without intent or plan, but with history of attempt, requires close monitoring and specialized psychotherapeutic interventions.
    - Active hallucinations and/or delusions, with mostly intact reality testing and no harmful impulses, require close monitoring and specialized psychotherapeutic interventions.
    - Functional deficits are so severe (e.g., extremely poor impulse control, severe sequelae of physical, sexual, or emotional trauma) that the patient is not likely to maintain mental stability if treatment is not provided in a residential setting with 24-hour, supervision, structure and support, and psychiatrically trained staff.
    - Antisocial behaviors (e.g., oppositional defiant disorder, low anger management skills with frequent verbal aggression) and attitudes (e.g., extreme lack of concern for others or regard for authority) prevent the patient from progressing toward recovery without specialized mental health treatment provided in a setting with 24-hour supervision, structure, and support, and psychiatrically trained staff.
    - Mood, personality or thought disorder(s) significantly limit and at times preclude the patient's ability to focus on recovery efforts, making the patient vulnerable to dangerous consequences outside of a treatment setting with 24-hour, supervision, structure, and support, and psychiatrically trained staff.
    - Other active psychiatric illness that regularly requires specialized psychotherapeutic interventions, including after hours.

OR

2. Patient has recently been treated in Level 3.7 COE and is stable on medication regimen but requires 24- hour monitoring to ensure behavioral stability and adherence to medication.

Minimum Level 3.5 = Risk Rating 3C

The patient has psychiatric concerns with periodic crises that require 24-hour supervision and/or access to an on-call physician after hours, and intensive psychotherapy, but do NOT require specialty psychiatric assessment or management, or high intensity staff support (higher staff-to-patient ratio, as in Level 3.5 COE). *Examples include, but are not limited to*:

- Intermittent suicidal ideation without intent or plan, requiring overnight monitoring and additional psychosocial support (but NOT medication management or mental health focused psychotherapy) to de-escalate.

- Moderate-complexity psychiatric concerns (e.g., depression or anxiety) with common exacerbation requires medication adherence support and/or non-specialized behavioral crisis intervention after hours.
- Other psychiatric symptoms (e.g., psychosis) for which patient is receiving external mental health care, with occasional non-violent exacerbation, which require non-specialized clinical monitoring and "as needed" (prn) additional medication doses (oral).

Minimum Level 3.1 COE = Risk Rating 3B

The patient has psychiatric concerns that interfere with SUD treatment and recovery to the point of requiring 24-hour residential structure and support, and skilled mental health treatment, but do NOT require 24-hour supervision or on-call psychiatric support. *Examples include, but are not limited to*:

- Suicidal and/or homicidal ideation without intent, plan, or history of attempt requires monitoring (including overnight), but not 24-hour supervision, for escalation of symptoms.
- Hallucinations and/or delusions require monitoring (including overnight), but not 24-hour supervision, but reality testing is intact, and the patient has no impulses to harm self or others.
- Mood, personality, or thought disorder impact patient's ability to focus on recovery efforts outside of a residential treatment setting, but with regular staff support, including overnight, the patient is able to engage in treatment and safely access the community during the day for work, school, or other treatment/social services.
- Other psychiatric illness regularly requires enhanced staff support and after-hours staff interventions (e.g., medication adherence support and specialized psychotherapeutic interventions) to help the individual manage symptoms and function semi-independently in the community.
- Functional deficits (e.g., sequelae of physical, sexual, or emotional trauma) make it difficult for the patient to maintain mental stability without regular support from skilled mental health staff, including overnight; but with access to this support, the patient is able to safely access the community during the day (e.g., for work, school, other treatment, or social services).

Minimum Level 3.1 = Risk Rating 3A

1. The patient has psychiatric concerns that are currently stable, and patient is usually able to function during the day in the community but requires overnight monitoring to ensure continued stability and optimal participation in treatment. The patient does NOT require specialty psychiatric assessment or management, intensive psychotherapy, or high intensity staff support. *Examples include, but are not limited to*:

- Psychiatric and/or cognitive symptoms (e.g., from schizophrenia) are well-controlled with consistent daily medication, but patient is unable to reliably self-administer medication AND lacks sufficient home support to help ensure medication adherence or monitor for changes in symptom severity or function.
- Low-complexity psychiatric concerns (e.g., depression or anxiety) impact patient's ability to focus on recovery efforts outside of a residential treatment setting, but with access to 24-hour support the patient is able to participate in treatment and access the community safely and independently for work, school, or other treatment/social services.
- Functional deficits (e.g., sequelae of physical, sexual, or emotional trauma) require non-specialized afterhours support but the patient is able to function in the community during the day.

OR

2. The patient has low-complexity psychiatric concerns with occasional exacerbations of psychiatric symptoms that require overnight monitoring but do not require specialty psychiatric assessment or management; AND patient does not have sufficient overnight monitoring at home.

Minimum Level 2.7 COE = Risk Rating 2D

1. The patient has psychiatric concerns at a level of acuity that interferes with SUD treatment and recovery, and requires frequent medication management such that the patient is unlikely to maintain stability without daily or near-daily clinical contact. Patient has adequate impulse control to resist acting upon any thoughts of harm to self or others, if present. The patient CAN reliably access daily care at Level 2.7 and does not require after-hours monitoring. *Examples include, but are not limited to*:

    - Active suicidal ideation without intent, plan, or history of attempt(s), and patient reliably contracts for safety and has adequate overnight support to ensure safety; requires daily or near-daily monitoring and regular medication adjustments.
    - Active mild to moderate psychotic illness with intact reality testing, no urges to harm self or others, and adequate overnight support to ensure safety; requires daily or near-daily monitoring and regular medication adjustments.
    - Acute, moderate impairment in ability to manage activities of daily living (e.g., due to psychiatric decompensation), requires daily monitoring and regular medication adjustments, but minimal function and self-care are intact.
    - Psychiatric disorder distracts patient from SUD treatment and requires active psychiatric management and stabilization concurrent with addiction treatment (e.g., unstable borderline personality disorder, compulsive personality disorder, or mood disorder).

OR

2. The patient meets Dimension 3 Criteria for Level 1.7 COE, and psychiatric concerns may be exacerbated by intoxication, withdrawal, or co-occurring Dimension 2 concerns and require monitoring and medication adjustment in a medically monitored intensive outpatient setting.

Minimum Level 2.7 = Risk Rating 2C

The patient has psychiatric concerns with occasional exacerbations of psychiatric symptoms that require daily or near-daily clinical contact and regular medication adjustments to successfully engage in SUD treatment, but do NOT require specialty psychiatric assessment or management. Patient has adequate impulse control to resist acting upon any thoughts of harm to self or others, if present. The patient CAN reliably access daily care at Level 2.7 and does not require after-hours monitoring. *Examples include, but are not limited to*:

- Low-moderate severity, common psychiatric concerns (e.g., depression or anxiety) that require initiation or adjustment of psychiatric medication and daily or near-daily monitoring to support medication adherence and treatment engagement; medication can be managed by a non-specialist physician (e.g., single psychiatric medication, no complications anticipated), but patient needs frequent contact due to history of side effects leading to medication discontinuation, and/or emotional lability during medication transitions requiring more intensive psychotherapy).

Minimum Level 2.5 COE = Risk Rating 2B

The patient has psychiatric concerns at a level of acuity that requires near-daily management with a higher level of individualized staff support and skilled mental health treatment than provided at Level 2.5 (non-COE) to help address psychiatric symptoms and maintain stability during SUD treatment. Patient has adequate impulse control to resist acting upon any thoughts of harm to self or others, if present. The patient can reliably access daily care at Level 2.5 and does not require after-hours monitoring. *Examples include, but are not limited to*:

- Psychiatric disorder (e.g., borderline personality disorder, compulsive personality disorder, or mood disorder) distracts patient from SUD treatment and requires near-daily skilled mental health treatment, active behavior management, and stabilization concurrent with addiction treatment.
- Significant trauma history with recent exacerbation and worsening anxiety contributing to SUD symptoms that requires near-daily skilled mental health treatment for recurrent refocusing, active behavior management, and stabilization.
- Mild to moderate psychotic illness requires near-daily skilled mental health treatment for individualized symptom management in order to participate effectively in SUD treatment.

Minimum Level 2.5 = Risk Rating 2A

The patient otherwise meets the ASAM Dimensional Admission Criteria for Level 2.1 but interaction with active psychiatric symptoms requires a higher level of psychotherapy.

Minimum Level 1.7 COE = Risk Rating 1

The patient has psychiatric symptoms that may interfere with SUD treatment participation and recovery and requires access to psychiatric medication initiation or adjustment within the SUD program; AND patient is able to function sufficiently and adhere to medication regimen with weekly or less frequent contact. No threats to safety or medication-related complications are anticipated. The patient CAN reliably access daily care at Level 1.7 and does not require after-hours monitoring. *Examples include, but are not limited to*:

- Unstable low complexity non-psychotic illness (e.g., mood, anxiety, OCD) without active suicidal ideation, requires medication initiation or regular medication adjustment in order to participate effectively in the SUD treatment.
- Mild psychotic illness requires medication initiation or adjustment in order to participate effectively in the SUD treatment.

No specific needs = Risk Rating 0

Persistent Disability

Minimum Level 3.5 COE = Risk Rating 3W

The patient has severe impairment in ability to manage activities of daily living or to participate in group programming due to chronic psychiatric or cognitive disorder(s) that require a higher level of individual staff support, including high-intensity assistance to manage activities of daily living and/or engage in programming. *Examples include, but are not limited to*:

- Severely inadequate ability to manage activities of daily living (e.g., due to schizophrenia) render the patient unsafe outside of a 24-hour co-occurring enhanced setting and regularly require enhanced staff support and/or skilled mental health staff to manage activities of daily living and participate in treatment.
- Severe functional deficits (e.g., due to traumatic brain injury) regularly require enhanced staff support to enable meaningful engagement in treatment.
- Neurobehavioral disorder (e.g., ADHD, ASD, OCD) with significant difficulty organizing activities of daily living, including adherence to medication, resulting in symptom exacerbation, and regularly requiring enhanced staff support and/or skilled mental health staff to manage activities of daily living and participate in treatment.

Minimum Level 3.5 = Risk Rating 3X

The patient has severe impairment in ability to manage activities of daily living due to chronic psychiatric or cognitive disorder(s) and requires intensive staff support, including after hours, to successfully engage in SUD treatment; but does NOT require skilled mental health staff support. *Examples include, but are not limited to*:

- Difficulty in ability to manage activities of daily living (e.g., due to traumatic brain injury or dementia) renders patient unable to reliably attend outpatient treatment or access the community for work, school, or other activities.
- Functional deficits (e.g., intellectual disability, sequelae of physical, sexual, or emotional trauma) make it difficult for the patient to focus on treatment if provided outside of a setting with 24-hour supervision, structure, and support.
- Moderate-complexity neurobehavioral disorder (e.g., ADHD, ASD, OCD) with difficulty organizing activities of daily living, resulting in need for 24-hour supervision.

Minimum Level 3.1 COE = Risk Rating 3Y

The patient has moderate impairment in ability to manage activities of daily living due to chronic psychiatric or cognitive disorder(s) that regularly require a higher level of individual staff support than available in Level 3.1 (non-COE), including assistance managing activities of daily living and/or engaging in programming, and at least occasional afterhours support, but do NOT require regular support during the day. *Examples include, but are not limited to*:

- Functional deficits make it difficult for the patient to engage in treatment without regular support from skilled mental health staff; but with access to this support (including at least occasional afterhours support), the patient is able to engage meaningfully in treatment and safely access the community during the day (e.g., for work, school, other treatment, or social services).
- Patient experiences moderate, pervasive challenges in organizing activities of daily living (e.g., due to traumatic brain injury, ADHD, ASD, OCD), but with 24-hour access to support from skilled mental health staff, the patient is able to participate in treatment and safely access the community during the day (e.g., for occupational therapy, other rehabilitative services).

*Minimum Level 3.1 = **Risk** Rating 3Z*

The patient has moderate impairment in ability to manage activities of daily living due to chronic psychiatric or cognitive disorder(s) with intermittent need for additional staff support, including afterhours support, to successfully engage in SUD treatment, but does NOT require regular staff

support during the day, or skilled mental health treatment within the SUD program. *Examples include, but are not limited to*:

- Moderate-complexity neurobehavioral disorder (e.g., ADHD, ASD, OCD) presents challenges with some activities of daily living, including adherence to medication, with resulting symptom exacerbation; but with medication adherence support, including after-hours, patient is able to access the community safely and independently during the day.
- Mild but pervasive difficulty in ability to manage activities of daily living (e.g., due to traumatic brain injury, intellectual disability) makes it difficult for patient to reliably attend and succeed in outpatient treatment, but patient is able to access the community during the day for work, school, or support services.

*Minimum Level 2.5 COE = **Risk** Rating 2Z*

The patient has moderate to severe impairment in ability to manage activities of daily living due to chronic but stable psychiatric or cognitive disorder(s) and requires intensive, full-day staff support nearly every day (but NOT afterhours) in a flexible treatment environment with more individualized attention or a higher level of staff mental health skills than available in 2.5. *Examples include, but are not limited to*:

- Functional deficits (e.g., intellectual disability) cause difficulty with comprehension and/or concentration, and require near-daily intensive clinical contact to retain new information and reinforce SUD treatment gains.
- Neurobehavioral disorder (e.g., ADHD, ASD, OCD) presents challenges with activities of daily living (e.g., following a schedule, adhering to rules, and managing basic activities of daily living, including medication adherence) and patient needs regular availability of extra support to succeed in outpatient SUD treatment.
- Mood or personality disorder(s) (e.g., effects of longstanding trauma, significant anxiety disorder, borderline personality disorder, significant dysthymia) make it more difficult for the individual to handle routine interactions with staff and clients, and requires near-daily clinical contact with significantly more individualized support and flexibility (compared to Level 2.5 (non-COE) to support active participation in SUD treatment.

***Minimum Level 1.5 COE = Risk** Rating 1Z*

The patient has mild impairment in ability to process information, organize schedules, and manage activities of daily living due to chronic, stable psychiatric or cognitive disorder(s), and requires a more flexible treatment environment with more individualized attention or a higher level of staff mental health skills than are available in Level 1.5 (non-COE). The patient has sufficient support at home (or in recovery residence) to reliably access care at Level 1.5. *Examples include, but are not limited to*:

- Mild functional deficits (e.g., intellectual disability) cause some difficulty with comprehension and/or concentration, requiring skilled accommodation.
- Mild neurobehavioral disorder (e.g., ADHD, ASD, OCD) presents challenges with following a schedule, adhering to rules, and managing basic activities of daily living, and patient needs regular availability of extra support to succeed in adhering to the expectations and scheduling needs of outpatient SUD treatment.
- Baseline mental health conditions (e.g., mild sequela of trauma, depression, anxiety disorder, stable borderline personality disorder) require specialized mental health support and flexibility to maintain treatment gains and/or optimize functioning.

No specific needs = Risk Rating 0

Dimension 4 – Substance Use Related Risks

Likelihood of engagement in risky substance use

Minimum Level 3.5 = Risk Rating E

The patient lacks recognition or understanding of the potential consequences of substance use, and is at **high risk of use with imminent danger** and needs 24-hour clinical support and supervision to prevent substance use. *Examples include, but are not limited to*:

- The patient has a recent history of substance use with dangerous consequences (e.g., overdose, automobile accidents while intoxicated, victimization/engaging in violent behavior while using substances), AND one or more of the following is true:
  - The patient is unlikely to be able to cope with cravings to use without 24-hour structure, support, and supervision.
  - The patient is ambivalent to treatment.
  - The patient has active drug cravings and very limited ability to postpone immediate gratification.
  - The patient does not recognize substance use triggers and is unlikely to avoid substance use without 24-hour supervision.

Minimum Level 3.1 = Risk Rating D

The patient has impaired recognition and understanding of the potential consequences of substance use, and is at **moderately high risk of use with dangerous consequences** without residential structure and some supervision. The patient has some ability to use peer or community supports when at risk for continued use. *Examples include, but are not limited to*:

- The patient's recent patterns of use put them at moderately high risk for overdose, violent behavior, victimization, automobile accidents while intoxicated, or other dangerous consequences AND one or more of the following is true:
  - The patient has some awareness of use triggers, and is somewhat committed to treatment, but has difficulty implementing use prevention strategies without residential structure and support.
  - The patient has intermittent drug cravings and difficulty postponing immediate gratification without daily structure and residential support.

Minimum Level 2.5 = Risk Rating C

The patient has minimal recognition and understanding of the potential consequences of substance use, and is at **high risk of use with negative but not dangerous consequences**. The patient needs close outpatient monitoring and daily structured therapeutic services to achieve recovery; AND the patient has sufficient home supervision and support, or will be placed in a recovery residence with sufficient support and supervision, to cope with urges to use when not receiving treatment services. *Examples include, but are not limited to*:

- The patient is at high risk of job, relationship, or child custody loss, or other negative consequences of substance use, AND one or more of the following is true:

- The patient lacks sufficient awareness of triggers for use and is somewhat ambivalent toward treatment but is mostly able to resist urges to use with intensive daily clinical support.
- The patient has limited ability to use peer or community supports when at risk for use.
- The patient experiences frequent drug craving and has limited ability to postpone immediate gratification but is able to cope on an outpatient basis with intensive daily clinical support.

Minimum Level 2.1 = Risk Rating B

The patient has some recognition and understanding of the potential consequences of use and is at **moderate risk of use with negative but not dangerous consequences**. The patient needs intensive clinical support several times per week to achieve recovery goals; AND the patient has sufficient home structure and support, or will be placed in a recovery residence with sufficient support and supervision, to cope with urges to use when needed. *Examples include, but are not limited to*:

- The patient is at moderate risk of job, relationship, or child custody loss, or other negative consequences of substance use, AND one or more of the following is true:
  - The patient has some but not full awareness of use triggers; and is willing to participate actively in treatment to strengthen awareness and implement substance use prevention strategies.
  - The patient is often, but not always, able to use peer or community supports when at risk for substance use; and has expressed commitment to work on seeking support.
  - The patient occasionally experiences intensified SUD symptoms (e.g., mild to moderate difficulty postponing immediate gratification, drug craving) but is able to seek support and self-manage with prompting.

Minimum Level 1.5 = Risk Rating A

The patient recognizes and understands triggers for substance use, has at least fair self-management skills, and has **low risk of use with negative but not dangerous consequences**. The patient needs occasional clinical support to consolidate recovery goals. *Examples include, but are not limited to*:

- The patient is at mild risk of job or relationship loss, or other negative consequences of substance use, AND both of the following are true:
  - The patient has high awareness of use triggers, high commitment to treatment, and is able to prevent use with peer and community support and scheduled therapeutic contact.
  - The patient rarely experiences intensification of SUD symptoms (e.g., mild cravings but no return to use) and is assessed as able to achieve or maintain recovery goals.

No specific needs = Risk Rating 0

Likelihood of engaging in other harmful SUD related behaviors in current environment

Minimum Level 3.5 = Risk Rating E

The patient lacks recognition or understanding of the potential consequences of harmful SUD-related behaviors, and is at very high risk of engagement in these behaviors with very high likelihood of imminent danger (e.g., life-threatening physical or sexual violence). The patient needs 24-hour supervision to prevent these behaviors. *Examples include, but are not limited to*:

- The patient has a history of reincarceration with an uninterrupted pattern of return to substance use outside of incarceration.
- The patient is unable to resist drug cravings that lead them to repeatedly engage in behaviors harmful to their health and/or safety (e.g., risky commercial sex work, drug dealing).

Minimum Level 3.1 = Risk Rating D

The patient has impaired recognition and understanding of the potential consequences of harmful SUD-related behaviors, and is at moderately high risk of engagement in these behaviors with moderately high likelihood of dangerous consequences (e.g., serious injury) without residential structure and some supervision. *Examples include, but are not limited to*:

- Recent criminal justice involvement due to SUD-related behaviors, and the patient is somewhat committed to treatment, but has difficulty preventing engagement in behaviors that pose significant criminal/legal risks without residential structure and support.
- The patient has some difficulty resisting drug cravings that lead them to engage in behaviors harmful to their health and/or safety (e.g., risky commercial sex work, drug dealing), but is able to do so with daily structure and residential support.

Minimum Level 2.5 = Risk Rating C

The patient has minimal recognition and understanding of the potential consequences of harmful SUD-related behaviors (e.g., antisocial behaviors), and is at high risk of use with negative, but not life threatening, consequences (e.g., incarceration). The patient needs close outpatient monitoring and daily structured therapeutic services to achieve recovery; AND the patient has sufficient home supervision and support, or will be placed in a recovery residence with sufficient support and supervision, to prevent engagement in harmful SUD-related behaviors when not receiving treatment services. *Examples include, but are not limited to*:

- Significant criminal justice involvement due to SUD-related behaviors, and is ambivalent toward treatment, but is mostly able to avoid behaviors that put them at risk for significant criminal/legal consequences with intensive daily clinical support.
- The patient has limited ability to resist cravings that lead them to engage in SUD-related behaviors harmful to their health and/or safety (e.g., risky commercial sex work, drug dealing), and needs daily intensive clinical services to do so.

Minimum Level 2.1 = Risk Rating B

The patient has some recognition and understanding of the potential consequences of harmful SUD-related behaviors, and is at moderate risk of engaging in these behaviors with negative but not dangerous consequences (e.g., eviction; relationship or job loss). The patient needs intensive clinical support several times per week to achieve recovery goals; AND has sufficient home structure and support, or will be placed in a recovery residence with sufficient support and supervision, to cope with urges to engage in harmful SUD behaviors when needed. *Examples include, but are not limited to*:

- Recent criminal justice involvement due to substance-related behaviors, and patient has some understanding of relationship between substance use and incarceration, but needs frequent clinical support to avoid SUD-related behaviors that put them at risk for significant criminal/legal consequences.
- The patient has some ability to resist cravings that lead them to engage in behaviors harmful to their health and/or safety (e.g., risky commercial sex work, drug dealing), but needs frequent clinical support to do so.

Minimum Level 1.5 = Risk Rating A

The patient recognizes and understands the potential consequences of harmful SUD-related behaviors and has low risk of engaging in these behaviors, which would have negative but not disastrous consequences (e.g., relationship or job difficulties). The patient needs occasional clinical support to consolidate recovery goals. *Examples include, but are not limited to*:

- Previous criminal justice involvement due to substance-related behaviors, but patient has demonstrated understanding of the relationship between substance use and behaviors leading to criminal/legal consequences and the ability to seek support when needed.
- The patient has previously engaged in behaviors harmful to their health and/or safety to procure more drugs (e.g., risky commercial sex work, drug dealing), but has demonstrated the ability to self-manage cravings and avoid these behaviors, reliably seeking support as needed.

No specific needs = Risk Rating 0

Dimension 5 – Recovery environment

Ability to productively and independently function in the current environment*

WHO Disability Assessment Schedule (WHODAS 2.0) or similar tools can be used to assess function.

Minimum Level 3.5 = Risk Rating D

The patient has severe to extreme impairment in functional areas, such as life activities (taking care of household responsibilities, day to day work/school) or social relationships (e.g., creating and maintaining relationships, interacting appropriately with people around you/in community), and needs therapist led habilitative services in a 24-hour supervised environment with a therapeutic milieu to learn basic interpersonal skills and/or skills of independent living. *Examples include, but are not limited to*:

- The patient exhibits antisocial behaviors (e.g., defiance, hostility) and needs intensive monitoring and clinical services to learn prosocial skills and avoid sabotaging self or others in a group setting.
- The patient cannot perform basic functions of independent living, such as working or paying bills, due to lifelong immersion in dysfunctional family, social environments and/or long-term substance use.
- The patient is unable to create a safe daily routine or social support network due to severe SUD and/or significant socio-behavioral dysfunction and needs to learn these skills in a 24-hour residential setting to remain safe.

Minimum Level 3.1 = Risk Rating C

The patient has moderate functional impairment in life activities (taking care of household responsibilities, day to day work/school) or social relationships (e.g., creating and maintaining relationships, interacting appropriately with people around you/in community), and needs a low-intensity 24-hour structured environment with a therapeutic milieu to further develop basic interpersonal skills/skills of independent living and to step down to a recovery residence; AND the patient is able to safely participate in activities in the community (e.g., work, school, social activities) with accountability checks and residential support. *Examples include, but are not limited to*:

- The patient is learning prosocial skills, but occasionally has difficulty resolving interpersonal conflict and/or respecting boundaries in a group setting.
- The patient is learning to perform basic functions of independent living, such as holding a job or paying bills, and needs residential support and clinical reinforcement on a daily basis while beginning to function independently in the community.
- The patient is learning to create a safe daily routine and social support network, and requires residential structure and clinical services to support transition from habilitative services to recovery residence or independent living in the community.

Minimum Recovery Residence = Risk Rating B

The patient has mild functional impairment in life activities (taking care of household responsibilities, day to day work/school) or social relationships (e.g., creating and maintaining relationships, interacting appropriately with people around you/in community), and needs peer support and a residential safety net while practicing basic interpersonal skills and skills of daily living; AND the patient is able to safely access community and social supports, and is able to work and/or attend school (or engage in other daily activities in the community) without accompaniment or supervision. *Examples include, but are not limited to*:

- The patient has moderate social challenges (e.g., few friends, or conflicts with peers or co-workers) but has at least basic prosocial skills, and needs peer support to reinforce and consolidate these skills.
- The patient is able to perform basic functions of independent living, such as holding a job or paying bills, and needs peer support and structure to assist with self-discipline and accountability during the recovery process.
- The patient has created a safe daily routine and is strengthening their social support network, but still needs a residential safety net while establishing increasing recovery capital (e.g., through building resilience/emotional regulation through community-based conflict resolution, etc.).
- The patient is beginning to build a recovery supportive community but needs experiential peer recovery in order to build and sustain remission.

No specific needs = Risk Rating A

The patient has some difficulty in social, occupational, or school functioning but is generally functioning well in the current recovery environment, and has some meaningful interpersonal relationships.

Safety in current environment

Minimum safe housing[4] = Risk Rating B

The patient's environment is hostile and/or threatens the patient's safety or well-being. *Examples include, but are not limited to*:

- The patient's environment is characterized by physical, sexual, or emotional abuse.
- The patient is experiencing homelessness.

No specific needs = Risk Rating A

The patient's current environment is safe.

Support in current environment

Minimum Recovery Residence = Risk Rating B

The patient's environment does not provide sufficient support to help the patient cope with cravings to use or other recovery threats. *Examples include, but are not limited to*:

a. The patient's social milieu is so infused with substance use that it will render recovery unachievable.
b. The patient lives with individuals who regularly use or sell alcohol/other drugs who exert direct or indirect pressure on the patient to use substances.

No specific needs = Risk Rating A

The patient's current environment is supportive of recovery.

Level of Care Determination

For each subdimension, enter the risk rating and the indicated minimum level of care.

Subdimensions	Risk Rating
Dimension 1 - Acute intoxication and withdrawal potential	
Intoxication Associated Risks	Choose an item.
Withdrawal Risks	Choose an item.
MOUD Needs	Choose an item.
Dimension 2 – Biomedical Conditions	
Physical Health Concerns	Choose an item.
Pregnancy-Related Concerns	Choose an item.
Dimension 3 – Psychiatric and Cognitive Conditions	
Active Psychiatric Symptoms	Choose an item.
Functional Disability	Choose an item.
Dimension 4 – Substance Use Related Risks	
Likelihood of engaging in risky substance use	Choose an item.
Likelihood of engaging in other harmful SUD related behaviors	Choose an item.
Dimension 5 – Recovery environment	
Ability to productively and independently function in the recovery environment	Choose an item.

[4] Safe housing is defined as a stable housing environment where the patient is safe from physical, sexual, or emotional abuse.

Safety in current recovery environment	Choose an item.
Support in current recovery environment	Choose an item.

Level of Care Determination Rules

See Appendix D for Decision Tree.

Inpatient Care (Level 4 and Level 4 COE)

- If the patient need Level 4 treatment for Dimension 1 and/or Dimension 2: refer or transfer to **Level 4**
- If the patient needs Level 4 treatment for Dimension 3 ONLY: refer or transfer to **Level 4 COE**

Non-Inpatient Medically Managed Care (Levels 1.7, 2.7, and 3.7)

- If the patient does not need Level 4 care, first determine if the patient needs a medically managed level of care.
    - If any subdimension requires a minimum level of care of 1.7, 2.7, or 3.7 the recommendation should be for a medically managed level of care.
- Next determine if the patient requires outpatient, intensive outpatient, or residential medically managed care.
    - Do any subdimension requires a minimum of residential care (e.g., 3.1, 3.5, or 3.7)?
        - If yes: Recommend **Level 3.7**
        - If no: Do any subdimensions require intensive outpatient care (e.g., 2.1, 2.5, or 2.7)?
            - If yes: Recommend **Level 2.7**
            - If no: Recommend **Level 1.7**

Clinically Managed Residential Care (Levels 3.1 and 3.5)

- If the patient does not need medically managed care, determine if the patient needs residential treatment.
    - If any subdimension requires a minimum level of care 3.1 or 3.5, the recommendation should be for clinically managed residential care.
- What is the highest level of residential care indicated in any subdimension?
    - If 3.5: Recommend **Level 3.5**
    - If 3.1: Recommend **Level 3.1**

Clinically Managed Intensive Outpatient Care (Levels 2.1 and 2.5)

- If the patient does not need medically managed care or residential treatment, determine if the patient needs intensive outpatient treatment.
    - If any subdimension requires a minimum level of care 2.1 or 2.5, the recommendation should be for clinically managed intensive outpatient care.
- What is the highest level of residential care indicated in any subdimension?
    - If 2.5: Recommend **Level 2.5**
    - If 2.1: Recommend **Level 2.1**

Clinically Managed Outpatient Care (Level 1.5)

- If none of the subdimensions recommend a level of care above Level 1.5: Recommend **Level 1.5**

Co-occurring Enhanced Care

- If the patient meets the criteria for any COE level of care, the final recommendation when considering all dimensions and subdimensions should be a **COE level of care**, with the specific LOC determined based on the rules above. [Note: patients who need Level 4 care for Dimension 1 or 2 issues as well as Dimension 3 should go to Level 4, NOT Level 4 COE.]

Recovery Residence or Safe Housing

- If the recommended level of care is an outpatient or intensive outpatient level of care (Levels 1.5, 1.7, 2.1, 2.5, or 2.7), is a minimum of a recovery residence or supportive housing recommended based on Dimension 5?
    - If a recovery residence is recommended, the final recommendation should be for the specific LOC determined based on the rules above **PLUS a recovery residence**.
    - If supportive housing is recommended (and a recovery residence is not recommended) the final recommendation should be for the specific LOC determined based on the rules above **PLUS safe housing**.

Appendix A – Level of Care Assessment Considerations

Dimension 1 (Acute intoxication and withdrawal potential)

Level of Care Assessment of Dimension 1 should include:

- **Vital signs**
  - If patient is at risk for or experiencing intoxication or withdrawal, is there any significant disturbance in vital signs (i.e., blood pressure, pulse rate, temperature)?
- **Substance use history**
  - Date of last use/duration/frequency/route of administration, for substances (including nicotine/tobacco products) used in the past 30 days (as self-reported or otherwise documented)
- **Intoxication and associated risks (including overdose)**
    - Is the patient oriented to person, place, time, and situation? Are there obvious problems with balance, gait, or sensory issues?
    - History or risk of overdose
    - What risk is associated with the patient's current level of acute intoxication?
      - Risk of life-threatening physical health problems (e.g., chest pain, respiratory depression)
      - Risk of harm to self or others (e.g., violence, self-harm)
- **Withdrawal and associated risks**
  - Are there current signs of withdrawal, or is withdrawal anticipated based on the amount, frequency, chronicity, and recency of discontinuation of (or significant reduction in) alcohol, tobacco, or other drug of use? If so, what is the anticipated severity?
    - Are there co-occurring physical or psychiatric conditions that may increase anticipated withdrawal severity?
    - History of severe withdrawal, including seizures or delirium tremens
    - History of withdrawal related complications
    - Is the patient at risk for nicotine withdrawal? If so, is the patient willing and able to initiate nicotine replacement therapy (NRT)
  - Consider using validated withdrawal severity assessment measures, e.g., CIWA-Ar, CINA, COWS, SOWS as indicated and available on-site, to establish baseline measure of withdrawal severity
- **Need of Medications for OUD (Dimension 4 of the Treatment Planning Assessment will assess need for other addiction pharmacotherapies)**
  - Is the patient at risk for opioid withdrawal?
    - Has the patient ever been treated with MOUD?
    - Does the patient have a history of difficulty with initiation of MOUD?
    - Has the patient indicated a preference for treatment with naltrexone?
  - If the patient has an opioid use disorder, are they currently receiving medications for opioid use disorder (MOUD)? If yes,
    - Is service coordination indicated for continuation of medication?
    - Will the patient be transitioned to a different medication (e.g., methadone to buprenorphine, buprenorphine to naltrexone)?

Dimension 2 (Biomedical conditions)

Level of Care Assessment of Dimension 2 should include:

- **Acute physical health concerns (including acute or uncontrolled pain)**

- Does the patient appear unwell to a layperson? (If yes, is there any significant disturbance in vital signs (i.e., blood pressure, pulse rate, temperature)?
  - If the patient appears acutely ill, refer for immediate medical evaluation.
- As per patient report, does the patient have any acute biomedical symptoms (other than intoxication or withdrawal) that need to be addressed due to their risk or potential for treatment complications?
  - If the patient reports urgent or emergent biomedical symptoms, refer for immediate medical evaluation, transfer to an emergency department, or call 911.
  - All patients who report acute biomedical symptoms should have a medical clearance exam before admission to a clinically managed level of care.
- Does the patient report any severe, undiagnosed, or uncontrolled pain? (If yes, refer for immediate medical evaluation))

- **Chronic physical health concerns**
  - Per patient report:
    - If chronic physical health problems are present, do they need active medical management?
    - If chronic physical health problems are present, are they currently being managed by an external provider?
- **Pregnancy-related concerns**
  - Is the patient pregnant, or is there a possibility they may be pregnant?
  - If patient is pregnant, do they report any known complications, concerns about the pregnancy, or any risk factors (e.g., acute vaginal bleeding, contractions, cessation of fetal movement, history of preeclampsia) that may require further medical evaluation or close monitoring?

Dimension 3 (**Psychiatric and cognitive conditions**)

Level of Care Assessment of Dimension 3 should include:

- **Active psychiatric concerns**
  - Does the patient have acute psychiatric symptoms or psychological, behavioral, emotional, or cognitive conditions that need to be addressed because they create risk or complicate treatment?
    - If yes, is the patient at risk of imminent harm to self or others?
      - If yes, further assessment is indicated, and patient may require stabilization in an acute care setting.
  - Per patient report and clinical judgement:
    - If psychiatric or cognitive problems are present, do they seem to occur independently of intoxication? Withdrawal? Are they expected to worsen due to withdrawal?
    - How well is the patient able to manage the activities of daily living right now?
    - How well can the patient cope with any emotional, behavioral, or cognitive symptoms right now?
      - Consider using validated psychiatric screening tools as needed – PHQ-2, GAD-2, C-SSRS Screener
        - If any of these screens is positive, consider follow-up assessment with PHQ-9 (depression), GAD-7 (anxiety), and/or C-SSRS Lifetime-Recent (suicidality).
- **Chronic mental health concerns**
  - Per patient report:

        - If chronic mental health problems are present, do they need active medical management?
        - If chronic mental health problems are present, are they currently being managed by an external provider?
        - Does the patient have a chronic psychiatric disorder that causes a persistent impairment in their ability to carry out activities of daily living, self-care, education, employment and/or participation in social life?
- **Cognitive functioning deficits**
    - Does the patient appear to have deficits in cognitive functioning that may make it difficult for them to understand information presented and participate in treatment without cognitively enhanced services? [If yes, use a validated screening tool such as the Montreal Cognitive Assessment (MoCA)].
    - Does the patient have a history of moderate to severe traumatic brain injury? [If yes, consider using validated screening tools such as The Neurobehavioral Symptom Inventory]

Dimension 4 (Substance use related risks)

Level of Care Assessment of Dimension 4 should include:

- **Likelihood of engagement in risky substance use in current environment**
    - Without intervention, how likely is the patient to use, and how soon are they likely to do so (e.g., today, within days, within weeks, within months)?
        - Is the patient experiencing pain? Does the patient have a history of misusing opioids to manage pain?
    - In the past, was the individual able to cease use without treatment for any period of time outside of a controlled environment (e.g., jail, prison)? If so, when and for how long?
    - Have medications for substance use or mental health disorders helped the patient avoid use in the past?
        - What are the person's strengths in coping with protracted withdrawal, cravings, or impulses?
    - How aware is the patient of triggers to use?
    - How well can the patient cope with emotional distress, environmental cues to use, peer pressure, and stress without recurrence of addictive thinking and/or behavior?
    - How risky is their likely use?
        - Consider risk for mental and physical health, etc.
        - [Note: this includes risks related to tobacco use, such as continued use in a patient with COPD as well as fire safety risks associated with smoking tobacco or marijuana.]
    - Consider using validated assessment tools, e.g., Brief Addiction Monitor (risk and protective scores), Visual Analog Scale (for craving) to establish baseline measures of addiction symptom severity.
- **Likelihood of engaging in other harmful SUD related behaviors in current environment**
    - What is the patient's risk of engaging in harmful SUD-related behaviors (e.g., DUI, violence, or behaviors that increase vulnerability to victimization) if they remain in their current environment?
    - How severe are the problems and further distress that may result if the patient is not successfully engaged in treatment and continues the high-risk or addictive behavior

Dimension 5 (Recovery environment)

Level of Care Assessment of Dimension 5 should include:

- **Ability to function effectively in current recovery environment**
  - How does the patient feel their current social network or living/ working/school environment will affect their ability to engage in treatment and recovery?
  - Does the patient have any deficits in social/interpersonal skills or skills of daily living that prevent them from functioning effectively in their environment?
  - Is the patient able to use community and social support if they are available?
  - Does the patient's current environment have sufficient daily structure and social supports to aid in recovery?
- **Safety in current recovery environment**
  - Does the patient's current living environment subject them to physical, emotional, sexual or any other form of abuse?
  - Are there other factors in the patient's current living environment that could compromise their recovery
- **Support in current recovery environment**
  - Does the patient have sufficient support in their current recovery environment to help the patient cope with cravings to use or other recovery threats?

Dimension 6 (Readiness and Resources)

Dimension 6 (Readiness and Resources) should be considered after Level of Care recommendation is determined based on needs identified in Dimensions 1-5.

- Is the patient able to attend the recommended Level of Care?
  - Are any services or resources needed to enable the patient to participate in the recommended Level of Care (e.g., transportation, childcare, financial, etc.)?
  - Are these services/resources available to the patient and sufficient to enable them to participate in the recommended LOC?
  - If not, how should the LOC be adjusted?
- Assuming the patient has sufficient resources and services are available, is the patient willing to attend the recommended Level of Care?
  - If not, what treatment services are acceptable to the patient?
  - If the patient's preferred treatment setting is adjudged to be unsafe or is unlikely to be effective, what can be done to increase the patient's willingness to attend treatment at the recommended Level of Care (e.g., motivational enhancement therapy, family counseling)?
  - Is the patient being compelled to follow clinical recommendations by an external source? If so, what are the requirements?

Appendix B – Recommended Staff Competencies

The following represent recommended staff competencies to support delivery of care in alignment with *The ASAM Criteria* standards. In developing the competencies outlined below, we sought to align with existing national competencies including:

- American Board of Addiction Medicine. n.d. *Core Competencies for Addiction Medicine.* Available at: https://acaam.memberclicks.net/assets/docs/Core-Competencies-for-Addiction-Medicine.pdf (accessed January 27, 2021).
- Substance Abuse and Mental Health Services Administration. n.d. *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice.* Available at: https://store.samhsa.gov/sites/default/files/d7/priv/sma12-4171.pdf (accessed January 27, 2021).
- Hoge, M. A., J. A. Morris, M. Laraia, A. Pomerantz, and T. Farley. 2014. *Core Competencies for Integrated Behavioral Health and Primary Care.* Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions. Available at: http://womenshealthcouncil.org/wp-content/uploads/2016/11/WF-Core-Competencies-for-Integrated-Behavioral-Health-and-Primary-Care.pdf (accessed January 27, 2021).
- Substance Abuse and Mental Health Services Administration. n.d. *Core Competencies for Peer Workers in Behavioral Health Services.* Available at: https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf (accessed January 27, 2021).
- Wason, Kristin MSN, NP-C, CARN; Potter, Annie MSN, MPH, NP-C, CARN-AP; Alves, Justin RN, ACRN, CARN; Loukas, Vanessa L. MSN, FNP-C, CARN-AP; Lastimoso, Charmaine MSN, MPH, NP-C; Sodder, Shereen BA; Caputo, Andrea DNP, FNP-C, CARN-AP; LaBelle, Colleen T. MSN, RN-BC, CARN. Addiction Nursing Competencies: A Comprehensive Toolkit for the Addictions Nurse. JONA: The Journal of Nursing Administration: September 2021 - Volume 51 - Issue 9 - p 424-429 doi: 10.1097/NNA.0000000000001041

Recommended competencies for all professional and allied health professional staff

- Basic understanding of *The ASAM Criteria*:
  - Multidimensional factors that contribute to SUD level of care recommendations and treatment needs
  - Continuum of care
  - Principles of *The ASAM Criteria*
- Basic understanding of SUD and SUD-related health conditions:
  - Prevalence and demography of addiction
  - Genetic/biological basis of addiction
  - Signs and symptoms of intoxication, withdrawal, and SUD
  - Common biomedical and psychiatric comorbidities
  - Substance use disorder treatment options and their efficacy, including:
    - Pharmacologic interventions (currently including OUD, AUD, and tobacco/nicotine use disorder)
    - Psychosocial interventions
  - Evidence supporting concurrent treatment or nicotine/tobacco use disorder treatment with other SUDs

    - Importance of recovery support services
- Provide services appropriate to the personal and cultural identity of the patient
    - Working effectively with a translator when needed
    - Deliver services with cultural humility and trauma responsiveness
    - Understanding how gender can influence SUD and mental health treatment needs and preferences
    - Understanding the core concepts of gender sensitive and responsive care
    - Demonstrates cultural humility and openness to understand and respond to patients needs related to their individual culture, including race, ethnicity, sex, sexual orientation, gender, socioeconomic status, religion, etc.
- Awareness of available treatment and recovery support service resources
- Recognizing the social, economic, and cultural contexts within which addiction exists, including:
    - Effects of other stigma and discrimination
    - Social determinants of health
    - Effects of racism, including structural racism
    - Risk and resiliency factors of individuals and groups
- Understanding the principles of harm reduction, including but not limited to:
    - The importance of educating patients and their support network about harm reduction techniques
    - Overdose prevention and reversal
- Collaborating with an interdisciplinary care team
- Behavior management techniques, including de-escalation
- Managing violent or threatening behaviors
- Response to urgent biomedical or psychiatric situations (including those that occur on-site)
- How and when to consult supervisor/chain of command
- Responding to requests to change treating providers
- Documentation of services provided, consistent with clinical and regulatory standards and with relevant medical necessity requirements, with awareness of utilization management needs
- The use of electronic health records and other health technologies used by the program
- Provision of patient-centered, whole-person care
- Communicating with patients and their families/significant others, as well as other professionals and staff, with empathy, respect, compassion, and understanding, including awareness of stigmatizing language
- Following federal and state privacy and confidentiality laws and regulations
- Work effectively in a multidisciplinary team
- Ethical considerations for providing SUD treatment and related services
- CPR

Recommended competencies for physicians and advanced practice providers

- Advanced understanding of *The ASAM Criteria*:
    - Assessment and treatment planning
    - Dimensional admission criteria, including risk ratings
    - Dimensional drivers of care at each level of care
    - Medical capabilities at each level of care

- Advanced understanding of the core medical knowledge about SUD and SUD-related health conditions, including:
    - Epidemiology and etiology of addiction
    - Neurobiology and genetics of addiction
    - Pharmacodynamics of commonly used substances
    - Pathophysiology and neuropsychological effects of chronic substance use and SUD
    - Common comorbid medical and co-occurring psychiatric conditions associated with SUD
    - Fetal and neonatal effects of commonly used substances and associated intoxication and withdrawal
- Assessment and Diagnosis
    - Perform an appropriate physical examination and detect physical signs of acute use (i.e., intoxication and withdrawal), chronic use, and complications of substance use (e.g., skin infections)
    - Conduct an accurate patient history including substance use history, trauma history, and addiction and mental health treatment history
    - Screen for and diagnose SUD, intoxication, withdrawal, and common comorbid medical and co-occurring psychiatric conditions
    - Formulate a reasonable differential diagnosis related to:
        - Signs and symptoms of acute substance use, intoxication, and withdrawal
        - Standard diagnostic criteria for Addiction Disorders
        - Common comorbidities including biomedical, psychiatric, and obstetrical complications of substance use
    - Explain diagnosis to the patient and explain rationale for treatment
    - Order appropriate diagnostic tests (routine laboratory tests, drug tests, diagnostic images) and interpret laboratory findings
    - Toxicology testing
        - Understanding benefits and limitations
        - Able to collect, interpret, and monitor toxicology data for patient treatment needs
        - Understanding how toxicology testing can support monitoring of adherence to medications
        - Use, interpret and respond to drug testing results
    - Use, interpret, and respond to prescription drug monitoring program reports.
    - Use of ECG rhythm strip evaluation ruling out malignant arrhythmias such as non-sustained venous tachycardia, previously undiagnosed atrial fibrillation, sinus bradycardia and tachycardia
    - Understanding the role of PDMPs and the benefits and limitations of the data in the local PDMPs
- Treatment and Treatment Planning
    - Pharmacological management of intoxication, withdrawal, and SUDs
    - Able to direct the medical management of:
        - Acute withdrawal and intoxication
        - SUD
        - Common medical and psychiatric comorbidities
    - Able to provide medical management for common, low-complexity psychiatric conditions, using appropriate assessment instruments to guide “treat to target” decision-making

    - Provide brief intervention, secure appropriate consultations, and make referrals for specialty treatment of addiction and other medical and psychiatric conditions
    - Design a management plan to address non-adherence and treatment failure.
    - For psychiatric and biomedical issues
        - Determining what is the primary driver of the patient's risks
        - Determining when to transfer/refer to other specialty systems
    - Understanding of unique clinical considerations related to:
        - Older adults
        - Safety Sensitive Populations
        - Pregnancy, perinatal, and postpartum care (parent-infant dyad)
        - Intravenous drug use
        - Pre and post operative care
- Care Coordination
    - Able to lead multidisciplinary treatment teams in medically managed treatment programs
    - Consult with other treatment resources as appropriate
    - Able to coordinate care with specialty biomedical and mental health treatment providers to support an integrated treatment plan
- Working with and leading an interdisciplinary team with non-medical staff
- Knowledge of the neurobiology of pain and ability to manage pain in patients with addiction, including:
    - Conducting a pain-focused history and physical examination
    - Using validated and reliable tools for measuring function in patients with pain
    - Prescribing pharmacotherapy, initial dosing, and titrating according to patient health status and risk factors for patients with pain and substance use disorder
    - Coordinating with other healthcare professionals, including when recommended treatment options may pose risk for harms and alternative interventions may be needed
    - Prescribing non-pharmacologic therapies to help manage pain.
    - Design a treatment plan for patients with pain with attention to patient and family centered goals.
    - Determining the difference between malignant and non-malignant pain
    - Knowing when to refer to a pain specialist
    - Ability to determine whether pain significantly hinders SUD recovery
    - Ability to coordinate care with pain specialist
- Understand the importance of families/significant others in addressing substance issues and communicate with them effectively as appropriate

Recommended competencies for addiction specialist physicians

In addition to the competencies listed above for physicians and advanced practice providers, specialist physicians should have the following competencies:

- Be able to supervise and teach other health care professionals
- Able to direct the medical management of:
    - Addiction, at any level or intensity of treatment
    - Substance use related psychiatric and medical emergencies

Recommended competencies for other professional medical staff (RNs, LPNs, MAs, etc.)

- Basic understanding of the core medical knowledge about SUD and SUD-related health conditions, including:
    - Epidemiology of addiction
    - Neurobiology and genetics of addiction
    - Pathophysiological and neuropsychological effects of chronic substance use and SUD
    - Common comorbid medical and co-occurring psychiatric conditions associated with SUD
    - Fetal and neonatal effects of commonly use substances and associated intoxication and withdrawal
- Perform an appropriate physical assessment and detect physical signs of acute intoxication and withdrawal
    - Assess for serious harm due to patient impairment from substance use
    - Identify overdose risks, treatment, and follow-up
    - Use standardized, validated tools for assessing withdrawal severity (e.g., Clinical Opioid Withdrawal Scale [COWS], Clinical Institute Withdrawal Assessment for Alcohol, revised [CIWA-Ar])
- Conduct an accurate patient history including substance use history, trauma history, and addiction and mental health treatment history
- Screening and/or assessing patients for depression and anxiety and applying protocol for management of patient in need of urgent psychiatric support within organization
- Addiction pharmacotherapies:
    - Identify indication for MOUD treatment, make dose adjustments, and address recurrent use
    - Outline medications for SUD and available formulations
- Approaches to special populations with addiction (patients with chronic pain, pregnancy, older adults, etc.)
    - Outline appropriate pain management strategies for patients with opioid use disorder
- Toxicology testing
    - Understanding benefits and limitations
    - Understanding how toxicology testing can support monitoring of adherence to medications
- Coordinate care between local treatment levels (transfer to acute treatment services, outpatient treatment programs)
- Implement recommended storage, handling, and administration of IM/SQ medications for SUD
- Identify local resources for peer support and collateral services
- Outline safety interventions required as a mandatory reporter if individual is at risk for harm.
- Employ chart review and tools in medical record to effectively document and monitor patients engaged in addiction care
- Comprehend the importance of nursing standing orders for laboratory assessment, medication refills, and interventions
- Trained in behavior management techniques and evidence-based psychotherapeutic and psychoeducational practices aligned with scope of practice
- Implementing physician-approved protocols for clinical management of intoxication and withdrawal including:

  - observation and supervision
  - determination of appropriate level of care
  - facilitation of the patient's transition to continuing care

Recommended competencies for all clinical staff

- Basic understanding of the core medical knowledge about SUD and SUD-related health conditions, including:
  - Epidemiology of addiction
  - Neurobiology and genetics of addiction
  - Biological and psychological effects of commonly used substances
  - Biological and psychological effects of chronic substance use and SUD
  - Common comorbid medical and psychiatric conditions associated with SUD
  - Efficacy and benefits of addiction pharmacotherapies
- Knowledge of evidence-based psychosocial treatments
- Psychoeducation related to the interaction of substance use and common biomedical and psychiatric comorbidities (e.g., HIV, HCV, COPD, depression, anxiety, etc.)
- Screening and assessment for SUD and co-occurring psychiatric conditions using validated instruments to both identify symptom severity and to monitor treatment progression
- Able to perform a crisis assessment
- Supporting symptom management for patients with co-occurring psychiatric conditions
- Working with mental health treatment providers to deliver integrated care for patients with co-occurring psychiatric conditions
- Screening for:
  - Psychoactive intoxication and withdrawal signs and symptoms
  - Danger to self or others
- Care coordination with other providers involved in a patient's care
- Conduct an accurate patient history including substance use history, trauma history, and addiction and mental health treatment history
- Recognize the potential for substance use disorders to mimic a variety of medical and mental health conditions
- Understanding of how adverse childhood experiences (ACEs) impact SUD and co-morbid psychiatric disorders
- Describe the behavioral, psychological, biomedical, and social effects of substance use to patients and their support network
- Recognize the importance of family, social networks, and community systems in the treatment and recovery process
- Describe a variety of strategies for reducing the negative effects of SUD and addiction
- Be familiar with local treatment resources for SUD and common comorbidities

Recommended competencies for master's level clinical staff

In addition to the competencies listed above for All Clinical Staff, master's level clinical staff should have the following competencies:

- Advanced understanding of *The ASAM Criteria*:
  - Treatment modalities and placement considerations within the continuum of care
  - Assessment and treatment planning
  - Dimensional admission criteria, including risk ratings

    - Dimensional drivers of care at each level of care
    - Medical capabilities at each level of care
- Understand the established diagnostic criteria for SUD
- Knowledge of evidence-based psychosocial treatments
- Be familiar with medical and pharmacological resources in the treatment of substance use disorders and their comorbid conditions
- Managing and supervision of a clinical team
- Monitoring the quality of care delivered by clinical staff

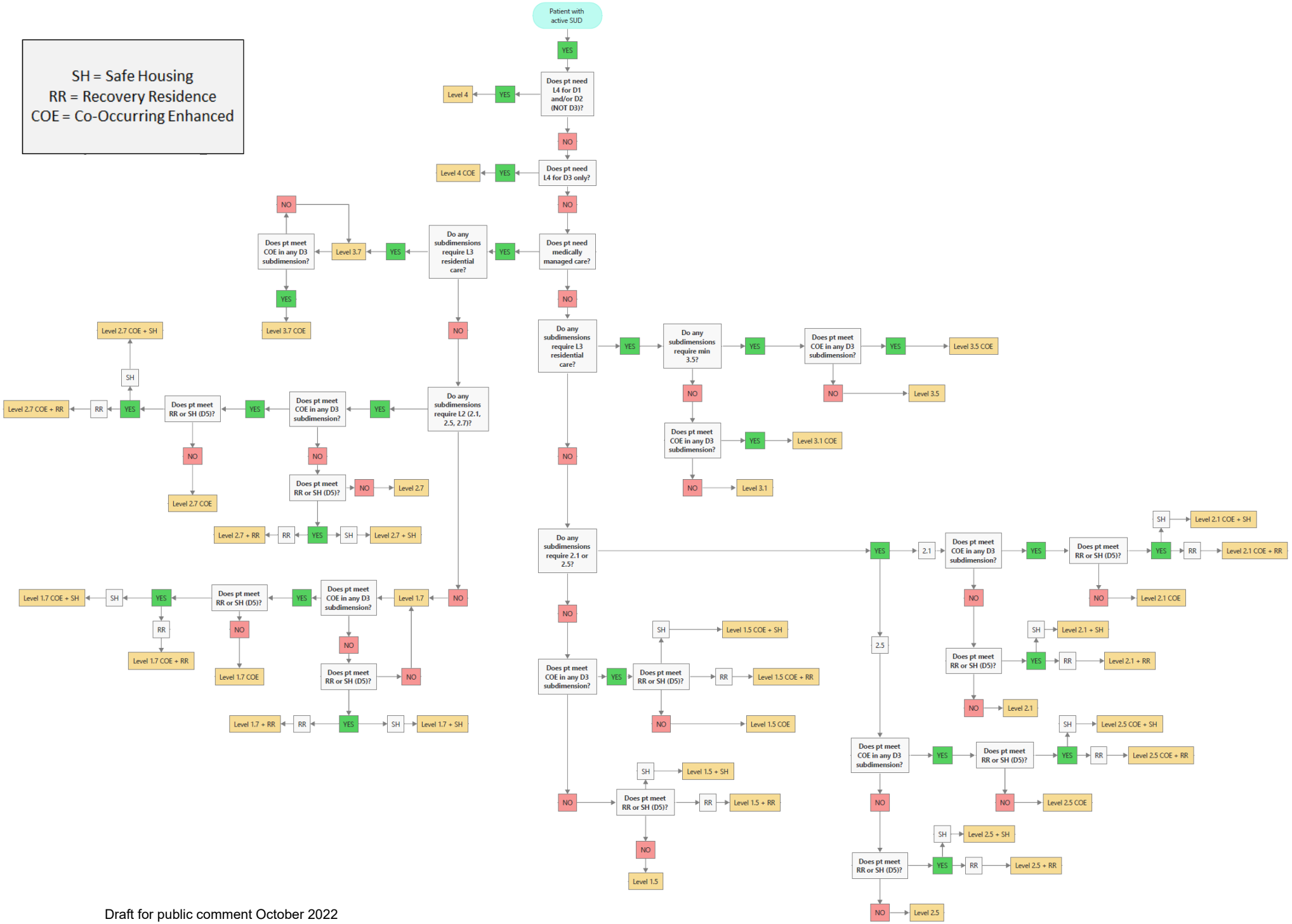
Recommended competencies for allied health professionals (e.g., peer support specialist, health educator, patient navigator, etc.)

- Building caring and collaborative relationships with patients
- Setting safe boundaries
- Communication with patients and families
- Advocating for the needs, desires, and legal and human rights of people with SUD
- Providing information on community and other resources related to health, wellness, and recovery services and supports
- Peer support workers should have further competencies in:
    - Building long-term supportive and collaborative relationships
    - Sharing personal recovery stories in a way that is inspiring and supportive
    - Personalizing peer support services
    - Supporting recovery planning
    - Helping peers to manage crises
    - Practicing strategies to protect personal recovery while providing peer support services for others
    - Recognizing countertransference and personal biases related to SUD and SUD treatment

Appendix C – Draft Table of Contents

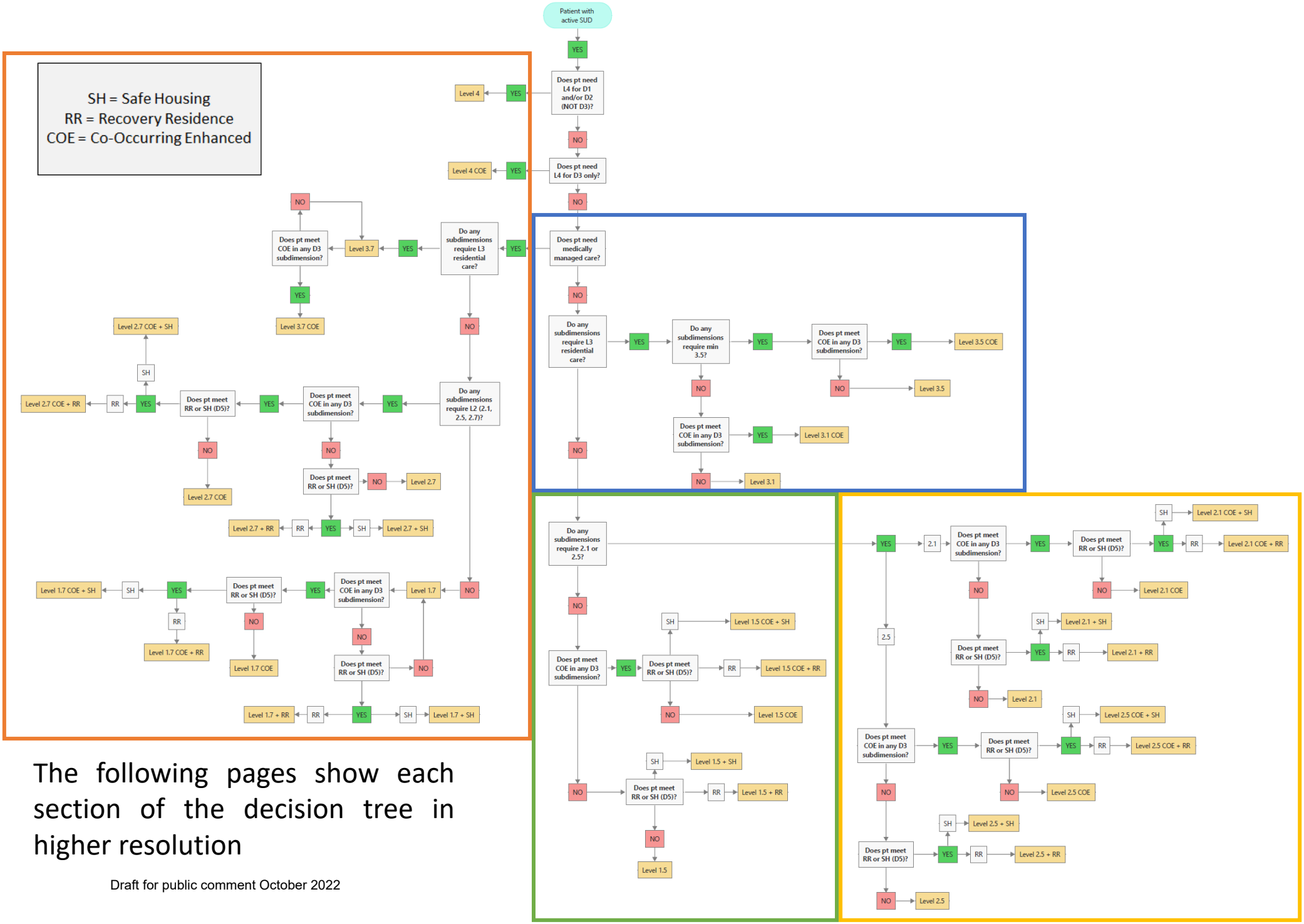
Appendix D - Proposed ASAM Criteria Decision Tree

SH = Safe Housing
RR = Recovery Residence
COE = Co-Occurring Enhanced



Draft for public comment October 2022

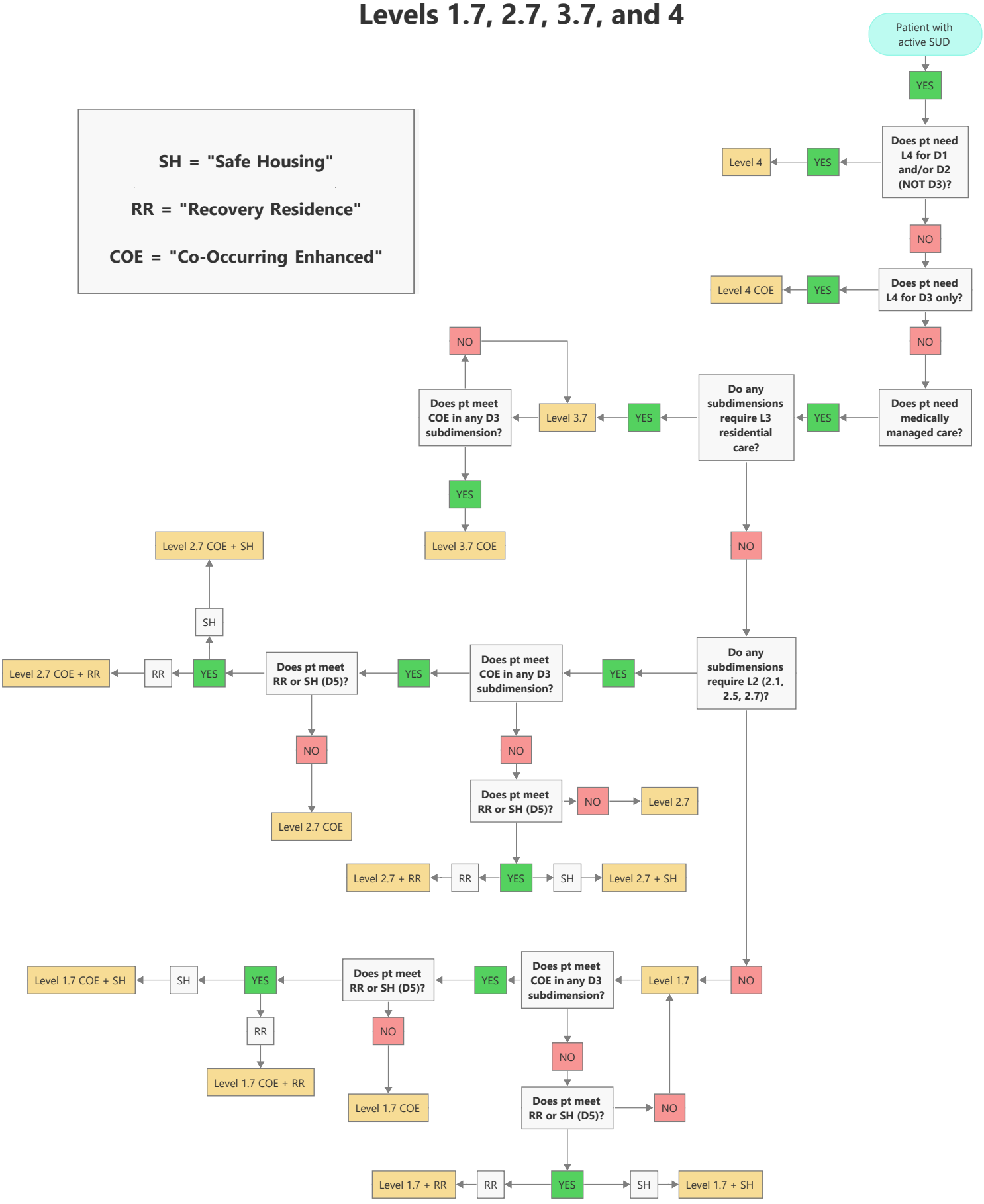
ASAM Criteria 4th Edition Proposed Decision Tree



The following pages show each section of the decision tree in higher resolution

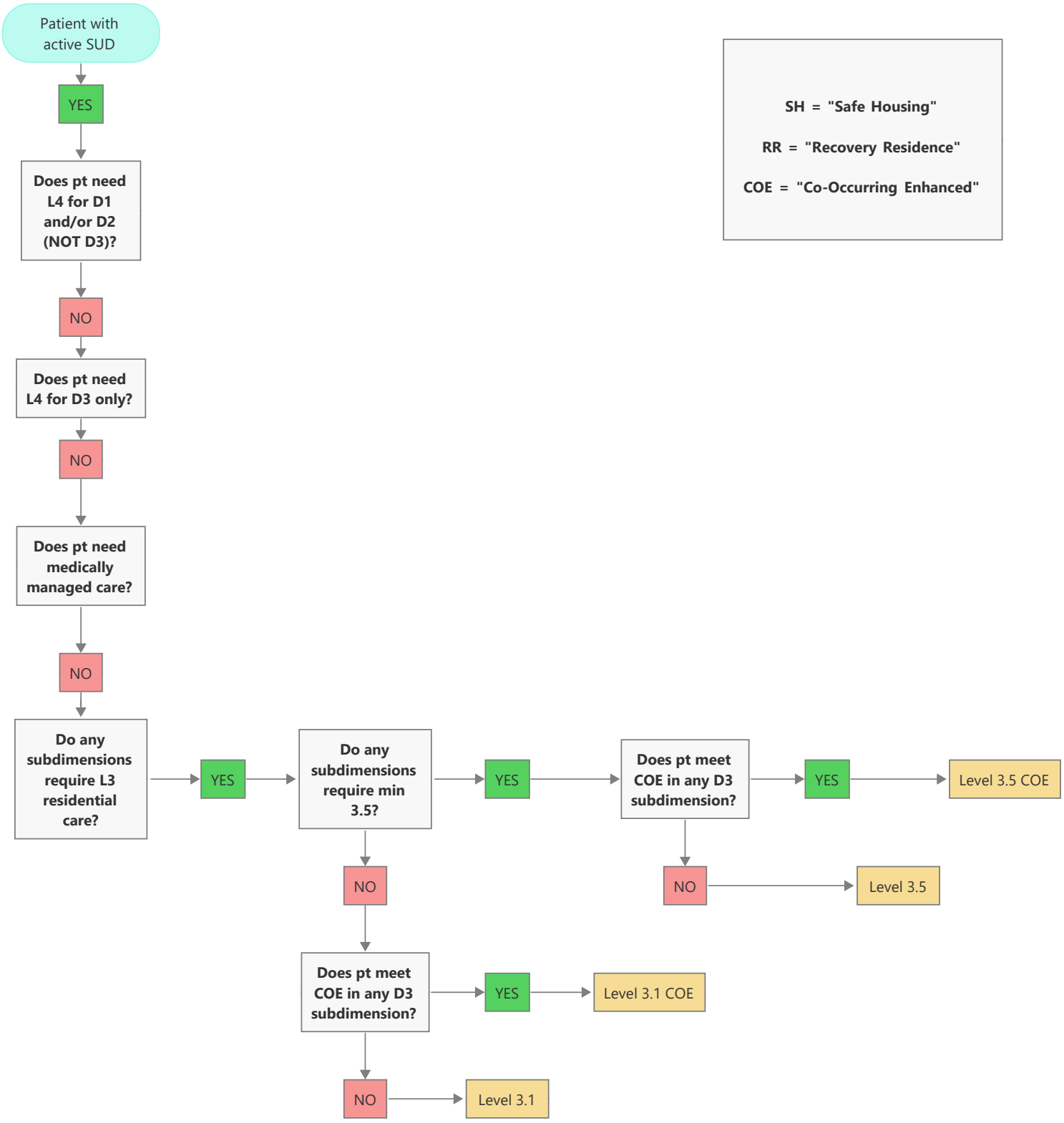
Draft for public comment October 2022

Medically Managed Levels of Care
Levels 1.7, 2.7, 3.7, and 4

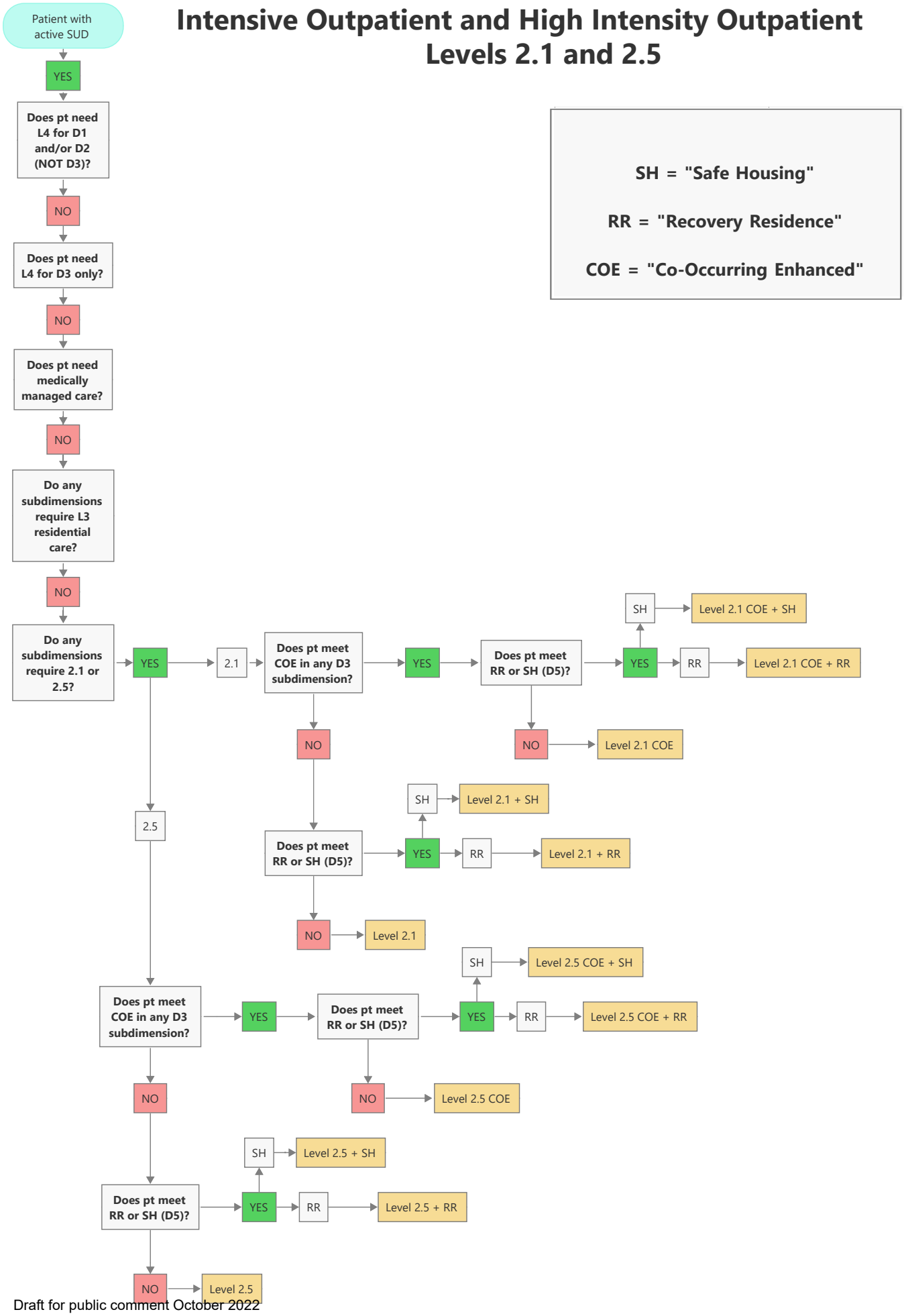


Draft for public comment October 2022

Residential
Levels 3.1 and 3.5



Intensive Outpatient and High Intensity Outpatient Levels 2.1 and 2.5

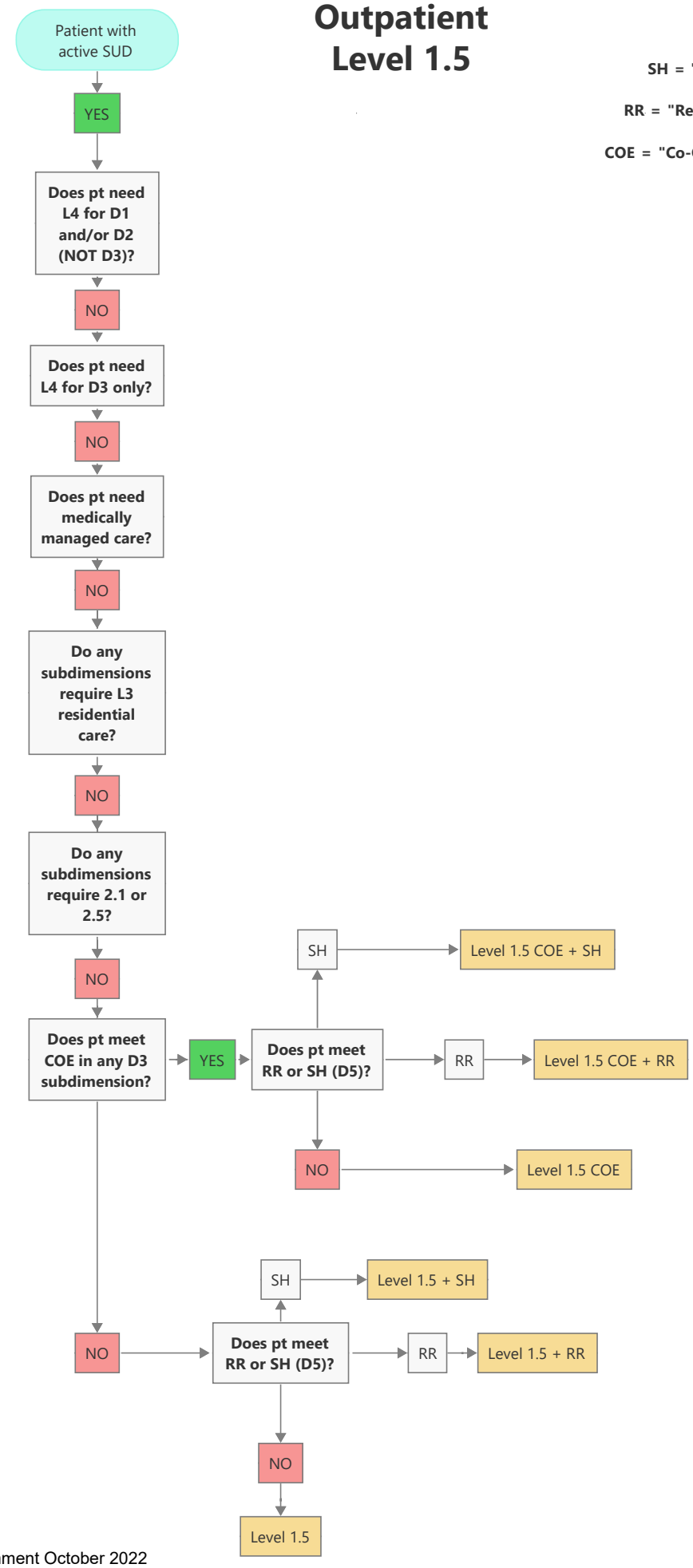


Outpatient Level 1.5

SH = "Safe Housing"

RR = "Recovery Residence"

COE = "Co-Occurring Enhanced"



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