

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:

Public comments accepted through **Friday, November 11th** through the online survey form at bit.ly/ASAM4th.

- 1 • [Assessment and Treatment Planning](#)
- 2 • [The ASAM Continuum of Care](#)
- 3 • [Service Characteristics for each Level of Care](#)
- 4 • [Dimensional Admission Criteria](#)

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

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

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

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

16 Please note that your comments may be made public.

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

22 Questions? ASAMCriteria@ASAM.org

23

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1 Summary of Major Changes

2 The editorial team is proposing major changes in the 4th Edition of *The ASAM Criteria* to facilitate
3 dissemination and implementation and to address known gaps in the quality of addiction treatment.

4 The core principles of *The ASAM Criteria* remain the same, including:

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

14 These central principles of *The ASAM Criteria* reflect the biopsychosocial nature of addiction. They
15 recognize that there is a complex interplay between an individual patient's biology, psychology, and
16 environment that influences both risk for substance use disorder (SUD) and prognosis. The
17 standards in *The ASAM Criteria* promote a holistic view of patients, acknowledging the role that
18 physical and mental health, life circumstances (e.g., education, employment, social support, housing,
19 trauma history, criminal legal involvement, etc.), and individual needs, strengths, and goals play in
20 the development and maintenance of addiction. All these factors are assessed to develop an
21 individualized treatment plan. *The ASAM Criteria* emphasizes the importance of treatment plans
22 tailored to the needs of individual patients and regular reassessment and modification of treatment
23 plans that reflect both response to treatment and the evolving needs of the patient as life
24 circumstances change.

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

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

- 1 (i.e., contract or memorandum of understanding), provide access to all addiction
2 pharmacotherapies, with limited exceptions for access to methadone when no Opioid
3 Treatment Programs exist within a reasonable distance of the program.
- 4 • **Promote more integrated care for co-occurring mental health conditions** by incorporating
5 standards for co-occurring capable care into the core standards for each level of care.
 - 6 • **Promote better integration of SUD treatment into general healthcare** by emphasizing the role
7 of primary care providers in managing patients with stable SUD and the role of emergency
8 departments in initiating treatment and supporting engagement in ongoing care.
 - 9 • **Incorporate treatment of individuals with cognitive impairments across the continuum.** The
10 4th edition will eliminate Level 3.3 and add a chapter that discusses standards for addressing
11 cognitive impairments within any level of care in the continuum.
 - 12 • **Support better communication of medical necessity.** The 4th Edition of *The ASAM Criteria* will
13 take a patient-centered and dimension forward approach to medical necessity by developing
14 more standardized medical necessity criteria as well as standards for medical necessity
15 documentation, in alignment with the clinical assessment standards. This approach is
16 intended to reduce the variance in implementation and usage.
 - 17 • Discuss how **telehealth, mobile treatment services, and digital therapeutics** can be
18 incorporated into treatment at each level of care.
 - 19 • Update the language throughout to **reflect evolving terminology in the field.**
 - 20 • Review and **update the standards with a focus on diversity, equity, and inclusion.**

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

23 **Assessment and Treatment Planning Standards**

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

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

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

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

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

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

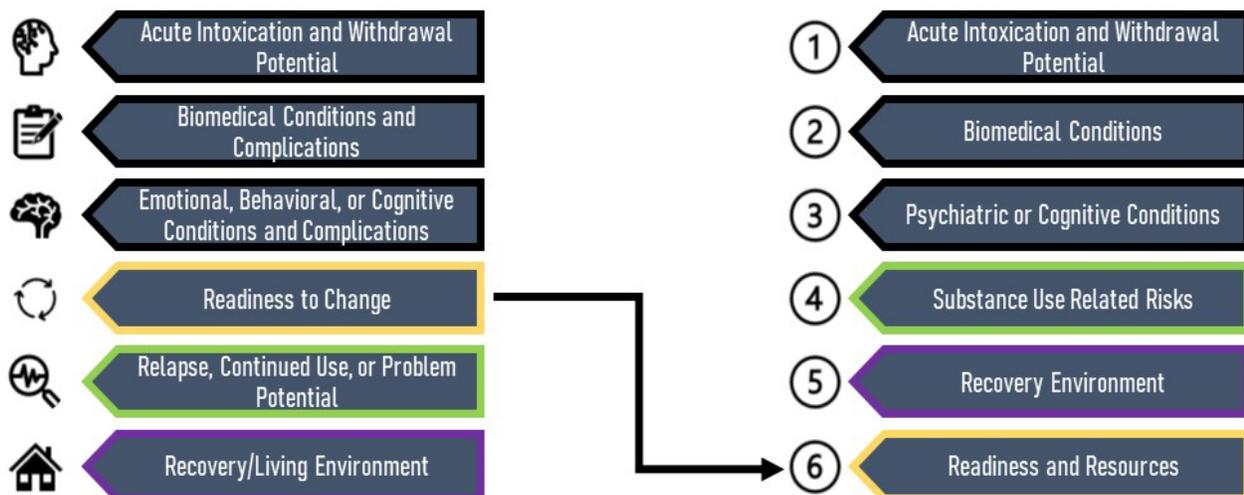
- 4 1. Define standards for a more concise level of care assessment to guide initial patient
5 placement with the goal of reducing the time it takes to make an appropriate level of care
6 recommendation.
- 7 2. Expand upon the standards for the multidimensional assessment, including descriptions of
8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

20

21 The ASAM Criteria Level of Care Assessment

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

Proposed Changes to the Dimensions



1

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

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

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

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

26

27 **The ASAM Criteria Treatment Planning Assessment**

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

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

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

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

5 **Dimensions and Subdimensions**

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

13 Dimension 1 – Acute intoxication and withdrawal potential

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

17 Dimension 2 – Biomedical conditions

- 18 • **Physical health concerns (including pain)**
- 19 • **Pregnancy-related concerns**
- 20 • Sleep problems

21 Dimension 3 - Psychiatric and cognitive conditions

- 22 • **Active psychiatric concerns**
- 23 • **Persistent disability**
- 24 • Cognitive functioning
- 25 • Trauma-related needs
- 26 • Psychiatric history

27 Dimension 4 – Substance use related risks

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

30 Dimension 5 – Recovery environment

- 31 • **Ability to interact productively with current environment**
- 32 • **Safety in current environment**
- 33 • **Support in current environment**
- 34 • Cultural perceptions of drug use and addiction

35 Dimension 6 – Readiness and Resources

- 36 • Readiness
- 37 • Resources
- 38 • Treatment Goals

1 Level of Care Assessment Standards

2 *Assessment Policies and Procedures*

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

27 *ASAM Level of Care Assessment Considerations*

28 The Level of Care Assessment should address the following considerations. See [Appendix A](#) for
29 detailed questions and recommendations for validated instruments in each dimension.

31 **Dimension 1**

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

- 1 ii. Is the patient at risk for opioid withdrawal AND another withdrawal
- 2 syndrome?
- 3 iii. Does the patient have a history of complications with initiation or titration of
- 4 MOUD?
- 5

6 **Dimension 2**

- 7 4. Is the patient experiencing physical health problems? If so, and as determined by a qualified
- 8 medical professional:
- 9 a. What is the current severity?
- 10 b. What level of medical management and/or monitoring is required?
- 11 5. Is the patient currently pregnant? If so, and as determined by a qualified medical
- 12 professional:
- 13 a. What is the status of the pregnancy?
- 14 b. What level of medical management and/or monitoring is required?
- 15

16 **Dimension 3**

- 17
- 18 6. Does the patient have active co-occurring mental health concerns? If so, and as determined
- 19 by a qualified mental health professional:
- 20 a. Does the patient need medical management or monitoring? If yes:
- 21 i. What level of medical management and/or monitoring is required?
- 22 ii. Is specialty psychiatric management and/or monitoring within the SUD
- 23 program needed?
- 24 b. What level of support, supervision and monitoring are needed to manage the
- 25 patient's mental health concerns?
- 26 7. Does the patient have chronic psychiatric or cognitive problems that cause PERSISTENT
- 27 DISABILITY? If so, (as determined by a qualified mental health professional) how severe are
- 28 their symptoms? What level of staff support and/or monitoring does the patient need to
- 29 manage activities of daily living?
- 30 a. Is specialty psychiatric management within the SUD program needed?
- 31

32 **Dimension 4**

- 33 8. How likely is the patient to engage in risky substance use (without treatment)? What level of
- 34 structure, supervision, and support does the patient need to minimize substance use-related
- 35 risk?
- 36 9. How likely is the patient to engage in harmful SUD-related behaviors (e.g., drug dealing, risky
- 37 commercial sex work) in their current environment (without treatment)? What level of
- 38 structure, supervision, and support does the patient need to minimize harmful consequences
- 39 of SUD-related behaviors?
- 40

41 **Dimension 5**

- 42
- 43 10. Is the patient able to function productively and independently in their current
- 44 (living/community) environment? If no:
- 45 a. Does the patient need habilitative services to learn basic interpersonal skills and/or
- 46 skills of independent living? If so, what level of habilitative services are needed?
- 47 b. Does the patient need a supportive environment in which to practice basic
- 48 interpersonal skills/skills of independent living?

1 11. Is the patient's current environment safe? Does the patient's environment pose a threat to
2 the patient's safety or well-being (e.g., homelessness and/or physical, sexual, or emotional
3 abuse)?

4 12. Is the patient's current environment supportive? Does the current environment provide
5 sufficient support to help patient cope with cravings/other recovery threats?
6

7 *Level of Care Recommendation*

- 8 • The Level of Care recommendation should be made on the basis of the patient's needs in
9 Dimensions 1 through 5, referring to the dimensional risk ratings and admission criteria.
10 After the clinician arrives at the Level of Care recommendation, Dimension 6 needs should
11 be assessed to determine the patient's readiness and resources needed to attend the
12 recommended Level of Care.
- 13 • The Level of Care placement may need to be adjusted based on patient readiness and on the
14 availability of, and patient access to, recommended services. Motivational interviewing
15 should be used during parts of the assessment related to Dimension 6 to encourage the
16 patient to engage in the recommended Level of Care.
- 17 • At the end of the assessment, the clinician should document both the indicated Level of Care
18 (determined by assessment of Dimensions 1 through 5) and the adjusted Level of Care, if
19 applicable (based on clinician recommendation following assessment of Dimension 6). If
20 there is a discrepancy between indicated and adjusted Level of Care, the reason(s) for this
21 discrepancy should be documented.
22

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

- 25 • Is the patient able to attend the recommended Level of Care?
 - 26 ○ Are any services or resources needed to enable the patient to participate in the
 - 27 recommended Level of Care (e.g., transportation, childcare, financial, etc.)?
 - 28 ○ Are these services/resources available to the patient and sufficient to enable them to
 - 29 participate in the recommended LOC?
 - 30 ○ If not, how should the LOC be adjusted?
- 31 • Assuming the patient has sufficient resources and services are available, is the patient
32 willing to attend the recommended Level of Care?
 - 33 ○ If not, what treatment services are acceptable to the patient?
 - 34 ○ If the patient's preferred treatment setting is adjudged to be unsafe or is unlikely to
 - 35 be effective, what can be done to increase the patient's willingness to attend
 - 36 treatment at the recommended Level of Care (e.g., motivational enhancement
 - 37 therapy, family counseling)?
 - 38 ○ Is the patient being compelled to follow clinical recommendations by an external
 - 39 source? If so, what are the requirements?
40

41 *Treatment Planning Assessment Standards*

42 *Assessment Policies and Procedures*

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

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

23

24 *Dimension 1 (Acute intoxication and withdrawal potential)*

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

41

42 *Dimension 2 (Biomedical conditions)*

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

- 47 • **Acute physical health concerns**

- 1 ○ Are there acute physical health concerns (including any acute, undiagnosed, or
2 uncontrolled pain) that require medical treatment or referral?
3 ▪ If yes, is the patient currently receiving treatment for their condition? (If no,
4 refer for treatment)
5 • Last medical visit for each issue (date, reason, outcome)
6 • Additional or different treatment needed?
7 • Is care coordination needed?
- 8 • **Chronic physical health concerns**
9 ○ Are there chronic physical health issues, including chronic pain, which require
10 medical treatment or referral?
11 ▪ If physical health problems are managed externally, are they well-controlled
12 with current treatment?
13 • Last medical visit for each issue (date, reason, outcome))
14 • Additional or different treatment needed?
15 • Is care coordination needed?
16 ○ Does the patient's continued use of substances, including tobacco/nicotine,
17 exacerbate any current physical health concerns (e.g., cancer, cardiovascular
18 disease, respiratory disease)?
19 ○ Does the patient have post-acute withdrawal symptoms?
20 ▪ Does the patient have significant sleep issues associated with the cessation
21 of substance(s)?
22 ▪ Have the patient's physical/medical conditions become more difficult to treat
23 since the cessation of substance(s)?
24 ○ For serious chronic health problems, does patient have caregiver/sufficient home
25 support (if not in a residential Level of Care)? Need daily nursing/rehabilitation to
26 control symptoms and maintain function?
27 ○ Does the patient require accommodations for any chronic physical health problems
28 (e.g., physical disability)?
- 29 • **Pregnancy or contraception-related concerns**
30 ○ Is the patient currently on medications for contraception?
31 ○ Does the patient desire medications or interventions for contraception?
32 ○ Currently pregnant or planning to become pregnant?
33 ▪ (If yes) Pregnancy-related concerns?
34 • If medical pregnancy-related concerns are identified the patient
35 should be referred to their obstetric provider.
36 ▪ (If yes) Receiving prenatal care?
37 ▪ (If yes) Pregnancy history, including complications
- 38 • **Medical history** (partial – full medical history should be completed by a medical professional)
39 ○ Current and past medical diagnoses
40 ○ Medications for physical health problems (name, dose, frequency, purpose, dose
41 adherence, effectiveness)
42 ▪ Current
43 ▪ Past (for significant physical health problems that might re-emerge
44 ▪ Allergies/adverse events
- 45 • **Treatment goals**
46 ○ What are the patient's goals for addressing any co-occurring physical health
47 conditions?
48 ○ What types of support and services does the patient need to address any co-
49 occurring physical health conditions?
50

1 ***Dimension 3 (Psychiatric or cognitive conditions)***

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

- 5 • **Acute mental health concerns**
- 6 ○ Are there current unstable or evolving mental health concerns that require treatment
7 or referral (include acute flares of chronic mental health conditions)?
- 8 ▪ Imminent risk of harm to self or others
- 9 ▪ Relationship of acute symptoms to substance use or withdrawal (are
10 symptoms expected to subside or change after substance use has
11 ceased/withdrawal is complete)
- 12 • **Chronic mental health concerns**
- 13 ○ Are there chronic mental health concerns that require psychiatric treatment or
14 referral
- 15 ▪ If mental health problems are managed externally, are they well-controlled
16 with current treatment
- 17 • Last medical visit for each issue (date, reason, outcome)
- 18 • Additional or different treatment needed?
- 19 ○ Does the patient have any post-acute withdrawal related mental health concerns?
- 20 ▪ Does the patient have new issues exerting emotional control since the
21 cessation of the substance(s)?
- 22 ▪ Have medications offered symptom relief from these issues?
- 23 ▪ Have the patient's mental health concerns become more difficult to treat
24 since the cessation of the substance(s)?
- 25 ○ Does the patient's continued use of substances, including tobacco/nicotine,
26 exacerbate any current mental health concerns (e.g., anxiety, suicidality)?
- 27 ○ Does the patient have pain that impacts their mental health? If yes:
- 28 ▪ Has the patient received treatment for their pain?
- 29 ▪ Have any of these interventions helped?
- 30 ▪ How do the symptoms change with pain relief?
- 31 ○ Exposure to abuse, including physical, sexual, emotional; and/or neglect
- 32 ○ Exposure to and impact of trauma
- 33 ○ Administer standardized mental health measures e.g., PHQ-9, GAD-7, C-SSRS, etc.,
34 as needed to establish baseline severity and inform interventions
- 35 • **Cognitive functioning deficits**
- 36 ○ Does the patient have any cognitive deficits that require modified treatment
37 services? If so,
- 38 ▪ Does the patient need specific treatment for cognitive issues? If yes:
- 39 • Do the patient's cognitive issues require external management or
40 medications?
- 41 • Are the patient's cognitive problems currently managed by an
42 external provider?
- 43 ○ If yes, are they well controlled with current treatment?
- 44 ○ Last medical visit for each issue (date, reason, outcome)
- 45 • **Psychiatric/cognitive history**
- 46 ○ Mental status examination, as needed (e.g., Mini-Mental State Examination, MoCA)
- 47 ○ Current and past co-occurring psychiatric/cognitive diagnoses
- 48 ▪ Determine symptomatology present before and after substance use
- 49 ○ Medications for psychiatric/cognitive conditions (name, dose, frequency, purpose,
50 dose adherence, effectiveness)

- 1 ▪ Current
- 2 ▪ Past (for significant psychiatric/cognitive problems that might re-emerge)
- 3 ▪ Allergies/adverse events
- 4 • **Treatment Goals**
- 5 ○ What are the patient's goals for addressing any co-occurring mental health and/or
- 6 cognitive conditions?
- 7 ○ What types of support and services does the patient need to address any co-
- 8 occurring mental health and/or cognitive conditions?
- 9

10 *Dimension 4 (Substance use related risks)*

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

1 *Dimension 6 (Readiness and resources)*

2 • **Readiness**

- 3** ○ What does the patient believe needs to be addressed or improved with treatment or
- 4** other professional services (substance use, mental health status, physical health,
- 5** other)?
- 6** ○ How ready does the patient feel to address the identified issues?
- 7** ○ Does the patient have concerns or fears that make it hard for them to attend or
- 8** remain in treatment?
- 9** ○ Is the patient willing to participate in the recommended treatment services? Why or
- 10** why not?
- 11** ○ For patients with nicotine/tobacco use disorder, is the patient willing to engage in
- 12** nicotine/tobacco use disorder treatment?
- 13** ○ What external pressures are motivating the patient to enter into and complete
- 14** treatment?
- 15** ○ What external factors are negatively impacting the patient's motivation for
- 16** treatment?
- 17** ○ What factors (based on clinician judgement) need to be addressed to improve the
- 18** patient's readiness to change?
- 19** ○ What services/interventions are needed to improve the patient's readiness to
- 20** change?

21 • **Resources**

- 22** ○ Does the patient have needs related to social determinants of health that impact the
- 23** ability to participate fully in treatment and achieve recovery?
 - 24** ■ Transportation or mobility challenges
 - 25** ■ Food or housing security
 - 26** ■ Childcare
 - 27** ■ Income or financial insecurity
 - 28** ■ Lack of educational or employment opportunities
 - 29** ■ Lack of healthcare coverage
 - 30** ■ Lack of appropriate social and community supports
- 31** ○ Are the support services that the patient needs available to the client in a timely
- 32** manner in the community? If so, how long will patient need to wait to receive these
- 33** services?
- 34** ○ What care coordination or recovery support services will the patient need to
- 35** maximize their chances of success?
- 36** ○ What sources of strength does the patient feel they already have to support their
- 37** recovery? How can these strengths be built upon?

38 • **Treatment goals**

- 39** ○ What are the patient's goals for addressing treatment readiness or attaining
- 40** resources to support them in their recovery?
- 41** ○ What types of support or services will the patient need to help them achieve these
- 42** goals?

44 *Reassessment and Measurement Based Care*

45 *Reassessment Standards*

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

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

31 *Core Reassessment Measures*

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

34 *Outpatient Treatment Settings*

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

- 1 ○ GAD-2 for all patients; GAD-7 for patients with anxiety-related diagnoses, or for
- 2 patients not previously diagnosed who screen positive on the GAD-2
- 3 ○ C-SSRS screener for all patients with past or present risk factors for suicidality; C-
- 4 SSRS full scale for patients who screen positive for current suicidality
- 5 ○ Ability to fulfill responsibilities, functioning in employment, relationships (e.g., TEA)
- 6 ○ MoCA for patients with risk for or current cognitive impairment
- 7 ● **DIMENSION 4 (Substance Use Related Risks)**
- 8 ○ Any substance use since last assessment
- 9 ○ Patient reported (e.g., BAM, TEA)
- 10 ○ Toxicology results
- 11 ○ Clinician or 3rd party observed
- 12 ▪ Cravings/urges to use since last assessment (e.g., BAM, VAS)
- 13 ▪ Current self-efficacy to avoid use (e.g., BAM)
- 14 ▪ Steps to maintain recovery since last assessment (e.g., counseling and/or
- 15 self-help attendance, medications for SUD treatment, mindfulness, stress
- 16 reduction) (e.g., BAM)
- 17 ▪ Recovery capital (e.g., BARC-10) {Note: Recovery capital is defined as the
- 18 total resources a person has to find and sustain recovery}
- 19 ● **DIMENSION 5 (Recovery environment)**
- 20 ○ Changes in recovery environment since last assessment
- 21 ○ Concerns with any social relationships or situations (e.g., BAM)
- 22 ○ Social and community involvement since last assessment (e.g., BAM, TEA)
- 23

24 *Residential/Inpatient Treatment Settings*

- 25 ● **DIMENSION 1 (Acute intoxication and withdrawal potential)**
- 26 ○ If new intoxicated or withdrawal risks are identified the patient should be evaluated
- 27 by a medical professional.
- 28 ● **DIMENSION 2 (Biomedical conditions)**
- 29 ○ Self-rated physical health (e.g., BAM, TEA)
- 30 ○ Sleep quality (e.g., BAM, PSQI)
- 31 ● **DIMENSION 3 (Psychiatric and cognitive conditions)**
- 32 ○ Changes in mental health/cognitive function since last assessment
- 33 ▪ Patient reported
- 34 ▪ Clinician observed
- 35 ○ PHQ-2 screener for all patients; PHQ-9 for patients with depression-related
- 36 diagnoses, or for patients not previously diagnosed who screen positive on the PHQ-2
- 37 ○ GAD-2 screener for all patients; GAD-7 for patients with anxiety-related diagnoses, or
- 38 for patients not previously diagnosed who screen positive on the GAD-2
- 39 ○ C-SSRS screener for all patients with past or present risk factors for suicidality; C-
- 40 SSRS full scale for patients who screen positive for current suicidality
- 41 ○ MoCA for patients with risk for or current cognitive impairment
- 42 ● **DIMENSION 4 (Substance use related risks)**
- 43 ○ Cravings/urges to use since last assessment (e.g., BAM, VAS)
- 44 ○ Current self-efficacy to avoid use (BAM)
- 45 ● **DIMENSION 5 (Recovery environment)**
- 46 ○ Progress towards creating a recovery environment that is safe and supportive.
- 47

48 *Treatment Planning Standards*

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

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

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

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

- 1 • The treatment plan should:
 - 2 ○ reflect the patient’s personal goals and incorporate the patient’s inherent strengths
3 and supports.
4 ○ be informed by the patient’s trauma history, cultural backgrounds, preferences, and5 practices.6 ○ consider potential vulnerabilities resulting from the patient’s trauma history.
- 7 • For patients in Level 1 or Level 2 programs, the treatment plan should also include a safety
- 8 plan that addresses how the patient should seek help in the event of urgent or emergent9 issues that arise after hours.
- 10 • The treatment plan should be signed by the patient and the primary therapist, and dated
- 11 when initiated and when revised
- 12 • Treatment planning should be a continuous process, with updates incorporated as needed
- 13 when new information is learned, or the patient’s circumstances evolve.
- 14 • Treatment Plan Reviews (TPRs) should be conducted at regular intervals to capture the
- 15 patient's progress toward their goals and make appropriate adjustments to the treatment16 plan (See level-specific service characteristics for the recommended frequency)
- 17 ○ TPRs should ideally include representation from all members of the patient's
18 multidisciplinary treatment team, e.g., the primary therapist, medical provider(s),19 social workers, peer recovery support specialists/recovery coaches, and housing20 manager/staff.21 ○ All treatment team members should understand and agree upon adjustments to the22 plan.23 ○ It is recommended that the patient be included in part of the TPR session to ensure24 the plan is patient-centered and promotes transparency around why the treatment25 team suggests new recommendations to the treatment plan26 ○ The patient’s primary therapist should be responsible for auditing/reviewing and27 record keeping of all updated treatment plans.
- 28 • During the TPR, clinicians should review the treatment plan with a focus on the dimensional
- 29 drivers of placement at the specific level of care, attending to the following areas:
- 30 ○ Presenting Problem & Goals
 - 31 ▪ Why did the patient initially enter treatment?
32 ▪ What initial goals were established?
33 ▪ Does the treatment goal align with patient priorities and interventions34 utilized?35 ▪ Has the presenting problem changed significantly enough to consider36 establishing a new problem statement?
- 37 ○ Goals for Treatment
 - 38 ▪ Have any of the initial goals been met or changed??
39 ▪ Has there been a perspective shift from the patient? How might this shift
- 40 affect the patient’s goals?41 ▪ Has new information been presented that is crucial to explore, like drug42 history and patterns, abuse or neglect, critical relationships, behaviors, etc.?43 Is the patient’s reticence to reveal information indicating a need to re-explore44 goals??45 ▪ Has anything changed in the patient’s life that calls for an adjustment to the46 treatment plan? Consider all six dimensions. (Refer to Reassessment47 Standards for more detail)
- 48 ○ Treatment Engagement

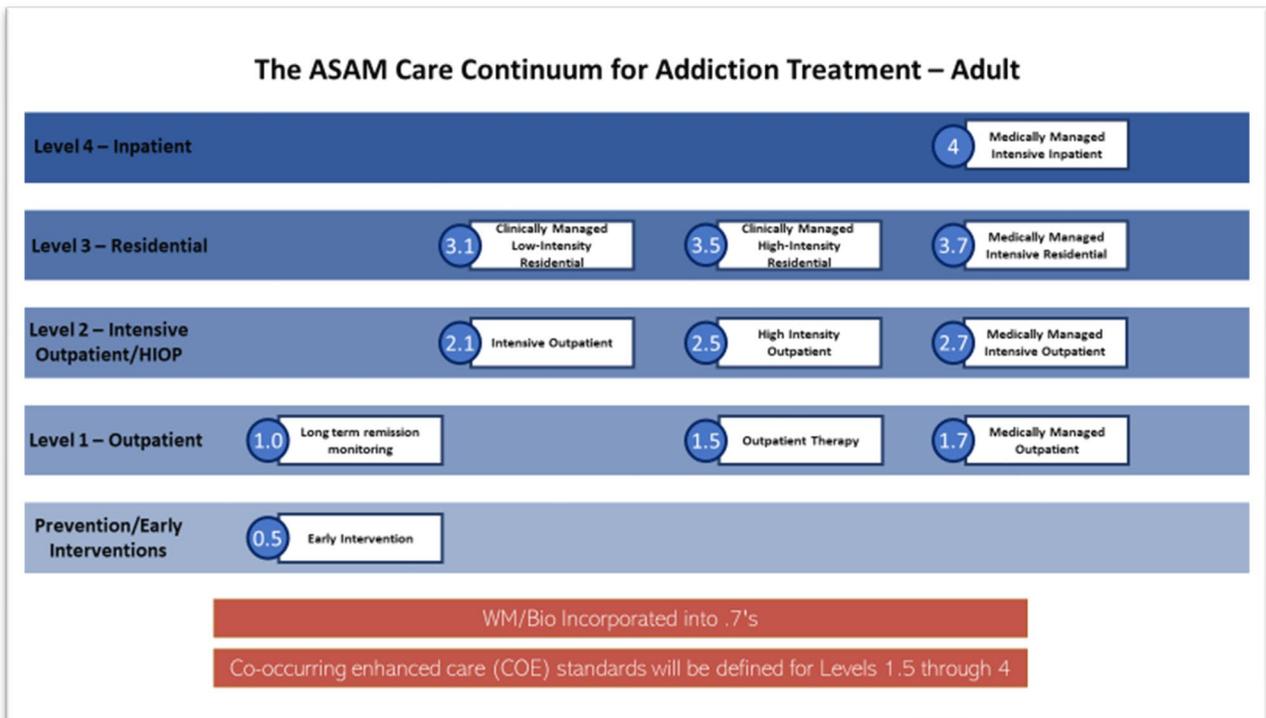
- 1 ▪ How is the patient responding to the current treatment plan? What evidence
- 2 do you have to support your response? (Refer to Reassessment Standards for
- 3 more detail)
- 4 ▪ How is the patient connected with other patients in the program? Has
- 5 relationship development been appropriate/healthy? Has there been conflict
- 6 between the patient and others in the cohort, and how was the conflict
- 7 managed?
- 8 ▪ How has the patient engaged in individual therapy and with clinicians? Which
- 9 modalities have been most effective? Which modalities have been
- 10 ineffective, or the patient struggled to acclimate?
- 11 ▪ How has the patient engaged in group therapy and with clinicians? Which
- 12 modalities have been most effective? Which modalities have been
- 13 ineffective, or the patient struggled to acclimate?
- 14 ▪ How has the patient engaged in concurrent or family therapy and with
- 15 clinicians? Which modalities have been most effective? Which modalities
- 16 have been ineffective, or the patient struggled to acclimate?
- 17 ▪ How has the patient engaged in medical care and with medical staff? How
- 18 has the patient responded to medications and other healthcare strategies
- 19 (e.g., exercise, stretching, etc.)?
- 20 ▪ How has the patient engaged in recovery programming? Which types of
- 21 support has the patient responded well to? E.g., recovery coaching, SMART
- 22 Recovery, 12-Step, etc. What recovery aspects have been ineffective or
- 23 disliked by the patient?
- 24 ○ Patient's Clinical Presentation and Progress
- 25 ▪ Patient needs and progress should be continuously reevaluated during
- 26 treatment.
- 27 ▪ Updates should be made to problems, goals and objectives as new needs are
- 28 identified with the patient.
- 29 ▪ The treatment plan should capture progress ratings to track patient progress
- 30 on goals and objectives. (Refer to the Measurement Based Care Standards
- 31 for specific validated items assessing clinical progress.)
- 32 ○ In determining whether changes should be made to the treatment plan, the clinical
- 33 staff should consider:
- 34 ▪ What new change (or changes) does the patient want to make? Did they
- 35 request the changes?
- 36 ▪ How motivated is the patient to make these changes?
- 37 ▪ How confident is the patient that the changes can be made?
- 38 ▪ Why does the patient want to make these changes?
- 39 ▪ What steps does the patient plan to take?
- 40 ▪ How can other people in the patient's life help?
- 41 ▪ How and when will the patient know the plan is working?
- 42 ▪ What are things that could interfere with the plan?

43 **The ASAM Continuum of Care**

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

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

- 3 • [Expanding Levels of Care within Level 1](#)
- 4 • [Updating Level 3.7 to reflect care in residential settings](#)
- 5 • [Better integrating withdrawal management](#) and [biomedical care into the continuum](#)
- 6 • [Encourage improved continuity of care along the continuum](#)



7

8 [Expanding Levels of Care within Level 1](#)

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

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

- 1 proposed Level 1.5 would be consistent with the current Level 1 standards for
2 outpatient counseling and psychotherapeutic services.
- 3 • Level 1.7 – Medically Monitored Outpatient Care
 - 4 ○ This proposed level would include specialty office based opioid treatment, opioid
 - 5 treatment programs, as well as low intensity, medically managed, ambulatory
 - 6 withdrawal management services. [Note that all levels of care will be expected to
 - 7 support access to addiction pharmacotherapies, discussed below]

8

9 **Updating Level 3.7 to reflect care in residential settings**

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

16 **Better integration of biomedical services in the continuum**

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

25 **Better integration of withdrawal management services in the continuum of care**

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

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

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

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

13 **Better integration of co-occurring capability along the continuum**

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

18 **Encourage improved continuity of care along the continuum**

19 *Increase the intensity of clinical services at Level 3.1*

20 Most patients who meet the admission criteria for Level 3.1 require concurrent treatment at Level
21 2.1 or 2.5. For patients in Level 3.1 alone, there is concern that 5 hours of clinical services per week
22 may represent too significant a drop from the intensity of care at Level 3.5. In addition, many Level
23 3.1 programs do not provide structured services on the weekends. As 24 hours of structure and
24 support are a core need at this level of care, the editorial team is proposing that the clinical
25 requirements align with Level 2.1 (9-19 hours of clinical services per week) and that structured
26 services (including mutual support and other recovery support services) are offered 7 days per week.

27 *Facilitate transitions of care within programs*

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

33 *Clarify how recovery support services fit into the continuum of care*

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

41

1 **Changes to the levels of care within the continuum**

3rd Edition	4th Edition	Anticipated Change
<i>Prevention/Early Intervention</i>		
Level 0.5 – Early Intervention	Level 0.5 – Early Intervention	No major changes envisioned
<i>Outpatient</i>		
	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
<i>Intensive Outpatient</i>		
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
<i>Residential</i>		
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 4 th 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		
<i>Inpatient</i>		
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

- 4 Level 0.5 programs provide prevention and early intervention services for individuals who engage in
- 5 risky substance use but who do not meet diagnostic criteria for a substance use disorder (SUD), with
- 6 the goal of preventing progression to SUD and other substance use related harms (e.g., overdoses,
- 7 car crashes).
- 8 Level 0.5 services are typically offered in non-specialty medical settings, such as hospital emergency
- 9 departments, or primary care medical clinics. Level 0.5 may also be offered by clinically delivered
- 10 programs that aim to prevent impaired driving or other substance use related harms.

1 *Setting*

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

4
5 Level 0.5 services may be offered in:

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

15 *Staff*

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

25 *Training/Competencies*

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

38 *Support Systems*

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

- 41 • Biomedical
 - 42 ○ Ability to refer for physical examination or biomedical assessment when needed
- 43 • Psychiatric
 - 44 ○ Ability to refer for mental health evaluation when needed

- 1 • Established relationships with more intensive levels of care to support coordinated referral
2 for SUD treatment if a person is found to meet diagnostic criteria for SUD.
3

4 *Screening, Brief Assessment, and Treatment Planning*

5 Level 0.5 provides:

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

17 18 *Services*

19 Level 0.5 services are designed to prevent the escalation of risky substance use into a SUD by
20 helping individuals recognize, explore, and address harmful consequences related to their substance
21 use.
22

23 Level 0.5 program services may include:

- 24 • Brief interventions (SBIRT)
25 • One-to-one counseling for at-risk individuals
26 • Motivational interventions
27 • Psychoeducational programs (e.g., clinically delivered psychoeducation to prevent DUI)
28 • Health education programs (e.g., HIV prevention, harm reduction)
29 • Coordinated referral for treatment
30 • Counseling with family, significant others, or other support persons
31 • Contingency management
32

33 All treatment services should be trauma informed responsive and delivered with cultural humility,
34

35 *Psychosocial Services*

36 Level 0.5 programs primarily provide psychoeducational services which may include:

- 37 • Interventions designed to enhance the patient's understanding of SUD and substance use
38 related risks
39 • Health education services regarding:
40 ○ The causes of addiction
41 ○ The course of addiction
42 ○ Risk of injury when intoxicated
43 ○ Substance refusal skills
44 ○ Pharmacotherapies for SUD

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

16 *Support Services*

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

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

27 *Documentation*

28 Documentation for Level 0.5 programs should include:

- 29 • Standardized screening and assessment results
- 30 • Overview and analysis of any problems within each of the six dimensions that may impact the
- 31 likelihood of progression to SUD
- 32 • Attendance and participation
- 33 • Significant clinical events, particularly those that require further assessment and referral
- 34 • Documentation of referral to other service providers including:
- 35 ▪ Review of the ASAM Criteria dimensions
- 36 ▪ Recommendations for care
- 37 ▪ Reasons for departures from recommendations if applicable
- 38 ▪ Program(s) that the patient will enroll in
- 39 ▪ Follow up plan to ensure engagement in care and documentation of follow
- 40 ups
- 41
- 42

1 Level 1.0 – Long Term Remission Monitoring

2 *Level of Care Description*

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

5 *Dimensional Drivers*

- 6 • Dimension 4
- 7 • Dimension 5
- 8 • Dimension 6

9 *Setting*

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

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

14 *Staff*

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

17 *Training/Competencies*

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

25 *Support Systems*

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

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

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

4 *Assessment and Treatment Planning*

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

40 *Services*

41 Level 1.0 programs should directly provide:

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

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

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

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

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

28

29 *Psychosocial Services*

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

33

34 *Recovery Support Services*

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

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

Public comments accepted through **Friday, November 11th** through the online survey form at bit.ly/ASAM4th.

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

10 *Documentation*

11 See the [Universal Documentation Standards](#). Core documentation in Level 1.0 includes:

- 12 • Results from recovery management checkups
- 13 • Individualized remission maintenance plans

14

15 **Level 1.5 – Outpatient Therapy**

16 *Level of Care Description*

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

18 *Dimensional Drivers*

- 19 • Dimension 3
- 20 • Dimension 4

21 *Setting*

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

- 24 • Office-based practices
- 25 • Health clinics
- 26 • Primary care clinics
- 27 • Outpatient addiction programs
- 28 • Mental health clinics
- 29 • Group homes or shelters

30 *Staff*

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

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

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

1 *Role of physicians and advanced practice providers*

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

14 *Role of addiction specialist physicians*

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

16 *Role of nurses*

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

18 *Role of clinical staff*

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

23 *Role of allied health professionals*

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

28 *Support Systems*

29 Support systems include the following:

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

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

13 *Assessment and Treatment Planning*

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

42 *Services*

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

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

29 *Medical services*

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

- 33 • Identifying appropriate medical providers
- 34 • Coordinating care with the patient’s medical providers as needed
- 35 • Integrating biomedical service needs in the patient’s treatment plan

36 *Psychosocial services*

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

40 *Recovery support services*

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

- 43 • Assessment of recovery support service needs

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

15 *Documentation*

16 See the [Universal Documentation Standards](#).

17

18 **Level 1.7 – Medically Managed Outpatient**

19 *Level of Care Description*

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

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

25 *Dimensional Drivers*

- 26 • Dimension 1
- 27 • Dimension 2

28 *Setting*

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

31 Level 1.7 services may be offered in:

- 32 • Physician's offices
- 33 • Health clinics
- 34 • Primary care clinics
- 35 • Outpatient addiction programs
- 36 • Opioid treatment programs
- 37 • Office based addiction treatment programs
- 38 • Mobile addiction treatment programs (i.e., street medicine)

1 **Staff**

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

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

11 **Medical and Nursing Staff**

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

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

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

21 **Clinical Staff**

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

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

33 **Allied Health Staff**

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

35 **Role of the addiction specialist physician:**

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

38 **Support Systems**

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

- 40 • Biomedical

- 1 ○ If primary care services are not available on site, the program should have a direct
- 2 affiliation with a primary care provider and be able to arrange an appointment within
- 3 14 days of the initial evaluation.
- 4 ○ The program should have established relationships with obstetricians to support
- 5 coordination of care for pregnant and postpartum patients.
- 6 • **Psychiatric**
- 7 ○ Psychiatric assessment by a psychiatrist or psychiatric nurse practitioner should be
- 8 available within a time frame appropriate to the severity and urgency of the need.
- 9 ▪ If the initial assessment occurs via telehealth, video telehealth should be
- 10 used
- 11 ▪ Follow up assessments may be audio only, when appropriate (as determined
- 12 by the provider))
- 13 ○ The program should have an established relationship with the local behavioral health
- 14 crisis system, if available, to respond to urgent mental health needs.
- 15 ○ The program should have established relationships with local mental health
- 16 treatment providers to support access to routine psychiatric consultation and to
- 17 facilitate mental health care appointment access when needed.
- 18 • **Psychological**
- 19 ○ If psychosocial services are not available on site, they should be available through a
- 20 directly affiliated provider or program.
- 21 • The program should have established relationships with more intensive levels of care.
- 22 • **After hours telephonic availability**
- 23 ○ The program should provide after-hours access through direct connection to clinical
- 24 staff or a call service, such as a nurse triage line
- 25 ○ A physician or advanced practice provider should be on-call during non-business
- 26 hours to respond to urgent concerns

27 ***Assessment and Treatment Planning***

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

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

21 *Services*

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

42 *Medical*

- 43 • Outpatient withdrawal management services, including:
 - 44 ○ Nursing assessment upon admission, including:
 - 45 ■ vitals
 - 46 ■ history of present illness

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

16 *Biomedical Capabilities*

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

- 19 • Glucose monitoring
- 20 • Pulse oximetry
- 21 • Basic wound care
- 22 • Basic first aid
- 23 • Blood pressure monitoring
- 24 • Injectable epinephrine available on site
- 25 • Naloxone available on site
- 26 • Automated external defibrillator (AED)
- 27 • Access to laboratory services during business hours
 - 28 ○ Access to laboratory that conducts blood cultures
- 29 • Access to toxicology services during normal business hours
 - 30 ○ CLIA waived point of care testing is preferred but not required.
 - 31 ○ Access to confirmatory testing should be available
 - 32 ○ Point of contact breath alcohol testing
- 33 • Point of care pregnancy testing

34 *Psychosocial Services*

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

39 *Recovery Support Services*

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

- 43 • Assessment of recovery support service needs
- 44 • Development of an individualized recovery plan

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

12 *Documentation*

13 See the [Universal Documentation Standards](#).

14

15 **Level 2.1 – Intensive Outpatient**

16 *Level of Care Description*

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

20 *Dimensional Drivers*

- 21 • Dimension 4
- 22 • Dimension 3

23 *Setting*

24 Level 2.1 services may be offered in any appropriate setting that meets state licensing criteria.

25 Examples of Level 2.1 programs are:

- 26 • Day outpatient programs
- 27 • Evening outpatient programs
- 28 • Weekend intensive outpatient programs

29 *Staff*

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

- 32 • Counselors
- 33 • Psychologists
- 34 • Clinical social Workers
- 35 • Others credentialed to assess and treat SUD and co-occurring psychiatric disorders

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

1 ***Role of physicians and advanced practice providers***

- 2 • Level 2.1 programs do not typically have physicians or advanced practice providers on staff.
3 However, Level 2.1 programs should have established relationships with physicians and/or
4 advanced practice providers to provide the following services when needed:
5 ○ Physical examinations
6 ○ Addiction pharmacotherapies
7 ○ Psychiatric pharmacotherapies
8 ○ Toxicology testing
9 ○ Laboratory testing
10 • When medical services are required concurrent with Level 2.1 treatment, care should be
11 coordinated to develop an integrated treatment plan and support adherence to treatment
12 recommendations.
13 • Physicians or advanced practice providers providing medical services to patients in this level
14 should have at least two years of specialty training and/or experience in addiction medicine
15 or addiction psychiatry.
16

17 ***Role of addiction specialist physicians***

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

20 ***Role of nurses***

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

22 ***Role of clinical staff***

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

35 ***Role of allied health professionals***

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

1 *Support Systems*

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

- 3 • Biomedical
 - 4 ○ Ability to conduct or arrange for physical examinations and medical assessments
5 when needed.
6 ○ Ability to conduct or arrange for medical assessments for addiction and psychiatric7 pharmacotherapies.
 - 8 ▪ The program should have a direct affiliation with a physician and/or
9 advanced practice provider waived to prescribe buprenorphine10 ▪ The program should have a direct affiliation with an opioid treatment program11 (OTP) if available within the local payment geography12 ○ Ability to refer for appropriate laboratory testing services (e.g., infectious disease13 screening), when needed.14 ○ Ability to refer for toxicology testing, when needed.
- 15 • Psychiatric
 - 16 ○ Psychiatric assessment, by a psychiatrist or psychiatric nurse practitioner, is available
17 within a time frame appropriate to the clinical severity and urgency of the need.
- 18 ○ Level 2.1 programs should have an established relationship with the local behavioral19 health crisis system, if available, to respond to urgent mental health needs.20 ○ Level 2.1 programs should have established relationships with local mental health21 treatment providers to support access to routine psychiatric consultation and to22 facilitate mental health care appointment access when needed.
- 23 • Psychological
 - 24 ○ Specialized consultation for psychological and cognitive problems should be
25 available through consultation or referral when needed.
- 26 • Level 2.1 programs should have established relationships with more and less intensive levels
- 27 of care.
- 28 • Level 2.1 programs do not need to have after hours telephonic availability. However,
- 29 programs should educate patients at intake on what to do if urgent or emergent issues arise30 after hours (e.g., community resources, help lines, 911, 988, etc.)

31 *Assessment and Treatment Planning*

- 32 • Assessment and treatment planning should be sensitive to trauma and designed to prevent
33 re-traumatization.34 • A Level of Care assessment, including an addiction-focused history, should be conducted (or35 reviewed) at admission to determine the recommended level of care.

 - 36 ○ For patients who are intoxicated or experiencing withdrawal the assessment should
37 be reviewed by a physician prior to admission.
38 • A full biopsychosocial treatment planning assessment should be conducted (or reviewed)39 and used to develop an individualized treatment plan within one week of admission.40 • For patients who have not had a physical exam within the past year, a physical exam should41 be conducted by a physician or advanced practice provider within 14 days of admission, or42 sooner if needed based on the patient's medical condition.

 - 43 ○ Such determinations should be made according to established protocols, which
44 should include reliance on the patient's personal physician whenever possible.45 ○ Protocols should be based on the program's capabilities and developed and46 approved by a physician or advanced practice provider.

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

34 *Services*

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

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

12 *Medical services*

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

31 *Psychosocial services*

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

35 *Recovery support services*

36 Level 2.1 programs should directly provide:

- 37 • Support, structure, and consistency
- 38 • Transfer planning, including warm handoffs

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

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

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

28 *Documentation*

29 See the [Universal Documentation Standards](#).

30

31 **Level 2.5 – High Intensity Outpatient**

32 *Level of Care Description*

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

36 *Dimensional Drivers*

- 37 • Dimension 3
- 38 • Dimension 4

39 *Setting*

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

- 42 • Day treatment programs

- 1 • Partial hospital programs

2 ***Staff***

- 3 • Level 2.5 programs are staffed by an interdisciplinary team of appropriately credentialed
4 addiction treatment professionals, typically including:
5 ○ Psychologists
6 ○ Master’s level clinical social workers
7 ○ Counselors
8 ○ Others who assess and treat SUD and co-occurring mental health conditions
9 • Clinician qualified to assess and manage mental health conditions should be on site or on
10 call at all times during program hours of operation. [Note: management includes determining
11 appropriate steps for addressing mental health problems including symptom management
12 support, further assessment, referral, crisis services, transfer, etc.]
13 • Level 2.5 programs should have a medical director who is a physician or advanced practice
14 provider with at least 2 years of addiction treatment experience.
15

16 ***Role of physicians and advanced practice providers***

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

22 ***Role of addiction specialist physicians***

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

25 ***Role of nurses***

- 26 • Level 2.5 programs do not typically provide nursing services.

27 ***Role of clinical staff***

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

40 ***Role of allied health professionals***

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

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

7 *Support Systems*

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

- 9 ● Biomedical
 - 10 ○ Ability to conduct or arrange for a physical examinations and medical assessments
 - 11 when needed
 - 12 ○ Ability to conduct or arrange for medical assessments for addiction and psychiatric
 - 13 pharmacotherapies.
 - 14 ▪ The program should have a direct affiliation with a physician and/or
 - 15 advanced practice provider waived to prescribe buprenorphine
 - 16 ▪ The program should have a direct affiliation with an opioid treatment program
 - 17 (OTP) if available within the local payment geography
 - 18 ○ Ability to refer for appropriate laboratory testing services (e.g., infectious disease
 - 19 screening), when needed.
 - 20 ○ Ability to refer for toxicology testing, when needed.
- 21 ● Psychiatric
 - 22 ○ Psychiatric assessment, by a psychiatrist or psychiatric nurse practitioner, should be
 - 23 available within a time frame appropriate to the clinical severity and urgency of the
 - 24 need.
 - 25 ○ Level 2.5 programs should have an established relationship with the local behavioral
 - 26 health crisis system, if available, to respond to urgent mental health needs.
 - 27 ○ Level 2.5 programs should have established relationships with local mental health
 - 28 treatment providers to support access to routine psychiatric consultation and to
 - 29 facilitate mental health care appointment access when needed.
- 30 ● Psychological
 - 31 ○ Specialized consultation for psychological and cognitive problems should be
 - 32 available through consultation or referral when needed.
- 33 ● Level 2.5 programs should have established relationships with more and less intensive levels
- 34 of care.
- 35 ● Level 2.5 programs do not need to have after hours telephonic availability. However,
- 36 programs should educate patients at intake on what to do if urgent or emergent issues arise
- 37 after hours (e.g., community resources, help lines, 911, 988, etc.)

38 *Assessment and Treatment Planning*

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

- 1 • For patients who have not had a physical exam within the past year, a physical exam should
2 be conducted by a physician or advanced practice provider within one week of admission or
3 sooner if needed based on the patient’s medical condition.
 - 4 ○ Such determinations should be made according to established protocols, which
5 include reliance on the patient’s personal physician whenever possible
 - 6 ○ Protocols should be based on the staff’s capabilities and developed and approved by
7 a physician or advanced practice provider.
 - 8 ○ For patients who have had a physical examination within the 3 months, the Level 2.5
9 clinician should obtain and review the physical examination results within 1 week of
10 admission.
- 11 • A full biopsychosocial treatment planning assessment should be conducted (or reviewed)
12 and used to develop an individualized treatment plan within 5 treatment days of admission.
- 13 • Individualized treatment plans should include problem identification in each dimension and
14 development of treatment goals and measurable treatment objectives, as well as activities
15 designed to meet those objectives.
 - 16 ○ The patient facing treatment plan should include a plan for contacting the program
17 after-hours and for accessing emergency care 24/7, including when to call 988 or
18 911.
- 19 • The multidisciplinary treatment team should meet at least weekly to discuss patient progress
20 and adjust the treatment plan as needed.
- 21 • Formal reassessment and treatment plan updates should be conducted at least every 2
22 weeks.
- 23 • Patient treatment plans should address any mental health treatment needs identified,
24 including:
 - 25 ○ Services to be delivered by the program’s treatment team.
 - 26 ○ Services to be delivered by external providers.
- 27 • Treatment plans should reflect:
 - 28 ○ coordination of addiction treatment, physical health care (obstetrics and gynecology,
29 infectious disease, cardiology, etc.), mental health care, and recovery support service
30 needs.
 - 31 ○ coordination of care with external treatment and service providers.
- 32 • Transfer planning should begin at admission and address:
 - 33 ○ Addiction treatment service needs
 - 34 ○ Physical health service needs
 - 35 ○ Mental health service needs
 - 36 ■ When individuals with co-occurring disorders are transferred to another level
37 of care, they should be transferred to a setting that can provide integrated
38 care for their continuing SUD and MH needs whenever possible.
 - 39 ○ Recovery support service needs
 - 40 ○ Continued access to medications
 - 41 ○ Overdose prevention, including access to naloxone

42 *Services*

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

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

19 *Medical services*

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

41 *Psychosocial services*

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

1 ***Recovery support services***

2 Level 2.5 programs should directly provide:

- 3 • Support, structure, and consistency
4 • Transfer planning, including warm handoffs

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

- 7 • Assessment of recovery support service needs
8 • Development of an individualized recovery plan
9 • Peer-support specialist services, including:
10 o Recovery coaching
11 o Recovery plan development
12 o Recovery resource navigation (i.e., supporting connection with other recovery
13 resources)
14 o Ally advocacy (i.e., advocating for the patient as needed with social service
15 organization and professional services to address healthcare, employment, housing,
16 education, and other needs)
17 • Support practicing skills of daily living, including:
18 o Transportation skills
19 o Health and healthcare navigation
20 o Self-care (healthy living and other activities to promote personal wellbeing)
21 o Support accessing services to further develop and practice core life skills building
22 (e.g., parenting, financial management, nutrition, etc.)
23 • Patient navigation services for patients who need concurrent treatment with external
24 providers
25 • Support accessing mutual help programs (e.g., support finding appropriate programs,
26 identifying transportation options, etc.)
27 • Assistance accessing social services for housing, nutritional assistance, health insurance,
28 etc.
29 • Assistance with transportation to necessary services (e.g., community rides to mutual help
30 meetings, help identifying public transit options and obtaining passes)
31 • Support coordinating with social service agencies (e.g., Children, Youth & Family Services,
32 criminal justice agencies, etc.)
33 • Assistance identifying and obtaining community services or supports to address potential
34 impediments to recovery (e.g., legal services, educational services, recovery housing,
35 childcare services, jobs training, parenting training, financial training, etc.)
36 • Assistance identifying and accessing community harm reduction services

37 ***Documentation***

38 See the [Universal Documentation Standards](#).

39

1 Level 2.7 – Medically Managed Intensive Outpatient

2 *Level of Care Description*

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

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

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

10 *Dimensional Drivers*

- 11 • Dimension 1
- 12 • Dimension 2

13 *Setting*

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

16 Level 2.7 services may be offered in:

- 17 • Intensive outpatient programs
- 18 • Partial hospital programs

19 *Staff*

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

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

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

32 *Medical staff*

- 33 • The medical director:
 - 34 ○ Develops the program's admission criteria
 - 35 ○ Develops clinical protocols
 - 36 ○ Directs patient care
 - 37 ○ Ensures the adequacy of individual treatment plans
 - 38 ○ Ensures daily medical coverage to meet patient needs.
 - 39 ○ Determines the credentials required of other physicians and advanced practice
40 providers serving the program

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

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

- 19 ● Appropriately licensed and credentialed nursing staff should be available during program
- 20 hours of operation to:
 - 21 ○ Conduct nursing assessments on admission
 - 22 ○ Monitoring patient progress
 - 23 ■ Administer validated withdrawal severity assessments.
 - 24 ○ Administer medications and non-pharmacological interventions in accordance with
 - 25 provider orders.
 - 26 ○ Provide medication management services
 - 27 ○ Conduct routine daily assessments of withdrawal, biomedical comorbidities, and
 - 28 psychiatric comorbidities
 - 29 ○ Provide patient education
- 30 ● The level of nursing care should be appropriate to the severity of patient needs

31

32 *Clinical Staff*

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

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

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

9 *Allied Health Staff*

- 10 • Level 2.7 programs may be staffed with appropriately certified peer support specialists and
- 11 other allied health staff
- 12

13 *Role of the addiction specialist physician:*

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

16 *Support Systems*

17 Support systems include the following:

- 18 • Biomedical
- 19 ○ The program should have a direct affiliation (e.g., MOU) with a nearby hospital to
- 20 support effective coordination of care.
- 21 ○ Ability to arrange for specialized clinical consultation for biomedical and cognitive
- 22 problems when needed.
- 23 ▪ All programs should have a formal relationship with an infectious disease
- 24 specialist.
- 25 ▪ Programs should consider local and treatment community needs when
- 26 determining other need for direct affiliations. (For example, if renal failure is
- 27 common in the patient population, consider a formal relationship with a
- 28 nearby dialysis center to support effective coordination of care)
- 29 ○ If primary care services are not available on site, the program should have a direct
- 30 affiliation with a primary care provider and be able to arrange an appointment within
- 31 48 hours.
- 32 ○ The program should have established relationships with obstetricians to support
- 33 coordination of care for patients who are pregnant or postpartum.
- 34 • Psychiatric
- 35 ○ Psychiatric assessment, by a psychiatrist or psychiatric nurse practitioner, is available
- 36 within a time frame appropriate to the severity and urgency of the need.
- 37 ▪ If the initial assessment occurs via telehealth, video telehealth should be
- 38 used
- 39 ▪ Follow up assessments may be audio only, when appropriate (as determined
- 40 by the provider)
- 41 ○ The program should have an established relationship with the local behavioral health
- 42 crisis system, if available, to respond to urgent mental health needs.

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

15 *Assessment and Treatment Planning*

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

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

16 *Services*

- 17 ● Level 2.7 programs directly provide daily clinical services including:
- 18 ■ Nursing and medical monitoring for stabilization of acute withdrawal,
- 19 ■ biomedical and psychiatric conditions.
- 20 ■ Psychosocial services to encourage engagement in ongoing treatment
- 21 ● Such services should be provided in an amount, frequency, and intensity appropriate to the
- 22 ○ patient's individual needs and level of function as determined by the multidimensional
- 23 ○ assessment.
- 24 ● All treatment services should be trauma informed responsive and delivered with cultural
- 25 ○ humility,
- 26 ● All services should be designed with the expectation that many if not most patients will have
- 27 ○ co-occurring mental health conditions
- 28 ○ The program should provide symptom management support for both SUD and co-
- 29 ○ occurring mental health conditions
- 30 ○ Patient mental health concerns should be treated concurrently by the program or
- 31 ○ through coordination with external providers
- 32 ● The program should coordinate care with any external mental health care providers involved
- 33 ○ in the patient's care, with appropriate patient consent:
- 34 ○ At admission and discharge
- 35 ○ As needed based to support effective care coordination for the individual patient
- 36 ● Care coordination with other providers involved in the patient's care
- 37 ○ The staff member responsible for care coordination for a given patient should be
- 38 ○ clearly documented.
- 39 ○ If psychosocial services are provided through affiliated programs, there should be
- 40 ○ daily touch bases regarding the care of each patient.
- 41 ● The program's services should be designed to provide a welcoming environment for
- 42 ○ individuals with co-occurring mental health conditions, where patients feel safe addressing
- 43 ○ their mental health concerns and experiences
- 44

45 *Medical*

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

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

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

31 Level 2.7 programs should have the following biomedical capabilities:

- 32 • ECG (at minimum with a 3-lead rhythm strip)
- 33 • Glucose monitoring
- 34 • Pulse oximetry
- 35 • Basic wound care
- 36 • Basic first aid
- 37 • Automated external defibrillator (AED)
- 38 • Blood pressure monitoring
- 39 • Injectable epinephrine available on site
- 40 • Naloxone available on site
- 41 • Ability to administer vaccines on site (including for hepatitis A and B, influenza, Covid,
- 42 etc.)
- 43 • Phlebotomy services
- 44 • Laboratory services
 - 45 • Ability to conduct or arrange for appropriate laboratory testing services during
 - 46 normal hours of operation
 - 47 • Access to laboratory that conducts blood cultures

- 1 • Toxicology services
- 2 • CLIA waived point of care testing is preferred but not required.
- 3 • Ability to conduct or arrange for confirmatory testing
- 4 • Point of care breath alcohol testing
- 5 • Point of care pregnancy testing
- 6

7 *Psychosocial Services*

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

23 *Recovery Support Services*

24 Level 2.7 programs should directly provide:

- 25 • Support, structure, and consistency
- 26 • Transfer planning, including warm handoffs
- 27

28 In addition, these programs should provide the following recovery support services either directly or

29 through formal affiliation with external service providers:

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

- 1 • Support accessing mutual help programs (e.g., support finding appropriate programs,
2 identifying transportation options, etc.)
- 3 • Assistance accessing social services for housing, nutritional assistance, health insurance,
4 etc.
- 5 • Assistance with transportation to necessary services (e.g., community rides to mutual help
6 meetings, help identifying public transit options and obtaining passes)
- 7 • Support coordinating with social service agencies (e.g., Children, Youth & Family Services,
8 criminal justice agencies, etc.)
- 9 • Assistance identifying and obtaining community services or supports to address potential
10 impediments to recovery (e.g., legal services, educational services, recovery housing,
11 childcare services, jobs training, parenting training, financial training, etc.)
- 12 • Assistance identifying and accessing community harm reduction services
- 13

14 *Documentation*

15 See the [Universal Documentation Standards](#).

16

17 **Level 3.1 – Clinically Managed Low-Intensity Residential**

18 *Level of Care Description*

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

21 *Dimensional Drivers*

- 22 • Dimension 4
- 23 • Dimension 5

24 *Setting*

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

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

9 *Patient Supervision*

- 10 • Level 3.1 programs should provide 24-hour structure and support.
- 11 ○ The whereabouts of each patient who is on-site should be monitored and
- 12 documented at least once per hour.
- 13 ○ At the start of treatment in Level 3.1 some patients may benefit from staff monitoring
- 14 or peer support when they are off-site. Programs should have policies and
- 15 procedures in place for providing monitoring or support when patients are off-site.
- 16 For example, allowing patients who need additional support to go off-site in groups of
- 17 3 or more.
- 18 ○ As patients progress clinically in treatment (as determined by their primary
- 19 counselor), they should be able to leave the program independently as they prepare
- 20 to reintegrate into their community.

21 *Staff*

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

30 *Role of physicians and advanced practice providers*

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

38 *Role of addiction specialist physicians*

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

42 *Role of nurses*

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

1 *Role of clinical staff*

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

16 *Role of allied health professionals*

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

30 *Support Systems*

31 Support systems include the following:

- 32 • Biomedical
 - 33 ○ Ability to conduct or arrange for physical examination or medical assessment when
 - 34 needed.
 - 35 ○ Ability to conduct or arrange medical evaluations for pharmacotherapy for psychiatric
 - 36 and addiction medications.
 - 37 ■ The program should have a direct affiliation with a physician and/or
 - 38 advanced practice provider with waived to prescribe buprenorphine
 - 39 ■ The program should have a direct affiliation with an opioid treatment program
 - 40 (OTP) if available within the local payment geography
 - 41 ○ Ability to refer for appropriate laboratory testing services (e.g., infectious disease
 - 42 screening), when needed.
 - 43 ○ Ability to refer for toxicology testing, when needed.
- 44 • Psychiatric

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

19 *Assessment and Treatment Planning*

20 In Level 3.1 programs:

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

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

29 *Services*

- 30 • Level 3.1 programs should directly provide:
- 31 ○ 9-19 hours of clinical services per week including:
- 32 ▪ Daily clinical services designed to improve the patient’s ability to structure
- 33 and organize the tasks of daily living and recovery, such as personal
- 34 responsibility, personal appearance, and punctuality.
- 35 ▪ Clinical program activities designed to stabilize and maintain the stability of
- 36 the patient’s substance use disorder symptoms, and to help him or her
- 37 develop and apply recovery skills, such as:
- 38 • relapse prevention
- 39 • exploring interpersonal choices
- 40 • development of a social network supportive of recovery.
- 41 ○ These services should be provided in an amount, frequency, and intensity
- 42 appropriate to individual patient needs as determined by the multidimensional
- 43 assessment.
- 44 • Structured services should be available 7 days per week
- 45 • Daily activities should be designed to allow patients to learn and practice prosocial behaviors
- 46 • Coordination of patient referrals and transfers to other levels of care when needed

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

26 *Medical*

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

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

5 *Psychosocial services*

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

9 *Recovery support services*

10 Level 3.1 programs should directly provide:

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

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

- 17 ● Assessment of recovery support service needs
- 18 ● Development of an individualized recovery plan
- 19 ● Peer-support specialist services, including:
 - 20 ○ Recovery coaching
 - 21 ○ Recovery plan development
 - 22 ○ Recovery resource navigation (i.e., supporting connection with other recovery
 - 23 resources)
 - 24 ○ Ally advocacy (i.e., advocating for the patient as needed with social service
 - 25 organization and professional services to address healthcare, employment, housing,
 - 26 education, and other needs)
- 27 ● Support developing and practicing skills of daily living, including:
 - 28 ○ Transportation skills
 - 29 ○ Health and healthcare navigation
 - 30 ○ Self-care (healthy living and other activities to promote personal wellbeing)
 - 31 ○ Parenting
 - 32 ○ Financial management
 - 33 ○ Nutrition
- 34 ● Patient navigation services for patients who need concurrent treatment with external
- 35 providers
- 36 ● Support accessing mutual help programs (e.g., support finding appropriate programs,
- 37 identifying transportation options, etc.)
- 38 ● Assistance accessing social services for housing, nutritional assistance, health insurance,
- 39 etc.
- 40 ● Assistance with transportation to necessary services (e.g., community rides to mutual help
- 41 meetings, help identifying public transit options and obtaining passes)
- 42 ● Support coordinating with social service agencies (e.g., Children, Youth & Family Services,
- 43 criminal justice agencies, etc.)

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

5 *Documentation*

6 See the [Universal Documentation Standards](#).

7

8 **Level 3.5 – Clinically Managed High-Intensity Residential**

9 *Level of Care Description*

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

14 *Dimensional Drivers*

- 15 • Dimension 4
- 16 • Dimension 5
- 17 • Dimension 3

18 *Setting*

- 19 • Level 3.5 services are offered in appropriately licensed facilities located in residential
- 20 settings (e.g., a therapeutic community or residential treatment center). Level 3.5 program
- 21 services may be offered in an appropriately licensed facility located in a community setting or
- 22 a specialty unit within a licensed health care facility.
- 23 • The facility should incorporate space for:
 - 24 ○ Counseling services
 - 25 ○ Group meetings
 - 26 ○ Therapeutic activities
 - 27 ○ Patient rest
 - 28 ○ Patient privacy
 - 29 ○ Meals
 - 30 ○ Hygiene
- 31 • The facility should provide a supportive living environment that provides the needs of daily
- 32 living.
- 33 • The setting should provide an environment that:
 - 34 ○ Is safe from substances, paraphernalia, and weapons.
 - 35 ■ Searches of patients, visitors, and their belongings that are necessary to
 - 36 provide an environment free from substances, paraphernalia, and
 - 37 weapons should utilize trauma-informed practices and preserve patient
 - 38 dignity and privacy
 - 39 ○ Provides privacy and security of personal belongings

40 *Patient Supervision*

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

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

21 *Staff*

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

40 *Role of physicians and advanced practice providers*

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

1 ***Role of addiction specialist physicians***

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

5 ***Role of nurses***

- 6 • Nursing staff are not required in Level 3.5 programs.

7 ***Role of clinical staff***

- 8 • Clinical staff:
9 ○ Provide a planned regimen of professionally directed evaluation, psychotherapy,
10 psychoeducation, and coordinate the delivery of recovery support services for
11 patients and their support systems.
12 ○ Assess and treat substance use and other addictive disorders.
13 ○ Assess and support management of cooccurring mental health conditions.
14 • Mental health treatment providers should be part of the multidisciplinary team.
15 ○ On the multidisciplinary team, staff members with more training and experience with
16 mental health care should support their team members to provide effective,
17 integrated co-occurring competent care.
18 • It is recommended that programs have dedicated staff responsible for care coordination.
19 • Supervisory clinical staff should be available 24/7 to respond to urgent situations
20

21 ***Role of allied health professionals***

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

34 ***Supports Systems***

35 Support systems include the following:

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

- 1 ▪ The program should have a direct affiliation with a physician and/or
- 2 advanced practice provider waived to prescribe buprenorphine
- 3 ▪ The program should have a direct affiliation with an opioid treatment program
- 4 (OTP)
- 5 ○ Programs should seek to establish a relationship (e.g., formal MOU or informal
- 6 connection) with nearby hospital(s) for coordination of care.
- 7 ○ Ability to conduct or arrange for appropriate laboratory testing services.
- 8 ○ Access to conduct or arrange for toxicology testing when needed (see ASAM Drug
- 9 Testing Guideline)
- 10 ○
- 11 • Psychiatric
- 12 ○ Psychiatric assessment, by a psychiatrist or psychiatric nurse practitioner, should be
- 13 available within a time frame appropriate to the clinical severity and urgency of the
- 14 need.
- 15 ○ Level 3.5 programs should have an established relationship with the local behavioral
- 16 health crisis system, if available, to respond to urgent mental health needs.
- 17 ○ Level 3.5 programs should have established relationships with local mental health
- 18 treatment providers to support access to routine psychiatric consultation and to
- 19 facilitate mental health care appointment access when needed. A psychiatric
- 20 assessment is available within 7 days.
- 21 • Psychological
- 22 ○ Specialized consultation for psychological and cognitive problems should be
- 23 available through consultation or referral when needed.
- 24 • Level 3.5 programs should have established relationships with more and less intensive levels
- 25 of care.
- 26 • Ability to provide transportation for off-site clinical or recovery support services when needed
- 27 • Level 3.5 programs should have established policies and procedures for responding to
- 28 urgent medical and psychiatric needs 24 hours a day, 7 days a week, including:
- 29 ○ When to engage the on-call medical provider
- 30 ○ When to call 911
- 31 ○ When to call 988

32 *Assessment and Treatment Planning*

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

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

35 *Services*

36 Level 3.5 programs directly provide the following services:

- 37 • 20 or more hours of clinical services per week including:
 - 38 ○ Daily clinical services designed to improve the patient’s ability to structure and
39 organize the tasks of daily living and recovery, such as personal responsibility,
40 personal appearance, and punctuality.
 - 41 ○ Clinical program activities designed to stabilize and maintain the stability of the
42 patient’s substance use disorder symptoms, and to help him or her develop and
43 apply recovery skills, such as:
 - 44 ▪ relapse prevention
 - 45 ▪ exploring interpersonal choices
 - 46 ▪ development of a social network supportive of recovery.

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

1 ***Medical***

- 2 • As discussed in the Staff Section, Level 3.5 programs do not need to have medical staff.
3 However, the program should provide coordinated access to physician(s) and/or advanced
4 practice providers with the scope of practice to provide the following services:
5 ○ physical examination
6 ○ laboratory testing
7 ○ Addiction pharmacotherapy
8 ○ Psychiatric pharmacotherapy
9 ○ Medication management
10 ○ Toxicology services (Random drug screening to shape behavior and reinforce
11 treatment gains, as appropriate to the patient's individual treatment plan).
12 ▪ CLIA waived point of care testing is available on site.
13 ▪ Access to confirmatory testing should be available when needed (see ASAM
14 Drug Testing Guideline)
- 15 • Level 3.5 programs should also:
16 ○ Arrange appointments with external medical providers when needed
17 ○ Advocate with external medical providers as needed to ensure that significant client
18 health issues are addressed in a timely manner
19 ○ Coordinate with prescribers of addiction and psychiatric pharmacotherapies
20 ○ Coordinate care with other medical providers concurrently providing care for issues
21 that may impact the patient's prognosis or recovery
- 22 • Point of contact breath alcohol testing should be available on site
23 ○ A physician or advanced practice provider should develop the program's policies and
24 procedures regarding interpretation of breath alcohol testing results, including when
25 to contact a medical professional.
- 26 • Point of care pregnancy testing should be available on site
27

28 ***Psychosocial services***

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

32

33 ***Recovery support services***

34 Level 3.5 programs should directly provide:

- 35 • Planned community reinforcement designed to foster prosocial values and milieu or
36 community living skills
37 • A therapeutic milieu including support, structure, and consistency
38 • Transfer planning, including warm handoffs
39

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

- 42 • Assessment of recovery support service needs
43 • Development of an individualized recovery plan
44 • Peer-support specialist services, including:
45 ○ Recovery coaching

- 1 o Recovery plan development
- 2 o Recovery resource navigation (i.e., supporting connection with other recovery
- 3 resources)
- 4 o Ally advocacy (i.e., advocating for the patient as needed with social service
- 5 organization and professional services to address healthcare, employment, housing,
- 6 education, and other needs)
- 7 • Support developing and practicing skills of daily living, including:
- 8 o Transportation skills
- 9 o Health and healthcare navigation
- 10 o Self-care (healthy living and other activities to promote personal wellbeing)
- 11 o Parenting
- 12 o Financial management
- 13 o Nutrition
- 14 • Patient navigation services for patients who need concurrent treatment with external
- 15 providers
- 16 • Support accessing mutual help programs (e.g., support finding appropriate programs,
- 17 identifying transportation options, etc.)
- 18 • Assistance accessing social services for housing, nutritional assistance, health insurance,
- 19 etc.
- 20 • Assistance with transportation to necessary services (e.g., community rides to mutual help
- 21 meetings, help identifying public transit options and obtaining passes)
- 22 • Support coordinating with social service agencies (e.g., Children, Youth & Family Services,
- 23 criminal justice agencies, etc.)
- 24 • Assistance identifying and obtaining community services or supports to address potential
- 25 impediments to recovery (e.g., legal services, educational services, recovery housing,
- 26 childcare services, jobs training, parenting training, financial training, etc.)
- 27 • Assistance identifying and accessing community harm reduction services
- 28

29 *Documentation*

30 See the [Universal Documentation Standards](#).

31

32 **Level 3.7 – Medically Managed Intensive Residential**

33 *Level of Care Description*

34 Level 3.7 programs provide medically managed intensive residential treatment focused on the

35 management of withdrawal and biomedical comorbidities for patients who need 24-hour

36 observation, monitoring, and treatment, but do not require the full resources of an acute care

37 hospital.

38 Level 3.7 programs provide coordinated services delivered by medical, nursing, and clinical

39 professionals in a permanent residential facility. Medical services are delivered under a defined set

40 of physician-approved policies and physician-managed procedures or medical protocols.

41 Level 3.7 programs should also be able to provide all the services of a Level 3.5 program either

42 directly or through formal affiliations with other programs.

1 *Dimensional Drivers*

- 2 • Dimension 1
3 • Dimension 2
4 • Dimension 5

5 *Setting*

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

8 The facility should incorporate space for:

- 9 • Medical and nursing services
10 • Counseling services
11 • Group meetings
12 • Therapeutic activities
13 • Patient rest
14 • Patient privacy
15 • Meals
16 • Hygiene

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

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

20 The setting should provide an environment that:

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

26 *Patient Supervision*

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

39

1 *Staff*

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

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

21 *Staffing Levels*

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

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

37 *Role of the addiction specialist physician:*

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

40 *Medical staff*

- 41 • The medical director:
 - 42 ○ Develops the program's admission criteria
 - 43 ○ Develops clinical protocols

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

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

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

43 *Clinical staff*

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

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

19 *Allied Health Staff*

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

22 *Support Systems*

23 Support systems include the following:

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

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

13 *Assessment and Treatment Planning*

14 In Level 3.7 programs:

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

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

15 *Services*

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

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

4 *Medical and Nursing*

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

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

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

24 ***Biomedical capabilities:***

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

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

7 *Psychosocial Services*

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

22 *Recovery Support Services*

23 Level 3.7 programs should directly provide:

- 24 • Transfer planning, including warm handoffs

25

26 In addition, these programs should provide the following recovery support services either directly or

27 through formal affiliation with external service providers:

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

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

16

17 *Documentation*

18 See the [Universal Documentation Standards](#)

19

20 **Level 4.0 – Medically Managed Intensive Inpatient**

21 *Level of Care Description*

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

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

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

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

33 *Dimensional Drivers*

- 34 • Dimension 1
- 35 • Dimension 2
- 36 • Dimension 3

37 *Setting*

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

- 40 • an acute care general hospital

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

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

6 Level 4 – General Hospitals

7 Staff

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

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

21 Medical Staff

22 In all Level 4 programs:

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

1 ***Role of the addiction specialist physician:***

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

6 ***Clinical staff***

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

23 ***Allied Health Staff***

24 Level 4 programs may also be staffed with appropriately licensed peer support specialists and other

25 allied health staff

26 ***Support Systems***

27 Support systems include a full range of acute care services, specialty consultation, and intensive

28 care services. The following support systems should be available in a Level 4 program:

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

1 *Assessment and Treatment Planning*

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

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

39 *Services*

40 Level 4 programs directly provide:

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

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

9

10 *Medical*

11 Level 4 programs provide:

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

39 *Psychosocial Services*

40 All Level 4 programs should provide basic psychotherapeutic and psychoeducational services

41 including:

- 1 • Interventions designed to enhance the patient’s understanding of addiction, completion of
2 treatment at Level 4, and engagement in an appropriate level of care for continuing
3 treatment.
4 • Patient and family education on withdrawal management and SUD treatment
5 • Coordination of engagement in psychosocial and recovery support services
6

7 *Recovery Support Services*

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

10 *Documentation*

11 Documentation should include:

- 12 • Scoring for withdrawal rating scale tables and flow sheets (which may include tabulation of
13 vital signs) as needed
14 • Standardized SUD screening and assessment results
15 • Standardized mental health screening and assessment results
16 • Transfer plan that ideally addresses:
17 ○ Review of the ASAM Criteria dimensions
18 ○ Recommendations for follow-up care
19 ○ Reasons for departures from recommendations if applicable
20 ○ Program(s) that the patient will transfer to
21 ○ Required medications and how patients will maintain access to medications during
22 the transfer
23 ○ Follow up plan to ensure engagement in care and documentation of follow ups
24

25 **Level 4 – Addiction Specialty Unit**

26 *Level of Care Description*

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

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

32 *Dimensional Drivers*

- 33 • Dimension 1
34 • Dimension 2
35 • Dimension 3

36 *Staff*

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

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

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

10 Staff includes:

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

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

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

25 *Medical staff*

26 In Level 4 specialty programs:

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

- 1 ○ Should meet the core competencies outlined in the [Addiction Nursing Competencies: A Comprehensive Toolkit for the Addictions Nurse](#)
- 2
- 3 ○ A registered nurse or other licensed and credentialed nurse should be available to
- 4 conduct a nursing assessment on admission and to provide primary nursing care
- 5 and observation 24 hours per day.
- 6 ○ The level of nursing care should be appropriate to the severity of patient needs.
- 7 ○ A nursing supervisor should be available 24/7 to respond to urgent situations
- 8 • Physicians and advanced practice providers should:
 - 9 ○ Be available onsite 24 hours a day
 - 10 ○ Serve as active members of the care team
 - 11 ○ Medically manage the care of the patient and assure the quality of care
 - 12 ○ Be responsible for diagnosis, treatment, and treatment plan decisions (in
 - 13 collaboration with the patient) for acute intoxication, withdrawal, SUD, and co-
 - 14 occurring biomedical, psychiatric, and cognitive conditions
 - 15 ○ Determine:
 - 16 ▪ whether and when to admit the patient
 - 17 ▪ continuation of patient care
 - 18 ▪ when to transfer the patient to a less intensive level of care

19 *Role of the addiction specialist physician:*

20 If Level 4 is a specialty addiction unit:

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

28 *Clinical staff*

29 In Level 4 specialty programs:

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

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

13 *Allied Health Staff*

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

16 *Support Systems*

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

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

34 *Assessment and Treatment Planning*

35 In Level 4 specialty programs:

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

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

43 *Services*

44 Level 4 specialty programs directly provide:

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

- 1 ○ Nursing services
- 2 ○ Medical services
- 3 ▪ Access to critical care services when needed
- 4 ○ Psychiatric services
- 5 ○ Case management services
- 6 ○ Psychotherapy
- 7 ○ Psychoeducation
- 8 ○ Health education
- 9 ○ Services integrating family/significant others
- 10 • Integrated care delivery
- 11 • Care coordination with other providers involved in the patient's care
- 12 ○ The staff member responsible for care coordination for a given patient should be
- 13 clearly documented.
- 14 • Management of transfers to other levels of care
- 15 • For the patient with a severe comorbid psychiatric disorder, psychiatric interventions should
- 16 be coordinated with intoxication, withdrawal, and/or SUD treatment services.
- 17 • For the patient with a severe comorbid biomedical disorder, biomedical interventions should
- 18 be coordinated with intoxication, withdrawal, and/or SUD treatment services.
- 19 • All treatment services should be trauma responsive and delivered with cultural humility,
- 20 • All services should be designed with the expectation that many if not most patients will have
- 21 co-occurring mental health conditions (e.g., individual and group interventions should
- 22 encourage patients to address both mental health-related concerns as well as SUD-related
- 23 concerns)
- 24 ○ The program should provide symptom management support for both SUD and co-
- 25 occurring mental health conditions
- 26 ○ Patient mental health concerns should be treated concurrently by the program or
- 27 through coordination with external providers
- 28 • The program should coordinate care with any external mental health care providers involved
- 29 in the patient's care, with appropriate patient consent:
- 30 ○ At admission and discharge
- 31 ○ As needed based to support effective care coordination for the individual patient
- 32 • The program's services should be designed to provide a welcoming environment for
- 33 individuals with co-occurring mental health conditions, where patients feel safe addressing
- 34 their mental health concerns and experiences

35 *Medical*

36 Level 4 specialty programs should be able to provide:

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

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

25 *Psychosocial Services*

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

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

32 *Recovery Support Services*

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

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

39 *Documentation*

40 See the [Universal Documentation Standards Section](#)

41

1 Co-Occurring Enhanced Levels of Care

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

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

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

12 *Level 1.5 COE*

13 *Setting*

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

17 *Staff*

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

24 *Support Systems*

- 25 • Level 1.5 COE programs should have an established relationship with a psychiatrist or
26 psychiatric nurse practitioner to provide:
27 ○ Psychiatric assessments
28 ○ Psychiatric medications and medication management
29 • Level 1.5 COE programs should ideally have established relationships with more intensive
30 levels of COE care, as well as mental health treatment programs and service providers such
31 as:
32 ○ Intensive case management services
33 ○ Psychosocial rehab programs
34 ○ Mental health group residential settings
35 ○ Mobile crisis intervention services
36 ○ Mental health treatment centers

37 *Assessment and Treatment Planning*

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

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

11 *Services*

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

34 *Level 1.7 COE*

35 *Setting*

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

39 *Staff*

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

1 *Support Systems*

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

10

11 *Assessment and Treatment Planning*

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

29 *Services*

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

1 should provide more guidance for managing significant acute symptoms (e.g., panic attacks,
2 psychosis), cognitive challenge, functional disability]. Educational materials should:

- 3 ○ Provide guidance for management of severe mental health symptoms
- 4 ○ Be accessible for individuals with severe cognitive disabilities or challenges due to
- 5 psychiatric disabilities
- 6 ○ Address how to discuss severe mental illness, mental health symptoms, and mental
- 7 health treatments appropriately in the context of mutual-support and other recovery
- 8 support programs.
- 9 ● Level 1.7 COE programs should provide gender sensitive and responsive care.

10

11 *Level 2.1 COE*

12 *Setting*

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

16 *Staff*

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

26 *Support Systems*

- 27 ● Level 2.1 COE programs should have direct affiliations with mental health treatment
- 28 programs and service providers including:
 - 29 ○ Intensive case management services
 - 30 ○ Psychosocial rehab programs
 - 31 ○ Mental health group residential settings
 - 32 ○ Mobile crisis intervention services
 - 33 ○ Mental health treatment centers

34 *Assessment and Treatment Planning*

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

- 1 ○ Medical management of psychiatric conditions
- 2 ○ Psychosocial treatment services for psychiatric conditions
- 3 • In a COE program, if an individual is engaged in ongoing mental health treatment by an
- 4 external provider the treatment team should share information and coordinate care with the
- 5 external provider(s):
- 6 ○ at admission
- 7 ○ regularly during treatment (not less than monthly)
- 8 ○ as needed during treatment

9 *Services*

- 10 • In COE programs, group programming should:
 - 11 ○ Be flexibly designed to accommodate those who have symptoms or functional
 - 12 impairments/disabilities that preclude full attendance and participation.
 - 13 ○ Typically have a smaller group size compared to groups in a non-COE program. For
 - 14 example, while groups programming in non-COE programs should typically include 6-12
 - 15 patient¹; COE programs may typically include 4-8 patients.
 - 16 ○ Deliver content in a format appropriate for individuals with challenges due to
 - 17 psychiatric disabilities.
- 18 • Level 2.1 COE programs should have the flexibility to provide individual support to:
 - 19 ○ Patients who need de-escalation or reduction of stimulation (e.g., due to panic
 - 20 attacks or feeling overwhelmed) during program hours.
 - 21 ○ Patients who need additional assistance due to functional impairment
- 22 • Level 2.1 programs should have educational materials available that address common
- 23 serious mental health concerns. [Note that, compared to non-COE programs, COE programs
- 24 should provide more guidance for managing significant acute symptoms (e.g., panic attacks,
- 25 psychosis), cognitive challenge, functional disability]. Educational materials should:
 - 26 ○ Provide guidance for acute mental health symptom management
 - 27 ○ Be accessible for individuals with cognitive challenges due to psychiatric disabilities
 - 28 ○ Address how to discuss mental illness, mental health symptoms, and mental health
 - 29 treatments appropriately in the context of mutual-support and other recovery support
 - 30 programs.
- 31 • Level 2.1 COE programs should provide gender sensitive and responsive care.

32

33 *Level 2.5 COE*

34 *Setting*

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

38 *Staff*

- 39 • Level 2.5 COE programs should have sufficient staff with the scope of practice to assess,
- 40 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)

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

8 *Support Systems*

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

18 *Assessment and Treatment Planning*

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

36 *Services*

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

- 1 ○ Patients who need additional assistance due to functional impairment.
- 2 • Level 2.5 programs should have educational materials available that address common
- 3 serious mental health concerns. [Note that, compared to non-COE programs, COE programs
- 4 should provide more guidance for managing significant acute symptoms (e.g., panic attacks,
- 5 psychosis), cognitive challenge, functional disability]. Educational materials should:
- 6 ○ Provide guidance for acute mental health symptom management.
- 7 ○ Be accessible for individuals with cognitive challenges due to psychiatric disabilities.
- 8 ○ Address how to discuss mental illness, mental health symptoms, and mental health
- 9 treatments appropriately in the context of mutual-support and other recovery support
- 10 programs.
- 11 • Level 2.5 COE programs should provide gender sensitive and responsive care.
- 12

13 *Level 2.7 COE*

14 *Setting*

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

18 *Staff*

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

30 *Support Systems*

- 31 • Level 2.7 COE programs should have direct affiliations with mental health treatment
- 32 programs and service providers including:
 - 33 ○ Intensive case management services
 - 34 ○ Psychosocial rehab programs
 - 35 ○ Mental health group residential settings
 - 36 ○ Mobile crisis intervention services
 - 37 ○ Mental health treatment centers

38 *Assessment and Treatment Planning*

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

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

13 *Services*

- 14 • Medical management of psychiatric conditions
- 15 • Consultation with a psychiatrist or psychiatric nurse practitioner should be available 24/7 (on-
- 16 site or via telehealth) to respond to psychiatric emergencies and adjust medications as
- 17 needed.
- 18 • Psychosocial treatment services for psychiatric conditions, including:
 - 19 ○ Symptom management supports
 - 20 ○ Disability management supports (e.g., for ADLs, assignments, etc.)
- 21 • Psychoeducation to help patients:
 - 22 ○ understand medication changes
 - 23 ○ report medication effects and side effects
 - 24 ○ report on symptoms and disabilities
- 25 • In COE programs, group programming should:
 - 26 ○ Be flexibly designed to accommodate those who have symptoms or functional
 - 27 impairments/disabilities that preclude full attendance and participation
 - 28 ○ Typically have a smaller group size compared to groups in a non-COE program.
 - 29 ○ Deliver content in a format appropriate for individuals with challenges due to
 - 30 psychiatric disabilities.
- 31 • Level 2.7 COE programs should have flexibility to provide individual support to:
 - 32 ○ Patients who need de-escalation or reduction of stimulation (e.g., due to panic
 - 33 attacks or feeling overwhelmed) during program hours.
 - 34 ○ Patients who need additional assistance due to functional impairment.
- 35 • Level 2.7 COE programs should have educational materials available that address common
- 36 serious mental health concerns. [Note that, compared to non-COE programs, COE programs
- 37 should provide more guidance for managing significant acute symptoms (e.g., panic attacks,
- 38 psychosis), cognitive challenge, functional disability]. Educational materials should:
 - 39 ○ Provide guidance for acute mental health symptom management
 - 40 ○ Be accessible for individuals with cognitive challenges due to psychiatric disabilities
 - 41 ○ Address how to discuss mental illness, mental health symptoms, and mental health
 - 42 treatments appropriately in the context of mutual-support and other recovery support
 - 43 programs.
- 44 • Level 2.7 COE programs should provide gender sensitive and responsive care.

1 ***Level 3.1 COE***

2 ***Setting***

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

7 ***Staff***

- 8 • A clinical supervisor qualified to assess and treat mental health problems should be on-site
9 or on-call during program hours of operation.
10 • Level 3.1 COE programs should have sufficient clinical staff with the scope of practice to
11 assess, diagnose, and treat mental health conditions on-site during business hours and on-
12 call overnight.
13 • Staff with the competency to supervise mental health treatment should be on site or on-call
14 24/7.
15 • All professional and paraprofessional staff should have competency to work with individuals
16 who have active, unstable co-occurring psychiatric symptoms and/or severe psychiatric
17 disabilities.
18 • COE programs should generally have a higher staff to patient ratio than non-COE programs in
19 order to provide additional flexibility and support.

20 ***Support Systems***

- 21 • Level 3.1 COE programs should have direct affiliations with mental health treatment
22 programs and service providers including:
23 ○ Intensive case management services
24 ○ Psychosocial rehab programs
25 ○ Mental health group residential settings
26 ○ Mobile crisis intervention services
27 ○ Mental health treatment centers

28 ***Assessment and Treatment Planning***

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

- 1 ○ At discharge

2 **Services**

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

23

24 **Level 3.5 COE**

25 **Setting**

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

30 **Staff**

- 31 • A psychiatrist or psychiatric nurse practitioner should be on call 24/7.
- 32 • Level 3.5 COE programs should have sufficient staff with the scope of practice to assess,
- 33 diagnose, and treat mental health conditions on site 24/7.
- 34 • Staff with the competency to supervise mental health treatment should be on site or on-call
- 35 24/7.
- 36 • All professional and paraprofessional staff should have competency to work with individuals
- 37 who have active, unstable co-occurring psychiatric symptoms and/or severe psychiatric
- 38 disabilities.
- 39 • COE programs should generally have a higher staff to patient ratio than non-COE programs in
- 40 order to provide additional flexibility and support.

41 **Support Systems**

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

- 1 ○ Intensive case management services
- 2 ○ Psychosocial rehab programs
- 3 ○ Mental health group residential settings
- 4 ○ Mobile crisis intervention services
- 5 ○ Mental health treatment centers

6 *Assessment and Treatment Planning*

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

23 *Services*

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

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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

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

3 *Services*

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

35

36 *Level 4 COE*

37 *Level of Care Description*

38 In this edition of *The ASAM Criteria*, we are recommending that all SUD treatment programs achieve,

39 at minimum, co-occurring capability. As outlined above, we also describe standards for a continuum

40 of co-occurring enhanced treatment programs. ASAM similarly recommends that the mental health

41 treatment field adopt commensurate standards such that all mental health programs are expected

42 to have the capacity to provide co-occurring capable care for individuals with comorbid SUD. Further,

43 it is critical that standards developed by the SUD and mental health treatment fields for co-occurring

44 enhanced, or dual diagnosis care, are well aligned. In the longer term, standards for COE care

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

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

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

10 *Setting*

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

14 *Staff*

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

20 *Support Systems*

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

28 *Assessment and Treatment Planning*

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

1 *Services*

- 2 • Inpatient mental health programs should be able to provide the equivalent of Level 3.7
3 withdrawal management and SUD treatment services, including:
 - 4 ○ Nursing and medical monitoring for stabilization of acute withdrawal, biomedical and
5 psychiatric conditions.
 - 6 ○ Psychosocial services to encourage engagement in ongoing treatment
 - 7 ○ Hourly nurse monitoring of the patient's progress and medication administration
 - 8 ○ Medical monitoring and management of signs and symptoms of intoxication and
9 withdrawal
 - 10 ○ Assessment with validated scales (e.g., COWS, CIWA-Ar, RASS) to determine the
11 severity of withdrawal when appropriate
 - 12 ○ Medication based methods of withdrawal management that are appropriate for the
13 severity of withdrawal or anticipated withdrawal
 - 14 ○ Non-medication-based methods of withdrawal management, when indicated,
15 including but not limited to:
 - 16 ■ Informing patients of what to expect over the course of treatment.
 - 17 ■ Offering reassurance
 - 18 ■ Providing a quiet environment
 - 19 ■ Educating patients on the importance of adequate hydration and nutrition
- 20 • Biomedical capabilities equivalent to a [Level 3.7 program](#).
- 21 • Addiction pharmacotherapies
 - 22 ○ Patient education regarding available pharmacotherapies, currently including those
23 available to treat opioid use disorder, alcohol use disorder, and tobacco use disorder
 - 24 ○ Initiation and continuation of addiction pharmacotherapies in alignment with current
25 best practices, such as those established in the ASAM National Practice Guideline for
26 the Treatment of Opioid Use Disorder, the APA Practice Guideline on Treatment of
27 Alcohol Use Disorder, and ASAM's clinical guidance on Integrating Tobacco Use
28 Disorder Interventions in Addiction Treatment.
- 29 • Services should be designed with the expectation that many if not most patients will have co-
30 occurring mental health conditions (e.g., individual and group interventions should
31 encourage patients to address both mental health-related concerns as well as SUD-related
32 concerns)
 - 33 ○ Programs should support patients to manage SUD related symptoms
 - 34 ○ Patient SUD should be addressed concurrently by the program and through
35 coordination with external providers as needed
- 36 • Programs should coordinate care with any external SUD care providers involved in the
37 patient's care, with appropriate patient consent:
 - 38 ○ At admission and discharge
 - 39 ○ As needed based to support effective care coordination for the individual patient
- 40 • The program should support access to pharmacotherapies for addiction, with appropriate
41 medication management.
- 42 • The program's clinical services should include:
 - 43 ○ Individual and group interventions for SUD
 - 44 ○ Interventions designed to address:
 - 45 ■ how to manage mental health symptoms and trauma without using
46 substances

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

9 *Dual Diagnosis Level 4 COE Programs*

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

16 *Staff*

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

23 *Support Systems*

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

25 *Assessment and Treatment Planning*

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

- 1 ○ The plan should reflect coordination of SUD treatment needs and coordination of
- 2 care with external SUD treatment providers.
- 3 • Transfer planning should begin at admission and address:
- 4 ○ SUD treatment needs
- 5 ○ SUD recovery support service needs
- 6 ○ Continued access to medications for SUD treatment
- 7 ○ Overdose prevention and harm reduction

8 *Services*

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

20

21 *Universal Psychosocial Service Standards – 4th Edition*

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

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

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

30 *Psychotherapy*

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

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

- 38 • Individual and group counseling that actively addresses and monitors:
- 39 ○ SUD
- 40 ○ Sequelae of SUD
- 41 ○ Cooccurring mental health concerns
- 42 ○ The interaction between SUD and mental health symptoms

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

17 *Psychoeducation*

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

- 23 • Interventions designed to:
 - 24 ○ Enhance the patient's understanding of addiction, completion of treatment, and
 - 25 engagement in an appropriate level of care for continuing treatment.
 - 26 ○ Educate patients on what to expect over the course of treatment
 - 27 ○ Enhance the patient's understanding of co-occurring mental health concerns and
 - 28 how they interact with addiction, including:
 - 29 ▪ how to discuss mental illness, mental health symptoms, and mental health
 - 30 treatments appropriately in the context of recovery programs/mutual support
 - 31 groups
 - 32 ▪ how to appropriately ask for help for mental health concerns from peers or
 - 33 professionals when needed
 - 34 ○ Support adherence to medications prescribed for addiction and mental health
 - 35 concerns, including:
 - 36 ▪ How to work honestly and effectively with prescribers
 - 37 ▪ The importance of taking meds as prescribed
 - 38 ○ Support successful initial involvement or reinvolved in regular, productive daily
 - 39 activity (such as work or school) and, as indicated, successful reintegration into
 - 40 family living
 - 41 ○ Support patients to develop and apply recovery skills, through:
 - 42 ▪ relapse prevention
 - 43 ▪ exploring interpersonal choices
 - 44 ▪ development of a social network supportive of recovery
 - 45 ▪ educational and skill building groups

- 1 ▪ vocational rehabilitation activities
- 2 ▪ occupational and recreational therapies
- 3 ▪ art, music, or movement therapies
- 4 ▪ physical therapy
- 5 ○ Encourage the patient's motivation to address SUD and co-occurring conditions
- 6 ○ Support integrated treatment for tobacco use disorders, including:
 - 7 ▪ The benefits of treating tobacco use disorder at the same time as other SUDs
 - 8 ▪ Evidence-based tobacco use disorder treatments (e.g., pharmacotherapy, counseling)
 - 9 ▪ Relative risk nicotine/tobacco products
 - 10 ▪ Motivational and harm reduction strategies for patients who are ambivalent about quitting
- 11
- 12
- 13 • Health education services regarding:
 - 14 ○ The causes of addiction
 - 15 ○ Factors that influence the progression of addiction
 - 16 ○ Pharmacotherapies for SUD
 - 17 ○ Pharmacotherapies for psychiatric disorders
 - 18 ○ Harm reduction strategies including overdose recognition and response training
 - 19 ○ Health-related risk factors associated with SUD (for example: HIV, hepatitis C, sexually transmitted infections, skin and soft tissue infections, unintended pregnancy).
 - 20 ○ The importance of taking care of physical and mental health
 - 21 ▪ All programs should have educational materials routinely available that address common physical and mental health concerns, including trauma.
- 22
- 23 • Psychoeducational services for the patient's family and significant others (with appropriate patient consent), including:
 - 24 ○ What to expect during treatment
 - 25 ○ How to support loved ones during treatment
 - 26 ○ The importance of self-care
 - 27 ○ Overdose recognition and response training
- 28
- 29
- 30
- 31 • Other evidence-based psychoeducation.

32 Universal Documentation Standards

33 Program documentation should include:

- 34 • The level(s) of care that the patient is receiving treatment from
 - 35 ○ Current
 - 36 ○ Past 12 months
- 37 • Summary of the results of the biopsychosocial assessment including:
 - 38 ○ Overview and analysis of problems within each of the six dimensions
 - 39 ▪ Prioritization of the problems identified
 - 40 ▪ The relationship between the problems identified and substance-related and addictive disorders
 - 41 ▪ The patient's current level of functioning (e.g., skills of daily living)
 - 42 ○ Level of care recommendation(s)
 - 43 ○ Final disposition and reason for any discrepancies
- 44
- 45 • Summary of physical examination

- 1 • Standardized mental health screening and assessment results (dated), with comparison to
- 2 past results
- 3 • Nicotine/tobacco use status including:
- 4 ○ Duration
- 5 ○ Frequency
- 6 ○ Pack years if applicable (i.e., number of packs of cigarettes smoked per day
- 7 multiplied by the number of years the person has smoked
- 8 ○ Type(s) of products used (e.g., combustible cigarettes, oral tobacco, e-cigarettes,
- 9 snus, etc.).
- 10 • Review of admission decision
- 11 • The patient's individualized treatment plan (or remission management plan for Level 1.0)
- 12 including:
- 13 ○ Problem identification in each dimension
- 14 ○ Treatment goals
- 15 ○ Measurable treatment objectives
- 16 ○ Patient strengths
- 17 ○ Services to address problems identified designed to meet stated objectives
- 18 ○ Medications and medication management plan
- 19 ○ The plan for after-hours medical advice and emergencies, if applicable
- 20 • The treatment plans for patients with co-occurring psychiatric conditions should have specific
- 21 documentation of:
- 22 ○ Patient mental health concerns
- 23 ○ Mental health screening and assessment results if applicable
- 24 ○ Services provided by the program to address mental health concerns, including
- 25 symptom management strategies
- 26 ○ Services to address mental health concerns provided by external providers
- 27 ▪ Care coordination with external providers
- 28 ○ individual strengths that support effective management of mental health symptoms
- 29 without using substances
- 30 • The treatment plans for patients with biomedical conditions should have specific
- 31 documentation of:
- 32 ○ Patient biomedical concerns (including pain)
- 33 ○ Biomedical assessment results if applicable
- 34 ○ Services provided by the program to address biomedical concerns
- 35 ○ Services provided by external providers to address biomedical concerns
- 36 ▪ Care coordination with external providers
- 37 • The treatment plans for patients with co-occurring pain conditions should have specific
- 38 documentation of:
- 39 ○ Screening and assessment results, if applicable
- 40 ○ Services provided by the program to address pain, including symptom management
- 41 strategies
- 42 ○ Services to address pain provided by external providers
- 43 ▪ Care coordination with external providers
- 44 ○ Continuing care plan post discharge from program.
- 45 • Individualized progress notes in the patient's record that clearly reflect implementation of the
- 46 treatment plan, the patient's response to therapeutic interventions for all disorders treated,
- 47 and capture:
- 48 ○ Significant events that may alter course of treatment

- 1 ○ Changes in frequency or types of services
- 2 ○ Changes in LOC
- 3 ○ Subsequent amendments to the plan.
- 4 ○ Signature of the clinician with date
- 5 ○ Signature of the supervisor if the clinician is a trainee, with date
- 6 • Documentation should allow for each clinician involved in a patient's care to see relevant
- 7 medical and psychosocial information
- 8 • A copy of the treatment plan should be provided to the client at the initiation of the plan and
- 9 subsequently when updated.
- 10 • Laboratory and toxicology order sets and notes regarding how the treatment plan was
- 11 modified based on results
- 12 • Documentation of patient consent, or refusal to consent, for care coordination and
- 13 information sharing with external providers or program.
- 14 • Documentation of consent, or decline of consent, to involve family members, significant
- 15 others, or other support persons
- 16 • Documentation of case management services
- 17 • Documentation of referral to other service providers should include:
- 18 ○ Recommendations for care
- 19 ○ Reasons for departures from clinical recommendations if applicable
- 20 ○ Incorporation of treatment/services in the patient's treatment plan
- 21 ○ Care coordination
- 22 ○ Follow up plan to ensure engagement in care and documentation of follow ups
- 23 • Transfer plan that addresses:
- 24 ○ Review of the ASAM Criteria dimensions
- 25 ○ Recommendations for follow-up care
- 26 ○ Reasons for departures from recommendations if applicable
- 27 ○ Program(s) that the patient will transfer to
- 28 ○ Required medications and how patients will maintain access to medications during
- 29 the transfer
- 30 ○ Access to naloxone if applicable
- 31 ○ Follow up plan to ensure engagement in care and documentation of follow ups
- 32 • Documentation of unplanned discharge, including:
- 33 ○ status at discharge
- 34 ○ reason for discharge
- 35 ○ care recommendations provided to the patient
- 36 ○ access to medications after discharge
- 37 ○ notifications made (signed and dated)
- 38 ○ plan for follow up with the patient and documentation of follow ups (signed and
- 39 dated)
- 40 • Medically monitored or managed programs should additionally document:
- 41 ○ Results of the nursing assessment
- 42 ○ Results of the physical examinations and medical assessments
- 43 ○ Toxicology and laboratory orders and results
- 44 ○ Scoring for withdrawal rating scale tables and flow sheets (which may include
- 45 tabulation of vital signs) as needed.

46

1 *Other program documentation*

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

16 *Program policies and procedures*

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

- 1 ▪ Appropriate training for assessment of pain and the interrelationship
- 2 between the patient's pain and addiction.
- 3 • Policies and procedures related to Dimension 3 concerns should be reviewed and approved
- 4 by qualified master's level mental health professionals. Policies include:
- 5 ○ Screening for mental health concerns
- 6 ○ Admission criteria and transfer criteria related to psychiatric and cognitive concerns
- 7 ○ Determining when a mental health assessment is needed for psychiatric concerns
- 8 including:
- 9 ▪ Determining what level of assessment is needed (e.g., assessment by a
- 10 master's level clinician vs. assessment by a psychiatrist or psychiatric nurse
- 11 practitioner)
- 12 ○ Accommodating patients affected by changes in mental health status that interferes
- 13 with their treatment participation.
- 14 ▪ Educating patients on how to ask for accommodation when needed and how
- 15 to provide appropriate accommodations in a way that is transparent and fair
- 16 for all clients
- 17 ○ Access to medications for psychiatric disorders
- 18 ▪ Oversight and monitoring of controlled medications
- 19 ○ Managing mental health advanced directives
- 20 • All other clinical policies and procedures should be reviewed and approved by a master's
- 21 level clinical professional with at least 5 years of experience in addiction treatment.
- 22 • All programs should have policies and procedures that address:
- 23 ○ Admission criteria and transfer criteria, in alignment with *The ASAM Criteria*
- 24 Dimensional Admission Criteria
- 25 ○ Coordination of referrals to alternate levels of care
- 26 ▪ What to do if a higher LOC is needed but not available
- 27 ○ Coordination of care with external providers
- 28 ○ Medication reconciliation, including:
- 29 ▪ Responsibility for conducting a complete medication reconciliation
- 30 ▪ Oversight of controlled substance prescriptions
- 31 ▪ Checking the prescription drug management program (PDMP) upon
- 32 admission
- 33 ▪ Requirements for patients to authorize release of information to coordinate
- 34 care with external prescribers
- 35 ▪ For outpatient programs, managing access to controlled prescriptions while
- 36 patients are on site
- 37 ▪ Coordination of care with external prescribers
- 38 • Upon admission
- 39 • Upon discharge
- 40 • As needed throughout treatment
- 41 ○ Treatment of tobacco use disorder, including:
- 42 ▪ Screening for tobacco/nicotine use
- 43 ▪ Barrier-free access to evidence-based treatments for tobacco use disorder,
- 44 including pharmacotherapy and behavioral therapy
- 45 ▪ Supporting integrated treatment

- 1 ▪ Restricting consumer tobacco and nicotine products for staff and patients
- 2 (e.g., combustible cigarettes, smokeless tobacco, e-cigarettes, etc.), including
- 3 smoke free policies
- 4 ▪ Organizational support for staff access to treatment
- 5 ○ Patient code of conduct, including:
- 6 ▪ Patient review and signature at admission
- 7 ▪ Response to conduct that presents risk for harm to self or others
- 8 ○ Harm reduction including:
- 9 ▪ Access to naloxone in the facility
- 10 ▪ Access to naloxone when patients are off site
- 11 ▪ Overdose reversal training for staff and patients
- 12 ▪ Patient and family access to naloxone after transfer/discharge
- 13 ○ Staffing, including:
- 14 ▪ Supervision and monitoring of staff competencies
- 15 ▪ Training of professional and para-professional staff
- 16 ▪ Mental health training and competencies
- 17 ▪ Determining appropriate staff to patient ratios
- 18 ○ Responding to current public health alerts
- 19 ○ How and when to consult a supervisor
- 20 ▪ Chain of command for urgent and emergent situations
- 21 ○ After-hours urgent needs or questions
- 22 ○ Formal grievance procedures
- 23 ○ Responding to requests to change treating clinicians
- 24 ○ Managing violent or threatening behaviors
- 25 ○ Confidentiality, including:
- 26 ▪ Consent
- 27 ▪ Access to health records
- 28 ▪ Storage of records
- 29 ▪ Client rights
- 30 ▪ Mandated reporting and communication with criminal justice entities
- 31 ○ Emergency preparedness addressing:
- 32 ▪ Emergency evacuation planning
- 33 ▪ Patient relocation (for residential and inpatient programs)
- 34 ▪ Considerations for patient discharge or transfers (pre- or post-disaster
- 35 evacuation)
- 36 ▪ Ensuring continued access to critical medications
- 37 ▪ Communications and coordination in an emergency
- 38 ▪ Identification of staff leads and emergency points of contact
- 39 ▪ Utilizing back-up strategies (cell, radio, internet) if telephone or electrical
- 40 power are inoperable.
- 41 ▪ Patient Education
- 42 ▪ Staff Training
- 43 ▪ Standards regarding reporting patient safety events
- 44 ▪ Accessing local, state, and/or federal services and support before, during,
- 45 and after a disaster
- 46 ○ Considerations regarding safe staffing levels, including:
- 47 ▪ Strategies for addressing staff shortages and procedures for when critical
- 48 positions cannot be filled.

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

23

24 **The ASAM Criteria Dimensional Admission Criteria**

25 **Integrating the Risk Ratings and Dimensional Admission Criteria**

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

31 **How to use the Dimensional Admission Criteria**

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

37

38 The dimensional admission criteria assume that:

- 39 • The clinician has determined that the patient's primary treatment need is for SUD.
- 40 • The severity of the patient's SUD is not significantly less severe than co-occurring issues in
- 41 Dimensions 2 or 3.
- 42 ○ If the patient has a mild SUD (as defined by DSM5) and severe psychiatric concerns,
- 43 the patient's Dimension 3 issues may be treated primarily in the mental health
- 44 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

- 1 • Intoxication and associated risks (including overdose)
- 2 • Acute withdrawal and associated risks
- 3 • MOUD needs
- 4 Dimension 2 – Biomedical conditions
- 5 • Physical health concerns
- 6 • Pregnancy-related concerns
- 7 Dimension 3 - Psychiatric and cognitive conditions
- 8 • Active psychiatric concerns
- 9 • Persistent Disability
- 10 Dimension 4 – Substance use related risks
- 11 • Likelihood of engaging in risky substance use
- 12 • Likelihood of engaging in other harmful SUD related behaviors
- 13 Dimension 5 – Recovery environment
- 14 • Ability to interact productively with current environment
- 15 • Safety in current environment
- 16 • Support in current environment

17
18 Note that Dimension 6 – Readiness and Resources, does not contribute to the initial
19 recommendation but will be discussed with the patient to determine what type of treatment the
20 patient is willing and able to participate in.

21 22 **Dimension 1 – Acute intoxication and withdrawal potential**

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

30 31 *Intoxication and associated risks (including overdose)*

32
33 Intoxication alone is not a reason to admit a patient to a higher level of care. However, concerning
34 biomedical or psychiatric signs or symptoms presenting in a patient who is intoxicated should be
35 considered as outlined below.

36 37 ***Level 4 = Risk Rating 4***

- 38
39 1. The patient is incapacitated, with very severe signs and symptoms who require the resources
40 of an acute care hospital. *Examples include, but are not limited to:*
- 41 • Very severe neurological signs or symptoms due to intoxication. *For example:*
 - 42 ○ Profound decrease in consciousness, including coma
 - 43 ○ Intoxication related seizure within the past 6 hours
 - 44 • Uncontrollable² or unexplained generalized tonic clonic seizures (e.g., stimulant-related
45 seizures).

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

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

24
25 OR

- 26
- 27 2. Issues of intoxication are exacerbating biomedical or mental health conditions that would
 - 28 otherwise meet the Dimension 2 or Dimension 3 criteria for Level 3.7 program
- 29

30 ***Minimum Level 3.7 = Risk Rating 3***

31

32 The patient is experiencing moderately severe to severe signs or symptoms of intoxication that

33 may pose an imminent risk of danger to self or others, and needs after-hours medical

34 monitoring, but does not require the full resources of an acute care hospital. *Examples include,*

35 *but are not limited to:*

36

- 37 • Moderately severe to severe neurological signs or symptoms due to intoxication. *For*
- 38 *example:*
- 39 ○ Controllable and explainable (i.e., known seizure disorder) intoxication-related
- 40 ○ seizures more than 6 hours ago
- 41 ○ Controllable and explainable somnolence
- 42 ○ Moderate ambulatory difficulty
- 43 • Moderately severe to severe cardiovascular signs or symptoms due to intoxication. *For*
- 44 *example:*
- 45 ○ Controllable and explainable hypertension
- 46 ○ Controllable and explainable bradycardia or tachycardia
- 47 • Moderately severe to severe respiratory signs or symptoms due to intoxication. *For*
- 48 *example:*
- 49 ○ Controllable and explainable moderately severe to severe respiratory depression
- 50 ○ (where mechanical ventilation is not anticipated to be needed)

- 1 • Moderately severe to severe gastrointestinal signs or symptoms. *For example:*
- 2 ○ Persistent vomiting or diarrhea that is responsive to medication
- 3 • Moderately severe to severe psychiatric signs or symptoms due to intoxication. *For*
- 4 *example:*
- 5 ○ Moderately severe to severe agitation responsive to medications
- 6 ○ Moderate to severe psychosis, responsive to medications, without immediate risk
- 7 of harm to self or others
- 8 ○ Acute suicidal or homicidal ideation without imminent risk to self or others (as
- 9 determined by a qualified healthcare professional using a validated assessment)
- 10 • Controllable and explainable, moderately severe to severe abnormalities of vital signs
- 11 (e.g., hypotension, hypothermia, hyperthermia)
- 12 • Patients who need services only available in a sub-acute care setting due to intoxication.
- 13 *For example:*
- 14 ○ Patients who need IV medications
- 15 ○ Patients who need medical services outside of normal business hours (e.g., post-
- 16 operative patients with pain adequately controlled with oral medications who
- 17 need ongoing medical support such as wound care)
- 18

19 *Minimum Level 2.7 = Risk Rating 2*

20
21 The patient is experiencing moderately severe to severe signs or symptoms of intoxication that
22 respond to support and treatment sufficiently that the patient does not pose an imminent danger
23 to self or others AND the patient does not need after-hours medical monitoring. Examples
24 include, but are not limited to:

- 25
- 26 • Moderately severe to severe neurological signs or symptoms due to intoxication AND the
- 27 patient does not need after-hours medical monitoring. *For example:*
- 28 ○ Controllable and explainable (i.e., known seizure disorder) intoxication related
- 29 seizures AND the patient has sufficient monitoring and support at home
- 30 ○ Controllable and explainable somnolence
- 31 ○ Moderate ambulatory difficulty
- 32 • Moderately severe to severe cardiovascular signs or symptoms due to intoxication AND
- 33 the patient does not need after-hours medical monitoring. *For example:*
- 34 ○ Controllable and explainable hypertension
- 35 ○ Controllable and explainable bradycardia or tachycardia
- 36 • Moderately severe to severe respiratory signs or symptoms due to intoxication AND the
- 37 patient does not need after-hours medical monitoring. *For example:*
- 38 ○ Controllable and explainable moderately severe to severe respiratory depression
- 39 • Moderately severe to severe gastrointestinal signs or symptoms due to intoxication AND
- 40 the patient does not need after-hours medical monitoring. *For example:*
- 41 ○ Persistent vomiting or diarrhea that is responsive to oral medication
- 42 • Moderately severe to severe psychiatric signs or symptoms due to intoxication AND the
- 43 patient does not need after-hours medical monitoring. *For example:*
- 44 ○ Moderate to severe agitation responsive to oral medication
- 45 ○ Moderate to severe psychosis responsive to oral medication without immediate
- 46 risk of harm to self or others
- 47 • Controllable and explainable, moderately severe to severe abnormalities of vital signs
- 48 (e.g., hypotension, hypothermia, hyperthermia)
- 49 • Patients who need services due to intoxication that are not available in a lower level of
- 50 care AND the patient does not need after-hours medical monitoring. *For example:*

- 1 ○ The patient needs observation or monitoring during normal business hours
2

3 ***Minimum Level 1.7 = Risk Rating 1***
4

5 The patient is experiencing mild to moderate signs or symptoms of intoxication that interfere with
6 functioning but do not pose imminent danger to self or others. Examples include, but are not
7 limited to:
8

- 9 • Mild-Moderate neurological signs or symptoms due to intoxication that are expected to
10 predictably resolve
11 • Mild-Moderate abnormalities of vital signs due to intoxication that are expected to
12 predictably resolve
13 • Mild-Moderate gastrointestinal signs and symptoms due to intoxication that are expected
14 to predictably resolve. *For example:*
15 ○ Vomiting and diarrhea easily controlled with oral medication
16 • Mild-Moderate psychiatric signs and symptoms due to intoxication that is expected to
17 predictably resolve
18

19 ***No specific needs = Risk Rating 0***
20
21

22 ***Acute Withdrawal and Associated Risks***

23 The withdrawal risk Criteria are not specific to substance. When applying the Withdrawal Risk
24 Criteria, the medical provider should consider potential interactions between withdrawal syndromes
25 when the patient has risks associated with multiple substances that elicit physiologic withdrawal. In
26 addition, the assessment of risks should consider the likely response to treatment (e.g., initiation of
27 methadone or buprenorphine).
28

29 ***Level 4 = Risk Rating 4***
30

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

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

10
11 OR

- 12
13 2. The patient is experiencing severe withdrawal, or evidence suggests that severe withdrawal
14 is imminent, AND the patient is not responding to standard medications

15
16 OR

- 17
18 3. The patient is experiencing severe withdrawal, or evidence suggests that severe withdrawal
19 is imminent, AND the patient has a co-occurring physical or mental disorder that is
20 expected to be exacerbated during withdrawal and requires medical management. *For*
21 *example:*
22 • Alcohol or sedative withdrawal and poorly controlled seizure disorder
23 • Unstable coronary artery disease and otherwise meets the Withdrawal Risks
24 criteria for 3.7
25 • Dysrhythmia and otherwise meets the Withdrawal Risks criteria for 3.7
26 • Dialysis dependent patient who otherwise meets the Withdrawal Risks criteria for
27 3.7
28 • Patient with acute liver failure (acute hepatitis) or acute renal failure who otherwise
29 meets the Withdrawal Risks criteria for 3.7
30 • Patient with persistent hyperglycemia (>300 glucose) or persistent hypoglycemia
31 (<60) despite treatment who otherwise meets the Withdrawal Risks criteria for 3.7
32 • Unstable psychiatric disorder and otherwise meets the Withdrawal Risk criteria for
33 3.7

34
35 OR

- 36
37 4. The patient is experiencing severe withdrawal from alcohol and/or sedative/hypnotics, or
38 evidence suggests that severe withdrawal is imminent AND the patient has a history of very
39 severe uncontrollable withdrawal syndrome.

40
41
42 ***Minimum Level 3.7 = Risk Rating 3B***

- 43
44 1. The patient is experiencing, or expected to imminently experience, moderately severe to
45 severe signs and symptoms of withdrawal, WITH the need for after-hours medical
46 monitoring, but not the full resources of an acute care hospital. *Examples include, but are*
47 *not limited to:*
48
49 • Moderately severe to severe neurological signs or symptoms. *For example:*
50 ○ Controllable and explainable generalized tonic clonic seizures

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

21
22 OR

23
24 2. The patient is experiencing moderate signs and symptoms of withdrawal AND has a co-
25 occurring physical or mental disorder that complicates withdrawal and requires medical
26 monitoring. *For example:*

- 27
- 28 • Poorly controlled diabetes and the patient otherwise meets the Withdrawal Risks criteria
29 for 2.7
- 30 • Poorly controlled hypertension and the patient otherwise meets the Withdrawal Risks
31 criteria for 2.7
- 32 • Unstable psychiatric disorder and the patient otherwise meets the Withdrawal Risks
33 criteria for 2.7
- 34 • Significant impairment in ability to manage activities of daily living and the patient
35 otherwise meets the Withdrawal Risks criteria for 2.7
- 36 • Suicidal or homicidal ideation without an immediate threat to self or others and the
37 patient otherwise meets the Withdrawal Risks criteria for 2.7

38
39 OR

40
41 3. The patient is experiencing moderate withdrawal from alcohol and/or sedative-hypnotics,
42 AND the patient has a history of severe withdrawal syndrome (e.g., delirium tremens,
43 seizures) that was controllable with treatment.

44
45
46 ***Minimum Level 3.5 = Risk Rating 3A***

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

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

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

11
12 ***Minimum Level 2.7 = Risk Rating 2***

13
14 1. The patient is experiencing, or expected to imminently experience, moderately severe to
15 severe signs and symptoms of withdrawal, WITHOUT the need for after-hours medical
16 monitoring. Examples include, but are not limited to:

- 17
18 • Moderately severe to severe neurological signs or symptoms AND the patient does not
19 need after-hours medical monitoring. *For example:*
 - 20 ○ Controllable and explainable (i.e., known seizure disorder) generalized tonic
21 clonic seizures AND the patient has sufficient monitoring and support at home
 - 22 ○ Controllable and explainable somnolence
- 23 • Moderately severe to severe cardiovascular signs or symptoms AND the patient does not
24 need after-hours medical monitoring. *For example:*
 - 25 ○ Controllable and explainable hypotension or hypertension
 - 26 ○ Controllable and explainable hypothermia or hyperthermia
 - 27 ○ Controllable and explainable bradycardia or tachycardia
- 28 • Moderately severe to severe gastrointestinal signs or symptoms AND the patient does
29 not need after-hours medical monitoring. *For example:*
 - 30 ○ Persistent vomiting or diarrhea that is responsive to oral meds
- 31 • Moderately severe to severe psychiatric signs or symptoms with minimal risk of
32 hallucinations, dissociation, or severe affective disorder during unobserved periods
33 outside the program AND the patient does not need after-hours medical monitoring. *For*
34 *example:*
 - 35 ○ Moderate to severe agitation responsive to oral medication
 - 36 ○ Moderate to severe psychosis responsive to oral medication without immediate
37 risk of harm to self or others
 - 38 ○ Moderately severe paranoia
 - 39 ○ Moderately severe depression or anxiety

40
41 OR

42
43 2. The patient is experiencing, or expected to imminently experience, moderately severe to
44 severe signs and symptoms of withdrawal AND needs services that are not available in a
45 lower level of care (e.g., patients who need IV medications during normal business hours)

46
47 OR

- 1 3. The patient meets the Withdrawal Risk criteria for Level 1.7 AND the patient or available
2 support system are unable to follow instructions necessary for withdrawal management AND
3 the patient has sufficient support to enable them to engage in Level 2.7 services
4
5

6 ***Minimum Level 1.7 = Risk Rating 1***
7

8 The patient is experiencing, or expected to experience, mild to moderate signs and symptoms of
9 withdrawal that interfere with daily functioning but do not pose imminent danger. Minimal risk of
10 severe withdrawal. The patient/support persons can clearly understand and follow instructions
11 necessary for care at this level. Examples include, but are not limited to:
12

- 13 • Mild-Moderate neurological signs or symptoms due to withdrawal that are expected to
14 predictably resolve
15 • Mild-Moderate abnormalities of vital signs due to withdrawal that are expected to
16 predictably resolve
17 • Mild-Moderate gastrointestinal signs and symptoms due to withdrawal that are expected
18 to predictably resolve. *For example:*
19 ○ Vomiting and diarrhea controlled with oral medication
20 • Mild-Moderate psychiatric signs and symptoms due to withdrawal that are expected to
21 predictably resolve
22

23 ***No specific needs = Risk Rating 0***
24

25 ***MOUD needs***
26

27 ***Minimum 3.7 for MOUD initiation or transition = Risk Rating D***
28

- 29 1. The patient is experiencing or at risk for opioid withdrawal AND another withdrawal
30 syndrome (e.g., recent polysubstance use with risk factors for withdrawal)
31

32 OR
33

- 34 2. The patient has an OUD and is not currently on MOUD AND has a history of difficulty with
35 initiation of MOUD.
36

37 OR
38

- 39 3. The patient will be transitioned from methadone or buprenorphine to naltrexone
40

41 OR
42

- 43 4. The patient is experiencing or at risk for opioid withdrawal and wants to initiate naltrexone
44

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

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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 O

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

- 1 ○ New onset seizure
- 2 ○ Signs or symptoms of stroke
- 3 ○ Meets criteria for Wernicke's or Korsakoff's
- 4 ○ Sudden, significant deficits in balance, gait, sensory, or motor abilities (not
- 5 related to intoxication)
- 6 ○ Significant head trauma or injury in the past 48 hours
- 7 ○ Loss of consciousness from physical trauma in the past 48 hours
- 8 ● Very severe cardiovascular signs and symptoms. *For example:*
- 9 ○ Malignant arrhythmias
- 10 ○ Hypertensive emergency
- 11 ○ Signs or symptoms of acute myocardial infarction
- 12 ○ Concern for syncope of cardiac origin
- 13 ● Very severe respiratory signs and symptoms. *For example:*
- 14 ○ Asthma not controlled by medications
- 15 ○ COPD exacerbation requiring monitoring, medication, and airway management
- 16 ○ Serious respiratory depression
- 17 ● Very severe gastrointestinal signs and symptoms. *For example:*
- 18 ○ Intractable vomiting and diarrhea (not controlled by medication)
- 19 ○ Vomiting blood (hematemesis)/concerns for gastrointestinal bleeding
- 20 ○ Concern for acute pancreatitis
- 21 ● Very severe hepatic or renal signs or symptoms. *For example:*
- 22 ○ Acute jaundice or other signs or symptoms consistent with acute liver failure
- 23 ○ Signs or symptoms consistent with acute renal failure
- 24 ● Very severe hematological signs and symptoms. *For example:*
- 25 ○ Uncontrolled bleeding
- 26 ○ Concern for pancytopenia
- 27 ● Very severe infectious signs or symptoms. *For example:*
- 28 ○ Concern for endocarditis or associated infection
- 29 ○ Concern for sepsis
- 30 ○ Skin infections not controlled by current antibiotic regimen
- 31 ○ Other severe infection requiring intravenous antibiotics
- 32 ● Very severe endocrine signs or symptoms. *For example:*
- 33 ○ Diabetic emergency (e.g., diabetic ketoacidosis (DKA); extreme hypo- or
- 34 hyperglycemia)
- 35 ○ Signs or symptoms consistent with new onset Addison's
- 36 ● New onset severe acute pain
- 37 ● Other very severe signs and symptoms that meet med-surg criteria for hospitalization. *For*
- 38 *example:*
- 39 ○ Unstable or abnormal vital signs that are unexplained and/or not responsive to
- 40 standard treatment
- 41 ● Patients who need services only available in an acute care setting. *For example:*
- 42 ○ Patients who need continuous cardiac monitoring
- 43 ○ Patients who need titratable infusions
- 44 ○ Patients who need rapid and/or frequent access to laboratory and/or imaging
- 45 studies

46
47 OR
48

- 1 2. The patient has moderately severe to severe acute physical health problems that may be
2 exacerbated by intoxication or withdrawal and require monitoring in an acute care setting
3 (e.g., poorly controlled seizure disorder, poorly controlled hypertension)
4

5 ***Minimum Level 3.7 = Risk Rating 3B***
6

- 7 1. The patient has explainable and controllable, moderately severe to severe acute physical
8 health problems that require 24-hour nursing and/or medical monitoring, but do not require
9 the full resources of an acute care hospital. Examples include, but are not limited to:
10
- 11 • Moderately severe to severe neurological signs or symptoms. *For example:*
 - 12 ○ Poorly controlled seizure disorder but no recurrent seizures in past 24 hours
 - 13 ○ Active neurological disorder (e.g., multiple sclerosis, Parkinson's disease) that
14 requires mobility assistance and/or medication monitoring, without sufficient
15 home support to enable access to daily care in a Level 2.7 program
 - 16 • Moderately severe to severe cardiovascular signs and symptoms. *For example:*
 - 17 ○ Controllable and explainable hypotension or hypertension
 - 18 ○ Controllable and explainable bradycardia or tachycardia
 - 19 • Moderately severe to severe respiratory signs and symptoms (without anticipated need
20 for mechanical ventilation)
 - 21 • Moderately severe to severe gastrointestinal signs and symptoms
 - 22 • Moderately severe to severe hematological signs and symptoms
 - 23 • Moderately severe to severe infectious signs or symptoms. *For example:*
 - 24 ○ Infections under treatment that require medication monitoring due to severity of
25 illness or medication adherence challenges (e.g., tuberculosis, hepatitis C,
26 significant injection site abscess, bacterial pneumonia)
 - 27 • Moderately severe to severe endocrine signs or symptoms. *For example:*
 - 28 ○ Diabetic urgency (e.g., severe hypo- or hyperglycemia that responds to
29 medication) without signs of active organ damage
 - 30 • Moderately severe to severe immunological signs or symptoms. *For example:*
 - 31 ○ Autoimmune disorder flareup requiring intensive symptom management but not
32 hospitalization
 - 33 • Moderately severe to severe hepatic or renal signs or symptoms. *For example:*
 - 34 ○ Active hepatitis from known cause with mild-moderately impaired liver function
35 but not liver failure
 - 36 ○ Dialysis-dependent renal failure that requires mobility assistance and/or
37 medication monitoring, without sufficient home support to enable access to daily
38 care in a Level 2.7 program
 - 39 • Other moderately severe to severe abnormalities in vital signs. *For example:*
 - 40 ○ Controllable and explainable hypothermia or hyperthermia
 - 41 • Patients who need services not available in a less intensive level of care. *For example:*
 - 42 ○ Need for wound care (e.g., for severe injection site abscess requiring
43 debridement)
 - 44 ○ Need for ostomy care (e.g., for new ostomy or ostomy site infection)
 - 45 ○ IV medications
 - 46 ○ Overnight nursing care

47
48 OR
49

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

4
5 OR

- 6
7 3. The patient meets the Dimension 2 admission criteria for Level 2.7 AND cannot reliably
8 access daily care at Level 2.7.

9
10 ***Minimum Level 3.5 = Risk Rating 3A***

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

15
16 ***Minimum Level 2.7 = Risk Rating 2***

- 17
18 1. The patient has explainable and controllable moderately severe to severe acute but non-life-
19 threatening physical health problems that impact daily functioning and may interfere with
20 SUD treatment and recovery and do not require after-hours medical monitoring. AND the
21 patient CAN reliably access daily care at Level 2.7. Examples include, but are not limited to:
22
- 23 • Moderately severe to severe neurological signs or symptoms AND the patient does not
24 need after-hours medical monitoring. *For example:*
 - 25 ○ Active neurological disorder that requires mobility assistance and/or medication
26 monitoring, with sufficient home support to enable access to daily care in a Level
27 2.7 program
 - 28 • Moderately severe to severe cardiovascular signs and symptoms AND the patient does
29 not need after-hours medical monitoring. *For example:*
 - 30 ○ Controllable and explainable hypotension or hypertension
 - 31 ○ Controllable and explainable bradycardia or tachycardia
 - 32 • Moderately severe to severe respiratory signs and symptoms AND the patient does not
33 need after-hours medical monitoring.
 - 34 • Moderately severe to severe gastrointestinal signs and symptoms AND the patient does
35 not need after-hours medical monitoring
 - 36 • Moderately severe to severe hematological signs and symptoms AND the patient does
37 not need after-hours medical monitoring
 - 38 • Moderately severe to severe infectious signs or symptoms AND the patient does not need
39 after-hours medical monitoring. *For example:*
 - 40 ○ Infections under treatment that require medication monitoring due to severity of
41 illness or medication adherence challenges (e.g., tuberculosis, hepatitis C,
42 significant injection site abscess, bacterial pneumonia)
 - 43 • Moderately severe to severe endocrine signs or symptoms AND the patient does not
44 need after-hours medical monitoring. *For example:*
 - 45 ○ Poorly controlled diabetes (may be associated with HbA1C <10%)
 - 46 ○ Diabetes requiring sliding scale management for insulin control (e.g., severe
47 swings in blood glucose; frequent episodes of hypo- or hyperglycemia)
 - 48 • Moderately severe to severe immunological signs or symptoms AND the patient does not
49 need after-hours medical monitoring. *For example:*

- 1 ○ Autoimmune disorder flareup requiring intensive symptom management but not
- 2 after-hours observation or monitoring
- 3 • Moderately severe to severe hepatic or renal signs or symptoms AND the patient does
- 4 not need after-hours medical monitoring. *For example:*
- 5 ○ Active hepatitis causing impaired liver function (but not liver failure)
- 6 ○ Dialysis-dependent renal failure that requires mobility assistance and/or
- 7 medication monitoring, WITH sufficient home support to enable access to daily
- 8 care in a Level 2.7 program
- 9 • Other moderately severe to severe abnormalities in vital signs AND the patient does not
- 10 need after-hours medical monitoring. *For example:*
- 11 ○ Controllable and explainable hypothermia or hyperthermia
- 12 • Patients who need services not available in a less intensive level of care AND the patient
- 13 does not need after-hours medical monitoring. *For example:*
- 14 ○ Patients requiring frequent laboratory monitoring

15
16 OR

- 17
- 18 2. The patient has moderate to severe acute physical health problems (e.g., complex partial
- 19 seizure disorder, hypertension, diabetes) that may be exacerbated by intoxication or
- 20 withdrawal and require observation but do not require after-hours observation or monitoring.
- 21

22 ***Minimum Level 1.7 = Risk Rating 1***

23
24 The patient has mild to moderate acute health problems that impact daily functioning but will not

25 interfere with SUD treatment and recovery. Examples include, but are not limited to:

- 26
- 27 a. Medication initiation for mild to moderate infection
- 28 b. Medication initiation/adjustment for other acute mild to moderate physical health
- 29 concerns
- 30

31 ***No specific needs = Risk Rating 0***

32 ***Pregnancy-related concerns***

33 ***Level 4 = Risk Rating 4***

34
35 The patient's pregnancy is immediately unstable (e.g., acute vaginal bleeding, contractions, or

36 cessation of fetal movement, concern for preeclampsia (e.g., new hypertension), leakage of fluid

37 unstable fetal heartbeat, cardiomyopathy) and requires fetal monitoring, 24-hour medical

38 management, and/or the full resources of an acute care hospital.

39

40

41

42 ***Minimum Level 3.7 = Risk Rating 3***

43
44 The patient is pregnant and requires frequent medical monitoring for non-life-threatening

45 pregnancy complications (e.g., stable gestational diabetes or chronic hypertension), including

46 after-hours medical monitoring, but does not require fetal monitoring or 24-hour medical

47 management

48

1 ***Minimum Level 2.7 = Risk Rating 2***
2

3 The patient is pregnant and requires frequent outpatient medical monitoring for non-life-
4 threatening pregnancy complications (e.g., stable gestational diabetes or chronic hypertension)
5 but does not require fetal monitoring or after-hours medical monitoring.
6

7 ***Minimum Level 1.7 = Risk Rating 1***
8

9 The patient is pregnant, is at low or average risk of pregnancy complications, and requires
10 assistance with coordination of prenatal care.
11

12 ***No specific needs = Risk Rating 0***
13

14 **Dimension 3 – Psychiatric and Cognitive Conditions**

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

19 Suicidal ideations alone are not a reason to deny admission. All programs should be co-occurring
20 capable, including being able to assess and triage patients to who report suicidal ideations to
21 determine if they need a psychiatric assessment/higher LOC.
22

23 ***Active Psychiatric Symptoms***
24

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

- 27 1. The patient has psychiatric concerns that pose an acute risk of serious harm to self or others
28 or deterioration without daily psychiatric management, 24-hour psychiatric nursing, and/or
29 the level of programming and structure, secure staffing and support provided by a psychiatric
30 inpatient setting. The patient does NOT require inpatient medical management for very
31 severe withdrawal or life-threatening biomedical problems (otherwise, the patient should be
32 treated in a Level 4 acute care hospital, then transferred to inpatient psychiatric once their
33 withdrawal and/or biomedical conditions are stabilized). Examples include, but are not
34 limited to:
- 35 • Immediate risk of suicide, homicide, or very severe self-harm
 - 36 • Active, uncontrolled violent impulses
 - 37 • Acute mental status changes (e.g., psychosis or mania) with unpredictable, disorganized,
38 or violent behavior
 - 39 • Severe treatment resistant depression with need for complex management, including
40 consideration for interventional psychiatry (e.g., electroconvulsive therapy, transcranial
41 magnetic stimulation)
 - 42 • Need for high-intensity monitoring, along with need for daily medication adjustments
43 based on potential for significant side effects, metabolic risk, or other factors
 - 44 • Acute, severe psychiatric symptoms that require medication AND the patient actively
45 resists medication assistance.
 - 46 • Other signs or symptoms which may require a secure unit
- 47

1 OR

2

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

5

6 OR

7

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

11

12 ***Minimum Level 3.7 COE = Risk Rating 3F***

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

17

18 • Active suicidal and/or homicidal ideation with some intent to act without a specific plan³,
19 AND patient demonstrates ability to seek help before acting and secured setting is not
20 required (as determined by a qualified mental health professional).

21 • Active, frequent impulses to harm self or others, but patient has ability to maintain
22 control with 24-hour access to staff support

23 • Acute mental status changes (e.g., psychosis or mania) without unpredictable or violent
24 behavior

25 • Active psychiatric concerns that require frequent but not daily management of complex
26 psychiatric medication regimen (e.g., initiation or adjustment of multiple psychiatric
27 medications, with need for residential medical monitoring during medication changes
28 due to psychiatric instability and/or potential for severe but non-life-threatening side
29 effects), AND patient is willing to take medications

30 OR

31

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

34

35 OR

36

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

40

41 ***Minimum Level 3.7 = Risk Rating 3E***

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

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

- 1 • Psychiatric concerns (e.g., depression or anxiety) that require medical intervention, and
2 medication can be managed by a non-specialist physician (e.g., patient requires initiation of,
3 or dose titration for, a single psychiatric medication), but potential interactions with
4 Dimension 1 or 2 (e.g., medication interactions) require 24/7 medical monitoring.
- 5 • Moderately severe psychiatric disorder (e.g., panic disorder, PTSD) that requires additional
6 doses of controlled psychiatric medication as needed (prn), but patient cannot safely and
7 reliably self-administer the medication, AND lacks sufficient supports or monitoring at home.
8

9 **Minimum Level 3.5 COE = Risk Rating 3D**

10 1. The patient has psychiatric concerns at a level of acuity that impacts safety and/or function to the
11 point of requiring intensive mental health focused psychotherapy or 24/7 on-call psychiatric
12 support; AND 24-hour residential supervision to monitor for changes in status and rapidly respond
13 to medical concerns that may arise; but the patient has sufficient control so as not to require an
14 acute or sub-acute psychiatric setting. Examples include, but are not limited to:
15

- 16 • Recurrent suicidal and/or homicidal ideation without intent or plan, but with history of
17 attempt, requires close monitoring and specialized psychotherapeutic interventions.
- 18 • Active hallucinations and/or delusions, with mostly intact reality testing and no harmful
19 impulses, require close monitoring and specialized psychotherapeutic interventions.
- 20 • Functional deficits are so severe (e.g., extremely poor impulse control, severe sequelae of
21 physical, sexual, or emotional trauma) that the patient is not likely to maintain mental
22 stability if treatment is not provided in a residential setting with 24-hour, supervision,
23 structure and support, and psychiatrically trained staff.
- 24 • Antisocial behaviors (e.g., oppositional defiant disorder, low anger management skills with
25 frequent verbal aggression) and attitudes (e.g., extreme lack of concern for others or regard
26 for authority) prevent the patient from progressing toward recovery without specialized
27 mental health treatment provided in a setting with 24-hour supervision, structure, and
28 support, and psychiatrically trained staff.
- 29 • Mood, personality or thought disorder(s) significantly limit and at times preclude the
30 patient's ability to focus on recovery efforts, making the patient vulnerable to dangerous
31 consequences outside of a treatment setting with 24-hour, supervision, structure, and
32 support, and psychiatrically trained staff.
- 33 • Other active psychiatric illness that regularly requires specialized psychotherapeutic
34 interventions, including after hours.
35

36 OR

37
38 2. Patient has recently been treated in Level 3.7 COE and is stable on medication regimen but
39 requires 24- hour monitoring to ensure behavioral stability and adherence to medication.
40

41 **Minimum Level 3.5 = Risk Rating 3C**

42 The patient has psychiatric concerns with periodic crises that require 24-hour supervision
43 and/or access to an on-call physician after hours, and intensive psychotherapy, but do NOT
44 require specialty psychiatric assessment or management, or high intensity staff support (higher
45 staff-to-patient ratio, as in Level 3.5 COE). Examples include, but are not limited to:
46

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

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

7 8 ***Minimum Level 3.1 COE = Risk Rating 3B***

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

- 13
- 14 • Suicidal and/or homicidal ideation without intent, plan, or history of attempt requires
15 monitoring (including overnight), but not 24-hour supervision, for escalation of symptoms.
- 16 • Hallucinations and/or delusions require monitoring (including overnight), but not 24-hour
17 supervision, but reality testing is intact, and the patient has no impulses to harm self or
18 others.
- 19 • Mood, personality, or thought disorder impact patient’s ability to focus on recovery efforts
20 outside of a residential treatment setting, but with regular staff support, including overnight,
21 the patient is able to engage in treatment and safely access the community during the day
22 for work, school, or other treatment/social services.
- 23 • Other psychiatric illness regularly requires enhanced staff support and after-hours staff
24 interventions (e.g., medication adherence support and specialized psychotherapeutic
25 interventions) to help the individual manage symptoms and function semi-independently in
26 the community.
- 27 • Functional deficits (e.g., sequelae of physical, sexual, or emotional trauma) make it difficult
28 for the patient to maintain mental stability without regular support from skilled mental
29 health staff, including overnight; but with access to this support, the patient is able to safely
30 access the community during the day (e.g., for work, school, other treatment, or social
31 services).

32 33 ***Minimum Level 3.1 = Risk Rating 3A***

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

- 39
- 40 • Psychiatric and/or cognitive symptoms (e.g., from schizophrenia) are well-controlled with
41 consistent daily medication, but patient is unable to reliably self-administer medication AND
42 lacks sufficient home support to help ensure medication adherence or monitor for changes
43 in symptom severity or function.
- 44 • Low-complexity psychiatric concerns (e.g., depression or anxiety) impact patient’s ability to
45 focus on recovery efforts outside of a residential treatment setting, but with access to 24-
46 hour support the patient is able to participate in treatment and access the community safely
47 and independently for work, school, or other treatment/social services.
- 48 • Functional deficits (e.g., sequelae of physical, sexual, or emotional trauma) require non-
49 specialized afterhours support but the patient is able to function in the community during
50 the day.

1
2 OR

- 3
4 2. The patient has low-complexity psychiatric concerns with occasional exacerbations of
5 psychiatric symptoms that require overnight monitoring but do not require specialty
6 psychiatric assessment or management; AND patient does not have sufficient overnight
7 monitoring at home.
8

9 ***Minimum Level 2.7 COE = Risk Rating 2D***

- 10 1. The patient has psychiatric concerns at a level of acuity that interferes with SUD treatment
11 and recovery, and requires frequent medication management such that the patient is
12 unlikely to maintain stability without daily or near-daily clinical contact. Patient has adequate
13 impulse control to resist acting upon any thoughts of harm to self or others, if present. The
14 patient CAN reliably access daily care at Level 2.7 and does not require after-hours
15 monitoring. Examples include, but are not limited to:
16

- 17 • Active suicidal ideation without intent, plan, or history of attempt(s), and patient reliably
18 contracts for safety and has adequate overnight support to ensure safety; requires daily
19 or near-daily monitoring and regular medication adjustments.
- 20 • Active mild to moderate psychotic illness with intact reality testing, no urges to harm self
21 or others, and adequate overnight support to ensure safety; requires daily or near-daily
22 monitoring and regular medication adjustments.
- 23 • Acute, moderate impairment in ability to manage activities of daily living (e.g., due to
24 psychiatric decompensation), requires daily monitoring and regular medication
25 adjustments, but minimal function and self-care are intact.
- 26 • Psychiatric disorder distracts patient from SUD treatment and requires active psychiatric
27 management and stabilization concurrent with addiction treatment (e.g., unstable
28 borderline personality disorder, compulsive personality disorder, or mood disorder).
29

30 OR

- 31
32 2. The patient meets Dimension 3 Criteria for Level 1.7 COE, and psychiatric concerns may be
33 exacerbated by intoxication, withdrawal, or co-occurring Dimension 2 concerns and require
34 monitoring and medication adjustment in a medically monitored intensive outpatient setting.
35

36 ***Minimum Level 2.7 = Risk Rating 2C***

37 The patient has psychiatric concerns with occasional exacerbations of psychiatric symptoms
38 that require daily or near-daily clinical contact and regular medication adjustments to
39 successfully engage in SUD treatment, but do NOT require specialty psychiatric assessment or
40 management. Patient has adequate impulse control to resist acting upon any thoughts of harm
41 to self or others, if present. The patient CAN reliably access daily care at Level 2.7 and does not
42 require after-hours monitoring. Examples include, but are not limited to:
43

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

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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:

- 1 • Severely inadequate ability to manage activities of daily living (e.g., due to schizophrenia)
2 render the patient unsafe outside of a 24-hour co-occurring enhanced setting and
3 regularly require enhanced staff support and/or skilled mental health staff to manage
4 activities of daily living and participate in treatment.
5 • Severe functional deficits (e.g., due to traumatic brain injury) regularly require enhanced
6 staff support to enable meaningful engagement in treatment.
7 • Neurobehavioral disorder (e.g., ADHD, ASD, OCD) with significant difficulty organizing
8 activities of daily living, including adherence to medication, resulting in symptom
9 exacerbation, and regularly requiring enhanced staff support and/or skilled mental health
10 staff to manage activities of daily living and participate in treatment.
11

12 ***Minimum Level 3.5 = Risk Rating 3X***

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

16 Examples include, but are not limited to:

- 17
- 18 • Difficulty in ability to manage activities of daily living (e.g., due to traumatic brain injury or
19 dementia) renders patient unable to reliably attend outpatient treatment or access the
20 community for work, school, or other activities.
 - 21 • Functional deficits (e.g., intellectual disability, sequelae of physical, sexual, or emotional
22 trauma) make it difficult for the patient to focus on treatment if provided outside of a
23 setting with 24-hour supervision, structure, and support.
 - 24 • Moderate-complexity neurobehavioral disorder (e.g., ADHD, ASD, OCD) with difficulty
25 organizing activities of daily living, resulting in need for 24-hour supervision.
26

27 ***Minimum Level 3.1 COE = Risk Rating 3Y***

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

- 33
- 34 • Functional deficits make it difficult for the patient to engage in treatment without regular
35 support from skilled mental health staff; but with access to this support (including at least
36 occasional afterhours support), the patient is able to engage meaningfully in treatment
37 and safely access the community during the day (e.g., for work, school, other treatment, or
38 social services).
 - 39 • Patient experiences moderate, pervasive challenges in organizing activities of daily living
40 (e.g., due to traumatic brain injury, ADHD, ASD, OCD), but with 24-hour access to support
41 from skilled mental health staff, the patient is able to participate in treatment and safely
42 access the community during the day (e.g., for occupational therapy, other rehabilitative
43 services).
44

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

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

1 support during the day, or skilled mental health treatment within the SUD program. Examples
2 include, but are not limited to:
3

- 4 • Moderate-complexity neurobehavioral disorder (e.g., ADHD, ASD, OCD) presents
5 challenges with some activities of daily living, including adherence to medication, with
6 resulting symptom exacerbation; but with medication adherence support, including after-
7 hours, patient is able to access the community safely and independently during the day.
- 8 • Mild but pervasive difficulty in ability to manage activities of daily living (e.g., due to
9 traumatic brain injury, intellectual disability) makes it difficult for patient to reliably attend
10 and succeed in outpatient treatment, but patient is able to access the community during
11 the day for work, school, or support services.
12

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

14 The patient has moderate to severe impairment in ability to manage activities of daily living due to
15 chronic but stable psychiatric or cognitive disorder(s) and requires intensive, full-day staff support
16 nearly every day (but NOT afterhours) in a flexible treatment environment with more individualized
17 attention or a higher level of staff mental health skills than available in 2.5. Examples include, but
18 are not limited to:
19

- 20 • Functional deficits (e.g., intellectual disability) cause difficulty with comprehension
21 and/or concentration, and require near-daily intensive clinical contact to retain new
22 information and reinforce SUD treatment gains.
- 23 • Neurobehavioral disorder (e.g., ADHD, ASD, OCD) presents challenges with activities of
24 daily living (e.g., following a schedule, adhering to rules, and managing basic activities of
25 daily living, including medication adherence) and patient needs regular availability of
26 extra support to succeed in outpatient SUD treatment.
- 27 • Mood or personality disorder(s) (e.g., effects of longstanding trauma, significant anxiety
28 disorder, borderline personality disorder, significant dysthymia) make it more difficult for
29 the individual to handle routine interactions with staff and clients, and requires near-daily
30 clinical contact with significantly more individualized support and flexibility (compared to
31 Level 2.5 (non-COE) to support active participation in SUD treatment.
32

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

34 The patient has mild impairment in ability to process information, organize schedules, and
35 manage activities of daily living due to chronic, stable psychiatric or cognitive disorder(s), and
36 requires a more flexible treatment environment with more individualized attention or a higher
37 level of staff mental health skills than are available in Level 1.5 (non-COE). The patient has
38 sufficient support at home (or in recovery residence) to reliably access care at Level 1.5.
39 Examples include, but are not limited to:
40

- 41 • Mild functional deficits (e.g., intellectual disability) cause some difficulty with
42 comprehension and/or concentration, requiring skilled accommodation.
- 43 • Mild neurobehavioral disorder (e.g., ADHD, ASD, OCD) presents challenges with following
44 a schedule, adhering to rules, and managing basic activities of daily living, and patient
45 needs regular availability of extra support to succeed in adhering to the expectations and
46 scheduling needs of outpatient SUD treatment.
- 47 • Baseline mental health conditions (e.g., mild sequela of trauma, depression, anxiety
48 disorder, stable borderline personality disorder) require specialized mental health
49 support and flexibility to maintain treatment gains and/or optimize functioning.
50

1 *No specific needs = Risk Rating O*
2

3 Dimension 4 – Substance Use Related Risks
4

5 Likelihood of engagement in risky substance use
6

7 *Minimum Level 3.5 = Risk Rating E*

8 The patient lacks recognition or understanding of the potential consequences of substance use,
9 and is at **high risk of use with imminent danger** and needs 24-hour clinical support and
10 supervision to prevent substance use. Examples include, but are not limited to:
11

- 12 • The patient has a recent history of substance use with dangerous consequences (e.g.,
13 overdose, automobile accidents while intoxicated, victimization/engaging in violent
14 behavior while using substances), AND one or more of the following is true:
 - 15 ○ The patient is unlikely to be able to cope with cravings to use without 24-hour
16 structure, support, and supervision.
 - 17 ○ The patient is ambivalent to treatment.
 - 18 ○ The patient has active drug cravings and very limited ability to postpone
19 immediate gratification.
 - 20 ○ The patient does not recognize substance use triggers and is unlikely to avoid
21 substance use without 24-hour supervision.
22

23 *Minimum Level 3.1 = Risk Rating D*

24 The patient has impaired recognition and understanding of the potential consequences of
25 substance use, and is at **moderately high risk of use with dangerous consequences** without
26 residential structure and some supervision. The patient has some ability to use peer or
27 community supports when at risk for continued use. Examples include, but are not limited to:
28

- 29 • The patient's recent patterns of use put them at moderately high risk for overdose,
30 violent behavior, victimization, automobile accidents while intoxicated, or other
31 dangerous consequences AND one or more of the following is true:
 - 32 ○ The patient has some awareness of use triggers, and is somewhat committed to
33 treatment, but has difficulty implementing use prevention strategies without
34 residential structure and support.
 - 35 ○ The patient has intermittent drug cravings and difficulty postponing immediate
36 gratification without daily structure and residential support.
37

38 *Minimum Level 2.5 = Risk Rating C*
39

40 The patient has minimal recognition and understanding of the potential consequences of
41 substance use, and is at **high risk of use with negative but not dangerous consequences**. The
42 patient needs close outpatient monitoring and daily structured therapeutic services to achieve
43 recovery; AND the patient has sufficient home supervision and support, or will be placed in a
44 recovery residence with sufficient support and supervision, to cope with urges to use when not
45 receiving treatment services. Examples include, but are not limited to:
46

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

- 1 ○ The patient lacks sufficient awareness of triggers for use and is somewhat
- 2 ambivalent toward treatment but is mostly able to resist urges to use with intensive
- 3 daily clinical support.
- 4 ○ The patient has limited ability to use peer or community supports when at risk for
- 5 use.
- 6 ○ The patient experiences frequent drug craving and has limited ability to postpone
- 7 immediate gratification but is able to cope on an outpatient basis with intensive
- 8 daily clinical support.
- 9

10 ***Minimum Level 2.1 = Risk Rating B***

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

- 17
- 18 • The patient is at moderate risk of job, relationship, or child custody loss, or other negative
19 consequences of substance use, AND one or more of the following is true:
 - 20 ○ The patient has some but not full awareness of use triggers; and is willing to
 - 21 participate actively in treatment to strengthen awareness and implement substance
 - 22 use prevention strategies.
 - 23 ○ The patient is often, but not always, able to use peer or community supports when
 - 24 at risk for substance use; and has expressed commitment to work on seeking
 - 25 support.
 - 26 ○ The patient occasionally experiences intensified SUD symptoms (e.g., mild to
 - 27 moderate difficulty postponing immediate gratification, drug craving) but is able to
 - 28 seek support and self-manage with prompting.
 - 29

30 ***Minimum Level 1.5 = Risk Rating A***

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

- 35
- 36 • The patient is at mild risk of job or relationship loss, or other negative consequences of
37 substance use, AND both of the following are true:
 - 38 ○ The patient has high awareness of use triggers, high commitment to treatment, and
 - 39 is able to prevent use with peer and community support and scheduled therapeutic
 - 40 contact.
 - 41 ○ The patient rarely experiences intensification of SUD symptoms (e.g., mild cravings
 - 42 but no return to use) and is assessed as able to achieve or maintain recovery goals.
 - 43

44 ***No specific needs = Risk Rating 0***

45 ***Likelihood of engaging in other harmful SUD related behaviors in current***

46 ***environment***

47

48

1 **Minimum Level 3.5 = Risk Rating E**

2 The patient lacks recognition or understanding of the potential consequences of harmful SUD-
3 related behaviors, and is at very high risk of engagement in these behaviors with very high
4 likelihood of imminent danger (e.g., life-threatening physical or sexual violence). The patient
5 needs 24-hour supervision to prevent these behaviors. Examples include, but are not limited to:
6

- 7
- 8 • The patient has a history of reincarceration with an uninterrupted pattern of return to
substance use outside of incarceration.
 - 9 • The patient is unable to resist drug cravings that lead them to repeatedly engage in
10 behaviors harmful to their health and/or safety (e.g., risky commercial sex work, drug
11 dealing).
- 12

13 **Minimum Level 3.1 = Risk Rating D**

14 The patient has impaired recognition and understanding of the potential consequences of harmful
15 SUD-related behaviors, and is at moderately high risk of engagement in these behaviors with
16 moderately high likelihood of dangerous consequences (e.g., serious injury) without residential
17 structure and some supervision. Examples include, but are not limited to:
18

- 19
- 20 • Recent criminal justice involvement due to SUD-related behaviors, and the patient is
somewhat committed to treatment, but has difficulty preventing engagement in behaviors
21 that pose significant criminal/legal risks without residential structure and support.
 - 22 • The patient has some difficulty resisting drug cravings that lead them to engage in
23 behaviors harmful to their health and/or safety (e.g., risky commercial sex work, drug
24 dealing), but is able to do so with daily structure and residential support.
- 25

26 **Minimum Level 2.5 = Risk Rating C**

27 The patient has minimal recognition and understanding of the potential consequences of
28 harmful SUD-related behaviors (e.g., antisocial behaviors), and is at high risk of use with
29 negative, but not life threatening, consequences (e.g., incarceration). The patient needs close
30 outpatient monitoring and daily structured therapeutic services to achieve recovery; AND the
31 patient has sufficient home supervision and support, or will be placed in a recovery residence
32 with sufficient support and supervision, to prevent engagement in harmful SUD-related behaviors
33 when not receiving treatment services. Examples include, but are not limited to:
34

- 35
- 36 • 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
37 criminal/legal consequences with intensive daily clinical support.
 - 38 • The patient has limited ability to resist cravings that lead them to engage in SUD-related
39 behaviors harmful to their health and/or safety (e.g., risky commercial sex work, drug
40 dealing), and needs daily intensive clinical services to do so.
- 41

42 **Minimum Level 2.1 = Risk Rating B**

43 The patient has some recognition and understanding of the potential consequences of harmful
44 SUD-related behaviors, and is at moderate risk of engaging in these behaviors with negative but
45 not dangerous consequences (e.g., eviction; relationship or job loss). The patient needs intensive
46 clinical support several times per week to achieve recovery goals; AND has sufficient home
47 structure and support, or will be placed in a recovery residence with sufficient support and
48 supervision, to cope with urges to engage in harmful SUD behaviors when needed. Examples
49 include, but are not limited to:
50

- 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 rehabilitative 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.

1 ***Minimum Level 3.1 = Risk Rating C***

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

- 10
- 11 • The patient is learning prosocial skills, but occasionally has difficulty resolving interpersonal
12 conflict and/or respecting boundaries in a group setting.
 - 13 • The patient is learning to perform basic functions of independent living, such as holding a job
14 or paying bills, and needs residential support and clinical reinforcement on a daily basis while
15 beginning to function independently in the community.
 - 16 • The patient is learning to create a safe daily routine and social support network, and requires
17 residential structure and clinical services to support transition from habilitative services to
18 recovery residence or independent living in the community.
- 19

20 ***Minimum Recovery Residence = Risk Rating B***

21

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

29

- 30 • The patient has moderate social challenges (e.g., few friends, or conflicts with peers or co-
31 workers) but has at least basic prosocial skills, and needs peer support to reinforce and
32 consolidate these skills.
 - 33 • The patient is able to perform basic functions of independent living, such as holding a job or
34 paying bills, and needs peer support and structure to assist with self-discipline and
35 accountability during the recovery process.
 - 36 • The patient has created a safe daily routine and is strengthening their social support network,
37 but still needs a residential safety net while establishing increasing recovery capital (e.g.,
38 through building resilience/emotional regulation through community-based conflict resolution,
39 etc.).
 - 40 • The patient is beginning to build a recovery supportive community but needs experiential peer
41 recovery in order to build and sustain remission.
- 42

43 ***No specific needs = Risk Rating A***

44

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

48 -----

49

1 ***Safety in current environment***
2

3 ***Minimum safe housing⁴ = Risk Rating B***

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

- 6
7 • The patient’s environment is characterized by physical, sexual, or emotional abuse.
8 • The patient is experiencing homelessness.
9

10 ***No specific needs = Risk Rating A***

11 The patient’s current environment is safe.
12

13 ***Support in current environment***
14

15 ***Minimum Recovery Residence = Risk Rating B***

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

- 18
19 a. The patient’s social milieu is so infused with substance use that it will render recovery
20 unachievable.
21 b. The patient lives with individuals who regularly use or sell alcohol/other drugs who exert
22 direct or indirect pressure on the patient to use substances.
23

24 ***No specific needs = Risk Rating A***

25 The patient’s current environment is supportive of recovery.
26

27 **Level of Care Determination**

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

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

1

2 *Level of Care Determination Rules*

3 See Appendix D for Decision Tree.

4 **Inpatient Care (Level 4 and Level 4 COE)**

- 5 • If the patient need Level 4 treatment for Dimension 1 and/or Dimension 2: refer or transfer
- 6 to **Level 4**
- 7 • If the patient needs Level 4 treatment for Dimension 3 ONLY: refer or transfer to **Level 4 COE**
- 8

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

- 10 • If the patient does not need Level 4 care, first determine if the patient needs a medically
- 11 managed level of care.
 - 12 ○ If any subdimension requires a minimum level of care of 1.7, 2.7, or 3.7 the
 - 13 recommendation should be for a medically managed level of care.
- 14 • Next determine if the patient requires outpatient, intensive outpatient, or residential
- 15 medically managed care.
 - 16 ○ Do any subdimension requires a minimum of residential care (e.g., 3.1, 3.5, or 3.7)?
 - 17 ▪ If yes: Recommend **Level 3.7**
 - 18 ▪ If no: Do any subdimensions require intensive outpatient care (e.g., 2.1, 2.5,
 - 19 or 2.7)?
 - 20 • If yes: Recommend **Level 2.7**
 - 21 • If no: Recommend **Level 1.7**
 - 22

23 **Clinically Managed Residential Care (Levels 3.1 and 3.5)**

- 24 • If the patient does not need medically managed care, determine if the patient needs
- 25 residential treatment.
 - 26 ○ If any subdimension requires a minimum level of care 3.1 or 3.5, the
 - 27 recommendation should be for clinically managed residential care.
- 28 • What is the highest level of residential care indicated in any subdimension?
 - 29 ○ If 3.5: Recommend **Level 3.5**
 - 30 ○ If 3.1: Recommend **Level 3.1**
 - 31

32 **Clinically Managed Intensive Outpatient Care (Levels 2.1 and 2.5)**

- 33 • If the patient does not need medically managed care or residential treatment, determine if
- 34 the patient needs intensive outpatient treatment.
 - 35 ○ If any subdimension requires a minimum level of care 2.1 or 2.5, the
 - 36 recommendation should be for clinically managed intensive outpatient care.
- 37 • What is the highest level of residential care indicated in any subdimension?
 - 38 ○ If 2.5: Recommend **Level 2.5**
 - 39 ○ If 2.1: Recommend **Level 2.1**
 - 40

1 **Clinically Managed Outpatient Care (Level 1.5)**

- 2 • If none of the subdimensions recommend a level of care above Level 1.5: Recommend **Level**
3 **1.5**

4
5 **Co-occurring Enhanced Care**

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

10
11 **Recovery Residence or Safe Housing**

- 12 • If the recommended level of care is an outpatient or intensive outpatient level of care (Levels
13 1.5, 1.7, 2.1, 2.5, or 2.7), is a minimum of a recovery residence or supportive housing
14 recommended based on Dimension 5?
15 ○ If a recovery residence is recommended, the final recommendation should be for the
16 specific LOC determined based on the rules above **PLUS a recovery residence**.
17 ○ If supportive housing is recommended (and a recovery residence is not
18 recommended) the final recommendation should be for the specific LOC determined
19 based on the rules above **PLUS safe housing**.

20
21
22

1 **Appendix A – Level of Care Assessment Considerations**

2 **Dimension 1 (Acute intoxication and withdrawal potential)**

3 Level of Care Assessment of Dimension 1 should include:

- 4 • **Vital signs**
 - 5 ○ If patient is at risk for or experiencing intoxication or withdrawal, is there any
 - 6 significant disturbance in vital signs (i.e., blood pressure, pulse rate, temperature)?
- 7 • **Substance use history**
 - 8 ○ Date of last use/duration/frequency/route of administration, for substances
 - 9 (including nicotine/tobacco products) used in the past 30 days (as self-reported or
 - 10 otherwise documented)
- 11 • **Intoxication and associated risks (including overdose)**
 - 12 ■ Is the patient oriented to person, place, time, and situation? Are there
 - 13 obvious problems with balance, gait, or sensory issues?
 - 14 ■ History or risk of overdose
 - 15 ■ What risk is associated with the patient’s current level of acute intoxication?
 - 16 • Risk of life-threatening physical health problems (e.g., chest pain,
 - 17 respiratory depression)
 - 18 • Risk of harm to self or others (e.g., violence, self-harm)
- 19 • **Withdrawal and associated risks**
 - 20 ○ Are there current signs of withdrawal, or is withdrawal anticipated based on the
 - 21 amount, frequency, chronicity, and recency of discontinuation of (or significant
 - 22 reduction in) alcohol, tobacco, or other drug of use? If so, what is the anticipated
 - 23 severity?
 - 24 ■ Are there co-occurring physical or psychiatric conditions that may increase
 - 25 anticipated withdrawal severity?
 - 26 ■ History of severe withdrawal, including seizures or delirium tremens
 - 27 ■ History of withdrawal related complications
 - 28 ■ Is the patient at risk for nicotine withdrawal? If so, is the patient willing and
 - 29 able to initiate nicotine replacement therapy (NRT)
 - 30 ○ Consider using validated withdrawal severity assessment measures, e.g., CIWA-Ar,
 - 31 CINA, COWS, SOWS as indicated and available on-site, to establish baseline measure
 - 32 of withdrawal severity
- 33 • **Need of Medications for OUD (Dimension 4 of the Treatment Planning Assessment will**
34 **assess need for other addiction pharmacotherapies)**
 - 35 ○ Is the patient at risk for opioid withdrawal?
 - 36 ■ Has the patient ever been treated with MOUD?
 - 37 ■ Does the patient have a history of difficulty with initiation of MOUD?
 - 38 ■ Has the patient indicated a preference for treatment with naltrexone?
 - 39 ○ If the patient has an opioid use disorder, are they currently receiving medications for
 - 40 opioid use disorder (MOUD)? If yes,
 - 41 ■ Is service coordination indicated for continuation of medication?
 - 42 ■ Will the patient be transitioned to a different medication (e.g., methadone to
 - 43 buprenorphine, buprenorphine to naltrexone)?
 - 44

45 **Dimension 2 (Biomedical conditions)**

46 Level of Care Assessment of Dimension 2 should include:

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

- 1 ○ Does the patient appear unwell to a layperson? (If yes, is there any significant
- 2 disturbance in vital signs (i.e., blood pressure, pulse rate, temperature)?
- 3 ▪ If the patient appears acutely ill, refer for immediate medical evaluation.
- 4 ○ As per patient report, does the patient have any acute biomedical symptoms (other
- 5 than intoxication or withdrawal) that need to be addressed due to their risk or
- 6 potential for treatment complications?
- 7 ▪ If the patient reports urgent or emergent biomedical symptoms, refer for
- 8 immediate medical evaluation, transfer to an emergency department, or call
- 9 911.
- 10 ▪ All patients who report acute biomedical symptoms should have a medical
- 11 clearance exam before admission to a clinically managed level of care.
- 12 ○ Does the patient report any severe, undiagnosed, or uncontrolled pain? (If yes, refer
- 13 for immediate medical evaluation))
- 14 • **Chronic physical health concerns**
- 15 ○ Per patient report:
- 16 ▪ If chronic physical health problems are present, do they need active medical
- 17 management?
- 18 ▪ If chronic physical health problems are present, are they currently being
- 19 managed by an external provider?
- 20 • **Pregnancy-related concerns**
- 21 ○ Is the patient pregnant, or is there a possibility they may be pregnant?
- 22 ○ If patient is pregnant, do they report any known complications, concerns about the
- 23 pregnancy, or any risk factors (e.g., acute vaginal bleeding, contractions, cessation of
- 24 fetal movement, history of preeclampsia) that may require further medical evaluation
- 25 or close monitoring?
- 26

27 Dimension 3 (Psychiatric and cognitive conditions)

28 Level of Care Assessment of Dimension 3 should include:

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

- 1 ▪ If chronic mental health problems are present, do they need active medical
- 2 management?
- 3 ▪ If chronic mental health problems are present, are they currently being
- 4 managed by an external provider?
- 5 ▪ Does the patient have a chronic psychiatric disorder that causes a persistent
- 6 impairment in their ability to carry out activities of daily living, self-care,
- 7 education, employment and/or participation in social life?
- 8 • **Cognitive functioning deficits**
- 9 ○ Does the patient appear to have deficits in cognitive functioning that may make it
- 10 difficult for them to understand information presented and participate in treatment
- 11 without cognitively enhanced services? [If yes, use a validated screening tool such as
- 12 the Montreal Cognitive Assessment (MoCA)].
- 13 ○ Does the patient have a history of moderate to severe traumatic brain injury? [If yes,
- 14 consider using validated screening tools such as The Neurobehavioral Symptom
- 15 Inventory]
- 16

17 Dimension 4 (Substance use related risks)

18 Level of Care Assessment of Dimension 4 should include:

- 19 • **Likelihood of engagement in risky substance use in current environment**
- 20 ○ Without intervention, how likely is the patient to use, and how soon are they likely to
- 21 do so (e.g., today, within days, within weeks, within months)?
- 22 ▪ Is the patient experiencing pain? Does the patient have a history of misusing
- 23 opioids to manage pain?
- 24 ○ In the past, was the individual able to cease use without treatment for any period of
- 25 time outside of a controlled environment (e.g., jail, prison)? If so, when and for how
- 26 long?
- 27 ○ Have medications for substance use or mental health disorders helped the patient
- 28 avoid use in the past?
- 29 ▪ What are the person's strengths in coping with protracted withdrawal,
- 30 cravings, or impulses?
- 31 ○ How aware is the patient of triggers to use?
- 32 ○ How well can the patient cope with emotional distress, environmental cues to use,
- 33 peer pressure, and stress without recurrence of addictive thinking and/or behavior?
- 34 ○ How risky is their likely use?
- 35 ▪ Consider risk for mental and physical health, etc.
- 36 ▪ [Note: this includes risks related to tobacco use, such as continued use in a
- 37 patient with COPD as well as fire safety risks associated with smoking
- 38 tobacco or marijuana.]
- 39 ○ Consider using validated assessment tools, e.g., Brief Addiction Monitor (risk and
- 40 protective scores), Visual Analog Scale (for craving) to establish baseline measures of
- 41 addiction symptom severity.
- 42 • **Likelihood of engaging in other harmful SUD related behaviors in current environment**
- 43 ○ What is the patient's risk of engaging in harmful SUD-related behaviors (e.g., DUI,
- 44 violence, or behaviors that increase vulnerability to victimization) if they remain in
- 45 their current environment?
- 46 ○ How severe are the problems and further distress that may result if the patient is not
- 47 successfully engaged in treatment and continues the high-risk or addictive behavior
- 48

1 Dimension 5 (Recovery environment)

2 Level of Care Assessment of Dimension 5 should include:

- 3 • **Ability to function effectively in current recovery environment**
 - 4 ○ How does the patient feel their current social network or living/ working/school
 - 5 environment will affect their ability to engage in treatment and recovery?
 - 6 ○ Does the patient have any deficits in social/interpersonal skills or skills of daily living
 - 7 that prevent them from functioning effectively in their environment?
 - 8 ○ Is the patient able to use community and social support if they are available?
 - 9 ○ Does the patient's current environment have sufficient daily structure and social
 - 10 supports to aid in recovery?
- 11 • **Safety in current recovery environment**
 - 12 ○ Does the patient's current living environment subject them to physical, emotional,
 - 13 sexual or any other form of abuse?
 - 14 ○ Are there other factors in the patient's current living environment that could
 - 15 compromise their recovery
- 16 • **Support in current recovery environment**
 - 17 ○ Does the patient have sufficient support in their current recovery environment to help
 - 18 the patient cope with cravings to use or other recovery threats?
 - 19

20 Dimension 6 (Readiness and Resources)

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

- 23 • Is the patient able to attend the recommended Level of Care?
 - 24 ○ Are any services or resources needed to enable the patient to participate in the
 - 25 recommended Level of Care (e.g., transportation, childcare, financial, etc.)?
 - 26 ○ Are these services/resources available to the patient and sufficient to enable them to
 - 27 participate in the recommended LOC?
 - 28 ○ If not, how should the LOC be adjusted?
- 29 • Assuming the patient has sufficient resources and services are available, is the patient
30 willing to attend the recommended Level of Care?
 - 31 ○ If not, what treatment services are acceptable to the patient?
 - 32 ○ If the patient's preferred treatment setting is adjudged to be unsafe or is unlikely to
 - 33 be effective, what can be done to increase the patient's willingness to attend
 - 34 treatment at the recommended Level of Care (e.g., motivational enhancement
 - 35 therapy, family counseling)?
 - 36 ○ Is the patient being compelled to follow clinical recommendations by an external
 - 37 source? If so, what are the requirements?
 - 38

39

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

- 1 ○ Importance of recovery support services
- 2 • Provide services appropriate to the personal and cultural identity of the patient
- 3 ○ Working effectively with a translator when needed
- 4 ○ Deliver services with cultural humility and trauma responsiveness
- 5 ○ Understanding how gender can influence SUD and mental health treatment needs
- 6 and preferences
- 7 ○ Understanding the core concepts of gender sensitive and responsive care
- 8 ○ Demonstrates cultural humility and openness to understand and respond to patients
- 9 needs related to their individual culture, including race, ethnicity, sex, sexual
- 10 orientation, gender, socioeconomic status, religion, etc.
- 11 • Awareness of available treatment and recovery support service resources
- 12 • Recognizing the social, economic, and cultural contexts within which addiction exists,
- 13 including:
 - 14 ○ Effects of other stigma and discrimination
 - 15 ○ Social determinants of health
 - 16 ○ Effects of racism, including structural racism
 - 17 ○ Risk and resiliency factors of individuals and groups
- 18 • Understanding the principles of harm reduction, including but not limited to:
 - 19 ○ The importance of educating patients and their support network about harm
 - 20 reduction techniques
 - 21 ○ Overdose prevention and reversal
- 22 • Collaborating with an interdisciplinary care team
- 23 • Behavior management techniques, including de-escalation
- 24 • Managing violent or threatening behaviors
- 25 • Response to urgent biomedical or psychiatric situations (including those that occur on-site)
- 26 • How and when to consult supervisor/chain of command
- 27 • Responding to requests to change treating providers
- 28 • Documentation of services provided, consistent with clinical and regulatory standards and
- 29 with relevant medical necessity requirements, with awareness of utilization management
- 30 needs
- 31 • The use of electronic health records and other health technologies used by the program
- 32 • Provision of patient-centered, whole-person care
- 33 • Communicating with patients and their families/significant others, as well as other
- 34 professionals and staff, with empathy, respect, compassion, and understanding, including
- 35 awareness of stigmatizing language
- 36 • Following federal and state privacy and confidentiality laws and regulations
- 37 • Work effectively in a multidisciplinary team
- 38 • Ethical considerations for providing SUD treatment and related services
- 39 • CPR
- 40

41 Recommended competencies for physicians and advanced practice providers

- 42 • Advanced understanding of *The ASAM Criteria*:
 - 43 ○ Assessment and treatment planning
 - 44 ○ Dimensional admission criteria, including risk ratings
 - 45 ○ Dimensional drivers of care at each level of care
 - 46 ○ Medical capabilities at each level of care

- 1 • Advanced understanding of the core medical knowledge about SUD and SUD-related health
2 conditions, including:
 - 3 ○ Epidemiology and etiology of addiction
 - 4 ○ Neurobiology and genetics of addiction
 - 5 ○ Pharmacodynamics of commonly used substances
 - 6 ○ Pathophysiology and neuropsychological effects of chronic substance use and SUD
 - 7 ○ Common comorbid medical and co-occurring psychiatric conditions associated with
 - 8 SUD
 - 9 ○ Fetal and neonatal effects of commonly used substances and associated intoxication
 - 10 and withdrawal
- 11 • Assessment and Diagnosis
 - 12 ○ Perform an appropriate physical examination and detect physical signs of acute use
 - 13 (i.e., intoxication and withdrawal), chronic use, and complications of substance use
 - 14 (e.g., skin infections)
 - 15 ○ Conduct an accurate patient history including substance use history, trauma history,
 - 16 and addiction and mental health treatment history
 - 17 ○ Screen for and diagnose SUD, intoxication, withdrawal, and common comorbid
 - 18 medical and co-occurring psychiatric conditions
 - 19 ○ Formulate a reasonable differential diagnosis related to:
 - 20 ▪ Signs and symptoms of acute substance use, intoxication, and withdrawal
 - 21 ▪ Standard diagnostic criteria for Addiction Disorders
 - 22 ▪ Common comorbidities including biomedical, psychiatric, and obstetrical
 - 23 complications of substance use
 - 24 ○ Explain diagnosis to the patient and explain rationale for treatment
 - 25 ○ Order appropriate diagnostic tests (routine laboratory tests, drug tests, diagnostic
 - 26 images) and interpret laboratory findings
 - 27 ○ Toxicology testing
 - 28 ▪ Understanding benefits and limitations
 - 29 ▪ Able to collect, interpret, and monitor toxicology data for patient treatment
 - 30 needs
 - 31 ▪ Understanding how toxicology testing can support monitoring of adherence to
 - 32 medications
 - 33 ▪ Use, interpret and respond to drug testing results
 - 34 ○ Use, interpret, and respond to prescription drug monitoring program reports.
 - 35 ○ Use of ECG rhythm strip evaluation ruling out malignant arrhythmias such as non-
 - 36 sustained venous tachycardia, previously undiagnosed atrial fibrillation, sinus
 - 37 bradycardia and tachycardia
 - 38 ○ Understanding the role of PDMPs and the benefits and limitations of the data in the
 - 39 local PDMPs
- 40 • Treatment and Treatment Planning
 - 41 ○ Pharmacological management of intoxication, withdrawal, and SUDs
 - 42 ○ Able to direct the medical management of:
 - 43 ▪ Acute withdrawal and intoxication
 - 44 ▪ SUD
 - 45 ▪ Common medical and psychiatric comorbidities
 - 46 ○ Able to provide medical management for common, low-complexity psychiatric
 - 47 conditions, using appropriate assessment instruments to guide “treat to target”
 - 48 decision-making

- 1 ○ Provide brief intervention, secure appropriate consultations, and make referrals for
- 2 specialty treatment of addiction and other medical and psychiatric conditions
- 3 ○ Design a management plan to address non-adherence and treatment failure.
- 4 ○ For psychiatric and biomedical issues
- 5 ▪ Determining what is the primary driver of the patient's risks
- 6 ▪ Determining when to transfer/refer to other specialty systems
- 7 ○ Understanding of unique clinical considerations related to:
- 8 ▪ Older adults
- 9 ▪ Safety Sensitive Populations
- 10 ▪ Pregnancy, perinatal, and postpartum care (parent-infant dyad)
- 11 ▪ Intravenous drug use
- 12 ▪ Pre and post operative care
- 13 ● Care Coordination
- 14 ○ Able to lead multidisciplinary treatment teams in medically managed treatment
- 15 programs
- 16 ○ Consult with other treatment resources as appropriate
- 17 ○ Able to coordinate care with specialty biomedical and mental health treatment
- 18 providers to support an integrated treatment plan
- 19 ● Working with and leading an interdisciplinary team with non-medical staff
- 20 ● Knowledge of the neurobiology of pain and ability to manage pain in patients with addiction,
- 21 including:
- 22 ○ Conducting a pain-focused history and physical examination
- 23 ○ Using validated and reliable tools for measuring function in patients with pain
- 24 ○ Prescribing pharmacotherapy, initial dosing, and titrating according to patient health
- 25 status and risk factors for patients with pain and substance use disorder
- 26 ○ Coordinating with other healthcare professionals, including when recommended
- 27 treatment options may pose risk for harms and alternative interventions may be
- 28 needed
- 29 ○ Prescribing non-pharmacologic therapies to help manage pain.
- 30 ○ Design a treatment plan for patients with pain with attention to patient and family
- 31 centered goals.
- 32 ○ Determining the difference between malignant and non-malignant pain
- 33 ○ Knowing when to refer to a pain specialist
- 34 ○ Ability to determine whether pain significantly hinders SUD recovery
- 35 ○ Ability to coordinate care with pain specialist
- 36 ● Understand the importance of families/significant others in addressing substance issues and
- 37 communicate with them effectively as appropriate
- 38

39 Recommended competencies for addiction specialist physicians

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

- 42 ● Be able to supervise and teach other health care professionals
- 43 ● Able to direct the medical management of:
- 44 ○ Addiction, at any level or intensity of treatment
- 45 ○ Substance use related psychiatric and medical emergencies
- 46

1 Recommended competencies for other professional medical staff (RNs, LPNs, 2 MAs, etc.)

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

- 1 ○ observation and supervision
- 2 ○ determination of appropriate level of care
- 3 ○ facilitation of the patient's transition to continuing care
- 4

5 Recommended competencies for all clinical staff

- 6 • Basic understanding of the core medical knowledge about SUD and SUD-related health
- 7 conditions, including:
 - 8 ○ Epidemiology of addiction
 - 9 ○ Neurobiology and genetics of addiction
 - 10 ○ Biological and psychological effects of commonly used substances
 - 11 ○ Biological and psychological effects of chronic substance use and SUD
 - 12 ○ Common comorbid medical and psychiatric conditions associated with SUD
 - 13 ○ Efficacy and benefits of addiction pharmacotherapies
- 14 • Knowledge of evidence-based psychosocial treatments
- 15 • Psychoeducation related to the interaction of substance use and common biomedical and
- 16 psychiatric comorbidities (e.g., HIV, HCV, COPD, depression, anxiety, etc.)
- 17 • Screening and assessment for SUD and co-occurring psychiatric conditions using validated
- 18 instruments to both identify symptom severity and to monitor treatment progression
- 19 • Able to perform a crisis assessment
- 20 • Supporting symptom management for patients with co-occurring psychiatric conditions
- 21 • Working with mental health treatment providers to deliver integrated care for patients with
- 22 co-occurring psychiatric conditions
- 23 • Screening for:
 - 24 ○ Psychoactive intoxication and withdrawal signs and symptoms
 - 25 ○ Danger to self or others
- 26 • Care coordination with other providers involved in a patient's care
- 27 • Conduct an accurate patient history including substance use history, trauma history, and
- 28 addiction and mental health treatment history
- 29 • Recognize the potential for substance use disorders to mimic a variety of medical and
- 30 mental health conditions
- 31 • Understanding of how adverse childhood experiences (ACEs) impact SUD and co-morbid
- 32 psychiatric disorders
- 33 • Describe the behavioral, psychological, biomedical, and social effects of substance use to
- 34 patients and their support network
- 35 • Recognize the importance of family, social networks, and community systems in the
- 36 treatment and recovery process
- 37 • Describe a variety of strategies for reducing the negative effects of SUD and addiction
- 38 • Be familiar with local treatment resources for SUD and common comorbidities
- 39

40 Recommended competencies for master's level clinical staff

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

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

- 1 • Dimensional drivers of care at each level of care
- 2 • Medical capabilities at each level of care
- 3 • Understand the established diagnostic criteria for SUD
- 4 • Knowledge of evidence-based psychosocial treatments
- 5 • Be familiar with medical and pharmacological resources in the treatment of substance use
- 6 disorders and their comorbid conditions
- 7 • Managing and supervision of a clinical team
- 8 • Monitoring the quality of care delivered by clinical staff
- 9

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

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

28
29
30

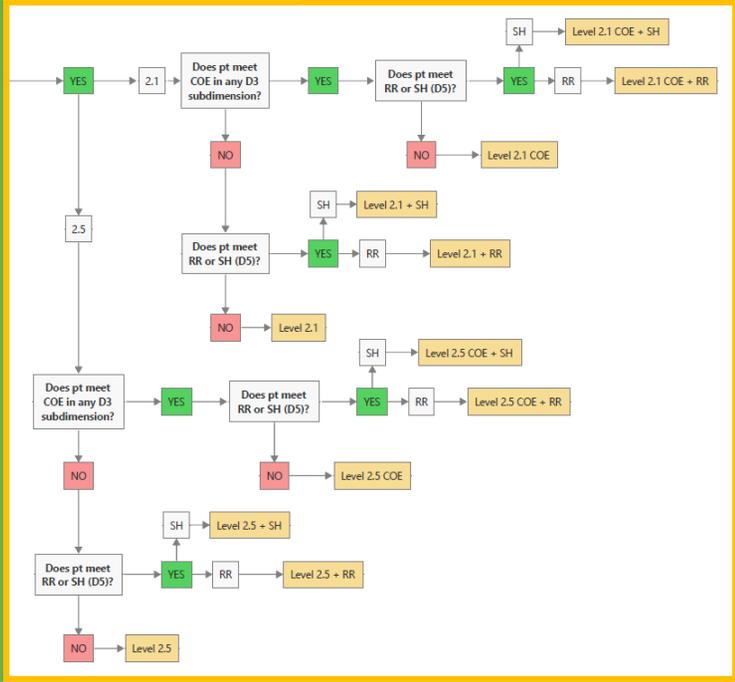
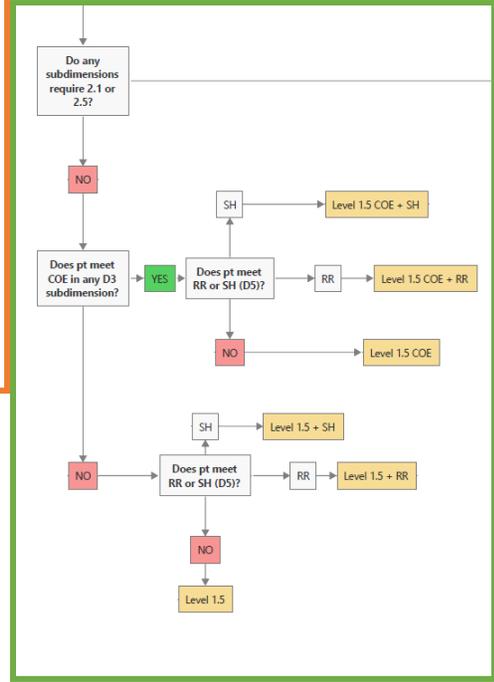
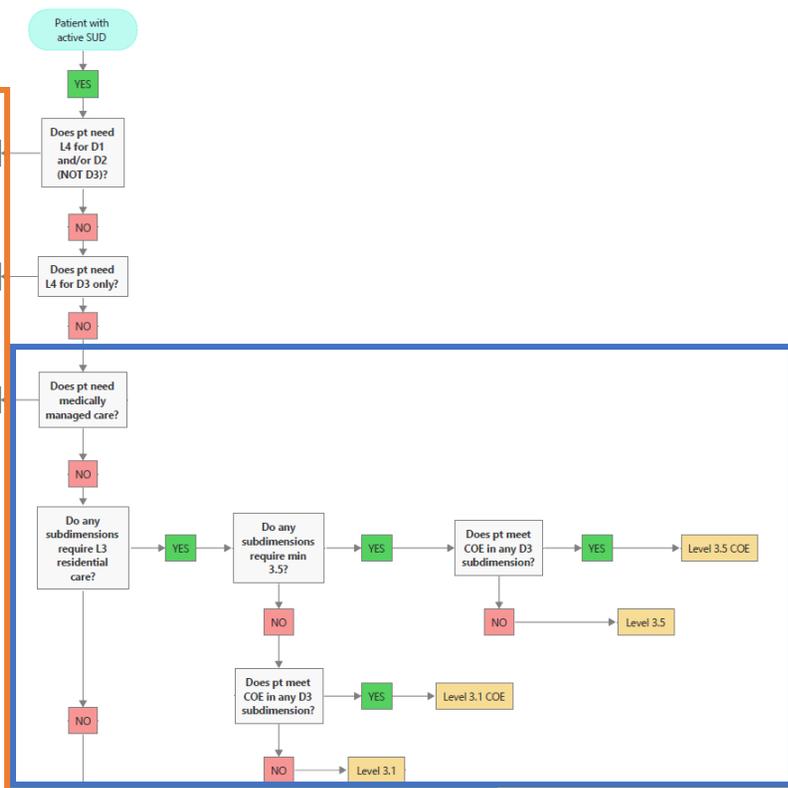
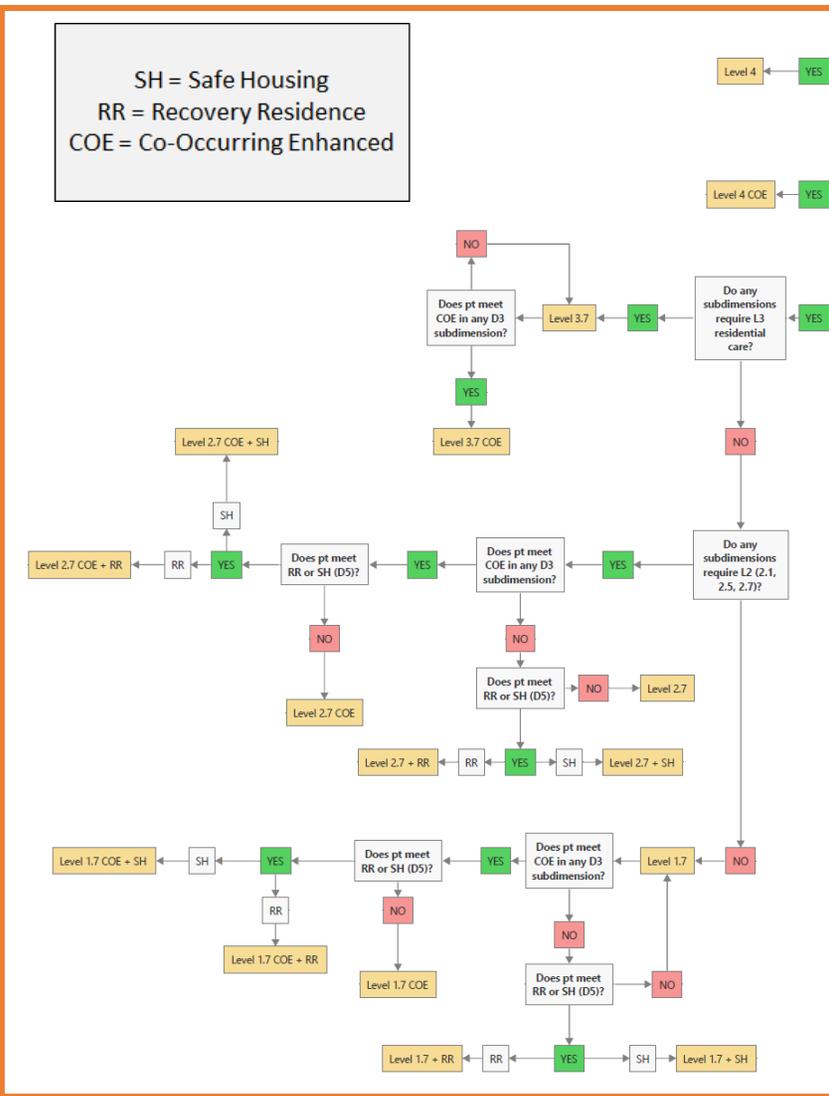
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Appendix C – Draft Table of Contents

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ASAM Criteria 4th Edition Proposed Decision Tree

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

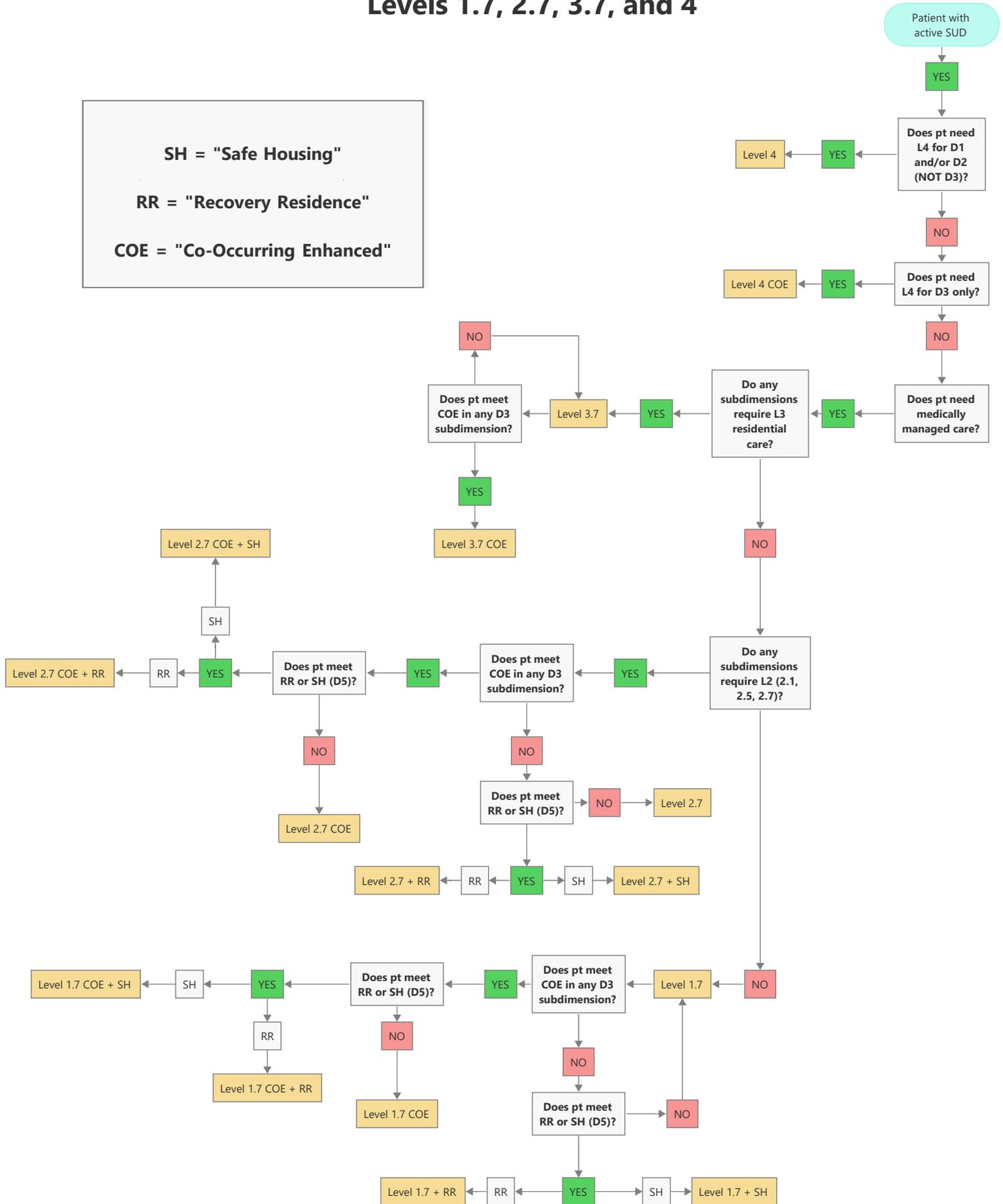


The following pages show each section of the decision tree in higher resolution

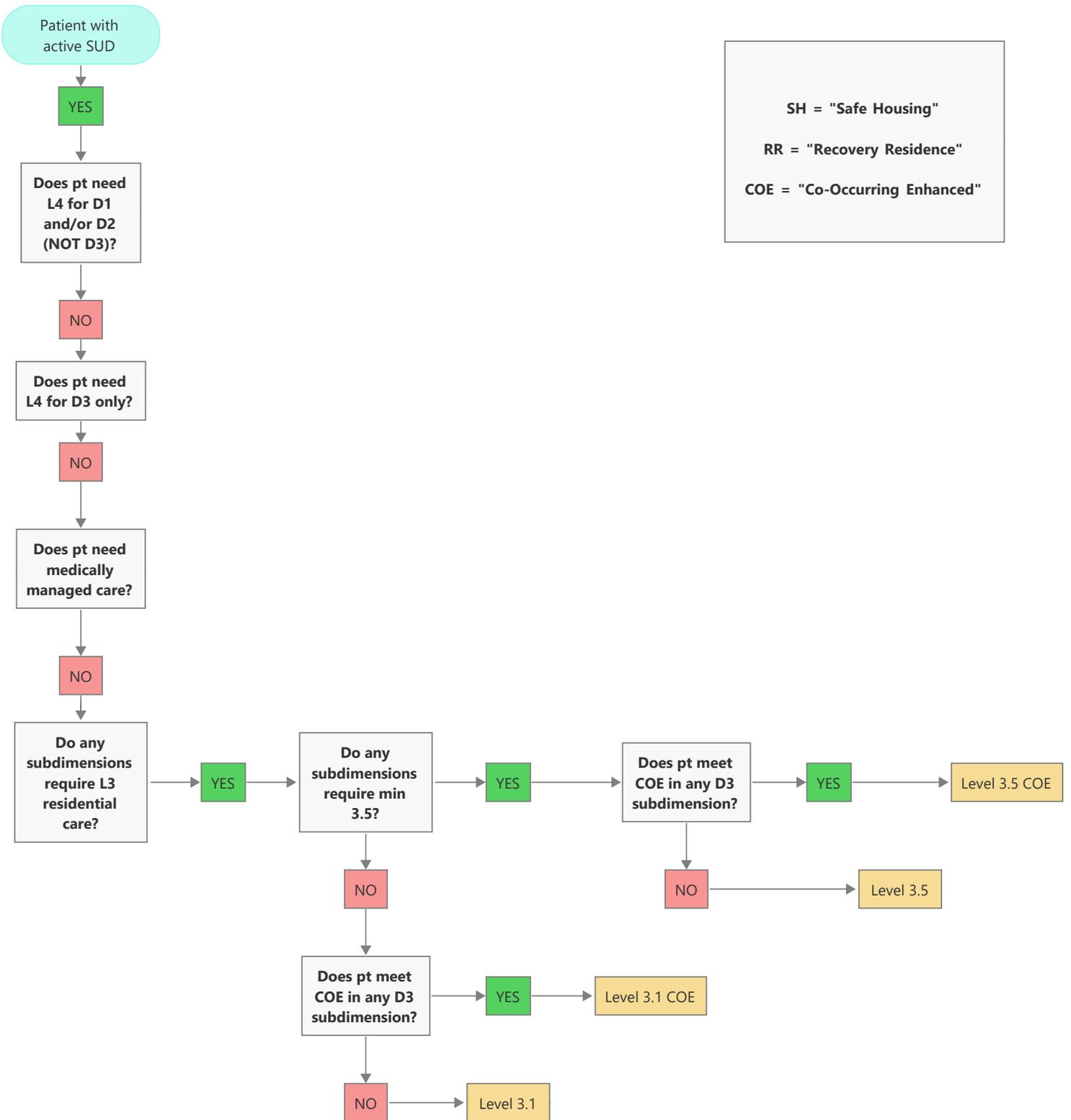
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Levels 1.7, 2.7, 3.7, and 4

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

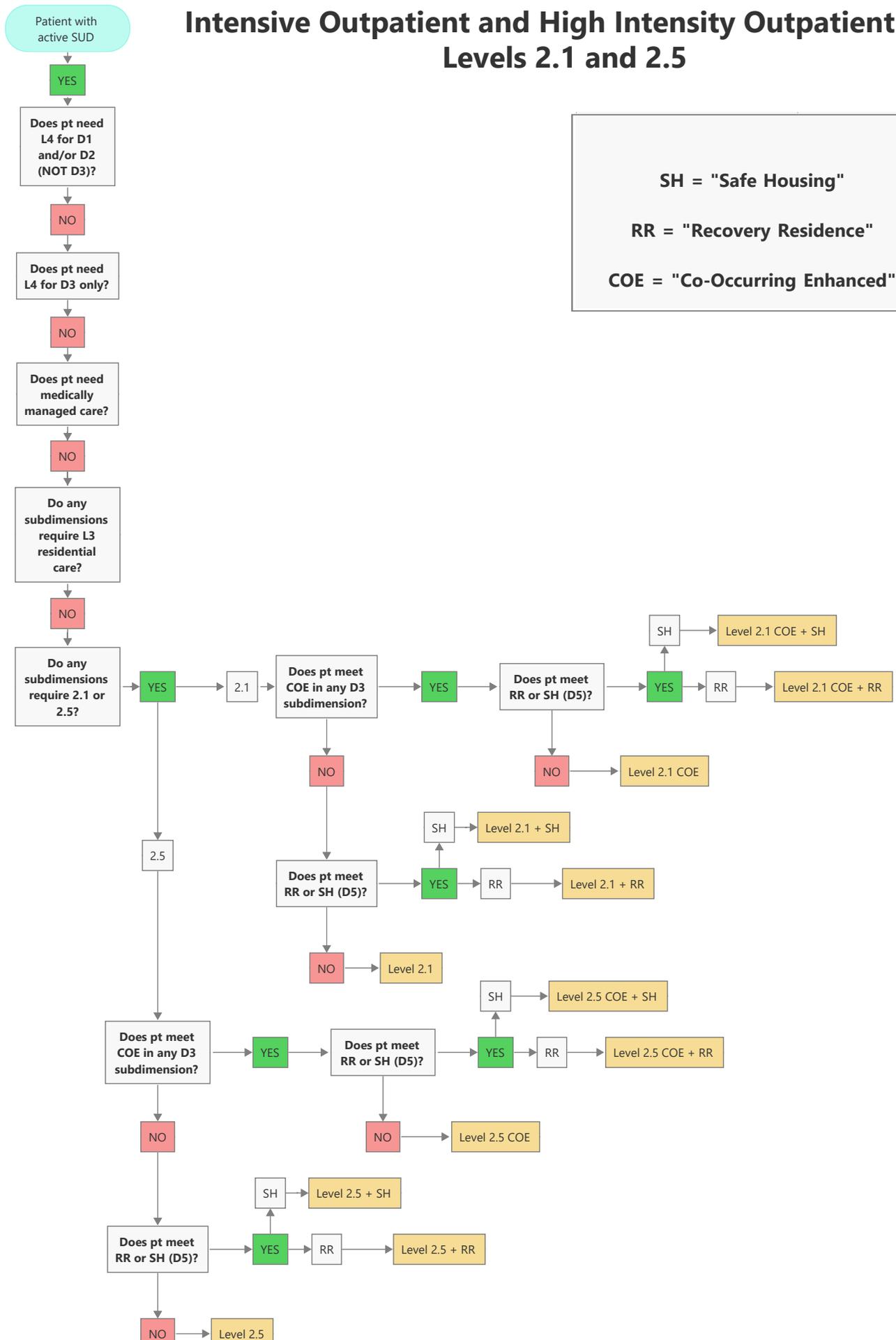


Residential Levels 3.1 and 3.5



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

Intensive Outpatient and High Intensity Outpatient Levels 2.1 and 2.5



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

Outpatient Level 1.5

SH = "Safe Housing"

RR = "Recovery Residence"

COE = "Co-Occurring Enhanced"

