



ASAM American Society of
Addiction Medicine

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Proposed updates to the 4th Edition of The ASAM Criteria

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 intensity of treatment and the staff and services needed for each level of care. 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. Since the release of the 3rd Edition in 2013 there has been widespread adoption of The ASAM Criteria by treatment programs as well as payors and managed care organizations and states across the country are using these standards as the foundation of efforts to improve their addiction treatment systems.

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. ASAM staff and the editorial team carefully analyzed this feedback. This input, along with their knowledge of evolving systems of care, research advances, and their own clinical experiences in implementation of The ASAM Criteria informed the framework of major changes proposed in this document.

The proposed changes in this document are preliminary. ASAM is seeking input from stakeholders to understand any potential unintended consequences for providers, treatment programs, state and local policy makers, health plans, patients, and families. 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. ASAM is hoping to publish the 4th Edition in 2023.

Major Changes Proposed for the 4th Edition

The editorial team identified the following areas of focus in developing updated for the 4th Edition of The ASAM Criteria.

Updating the continuum of care to reflect the evolving treatment system

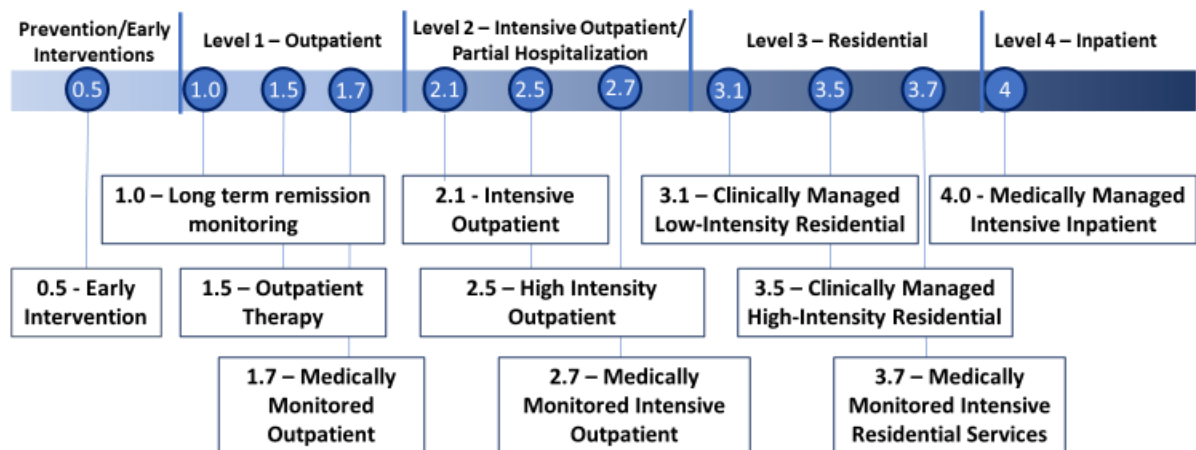
Expanding Levels of Care within Level 1

Addiction treatment has evolved significantly since the development of the 3rd Edition of The ASAM Criteria, particularly with the expansion of the types of low to moderate intensity care that occur in outpatient settings. The current Level 1 incorporates a broad range of services that

occur in ambulatory care setting. The editorial team is proposing to expand the levels of care to provide more detailed standards for the care that occurs at Level 1, including:

- Level 1.0 – Long-term Remission Monitoring
 - Consistent with the chronic care model of treatment, this level would provide ongoing monitoring for patients who have achieved long-term remission. Treatment at this level of care could include ongoing medication management services for patients who are stable in remission. This level of care will not be tied to a specific location of treatment as continuity of care may at times be best provided by the same provider or program that helped the patient achieve remission. This proposed level would reflect a set of services and capabilities that could be provided by a variety of providers or programs, depending upon where the patient is most comfortable.
- Level 1.5 – Outpatient therapy
 - In the 3rd Edition, Level 1 incorporates multiple distinct types of care, including outpatient therapy. The proposed Level 1.5 would be consistent with the current Level 1 but would delineate the expectations for this specific type of treatment.
- Level 1.7 – Medically Monitored Outpatient Care
 - This proposed level would include specialty office based opioid treatment, opioid treatment programs, as well as low intensity, medically monitored, ambulatory withdrawal management services.

The ASAM Care Continuum for Addiction Treatment – Adult



Updating Level 3.7 to reflect care in residential settings

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

individuals receiving care at this level and to align standards with those of skilled nursing facilities, acute inpatient rehabilitation facilities, and long-term acute care hospitals (LTACH).

Better integration of biomedical services in the continuum

Identification of programs that provide biomedically enhanced treatment services (BIO) is currently difficult and these programs are not generally recognized as a distinct, more intensive level of care. This misconception can put patients at risk if the treatment offered does not provide the appropriate services for an unstable biomedical problem. The editorial team is proposing the integration of BIO service standards into the continuum of care within levels 1.7, 2.7, and 3.7, as these levels have the medical monitoring and nursing staff to integrate appropriate biomedical care.

Clarify how recovery residences fit into the continuum of care

For many patients, the need for recovery supportive housing with a supportive social milieu and/or supportive housing may extend past the need for residential treatment. ASAM and the editorial team are working with the National Association of Recovery Residences (NARR) to define how the ASAM levels of care should be integrated with the NARR recovery residence standards.

Better integration of withdrawal management services into the continuum of care

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

- Levels 1.7 – Medically Monitored Outpatient Care
 - This proposed level would provide services consistent with the current Level 1-WM, Ambulatory Withdrawal Management without Extended On-Site Monitoring.
 - As discussed above, this level would also have the capacity to provide services consistent with the current Level 1 BIO.
- Level 2.7 – Medically Monitored Intensive Outpatient Care
 - This proposed level would provide services consistent with the current Level 2-WM, Ambulatory Withdrawal Management with Extended On-Site Monitoring.
 - As discussed above, this level would also have the capacity to provide services consistent with the current Levels 2.1 BIO and 2.5 BIO.
- Level 3.7 - Medically Monitored Intensive Residential Services
 - There is currently significant confusion in the field between Level 3.7 and Level 3.7 WM. The setting, staffing, and other service characteristics are not significantly different. In addition, the current level 3.7 is not distinguishable from Level 3.5 with BIO.

- This proposed level would provide services consistent with the current Level 3.7 WM, Medically Monitored Inpatient Withdrawal Management.
- As discussed above, this level would also have the capacity to provide services consistent with the current Levels 3.1 BIO and 3.5 BIO.

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

Encourage improved continuity of care along the continuum

Eliminate steep drop-offs in the intensity of clinical services

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

Facilitate transitions of care within programs

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

Better Implementation Support for the ASAM Criteria Standards

Addiction is a complicated biopsychosocial illness. The process of determining appropriate treatment is similarly complex. However, the editorial team is working to simplify the presentation of the standards to improve clarity and support implementation with greater fidelity. In the 4th Edition, the editorial team current plans include (but are not limited to):

- Clearly delineating the assessment and treatment planning process by:
 - Describing standards for an intake assessment to make determinations for initial patient placement versus a full biopsychosocial assessment used for treatment planning purposes.
 - Providing a standardized treatment planning template.
 - More fully describing the process for collaborating with the patient to develop a treatment plan based on the results of the multidimensional assessment.
 - Describing standards for how the treatment plan should be updated based on reassessments.
- Defining the critical “subdimensions” that should be assessed during the multidimensional assessment. For example, discuss the standards for assessing trauma within Dimension 3

and how to determine what services need to be delivered based on the assessed needs in this subdimension.

- Organizing the admission criteria with a “dimension forward” approach focusing on which dimensions drive admission to each level of care and which dimensions need to show improvement to support transition to a less intensive level of care.
- Providing more standardized tools to support implementations (e.g., a standard medical necessity form).

Updating the standards to reflect evolving priorities of the field

To reflect the evolving needs of the field the 4th Edition the editorial team will seek to:

- Promote more integrated care for co-occurring mental health conditions by incorporating standards for co-occurring capable care into the core standards for each level of care.
- Promote better integration of SUD treatment into general healthcare. For example, emphasizing the role of primary care providers in managing patients with stable SUD and the role of emergency departments in initiating treatment and supporting engagement in ongoing care.
- Define standards within each level of care for providing coordination of biomedical services (e.g., referrals to primary care or specialty care, coordination with those providers, overseeing medication adherence, etc.).
- Emphasize the importance of treating this chronic disease with a team-based chronic care model, including incorporating standards for remission monitoring as discussed above.
- Discuss the unique treatment needs of lesbian, gay, bisexual, and transgender.
- Address how social determinants of health influence prognosis and how they should be addressed within the treatment plan.
- Discuss how telehealth, mobile treatment services, and digital therapeutics can be incorporated into treatment.
- Incorporate principles of measurement-based care to support a patient-centered approach to symptom and progress monitoring.
- Update the language throughout to reflect evolving terminology in the field.
- Review and update the standards with a focus on diversity, equity, and inclusion.

Incorporate treatment of individuals with cognitive impairments across the continuum

Currently the continuum of care includes Level 3.3 which is focused on providing services to individuals with cognitive impairments that can impact their ability to benefit from standard treatment services. Despite the prevalence of cognitive problems in patients with addiction (due to the direct and indirect effects of substance use, withdrawal, and post-acute withdrawal; as well as the increased prevalence for addiction in individuals with traumatic brain injuries and other conditions associated with cognitive impairments), very few Level 3.3 programs exist across the country. This level of care remains misunderstood. In addition, patients with cognitive impairments may benefit from services at other levels of care. Therefore, the editorial team is proposing to eliminate Level 3.3 and add a chapter that discusses standards for addressing cognitive impairments within any level of care in the continuum.

Support Better Communication of Medical Necessity

Health plans and managed care organizations use The ASAM Criteria for medical necessity determinations, and states across the country have begun mandating that The ASAM Criteria standards be used for this purpose. As a result, many health plans, managed care organizations, and providers utilize the current edition of the ASAM criteria to communicate requests for payment and determine if these requests meet medical necessity. Some states have also incorporated elements of the ASAM criteria into their service definitions. The 4th Edition editorial team applauds the efforts of policy makers, payers, and providers in their efforts to utilize the ASAM Criteria as a shared language. At the same time, the ASAM editorial team recognizes that variance exists in how the ASAM Criteria are implemented by these stakeholders. The 4th Edition of the ASAM criteria will take a patient-centered and dimension forward approach to medical necessity by developing more standardized medical necessity criteria as well as standards for medical necessity documentation. This approach is intended to reduce the variance in implementation and usage.

Supporting implementation for justice-involved individuals and behavioral addictions

While the current edition of The ASAM Criteria discusses the care of justice-involved patients and the treatment of behavioral addictions, it does not provide sufficient detail to support implementation in these settings. ASAM plans on releasing separate volumes on these topics. These volumes will describe comprehensive, implementable standards regarding:

- Assessment
- Level of care determination
- The continuum of care that should be available within jails and prisons
- Continuity of care for individuals who are returning to the community

Provide more complete standards and decision rules for adolescent treatment

In the 3rd Edition of The ASAM Criteria, standards and admission criteria for adolescents were interwoven with standards for adult. In addition, research on the treatment of adolescents has evolved significantly since these standards were last updated. ASAM plans on releasing a separate volume for adolescents and transition age youth to comprehensively cover these topics.

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