Q12 Level 1: Overall: Is this level clearly delineated? If no, tell us how it could be clarified.

Answered: 40 Skipped: 184

#	RESPONSES
1	yes
2	yes, clearly delineated
3	As stated earlier, our regulatory oversight has ASAM embedded in our regulatory standards - thus, the ASAM criteria and our state regulation, as well as CARF standards align fairly well.
4	Yes.
5	Yes level one is clearly delineated.
6	n/a
7	Yes, it is very clear.
8	Need more specific time framing for achieving abstinence once treatment has begun. Do they need a specific number of of relapses in order to advance levels? More specifications related to the substance of use (meth vs marijuana). How to address marijuana since now legal and used as
9	Consider adding language to recognize and formalize criteria and recommendations for providers working with people who use/are addicted to stimulants such as cocaine, crack cocaine, and amphetamines.
10	yes
11	Assertive outreach has to be categorized as a type Level One Tx.
12	Yes
13	Yes it is.
14	Yes
15	yes
16	Programs struggle at times with developing a distinct Level 1 program that is available for persons that meet the criteria at admission. I also think it would be good to describe using a distinct Level 1 care for individuals transitioning from Level 2.1
17	Speaking to Level 1 outpatient, the level is clearly explained. However, there may need to be more understanding of how Level I-D works into this for Medication Assisted treatment. In the Level 1 outpatient services, it does not reference Level I-D exceptions/additions.
18	The level is not specific to substance abuse issues; it is a wide range between intoxication and withdrawal. This range can differ vastly throughout a patients treatment episode.
19	No. I feel like there needs to be more to separate Level I from Early intervention. There are times where someone doe snot have a diagnosis but needs to be in Level I over EI and insurance does not allow that or cover it.
20	yes
21	Yes, this level is clearly deliniated.
22	a
23	Severity ratings of the ASAM may not be clearly identified due to the county utilizing their own
24	Yes.
25	n/a
26	IT IS CLEARLY DELINEATED
27	Yes, I would say so.
28	yes
29	Yes.

30	Why don't we educate the families to demand this be used and to have the clinical team address its value when using it with the family members. If they start talking the language, the clinical people will have to respond.
31	MAT in OTP program is considered 1.0 but is very different than traditional 1.0. I would say it is a special LOC in between 1.0 and IOP
32	I think it is clearly delineated overall.
33	yes
34	It would be better to redefine level 1 as aftercare or recovery services. Having sub-levels within level 1 can be confusing. We provide outpatient treatment, which is part of level 1.
35	Yes
36	It is
37	Yes
38	It is yes, but would want to be very clear that Level 1 includes up to 9 hours/week of clinical services; also there are times when Level 1 or Level 1-WD might benefit from bundled billing like
39	.
40	It is clearly delineated in terms of scope, duration, and intensity/frequency Established matrices for individual and group programs are utilized

Q13 Level 1: Overall: What is working well?

Answered: 28 Skipped: 196

#	RESPONSES
1	As previously mentioned, having a set of standards to operate from is very beneficial to the organization, our policy and procedure development as well overall treatment delivery, insurance interface, as well as the patient treatment experience is related to having standards to operate
2	Our team is able to reach individuals in a wide number of life situations w/ quality substance use treatment services.
3	We have a good supply of level one providers, including 88 Opioid Treatment Programs (OTPs).
4	n/a
5	The delineation.
6	Fair
7	Yes
8	The placement criteria works well...also the 6 Dimensions in assessment.
9	Yes
10	Easily understandable.
11	The clinical presentation of the patient allows us to select this level and establish a plan for all substance use patients.
12	the entry level of treatment for these individuals and for continued care after a higher level of care
13	a
14	The assessment helps us to tease out those who qualify for LOC 2, but who may benefit from starting at LOC 1, due to treatment resistance and/or no prior treatment experience.
15	ALL SIX DIMENSIONS ARE WORKING WELL FOR US.
16	Identifying treatment goals based on Dimensions 4-6.
17	Clear
18	Treatment planning, referrals
19	It can be modeled in a learning seminar are a tool the family takes with them, a sort of check list for the family.

20	Looking at the dimensions and criteria which clearly puts the patients in specific levels and ratings overall works well.
21	Having an entry level of treatment for clients is great.
22	our agency is supportive of the continuity of the standardize training and structure of the ASAM.
23	Practices makes perfect.
24	assessment of who is appropriate for outpatient groups
25	The ASAM allows me to understand exactly what a client would need to focus on in outpatient treatment and is an effective tool for treatment planning.
26	Flexibility; variety of types of staff; incorporation of withdrawal management
27	.
28	Access and intake are working well Retention has been good overall

Q14 Level 1: Overall: What challenges have you observed?

Answered: 33 Skipped: 191

#	RESPONSES
1	None noted at this time.
2	It's been tough to link clients to 1.0 and keep them engaged. Clients frequently need a higher level of care, but aren't willing to participate in a higher level, so experience limited progress and contiuing impairment while participating in 1.0 treatment.
3	Challenges relate to individuals who have substance use disorders and serious and persistent mental illness. Some programs struggle with managing mental health disorders and although they report are co-occurring capable or enhanced they seem to have difficulties engaging this
4	Guidance is needed in terms of length of stay and elimination of program-driven care. Providers focus on length of stay, rather than emphasis of treatment required for the individual receiving services. There is no research behind the length of stay in residential settings, nonetheless, providers have created admission and treatment protocols around fixed episodes of care. Integrating measurement-based care would help residential and OP treatment programs in transitioning from fixed episode of care, based on historical funding protocols, to patient-centered care, based on reliable metrics of progress. We suggest including existing scales, such as the brief addiction measure (BAM) and other metrics, such as employment, housing stability or reductions in substance use via biomarkers or developing hybrid measures. The goal would be to use these tools across the continuum to assist providers in determining progress as well as tailoring lengths of stay within a level of care. Enhanced guidance is needed on the application of individualized treatment towards everyone receiving services, not only people that might fall into a specialty population. A related metric is continuum of pharmacological treatments across levels of care. Treatment providers in PA continue to view pharmacological interventions as separate from ASAM levels of care, instead of an essential element within all levels of care. We suggest emphasizing pharmacological interventions as essential elements within and across the four levels of care in the next edition. Notably, the menu of evidence-based medications for SUDs will likely expand before and after the next evolution of ASAM criteria. Treatment providers will need to integrate medical staff within all levels of care to assist individuals on the ever-growing list of effective medications for
5	None.
6	The criteria are very subjective.
7	Consider adding language to recognize and formalize criteria and recommendations for providers working with people who use/are addicted to stimulants such as cocaine, crack cocaine, and amphetamines.

8	Assertive outreach has to be categorized as a type Level One Tx. State and private insurance will not reimburse this service which follows ASAM criteria. IT needs to be specifically delineated.
9	None identified
10	Honestly, not many.
11	None
12	None, other than referencing MAT services as noted above.
13	Clinicians have different definitions of what warrants level 1 based on their own experiences, the substance the client is using, the willingness of the client, etc. One person could assess and think they needed residential, while the other could say the client could benefit from outpatient with a firmly wrapped treatment model. The model is too subjective!
14	Patient severity within the defined level can change drastically through their treatment episode.
15	none
16	a
17	none
18	GETTING PAST THE STAKEHOLDER'S DENIAL.
19	Identifying treatment goals in Dimensions 1-3 can be a bit nebulous.
20	Provider responses tend to be yes or no - there is no elaboration. If sxs are present they are not identified & in other areas of clinical it is not spelled out to what a plan will be for addressing such
21	No challenges
22	Format cumbersome, poorly worded in some instances, required to be updated too frequently for time management purposes, repetitive at some points, unclear verbiage
23	Long documentation times which leads to longer time documenting vs. providing treatment or
24	Getting youth to engage in the process can be a challenge. We are finding that the juvenile court is no longer holding the kids accountable which makes it harder for use to keep them engaged and
25	Referral process is unclear. There is no follow through with messages to services and no one answers the phones.
26	The assessment is very long and takes a lot of staff time to complete with the other required documentation for the an assessment and intake.
27	Not much anymore.
28	Clinician's lack of knowledge regarding the ASAMS
29	It has been challenging due to the sheer amount of level 1 clients that I have had. Understandably, we want to work at the least restrictive environment, however, it sometimes seems like level one is used more as a holding place for client's who MIGHT be a higher level but are not appropriately
30	Payment/reimbursement issues, esp for individualized care plans
31	Sometimes hard to articulate the role of peer specialists in Level 1; also at times hard to articulate bundled programs that may offer what people need in less than 9 hours/week but more than one therapy service a week; also at times hard to integrate case management services, which are more and more incorporated into Level 1.
32	.
33	Patients who clearly require higher levels of care are without access, and are winding up in level 1 treatment due to lack of resources and funding.

Q15 Level 1: Overall: What changes would you recommend for the 4th edition of The ASAM Criteria?

Answered: 30 Skipped: 194

#	RESPONSES
1	We would like to see ASAM Criteria for peer recovery support services under ASAM level 1.
2	None noted at this time

3	None noted.
4	Provide more details on the staffing per patient ratio and more information on what a co- occurring enhanced program should look like.
5	More emphasis on family involvement in all levels of care and inclusion of measurement-based
6	None.
7	Less subjective, more specific criteria (numbers, time frames).
8	Consider adding language to recognize and formalize criteria and recommendations for providers working with people who use/are addicted to stimulants such as cocaine, crack cocaine, and amphetamines. Additionall
9	Assertive outreach has to be categorized as a type Level One Tx.
10	at this point none.
11	None
12	Per the first comments, providing clarity on developing 2 level 1 tracks, one for individuals who are appropriate for this level at intake and another that is specific for person successfully completing Level 2.1.
13	Stated above.
14	Broader categories and less acute details; specific to the sublevels.
15	continued definitions that are specific for guidance
16	a
17	none
18	NONE, AS I FEEL IT IS ACCOMPLISHING IT'S PURPOSE.
19	Some more content describing challenging areas in Dimensions 1-3, with more specifics in the areas of behavioral challenges and impulsivity, which can be present and challenging to identify.
20	something to encourage more specifics
21	Provide a standardized form for LOC selection...check off boxes, etc.
22	Be concise, less wordy. Clarify format and questions. Make the format concise questions vs responses written as if the form is a grant proposal. Make the questions user friendly re: language level for all client educational levels
23	We can make it even more comprehensive where we include even more therapeutic guidelines for therapy and treatment.
24	Make the ASAM less text-book like and more user friendly. I feel like I am picking up a text book when I use it. Additionally the cost makes it so that agencies have one copy for multiple therapists rather than having a copy for each therapist. Therapists are less familiar with the criteria as a result. therapists rather than having a copy for each therapist. Therapists are less familiar with the criteria as a result.
25	If it could be shortened that would be helpful with managing staff time.
26	The format our County uses has gray boxes that are difficult to photocopy. We are still using paper charts.
27	As stated before, it would be nice to not have to update an ASAM for a client who is either not attending or has not been seen for a while as it is impossible to get an accurate update and frankly feels like busy-work to simply re-attest to the previous ASAM without having eyes on the client.
28	Include options for bundling; include a section regarding peer specialists; include a section on Intensive Case Management and Integrated Dual Disorder Treatment (IDDT)/Assertive Community Treatment (ACT)
29	.
30	More focus on the neurobiological characteristics of addiction and SUD's

Q16 Level 1: Standards that relate to treatment setting: what are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 21 Skipped: 203

#	RESPONSES
1	None noted at this time.
2	None noted.
3	Discuss combination of services recommended for those with co-occurring disorders.
4	n/a
5	none
6	Assertive outreach has to be categorized as a type Level One Tx.
7	none.
8	None
9	Stated above.
10	None.
11	none
12	a
13	none
14	I HAVE NONE AS I AM SATISFIED WITH IT AS IS.
15	Some more descriptions for risk ratings 0-1 in Dimensions 1-3 that address PAWS symptoms and impulsivity to make it more clear that they can still be an issue in recovery at this level and still may need to be addressed in this level of care.
16	something to encourage more specifics
17	Recommendc ASAM administration at assessment and level of care changes and at discharge only
18	If it could be shortened that would be helpful with managing staff time.
19	We have always addressed multiple aspects of the client's life on our treatment plans. The County has started Care Coordination to supplement the ASAM. This requires two treatment/service plans rather than one comprehensive one. Just more and more paperwork.
20	.
21	Many level 1 are affiliated with primary care clinics and FQHC or FQHC look-alike facilities and the standards should reflect the capabilities and resources of these facilities.

Q17 Level 1: Multidimensional assessment and treatment planning standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 20 Skipped: 204

#	RESPONSES
1	None noted at this time.
2	Use of paper and electronic assessment tools should be stronly encouraged so that the approach can be tailored toward engaging the client w/ their individual needs.
3	none

4	Further guidance is needed on the definition of individualized treatment. Currently, individualized care is interpreted as needs of specialty populations (i.e. parents with children, LGBTQIA+, veterans), rather than looking at the individual receiving services that might not fall under a specialty population, but still needs an individualized treatment regimen. Additional guidance is needed on how to develop a treatment plan based off the assessment, especially as it relates to evidence-based practices. Additional guidance is needed on evidence-based practices as they relate to treatment of substance use disorders, as some providers are using multiple evidence-based practices on one individual receiving services, some of which are not evidence-based for substance use disorders or for the level of service the person is receiving.
5	none
6	Amend the dimensions to take the social determinants of health into consideration, as they have a critical impact on patients' potential for relapse. For example, homelessness, unemployment/under-employment, lack of education or vocational skills, food insecurity, lack of childcare, and environmental stressors all play a role in achieving and maintaining recovery. Additionally, ASAM should consider including guidance relative to cultural diversity, non- English speaking populations, and LGBTQ+ populations.
7	Assertive outreach has to be categorized as a type Level One Tx.
8	More available training
9	None
10	None
11	No major concerns.
12	continued explanation
13	a
14	NONE
15	That Dimension 1 include criteria based on PAWS, Dimension 2 make it more clear that medical needs may still be present and monitored but are capable of being addressed only periodically, and impulsivity language and problems with authority language be included in Dimension 3
16	Be CONCISE
17	The ASAM could be shortened and attention to the referral for levels of care to be reimagined. What do the evaluators do if the level of care that the clients ASAM indicates is not available, what is the best course of action.
18	Have assessment components best done by peers (include the SAMHSA Recovery and Wellness wheel materials)
19	.
20	better defined medical consequences of substance us more detailed questions for co-occuring mental health issues more defined questions regarding grief, loss, abuse, and trauma

Q18 Level 1: Staffing standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 18 Skipped: 206

#	RESPONSES
1	None noted at this time.
2	None noted
3	More details on how many staff of each disciple per patient ratio.

4	We support telehealth services but want to make sure physician is part of the treatment team and understands how to support treatment. There is bare minimum in-person time for physicians at some agencies. We do not want to create barriers to access, but we want to ensure physicians understand the culture at agency and monitoring processes. When physical exams are done at some agencies, people are not required to take off shirts or shoes. This led to the provider not being aware of infection sites and abscess sites, as common injection sites were not checked during the physical exam. Guidance in best practice in telehealth expectations for physical health
5	none
6	Assertive outreach has to be categorized as a type Level One Tx. Training and better approvals for following ASAM by the reimbursors.
7	none
8	I think there should be a greater emphasis in ASAM training for all medical providers, not just psychiatrists or addictionologists.
9	This question is unclear. Are you speaking to the credentials of the person determining PPC? Or, caseload staffing requirements?
10	No major recommendations.
11	none
12	a
13	NONE
14	I would recommend having someone at the state level be a "Train the Trainer" who can provide trainings regularly to agencies across the state. This is important especially when there is attrition in an agency.
15	The current training is adequate.
16	Include peers and medical providers engaged in withdrawal management - this is less understood than it should be.
17	.
18	Minimum level CADC-1 for initial assessments Addiction Medicine-experienced physician oversight and clinical supervision Clinical supervision defined

Q19 Level 1: Support system standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 18 Skipped: 206

#	RESPONSES
1	None noted at this time.
2	None noted
3	Inclusion of certified recovery specialists across the continuum of care to ensure this service is offered in each level of care.
4	none
5	Assertive outreach has to be categorized as a type Level One Tx.
6	none currently
7	None
8	none.
9	Peer support and patient guides. Patient advocacy programs.
10	none
11	a
12	NONE
13	More focus on family systems
14	Be specific about what is to be required for compliance. Not vague

15	Increase training and system documentation.
16	All level of care should be available for the client if the ASAM is going be a requirement.
17	Include not only housing, transportation, and childcare, but also of course digital access to healthcare and educational resources; also include a section on employment and education for people with SUDs. Include data from Harrison et al (2019) Individual Placement and Support (IPS) Review of Employment Services for Individuals with SUD.
18	.

Q20 Level 1: Therapies standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 19 Skipped: 205

#	RESPONSES
1	None noted at this time.
2	None noted
3	More discussion on evidence-based therapies.
4	Guidance that a substance use disorder alone cannot be the justification for treatment. Providers need to identify problems (outside of substance use) and how the problems can be addressed during that level of care. Providers need a better understanding of evidence-based practices as they apply to levels of care and realistic expectations of what can be resolved during the treatment episode (i.e. trauma may be more effectively addressed in outpatient services, but groundwork can start in a residential program).
5	none
6	Assertive outreach has to be categorized as a type Level One Tx.
7	Nothing...I think it allows Therapist to provide holistic therapy
8	I think it is important to include recommendations and guidelines for telehealth therapy services in light of the COVID pandemic and treatment centers not allowing in-person treatment. Also, what exactly counts as recreational therapy and are there recommendations to integrate them into
9	n/a
10	Continue to promote the multidisciplinary approach to include motivational interviewing, CDT, and individual/group therapy with pharmacotherapy.
11	more details
12	a
13	NONE
14	Specificity per level of care recommendations,, not vague
15	Therapeutic interventions should improve and increase.
16	All level of care should be available for the client if the ASAM is going be a requirement.
17	Include more content on the basic therapy standards - Motivational Interviewing and Cognitive Behavioral Therapy. Others are drawn primarily from those mothers. Also incorporate Trauma-Information Organization materials from SAMHSA.
18	.
19	Evidence-based psycho-social matrices Availability of MOUD for opioid use disorder Availability of MAT for other SUD's

Q21 Level 1: Documentation Standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 19 Skipped: 205

#	RESPONSES
1	None noted at this time.
2	None noted
3	Y
4	Clarification is needed that the documentation to relate back to the treatment plan. Additionally that the group note should not be the same for every person receiving services as a standard note.
5	none
6	Assertive outreach has to be categorized as a type Level One Tx.
7	I believe that ASAM makes documentation process efficient
8	None
9	n/a
10	Ultimately we would gather most of this information in our standard of care, ASAM does provide it in one place/one document.
11	more information provided - more guidance
12	a
13	NONE
14	We emphasize risk ratings, which can be a bit of a mess when relying on the descriptions based I. The text, so allowing for more descriptions to encompass the variety of challenges in recovery.
15	Reduce and condense standards
16	If it is not written, it is not done. Providing facilities and agencies keep rolling log of dates to update ASAMs by client
17	DMC documentation standards is our agencies minimum standards and ASAM could parallel with those standards. and
18	.
19	Standardized EHR assessment programs with interoperability between platforms Documenting progress, stages of recovery or relapse, use-episodes, cross-addiction, relapse behavior identification Documentation of compliance with MOUD and other prescribed medications Documentation of participation in peer-support activities Documentation of changes in all ASAM dimensions as a continuum

Q22 Level 1: Adult dimensional admission criteria: Do the dimensional admission criteria presented in the textbook support you in making Level of Care placement decisions? What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 21 Skipped: 203

#	RESPONSES
1	None noted at this time.
2	None noted
3	Yes

4	If the risk level is retained, there needs to be more emphasis in the book about the importance of the risk level and clearly delineate the risk. Providers have been resistant with providing a risk level, including establishing a risk level.
5	none
6	Assertive outreach has to be categorized as a type Level One Tx.
7	Yes
8	Yes because it addresses the areas of concern that are vital to the process.
9	Yes they do.
10	No recommendation.
11	ASAM is in line with standard of care and regulatory requirements.
12	yes - supportive
13	a
14	NONE
15	Again with making the descriptions for risk ratings more inclusive and clear about the variety of issues that could be included.
16	ASAM does not take into account requirements of court despite level of care
17	Be concise
18	NA
19	Yes; this is huge for all admission criteria; keep the tools present.
20	.
21	No changes

Q23 Level 1: Adolescent dimensional admission criteria: Do the dimensional admission criteria presented in the textbook support you in making Level of Care placement decisions? What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 17 Skipped: 207

#	RESPONSES
1	None noted at this time.
2	None noted
3	Guidance is needed on the importance of the stages of change in treatment, as some residential providers report that adolescents remain in the precontemplation stage of change for six months or longer. Guidance on shifting focus from a person's illness to a person's progress. Guidance on determination of the effectiveness of the level of service and how to transition someone if the service is ineffective.
4	none
5	There should be an increased focus on cutting and suicidality as these conditions are prevalent among the adolescent population, particularly for LGBTQ+ populations. Additionally, consider pulling out adolescent-related admission criteria into their own dedicated section, as the current framework of having adolescent sections built into adult sections can be counter to adolescent service providers' ability to quickly/consistently using the Criteria (i.e. preventing the need to hunt and peck through multiple adult-focused sections for the adolescent-devoted language).
6	Assertive outreach has to be categorized as a type Level One Tx.
7	n/a
8	N/A
9	No recommendation
10	N/A
11	yes
12	a
13	NONE

14	Once again the ASAM could be shortened to support the staff time.
15	Yes this is critical as well.
16	.
17	No changes

Q25 Level 2: Overall: Is this level clearly delineated? If no, tell us how it could be clarified.

Answered: 30 Skipped: 194

#	RESPONSES
1	yes
2	Clearly delineated although partial and difference between IOP and Partial can be hard to
3	Same as reported in Level 1.
4	n/a
5	Yes
6	It is my understanding that level 2 determines the client's level of care in a setting that allows the client to function independently at home while working his or her recovery and applying the skills to achieve stability. This determination is subjective to the client's ability to perform the goals expected and whether or not this level of care is realistic for the client.
7	In reality it seems that consumers have a very difficult time maintaining regular intensive hours weekly as needed for ASAM 2.1 (9 or more hours per week) - many IOP programs are 3-4 months longs but few consumers can keep up regular attendance at 3-4 groups per week, in reality our consumers can keep this up for 2 months, then do well with stepping down to 1.0 hours (less than 9 hours per week), would appreciate more discussion is there any evidence around being in 2.1 then stepping down at month 3 to 1.0 but still calling it IOP? Insurance carriers and Medicaid are strict in counting up the treatment hours per week, agencies are so afraid of audits and having to return $$, so if a 2.1 consumer doesn't make 9 or more documented clinical treatment hours per week, then none of those services are billed for that week, why can't documented attendance at 12 step meetings or other recovery support meeting count towards the 9 hours of required treatment per week. ASAM criteria implies this in so me sections, and I have heard David MeeLee speak to using other non-agency - treatment hours to count towards the required 9 hours treatment per week. This create an issue if a consumer is court ordered to IOP services, we will have the consumer in 2 months of IOP and then 2 months of OP because of hours, this is confusing to say consumer has completed IOP treatment. Matrix model doesn't have full treatment
8	More examples of what is considered biomedically unstable would be helpful, particularly related to communicable diseases. The ASAM manual needs to have a more comprehensive description of criteria in Dimension 3 for 2.5 level of care in co-occurring capable programs. Dimension 3 focuses
9	Clarifying the difference between 2.5 and 3.7 - what are the factors that determine one over the other? The term partial-hospitalization is confusing for providers and may benefit from additional examples being provided.
10	There is a need for structured sober living standards (however, they would not be staffed like Level 3.1).
11	Can the criteria provide more differentiation between level 2.1 and 2.6 IOP and PHP on dimensions 3,4 and 5? Can there also be more clarification regarding definitions of levels of care? For example, some programs run PHP and IOP 5 days a week while others run theses programs 7 days a week. Can ASAM offer more clarity regarding the frequency and intensity of services by level of care? Also, is there opportunity to identify coordination of care between prescribers and treatment programs within the criteria? For IOP the prescribers are often not connected to the IOP
12	yes

13	Yes
14	Yes
15	yes
16	I think the level is clearly delineated, but the partial hospital level of care exists with 2 treatment facilities in our whole state. And it is hard to get patients into those facilities. As such, insurance companies will decline Level 3 care stating that our patient needs partial hospital care, and when told that does not exist, does not seem to matter. It is ok as most of them will then attempt IOP, get much worse, and end up in Level 3 care anyway.
17	Yes. No recommendation.
18	Yes. I feel it draws a line between if someone needs to be in Level II or inpatient
19	yes
20	Yes
21	I think IOP needs to be separated from PH. IOP should be at least 9 hours of treatment per week with at least one hour of individual treatment. PH needs to be at least 20 hours of treatment per week with at least one hour of individual treatment.
22	no - needs to be more information about a medical hx, need to have more requests for specific providers and treatments
23	Please clarify the types of patients that may be need ambulatory withdraw management. Mentioning that the patient may be in level 2.5 and receive the withdraw management 2.0 does not fully make sense. Clarify what the patient's presentation is to qualify for a nurse or provider to monitor. It states the nurse doesn't have to be face to face
24	mostly yes
25	No. We need options for each level and dimension to simplify this process and ensure that all providers are doing it the same way.
26	Yes, the level is clearly defined.
27	The number of days a week of IOP or PHP is appropriate. Many providers want 7 days a week. Is UDS appropriate everytime patient comes to program.
28	Most of this level of care is clearly delineated within the ASAM Criteria. One confusing note is that there is a stated minimum of 20 hours per week but no stated maximum. It is understood that if a person needs 24/7 care they should be in an RTC level of care, however; with some of the requirements within the dimensions of the PHP LOC it is unclear based on patients need how much treatment is ok within this level. With so many similarities to the RTC LOC, More clarification could be provided on the true differences of this level of care outside of the hour requirements.
29	.
30	This level is very clear for us. we are formed all of our groups and programming around the criteria.

Q26 Level 2: Overall: What is working well?

Answered: 19 Skipped: 205

#	RESPONSES
1	Less restrictive. Works as good step down from residential and or step in for many people.
2	Same as reported in Level 1.
3	The ASAM Criterial brings the medical presence back into SUD services, where it was missing in the past.
4	This is working well because the client's ability to perform the expectations is monitored weekly.
5	Understanding the role of biomedical needs in the treatment of substance use disorders such as a physical health screening and taking vitals to better address the clients medical needs.

6	Staffing requirements are good and imperative for programs to be effective. Therapies and co-occuring information is great.
7	All of it.
8	We utilize level 2 in our programming. I have seen the ASAM criteria assessment tool assist us in appropriately placing Clients at this level when it is time to update their treatment and care
9	Understanding that it is a step-down from residential level of care, but that the goal should be for transitioning people to real life.
10	ASAM defines this level of care well.
11	We have a lot of strong IOP providers in our state.
12	No recommendation.
13	the explanation of all services that fit into this level of care (PHP)
14	application to determine client readiness to enter PHP
15	I don't believe this system is working simply because the payers have the ultimate decision with what loc they pay for and this is unfortunate.
16	All out patient LOC service is working well.
17	we are having good success
18	.
19	Having sober living for These patients makes a difference for attendance.

Q27 Level 2: Overall: What challenges have you observed?

Answered: 24 Skipped: 200

#	RESPONSES
1	Obtaining enough hours during a week
2	Payors have different # of session and is not always based on recovery needs. Dimensions 4, 5, 6 may may OP not the best level of care but payor may say they have to start there.
3	The ASAM criteria specifies that IOP should be able to offer: (page 198) · "Psychiatric and other medical consultation is available within 24 hours by telephone and within 72 hours in person". · "Emergency services, which are available by telephone 24 hours a day, 7 days a week when the treatment program is not in session." · "Direct affiliation with (or close coordination through referral to) more and less intensive levels of care and supportive housing services." Our experience is that it is far from the reality of many community IOP programs. That being said, we don't disagree with ASAM criteria level of expectations and do not recommend changing the criteria as
4	None at this time

5	Guidance is needed in terms of length of stay and elimination of program-driven care. Providers focus on length of stay, rather than emphasis of treatment required for the individual receiving services. There is no research behind the length of stay in residential settings, nonetheless, providers have created admission and treatment protocols around fixed episodes of care. Integrating measurement-based care would help residential and OP treatment programs in transitioning from fixed episode of care, based on historical funding protocols, to patient-centered care, based on reliable metrics of progress. We suggest including existing scales, such as the brief addiction measure (BAM) and other metrics, such as employment, housing stability or reductions in substance use via biomarkers or developing hybrid measures. The goal would be to use these tools across the continuum to assist providers in determining progress as well as tailoring lengths of stay within a level of care. Enhanced guidance is needed on the application of individualized treatment towards everyone receiving services, not only people that might fall into a specialty population. A related metric is continuum of pharmacological treatments across levels of care. Treatment providers in PA continue to view pharmacological interventions as separate from ASAM levels of care, instead of an essential element within all levels of care. We suggest emphasizing pharmacological interventions as essential elements within and across the four levels of care in the next edition. Notably, the menu of evidence-based medications for SUDs will likely expand before and after the next evolution of ASAM criteria. Treatment providers will need to integrate medical staff within all levels of care to sustain individuals on the growing list of effective medications for
6	This is an area that we need to work on in our state, specifically 2.5. We are observing that providers are having challenges understanding the step-down level of care in the continuum.
7	the challenges observed is the barrier with transportation. If the client is not able to attend their group therapy or meet with their counselors then another challenge is created and that is
8	The ASAM criteria for D2 is relatively vague in its description, so it is difficult to argue justification of care with insurance companies. This hinders treatment for the client. Using thr Criminal Justice Settings Criteria- Settings should include outpatient treatment facilities because we are certified with the state to show that we are addressing recividism.
9	2.5 LOC isn't utilized as often as may be appropriate due to a lack of understanding and clarity.
10	It seems patients would benefit from increasing the hours required. Ideally, 12 hours per week for IOP. We have tried offering this, however because only 9 is required, other treatment centers and the state only require 9, so patients will choose those programs over the 12 hour one even though results are better with 12 hours.
11	The primary challenges that I have observed are with insurance companies not taking into consideration the severity of problems that occur in Dimensions 2, 3, 5, or 6. Most of the patients I work with have biomedical conditions that require ongoing monitoring by our APN's and assistance with scheduling appointments for outside providers. Insurance companies also minimize the impact unstable mental health has on ability to stay sober and that it takes time for patients to adjust to new medications, especially antidepressants. Many of our patients have histories of chronic relapse and overdose, which insurance providers do not seem to consider as evidenced by approving only 1-2 weeks of PHP. We've had cases when a patient overdosed 1 week prior to admitting to PHP (patient did not have detox or residential benefits) and was only given 5 days of PHP. Lastly, not having a job or stable living environment makes it very difficult for a patient in IOP, who receives only 3 hours of treatment per day, to stay sober due to lack of structure. In my opinion, I think it is imperative that ASAM work with insurance providers to educate them on the 6 dimensions and what is being done in PHP/IOP LOC to help patients recover.
12	No challenges.
13	With COVID had to rethink a lot of things about what transitioning to daily life sober looked like for clients.
14	Providers do not always have the same interpretation of the level.
15	Already stated
16	None
17	insurance and state doesn't follow all of the guidelines, boarded PHP should be addressed in this
18	MCOs not interpreting criteria the same

19	Payers. We need to all follow the same direction.
20	The time it takes to administer the ASAM is one of the biggest challenges.
21	client's honesty
22	With the approach to individualized treatment and the need for at least 20 hours a week of treatment, it is difficult to define how much independence is needed within this level of care for individuals. How much autonomy can a facility have with this level of independence? More clarification is needed in this area.
23	.
24	if it is a free standing PHP or IOP the attendance is not as strong and IOP is even less . These are the biggest challenges. managed care company's do not want to pay as long as the patient needs for full recovery. It is know the longer the patients stays the more successful the recovery can

Q28 Level 2: Overall: What are your recommendations for the 4th edition of The ASAM Criteria?

Answered: 20 Skipped: 204

#	RESPONSES
1	None at this time
2	More emphasis on family involvement and inclusion of measurement-based care.
3	Have a clear definition of step-down to the appropriate level of care.
4	The recommendations is not necessarily in the ASAM but with the assistance of other resources and county benefits to meet the program therapies recommendation of 9 weekly hours.
5	* a step down approach in outpatient services (eg consumers in 3.5 programs often step down to 3.1 during the end of stay) - what about consumer in 2.1 stepping down to 1.0 during end of stay..?? * better to keep consumers with same counselors in outpatient services, many agencies have separate 2.1 & 1.0 programs (supported by CARF) but would be a mess to have a consumer change programs and staff from 2.1 to 1.0
6	Have a better delineation between the risk ratings of Dimension 2 and intensity of services. Provide more specific criteria for co-occurring capable programs in Dimension 3 that incorporate mental health diagnoses and/or behaviors.
7	Include criteria that indicates the need for Medication for Addiction Treatment/Medications for Opioid Use Disorder, and which medications are recommended based on substance(s) used. Additionally, add criteria for individuals in an actionable state of change relative to their need for continuing services in Level 1 outpatient services, in order to provide an ongoing structured
8	Increase hours of IOP
9	Provide examples of recreational activities and how to incorporate them into programming when a lot of treatment centers are virtual.
10	None at this time.
11	More cultural awareness and a more trauma informed lense on people's experiences especially with prior incarceration how that affects the receipt and delivery of services.
12	Make it a simpler process for providers to follow with less documentation burden
13	More information about moving up levels when a certain level of care is not available in some areas of the country, which means the vast majority of rural Nebraska.
14	No recommendation.
15	none
16	Drop down options. Simplify the process. The ASAM assessment takes just as long as the comprehensive diagnostic assessment.
17	Attempt to shorten the ASAM.

18	More clarification of how this level of care, related to the ASAM Criteria, differs from other levels of care (RTC) outside of the hourly requirements. Increased areas or better streamlining of co-occurring enhanced/capable facilities.
19	.
20	maybe more flexible time and more focus on relapse.

Q29 Level 2: Standards that relate to treatment setting: what are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 13 Skipped: 211

#	RESPONSES
1	None at this time
2	n/a
3	these are fine.
4	Clarifying the difference between 2.5 and 3.7 - what are the factors that determine one over the other? Provide more examples of programming for 2.5 LOC versus 3.7 LOC.
5	Factors to consider when providing services via telehealth.
6	None at this time.
7	No comment
8	No recommendation.
9	insurance doesn't follow ASAM
10	NA
11	Increased ability to relate this level of care to those with true co-occurring disorders or substance use concerns that might present past initial assessment. This would include better streamlining the co-occurring enhanced versus co-occurring capable programs as this can be very confusing when establishing the facilities standards for level of care designation.
12	.
13	N/A I see pros and cons in treatment settings. I think virtual, free standing brick and mortar , hospital setting all serve a purpose it defends on patients geography and mind set.

Q30 Level 2: Multidimensional assessment and treatment planning standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 11 Skipped: 213

#	RESPONSES
1	None at this time

2	Further guidance is needed on the definition of individualized treatment. Currently, individualized care is interpreted as needs of specialty populations (i.e. parents with children, LGBTQIA+, veterans), rather than looking at the individual receiving services that might not fall under a specialty population, but still needs an individualized treatment regimen. Additional guidance is needed on how to develop a treatment plan based off the assessment, especially as it relates to evidence-based practices. Additional guidance is needed on evidence-based practices as they relate to treatment of substance use disorders, as some providers are using multiple evidence-based practices on one individual receiving services, some of which are not evidence-based for substance use disorders or for the level of service the person is receiving.
3	These are fine. Again, meeting the realistic expectation of clients ability and means to perform the tasks.
4	None
5	None at this time.
6	No comment
7	No recommendation.
8	none
9	We have several options that fit our treatment program and the clients needs. No recommendations at this time.
10	.
11	Treatment needs to be individualized and maybe less restrictions on on who on the multidisciplinary team needs to sign off on . the assessments are do need to meet the patient where they are need to take in to consideration all aspects but not overwhelm the patient.

Q31 Level 2: Staffing standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 13 Skipped: 211

#	RESPONSES
1	None at this time
2	We support telehealth services but want to make sure physician is part of the treatment team and understands how to support treatment. There is bare minimum in-person time for physicians at some agencies. We do not want to create barriers to access, but we want to ensure physicians understand the culture at agency and monitoring processes. When physical exams are done at some agencies, people are not required to take off shirts or shoes. This led to the provider not being aware of infection sites and abscess sites, as common injection sites were not checked during the physical exam. Guidance in best practice in telehealth expectations for physical health
3	this are fine.
4	ASAM speaks to 2.1 being supervised by a medical professional, makes sense but there is a lack of medical professionals trained in addictions (especially in Alaska) would be great to add in non-medical staff such as licensed clinicians with training/certification in addictions to supervise 2.1
5	None
6	None at this time.
7	No comment
8	No recommendation.
9	none
10	NA

11	Increased mention of the ability for a physician OR nurse practitioner (in areas allowed) should be included. Nurse Practitioners are a vital part to the multidisciplinary team and can offer vital services including diagnosis, mediation management and treatment planning. The term “appropriately credentialed addiction professionals” is seen in many areas throughout the ASAM Manual. Does this include those who are an LPC,MFT, LCSW, etc or those who need to hold a CADC, LCADC, etc? What does the term “appropriately credentialed additional professional” mean regarding training and certification? This needs to be better clarified.
12	.
13	I think it needs to be more standardize on who can treat by licensure. I think that maybe requiring a staffing ration that takes into consideration sometimes smaller groups are more productive.

Q32 Level 2: Support system standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 12 Skipped: 212

#	RESPONSES
1	None at this time
2	Inclusion of certified recovery specialists across the continuum of care to ensure this service is offered in each level of care.
3	Washington State is implementing SUD Peers.
4	these are fine
5	It would be helpful for ASAM to provide resources for supportive housing services.
6	None at this time.
7	No comment
8	No recommendation.
9	none
10	NA
11	.
12	I think the support system is fine may spell out family can be defined as your own support system.

Q33 Level 2: Therapies standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 12 Skipped: 212

#	RESPONSES
1	None at this time
2	Guidance that a substance use disorder alone cannot be the justification for treatment. Providers need to identify problems (outside of substance use) and how the problems can be addressed during that level of care. Providers need a better understanding of evidence-based practices as they apply to levels of care and realistic expectations of what can be resolved during the treatment episode (i.e. trauma may be more effectively addressed in outpatient services, but groundwork can start in a residential program).
3	these are fine
4	Again, examples of recreational therapy and recommendations for telehealth.

5	None at this time.
6	No comment
7	No recommendation.
8	none
9	NA
10	None
11	.
12	Maybe TMS . it seems to be something that patients have been asking about.

Q34 Level 2: Documentation standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 12 Skipped: 212

#	RESPONSES
1	None at this time
2	Clarification is needed that the documentation to relate back to the treatment plan. Additionally that the group note should not be the same for every person receiving services as a standard note.
3	these are fine and self-explanatory
4	None
5	None at this time.
6	No comment
7	No recommendation.
8	none
9	The DMC documentation standards are required for our funding sources and that is the standard we would recomend to be the standard.
10	None
11	.
12	These need to be less academic and more clinical. i would like to see some of the documentation be more flexible , still capturing the needs and the whole picture of the patient but not as wordy. This is where we struggle the most.

Q35 Level 2: Adult dimensional admission criteria: Do the dimensional admission criteria presented in the textbook support you in making Level of Care placement decisions? What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 13 Skipped: 211

#	RESPONSES
1	None at this time
2	If the risk level is retained, there needs to be more emphasis in the book about the importance of the risk level and clearly delineate the risk. Providers have been resistant with providing a risk level, including establishing a risk level. Some providers believe that everyone in residential treatment has the highest risk across all dimensions, justifying this as the need for residential placement, rather than using the risk to identify treatment needs and areas of focus that can be addressed at

3	These are fine and fall along the needs of the client and subjective between the client and the staff member. the advantage is that the ASAM book serves a wonderful guide to allow the writer to rule out and assess the clien needs.
4	Have a better delineation between the risk ratings of Dimension 2 and intensity of services. Provide more specific criteria for co-occurring capable programs in Dimension 3 that incorporate mental health diagnoses and/or behaviors.
5	Yes
6	None at this time.
7	No commnet
8	No recommendation.
9	none
10	NA
11	The ASAM Manual, though laid out in detail, can be confusing and difficult to decipher when also trying to compare to another level of care. A more simplified presentation would be recommended.
12	.
13	Yes the admission criteria I think has been thought through. I would keep these in place.

Q36 Level 2: Adolescent dimensional admission criteria: Do the dimensional admission criteria presented in the textbook support you in making Level of Care placement decisions? What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 13 Skipped: 211

#	RESPONSES
1	None at this time
2	Guidance is needed on the importance of the stages of change in treatment, as some residential providers report that adolescents remain in the precontemplation stage of change for six months or longer. Guidance on shifting focus from a person's illness to a person's progress. Guidance on determination of the effectiveness of the level of service and how to transition someone if the service is ineffective.
3	Yes, the book serves as wonderful guide and allows the writer to assess the client's needs and LOC.
4	Consider pulling out adolescent-related admission criteria into their own dedicated section, as the current framework of having adolescent sections built into adult sections can be counter to adolescent service providers' ability to quickly/consistently using the Criteria (i.e. preventing the need to hunt and peck through multiple adult-focused sections for the adolescent-devoted
5	N/A
6	NA
7	No comment
8	No recommendation.
9	none
10	NA
11	N/A
12	.
13	N/a

Q38 Level 3: Overall: Is this level clearly delineated? If no, tell us how it could be clarified.

Answered: 42 Skipped: 182

#	RESPONSES
1	Yes, however focused much on Dimensions 1, 2, 3 without much on Dimensions 4, 5, 6.
2	The current levels are relatively well articulated. However, there is significant overlap between some of the currently identified levels which could be simplified in the new version of the criteria. For instance, the distinction between 3.5 and 3.7 is negligible, and rather, the focus should be on making a clear delineation between what can be considered supportive living and that which requires some kind of advanced clinical oversight (monitoring of complex comorbities and need for complex medication management). With this in mind, there could be two levels of RTC including 3.1 and 3.5 to be in-step with level 2 which is broken down into 2.1 and 2.5. In addition, there is often confusion with the use of "inpatient" for 3.7 and differentiating the Level 3 withdrawal management and residential is not always clear.
3	• Criteria are nebulous and poorly defined: Have to jump sections to pull together. Criteria are often not specific and ASAM itself notes that they are not for Medical Necessity. o Example #1 – Continued stay criteria (Residential) are very general; it discusses making progress or lack of progress, but does not go into specifying clearly what they need to be working on in that LOC. • No Guidance on Length of Stay (LOS): No listed expectation on any length of stay (LOS) or average LOS. MCO's are left to speculate on a reasonable timeframe. No research cited.
4	No. Provide examples or more details on each residential level of care.
5	No. Provide examples or more details on each residential level of care.
6	Yes, I believe it is clear overall; however, the layout of the manual is a little confusing - as the rating elements are broken out throughout each section, versus having one complete set of rating standards to review.
7	Yes.
8	Level 3.1 some providers refer themselves as a halfway house and some providers rendering level 3.1 are defining themselves are recovery residences. More clear delineation on what a level 3.1 is
9	Overall, Level 3 services discuss staff availability requirements, but do not provide information regarding unit structure and treatment structure. Clinical services need to be more clearly defined for Level 3 services. It would be helpful to have clarification and emphasis of family services in terms of engagement, education, and therapy. Guidance regarding expectations for the provision of family services would help providers. Additional guidance regarding fulfilling physician time through telehealth versus in person assessments is needed. 3.5 level of care discusses habilitation and rehabilitation services, which has caused confusion for some of our providers. Our providers want to offer either habilitation services or rehabilitation services and then cross refer to other 3.5 providers for the service not offered at their facility. This creates confusion and has the potential to lead to disengagement for people receiving services. Level 3.3 does not exist in Pennsylvania, and it could be clarified if the level applied to all specialty services (i.e. parents with children programs, services in the jail for individuals in need of treatment, and skilled nursing). Clarification is needed for 3.7 in the determination of enhanced physical health versus enhanced mental health programs.
10	There is confusion between adult 3.5 and adolescent 3.5, they should be the same level of care.
11	Yes
12	Could use additional clarification on the differences between the different levels - better case examples.

13	Admission criteria appears to be pretty well defined, however continued stay criteria is not. Continued stay is defined as progress, lack of progress or new problems. This can often be subjective based on who is reviewing material and what managed care organization polices are.
14	For Levels 3.1, 3.5, and 3.7, suggest adding to Dimensions 3, 4, and 5 criteria relative to Medication for Addiction Treatment, social determinants of health, and cultural/linguistic and LGBTQ+ specific
15	For these levels of care would it be helpful to address family work, MAT, Sober support emphasis and can any medical comorbid factors be outlined more clearly?
16	Yes
17	Clearly, SLEs have been operating for decades within a sort of "wild west" operational and supervisorial structure. In my view, much legal and operational standardization is needed in this
18	Yes it is
19	Overall yes but adding minimum hours a week of activities at 3.5 would be helpful. In Nevada, we have provided this but it would be nice for ASAM to provide some clarity on this. I'm working with NV Medicaid now related to a waiver which would pay for more residential services.
20	yes
21	There seems to be a discrepancy between how ASAM conceptualizes residential level 3.1 and how this level of care is viewed in California's implementation of its Drug Medi-Cal Organized Delivery System waiver. Specifically, ASAM states that the minimum number of clinical hours in residential level 3.1 is only 5 hours per week and in discussions with ASAM leadership, this level of care has been described as a "halfway house" model of care. However, in CA, outpatient services require up to 19 hours of service per week and residential 3.1 is typically treated as a higher level of care with more clinical service hours than outpatient services, which seems reasonable. Suggest that ASAM review if the minimum level of clinical service hours in 3.1 makes sense to maintain at 5 hours per week, and recommend considering increasing this clinical service hour minimum so that residential services are treated as a higher level of care than outpatient services, which seems ideal considering that this is how counties are structuring residential rates (as a higher level of care with
22	The Criteria FAIL to account for the therapeutic effect of community. Some re-training requires a community that is more intense and bonded than what can be achieved in outpatient settings. This is the BIGGEST HOLE in the Criteria. If we fail to address this in Revision 4, we will lose one of the central components of healing. The work of George deLeon should be considered. Patients should have an assessment as to their need for community healing and this be a criterion for this level of care -- especially Level 3.5.
23	Need to be simply as possible for the fast pace of residential tx.
24	There could be benefit from giving more clarity for how to determine whether a client might need a more acute intervention versus a higher intensity/clinically managed level of care for a longer period of time in order to begin recovery efforts that can begin preparing for transition to an IOP or outpatient while sustaining within the community.
25	Clarification on the difference between the 3.7 W/M and the 3.7 LOC. Better clarification on the use of 3.1 LOC, for people w/o motivation and for patients motivated but need to practice their recovery skills.
26	Not always, it can sometimes be difficult for our assessment and treatment counselors to identify the differences between a level 2.5 and 3.5 when presented with a client with problems with authority and impulsivity and PAWS symptoms that affect their ability to concentrate.
27	I would appreciate more guidance on service hours for 3.5. I'm not sure why 3.1 minimum hours are 5 hours a week but that's less direct services hours then 2.1. Some guidelines on the amount of time or suggestions on how much the clients in residential should have interaction with the
28	Not clearly delineated. I can't get approval to buy the textbook/take the course as yet and find resources to help me.
29	No. Level 3.3 is still ambiguous. Initially, it was presented as dual diagnosis; however, that is not the case and it still remains unclear in the text.

30	In the ASAM criteria the level is clearly delineated. However managed care companies often challenge our request for continued stay--the managed care companies state they use the ASAM criteria however many of them utilize a computer software system that is loosely based on the ASAM criteria and is not directly affiliated with ASAM, so we do not always see eye to eye and frequently have to request peer to peer interviews with the managed care to justify the continued stay. Peer to peer interviews are daunting for our clinicians because they are done with a physician from the managed care companies, they are time consuming and often take place when the clinicians are in the middle of group treatment (they do not respect our request for certain
31	Yes
32	Level 3.5 is very clearly defined. We often get pushback on levels 3.1 and 3.2WM. Some organizations will argue that 3.1 is intended for sober living environments and is not a residential level of care even though ASAM Criteria clearly states otherwise. Some organizations will not recognize 3.2WM as a residential detoxification level of care and will attempt to require ASAM 3.7 which is intended for acute/hospital care and not sub-acute detox. Clarification on levels 3.7 and 3.2WM and how each relates to residential care would be highly beneficial. Further clarification on when residents are ready to move out of a 3.5 or 3.1 level of care and to an outpatient setting would also be helpful. Residents at this point in treatment will often meet both Level 3 and Level 2 Criteria depending on how the individual is evaluated. Criteria further specifying when discharge is appropriate and not just when admission is appropriate could be helpful
33	Yes, the level is clearly defined.
34	There is a wide range of mental health problems that fall into this category. Sometimes clients are placed in high risk categories without justification. There should be a way to clarify client vs family or child issues.almost all our moms are rated high risk if their child is under 3 years old and family services is involved. I would like some clarification in this area.
35	Based on recent work experiences, the biggest barrier that I faced in utilizing ASAM how to do with the state of California's Department of Health care services, and its recent attempts to preclude services at the 3.7 level of care. The state's parallel interpretation of ASAM is very much at odds with the official criterion as encompassed in ASAM’s LOCUS.
36	3.7 should clearly state that this level can be offered in a residential setting. I have combed through the book and it is clear to me that "separate, more intensive unit of a freestanding level 3.5 residential facility" refers to residential programs. Unfortunately, DHCS disagrees and is now stating that residential facilities cannot hold a 3.7 designation.
37	Many patients go from one facility to another after short relapse. When member lacks motivation to remain sober and has been using RTC for food and shelter, when do you say enough is enough. I would recommend weekly psychiatrist/addictionologist intervention for 3.5,
38	Most of the data presented is clear and can be applied to the individuals presenting concerns. However, the names of the different levels of care within the RTC can be confusing. For instance, many would assume that a 3.1 (Clinically Managed Low-Intensity Residential Services) would be the next step down from a 3.5. This is not the case as 3.1 has very specific guidelines on the treatment focus and has less hourly requirements of treatment than a 2.5. In contrast, the 3.1 provides 24/7 care (not treatment) where a 2.5 does not. I have found in training individuals in ASAM that this can be very confusing without additional training and increased understanding of the setting and services provided at a 3.1. On a macro level, if you understand ASAM clearly this is an easy concept. I find most people understand ASAM on a more macro rather than micro level which is why wrong LOC’s are designated. My suggestion would be changing the name of the 3.1 and 3.3 levels of care so that individuals do not feel they are always the best automatic progression
39	Yes I think this level is more defined that any other.
40	There is still some confusion between 3.5 and 3.7
41	yes
42	The only thing that could be clearer is how homelessness affects the level of care decision. I've found that a lot of the time the justification of a level 3 admission is heavily drawn from dimension 6, specifically, homelessness, when that alone should not justify a residential level of care.

Q39 Level 3: Overall: What is working well?

Answered: 18 Skipped: 206

#	RESPONSES
1	Once you figure out how the manual is designed, it is fine to work within. I like having the "shaded" mandatory standards noted for reference.
2	The stability and structure of residential treatment has been a great launching pad into recover for many individuals.
3	The ASAM Criterial brings the medical presence back into SUD services, where it was missing in the past.
4	Understanding what is needed for admission into residential treatment based off of risk ratings.
5	Facilities operated with rigorous fidelity to trade-industry and State regulations and guidelines. Frankly, I would like to see a push for qualified State and/or Federal government subsidies for/to selective SLEs, allowing for voucher-type mobility, consistent operational review by trade-associations and government, rigorous surveillance to minimize patient-brokering of all types, and higher salaries for better trained and educated operating staff down to the midnight shift level.
6	ASAM works particularly well for Residential
7	Using dimenmsions
8	Placement and engagement with the population we serve
9	Having the guide for all life domains and being able to work toward a more standard lifestyle while the client is in residential treatment. Re-assessing using these same guidelines in order to hold the staff and the program accountable to identifiable standards.
10	The admission criteria seem understandable and helpful. The descriptions have been helpful though at times vague.
11	na
12	Our agency is fortunate to be doing relatively well getting bed days.
13	Limiting my comments to challenges.
14	Level 3.5 for residential levels of care is generally being respected by all players. As stated above, this is less true of the 3.1 and 3.2WM levels of care.
15	The level of care is working well. As indicated in the other survey questions we need all levels of care to support the overall effectives of the ASAM.
16	Better placement in treatment and a common language we can all discuss.
17	Insurance companies seem to be starting to conform with using ASAM on the national level.
18	Clear lines of what is needed for residential. Again would like to have more flexibility for definition of relapse. risk of relapse

Q40 Level 3: Overall: What challenges have you observed?

Answered: 36 Skipped: 188

#	RESPONSES

1	Dimensions 4, 5, 6 may be reason for residential recommendations but within Dim 1, 2, 3 needs it's likely not going to be possible.
2	Difficulty in establishing a true sense of what clinical services are being delivered at what level of RTC. Providers not knowing how to rate a dimension.
3	Many states have medical necessity standards that do not come in until after 30 days in a Resi setting, therefore only continued stay criteria apply. More difficult to consider than use of admission criteria Need for housing or court requests are not a reason for continued stay criteria in a Residential setting - A regular request
4	The feedback we have received is that clinicians have difficulty delineating between Levels 3, 5 and
5	The feedback we have received is that clinicians have difficulty delineating between Levels 3, 5 and
6	None at this time.
7	In overseeing our implmementation of utilizing the ASAM criteria, LA County has limited the activities that count toward treatment service hours, excluding a number of activities that are critical to early recovery. This has led to a sense of client and staff busyness, without the time to engage in some of these essential activities. At times, our utilization of the ASAM criteria has led to excessive transitions between programs and levels of care, with many individuals never quite stabilizing enough to really benefit from the treatment they're receiving.
8	Challenges with providers understanding the required staffing and the role of peers working in level 3.1 programs.
9	Guidance is needed in terms of length of stay and elimination of program-driven care. Providers focus on length of stay, rather than emphasis of treatment required for the individual receiving services. There is no research behind the length of stay in residential settings, nonetheless, providers have created admission and treatment protocols around fixed episodes of care. Integrating measurement-based care would help residential and OP treatment programs in transitioning from fixed episode of care, based on historical funding protocols, to patient-centered care, based on reliable metrics of progress. We suggest including existing scales, such as the brief addiction measure (BAM) and other metrics, such as employment, housing stability or reductions in substance use via biomarkers or developing hybrid measures. The goal would be to use these tools across the continuum to assist providers in determining progress as well as tailoring lengths of stay within a level of care. Enhanced guidance is needed on the application of individualized treatment towards everyone receiving services, not only people that might fall into a specialty population. A related metric is continuum of pharmacological treatments across levels of care. Treatment providers in PA continue to view pharmacological interventions as separate from ASAM levels of care, instead of an essential element within all levels of care. We suggest emphasizing pharmacological interventions as essential elements within and across the four levels of care in the next edition. Notably, the menu of evidence-based medications for SUDs will likely expand before and after the next evolution of ASAM criteria. Treatment providers will need to integrate medical staff within all levels of care to sustain individuals on the growing list of effective medications for
10	One of the challenges is there is a level of care for adult and not one for adolescent. It would be beneficial to have a adolescent placement cheat sheet. Extend the guidance for younger ages into the adolescent age groups.
11	Did required 20 hours of treatment per week for level 3 services disappear from the ASAM Criteria? I don't see this stated much if at all, was this on purpose? Medicaid and auditing agencies stick to week is not billed, so much loss of revenue, due to fears of auditors and pay backs. Consumers entering level 3 often feeling physically ill, first week of treatment we see a lot of missed groups as consumers are getting used to treatment and beginning to engage, can ASAM speak to having first part of level 3 services being 3.2 WM at the same facility? For consumers who meet that criteria? There are challenges because level 3.2 WM wording implies a medical setting not a clinical setting, so consumer needs to go from 1 program to another program, how can transitioning between levels of care be more smooth/see less for the consumer? Instead of consumer needing to go from 1 building to another building, instead wrapping the services around the consumer.

12	Continuity and consistence in continued stay request between managed care companies and time allowed to be requested by the provider is very inconsistent. As it relates to denial of services by the managed care companies, these are often generic letters that are generated stating that denial is based off of not meeting ASAM criteria, however no other specifics are needed. We have to provide individualized treatment needs for each client, yet denials can be generic and the same.
13	Location is not addressed. Some people travel great distances to get this level of care then return to their home for treatment at lower levels of care and experience difficulty with supports resulting in a high level of relapse. What measurable medical monitoring is recommended at this level of care? Specific measurable monitoring could provide objective feedback to inform progress in care. Can there be greater clarity regarding the ability to control impulses? For residential detox - can there be more clarity around stabilization, withdrawal protocols and a range of a members risk level for relapse? There could be greater clarity and specification regarding the detox protocols and
14	See the inferences and their implications in my narrative in #15.
15	none currently
16	Ensuring a client is receiving the appropriate level of care for them while they are in treatment for an appropriate amount of time. I want to ensure the ASAM criteria is allowing the provider to accurately measure and communicate that to the MCO's for the necessary services. Age of client and lack of exposure to treatment are not accounted for which can create a barrier for coverage needs. When an individual is learning information for the first time, they often need more exposure. This should be reflected.
17	There is no way to address a willful disinterest in recovery and treatment. Dimension 4 requires a lack of insight and motivation, but does not account for members who repeatedly admit but have no intention or want to receive treatment.
18	none
19	some questions not asked related to childhood trauma
20	Clients who are not as open and the need for further motivational interviewing
21	Differentiating between the various levels of severity and having an understanding for how those apply according to ASAM criteria versus individual clinician's understanding.
22	Cont. stay is not based on progress on measurable goals and objectives.
23	Identifying medical necessity for Dimension 2 can be difficult with the descriptions provided.
24	Currently we're providing a very high number of service hours to our residential clients. It's difficult to provide more individualized services such as more individual psychotherapy, case management or specialized groups due to the amount of staff focused on providing the agency's set minimum service hours for this level of care.
25	See previous remarks
26	Providers complete this are with redundancy of historical data and not enough of what the current sxs are, current dx if the member is being treated, labs needed or past labs.
27	again MCO using their interpretation of text to approve or decline client's coverage, OFTEN not aligning with the client's providers/clinicians view
28	1. Criteria tend to be overly extensive with some repetition in different Dimensions. 2. For some services, it is unclear if they are requirements or just recommendations (in a managed care environment, providers tend to ignore recommendations).
29	Misinterpretations and different interpretations. Health plans using only bits and pieces of criteria not the criteria as a whole.
30	Not having all levels of care available for the client to utilize.
31	Legal involvement causing treatment to keep clients longer than ASSM recommends. Programs following court pressure and not clearly advocating for clients. Staying in residential too long.
32	Sometimes even when insurance companies are using ASAM, they are applying their own interpretation of "medical necessity" which are not in ASAM. For example, suicidal ideation.
33	The most common errors I have found are staff not understanding the typical treatment settings for a level 3.1, not understanding that 3.3 is not an automatic stepdown but a level of care for specialized populations and the confusion between the 3.7 and 4.0 levels of care when designating
34	Some of the same challenges at all levels of care. it is supporting ASAM criteria in the

35	threshold for RTC level of care seems too high on ASAM criteria.
36	See question 14.

Q41 Level 3: Overall: What are your recommendations for the 4th edition of The ASAM Criteria?

Answered: 31 Skipped: 193

#	RESPONSES
1	Put more weight in Dim 4, 5, 6 as that's the reason for residential at times.
2	Noted above: Consider limiting level of ASAM Level 3 to levels 3.1 and 3.5, and firmly establish clinical expectations for level 3.1 which could potentially assist with addressing a nationwide concern over how "sober living" is defined More clearly separate Inpatient from Residential care. It was observed that ASAM tends to refer to residential care as inpatient care and this leads to confusion for end users about the level of care and intensity of service being provided. This is particularly aimed at Level 3.7 which has the title Medically Monitored Intensive Inpatient Treatment. Those facilities have a residential license from their various States and not an inpatient hospital license. By using the inpatient label for both Level 4 care and Level 3.7 care it creates confusion Providing thorough training on the provider's side on both multidimensional assessment
3	ASAM Recommendations • Updated treatment perspective: Since the last ASAM edition was printed in 2013, a lot has happened in the treatment of addiction, especially with opioids. The newest edition would need an updated treatment perspective with the most updated research cited in its text. • ASAM for Managed Care: There is current advocacy for using ASAM criteria for Managed Care and many states now require use of ASAM criteria for Medical Necessity determination which directly contradicts the ASAM book itself where it clearly states it was not designed for medical necessity decisions. • Poor Inter-rater reliability. Consistent determinations are difficult for medical necessity – making providers having consistent expectations from the MCO's difficult. • Electronic Template is limited and cost prohibitive: The majority of providers are not submitting their Medical Necessity requests based on the tool, which makes it difficult to apply ASAM criteria. o Time to complete the electronic tool is prohibitive. o There is a lack of transparency in the electronic tool when a decision is rendered; You put in data and it outputs a decision. • Lack of evidence (in Levels of Care): Need better evidence to justify the designed levels of care. Need to go beyond expert or consensus opinion (least reliable method of evidence). Cite and list research. • Need better reference to criteria: Info is not laid out in a way that references their opinion. Making it difficult to easily support determinations based on the criteria. For example, when referencing Withdrawal Management, you must go back and forth to multiple sections to combine relevant information to make a thorough determination. Another example would be determining medical necessity across substances. Very disjointed and often times, not specific or ill defined. Opinions do not cite the research info where they are referenced • Criteria are nebulous and poorly defined: Have to jump sections to pull together. Criteria are often not specific and ASAM itself notes that they are not for Medical Necessity. o Example #1 – Continued stay criteria (Residential) are very general; it discusses making progress or lack of progress, but does not go into specifying clearly what they need to be working on in that LOC. o • No Guidance on Length of Stay (LOS): No listed expectation on any length of stay (LOS) or average LOS. MCO's are left to

4	• Criteria are nebulous and poorly defined: Have to jump sections to pull together. Criteria are often not specific and ASAM itself notes that they are not for Medical Necessity. o Example #1 – Continued stay criteria (Residential) are very general; it discusses making progress or lack of progress, but does not go into specifying clearly what they need to be working on in that LOC. • ADD Length of Stay recommendations; No Guidance on Length of Stay (LOS): No listed expectation on any length of stay (LOS) or average LOS. MCO's are left to speculate on a reasonable timeframe. No research cited. Residential Utilization lacks efficacy or research and none is cited in ASAM for use of Residential services
5	Some of the standards are very burdensome and do not truly reflect the level of care and patient functionality within the level of care they are being served. Also, some of the standards do not reflect patient choice and decision making for their own care. Such as, requiring patients receive a physical examination while in 3.5. Some patients report to be in fine health and appear to be so following completion of a comprehensive health screen. The intrusive nature of a physical exam that is not requested by the patient, nor flagged as needed during the comprehensive health screen, seems invasive and does not reflect the patient's choice in deciding their own health care. Not to mention the expense associated with having to deliver this service - as insurance companies typically do not pay for this service and thus agencies are left to absorb more and more expenses such as these. Some patients will have had a physical examination done at withdrawal management, hospital, etc. just days before admission, yet the standard states we have to do it again within 48-hours of admission. Not all programs have the capacity to provide both SUD and MH services onsite - some have to contract out services, or only provide one type of service at
6	None noted
7	More discussion on requirements for 3.1 who wants to develop programs specifically for pregnant women and women with children.
8	Overall changes recommended include delineating clinical treatment time requirements for residential treatment levels of service, including induction as part of withdrawal management, more emphasis on family involvement in levels of care, and inclusion of measurement-based care.
9	Speak more to the 20 required treatment hours per week, specifically how programs can have residential aides or other non-clinical staff facilitate recovery support activities to count towards the 20 treatment hours - healthy group - walking, working out, knitting, storytelling, programs experience issues around having enough counselors to meet all the requirements of the State, 1115 waiver requirements, insurance requirements etc. so treatment team is a mix of clinical and
10	Clearly outline additional continued stay criteria. Adapt criteria for managed care companies so that there is more consistency and accountability with managed care companies.
11	I'm not qualified to say.
12	none currently
13	Suggested added wording to dimensions for in levels 3.5 and 3.7: "However, the patient's willingness to participate in treatment and to explore his or her level of awareness and readiness to change suggest that treatment at level 3.5 can be effective."
14	none
15	There seems to be a discrepancy between how ASAM conceptualizes residential level 3.1 and how this level of care is viewed in California's implementation of its Drug Medi-Cal Organized Delivery System waiver. Specifically, ASAM states that the minimum number of clinical hours in residential level 3.1 is only 5 hours per week and in discussions with ASAM leadership, this level of care has been described as a "halfway house" model of care. However, in CA, outpatient services require up to 19 hours of service per week and residential 3.1 is typically treated as a higher level of care with more clinical service hours than outpatient services, which seems reasonable. Suggest that ASAM review if the minimum level of clinical service hours in 3.1 makes sense to maintain at 5 hours per week, and recommend considering increasing this clinical service hour minimum so that residential services are treated as a higher level of care than outpatient services, which seems ideal considering that this is how counties are structuring residential rates (as a higher level of care with
16	ask about childhood trauma
17	None

18	Adding useful and understandable identifiers for how third party payors determine various LOC because there seems to be a significant gap between those definitions and the understanding of those serving the clients.
19	See # 14.
20	That medical necessity in Dimensions 2 and 3 be clearer and easier to identify and delineate between level 2.5 and 3.5.
21	Please add a minimum service hours for all residential levels of care with the consideration that group living skills, socialization with peers and downtime can also be important recovery skills which may not be captured in direct service such as case management, psychotherapy or group
22	Make available some kind of free resource containing basic information needed by practitioners/institutions.
23	1. Try to make criteria more focused and concise. 2. Eliminate redundancies between Dimensions. 3. Clearly indicate which service criteria are seen as mandatory.
24	See #14.
25	Shorten the assessment.
26	More clarification in the areas mentioned above. How about a call-in line like the SASSI? Just
27	Clearly state what facilities are allowed to offer which levels. Does ASAM support only hospital offering 3.7? If not, please specifically say that residential programs have the potential to offer 3.7, if they can do so safely. Be clear that outdated insurance requirements are debunked. For example, being in 3.7 does not require SI/HI (obviously if there was active SI/HI they person would need inpatient mental health treatment). Also, insurance companies often don't want to authorize treatment for individuals who haven't failed first at a lower level of care and alternatively tend to deny residential if the individual has had "too much" treatment.
28	See above
29	none other than flexibility or more support for judgment for relapse.
30	lower the threshold a little for RTC criteria.
31	See question 14.

Q42 Level 3: Standards that relate to treatment setting: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 20 Skipped: 204

#	RESPONSES
1	Noted above: limit level of ASAM Level 3 to levels 3.1 and 3.5, and firmly establish clinical expectations for level 3.1 which could potentially assist with addressing a nationwide concern over how "sober living" is defined.
2	See answer in #41
3	Treatment hours should explicitly include a wider range of activities.
4	Clear delineation on the role of peers in this setting. Best treatment practices, including evidence-based practices.
5	Include clinical time requirements or recommendations for a treatment week of seven days, measurement-based care that can be used across all four levels to determine length of staff requirements for the continuum of pharmacotherapy at admission, during treatment and upon transfer to another level of care, family involvement, including a minimum of education and steps for more advance family interventions

6	Adapt clauses or criteria that relate to concerns surrounding linkage to community supports in event of uncontrollable circumstances such as Covid 19 which created significant barriers to safe and structured discharge to the community. Identify readiness to change more clearly. Clients can often present in treatment with readiness to change, however are unable to apply learned skills in the community setting without supportive interventions. If a client is making progress in treatment as they should, they are often denied additional time due to progress in
7	Not qualified to say specifically.
8	I think the strengths based nature of ASAM works well
9	no issues
10	short for 3,5 LOC
11	None
12	This seems to be the most difficult aspect for assessing the client and situation, so it would be beneficial to factor the client's status ONLY based on the particular treatment setting and the services/support they are receiving and requiring in order to maintain at their current status.
13	I would clearly match the S/LOF rating scores, matched with the Intensity of Service and LOC placement.
14	as above
15	Clarification that 3.1 is a residential level of care and not just sober living.
16	The SMI population needs services that fit their disorders and recovery process.
17	3.7 can be done in residential.
18	It is also confusing for some, as mentioned in the previous level of care, to integrate the co-occurring enhanced versus capable programs within all the levels of care for 3.1 and greater. Streamlining these could assist greatly for those programs who are not strictly substance abuse providers but have a larger combination of those with SUD and MH.
19	Same as the other levels. I think all different treatment settings are necessary.
20	See question 14.

Q43 Level 3: Multidimensional assessment and treatment planning standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 20 Skipped: 204

#	RESPONSES
1	The use of multidimensional assessment, at the core, is well formulated and well intentioned. However, this tends to be used loosely when making final clinical determinations regarding placement, particularly when there are factors such as housing insecurity, lack of specific levels of care within a particular community, and various other barriers such as cost and feasibility for an individual to make child care arrangements. The fourth edition could call this out overtly and offer pragmatic solutions to these common scenarios. Additionally, the fourth edition could provide frameworks for documentation of these dynamics using current references to "social determinants of health" as well as make reference to the ability to document these SDOH concerns using
2	See answer in #41
3	None noted.

4	Further guidance is needed on the definition of individualized treatment. Currently, individualized care is interpreted as needs of specialty populations (i.e. parents with children, LGBTQIA+, veterans), rather than looking at the individual receiving services that might not fall under a specialty population, but still needs an individualized treatment regimen. Additional guidance is needed on how to develop a treatment plan based off the assessment, especially as it relates to evidence-based practices. Additional guidance is needed on evidence-based practices as they relate to treatment of substance use disorders, as some providers are using multiple evidence-based practices on one individual receiving services, some of which are not evidence-based for substance use disorders or for the level of service the person is receiving.
5	These should follow the "golden thread" model, where what is identified in the assessment should correlate into treatment plan. Most managed care companies are requiring treatment plans to be submitted for determination of continued stay.
6	Not qualified to opine.
7	none at present
8	nothing
9	n/a
10	None
11	It might be more efficient and useful to have more of a "decision tree" method for some of the sections within the various domains. There seems to be a number of sections for any given client that are not applicable, but then continue to require being addressed throughout an assessment in order to meet standards.
12	Emphsize a need to have a clinical information flow-over from the MD assessment onto the problem statment on the ITP.
13	as above
14	Recommended discharge criteria in addition to admission criteria.
15	NA
16	This is a great area to start applying ASAM but we are still learning in our system. Sometimes the treatment plan is done at the beginning of treatment and subsequently never updated.
17	none.
18	same . Have one major owner of the treatment plan taking in account the whole person for treatment including the multidimensional standards.
19	In my opinion, dimension five seems a little unnecessary the way it is written now. All the pts we see in treatment are considered high risk for relapse and since they are usually all rated as high, it should be a given and not needed to rate.
20	See 14

Q44 Level 3: Staffing standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 18 Skipped: 206

#	RESPONSES
1	Staffing standards should be clearly defined to include the incorporation of peer recovery support specialists, care coordinators, and other non-clinical support staff for each of the ASAM level 3 levels of care.
2	Number of staff per level of care would be nice. None noted and states tend to make them up based on recommendations from provider only groups. Emphasis on use of Peers
3	See answer in #41
4	Funders need to provide adequate compensation for organizations to meet staffing standards. This isn't happening.

5	Define required staffing per patient ratio.
6	We support telehealth services but want to make sure physician is part of the treatment team and understands how to support treatment. There is bare minimum in-person time for physicians at some agencies. We do not want to create barriers to access, but we want to ensure physicians understand the culture at agency and monitoring processes. When physical exams are done at some agencies, people are not required to take off shirts or shoes. This led to the provider not being aware of infection sites and abscess sites, as common injection sites were not checked during the physical exam. Guidance in best practice in telehealth expectations for physical health
7	N/A
8	See #15 above. The higher the educational standards, the better, current cost structures notwithstanding. The days of the peer experienced and qualified operators and staff are gone if a professional response to this national tragedy is to be successfully addressed. Peers are needed and are helpful, but only in limited and more personal roles.
9	none
10	nothing
11	Make sure all staff receive training yearly
12	It would be greatly beneficial to identify and declare what is most beneficial for this client population as indicated by empirical data rather than leaving so much latitude to each agency. There is too much variance for what is offered or required and it significantly impacts how the clients meet or may meet the ASAM criteria.
13	Making the argument for integrated care with on site nursing and medical care being provided.
14	as above
15	The staff are trained in the application of the ASAM.
16	None.
17	Increased mention of the ability for a physician OR nurse practitioner (in areas allowed) should be included. Nurse Practitioners are a vital part to the multidisciplinary team and can offer vital services including diagnosis, mediation management and treatment planning. The term “appropriately credentialed addiction professionals” is seen in many areas throughout the ASAM Manual. Does this include those who are an LPC,MFT, LCSW, etc or those who need to hold a CADC, LCADC, etc? What does the term “appropriately credentialed additional professional” mean regarding training and certification? This needs to be better clarified.
18	same as what I recommended in 2.1 . smaller groups to accommodate more focused care.

Q45 Level 3: Support system standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 15 Skipped: 209

#	RESPONSES
1	There should be clear guidance as to the leveraging of integrated health solutions such as partnering with physical health and outpatient entities.
2	See answer in #41
3	None noted.
4	Inclusion of certified recovery specialists across the continuum of care to ensure this service is offered in each level of care. Some residential programs believe having techs with lived experience is the same as having a certified recovery specialist, which is not the same.
5	Support systems is a critical element in transitioning from residential treatment to the community. Allowing additional time or set standards to address lack of recovery housing or community supports would be helpful.

6	Include language regarding care coordination across Levels, and guidance on aftercare supports post-completion of Level 3.1 in order to sustain recovery.
7	Not qualified to say.
8	None...I feel that the strengths based holistic nature of ASAM works well
9	this level has both clinically and medically managed levels - may more definition between 3.5 and
10	None
11	It would be extremely helpful to give more definition for the various kinds of support within a client's recovery. For example, family support, peer support, recovery support, work support, etc.
12	Clarification that 12-step programming is not a requirement of ASAM. Other supports, mentors, etc. are also acceptable and individuals have other options outside of strictly 12-step programming and sponsorship.
13	NA
14	None.
15	same as 2.1 definition of family as multi dimensional as the patient sees it.

Q46 Level 3: Therapies standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 17 Skipped: 207

#	RESPONSES
1	See answer in #41
2	None noted.
3	Guidance that a substance use disorder alone cannot be the justification for treatment. Providers need to identify problems (outside of substance use) and how the problems can be addressed during that level of care. Providers need a better understanding of evidence-based practices as they apply to levels of care and realistic expectations of what can be resolved during the treatment episode (i.e. trauma may be more effectively addressed in outpatient services, but groundwork can start in a residential program). Residential levels should have a clinical service hourly expectation, as providers are using the lack of expectation as justification that 1-2 hours of clinical services per day, 5 days per week, in residential treatment is sufficient.
4	If not providing minimum weekly clinical hours for Levels 3.5 and 3.7, possibly provide recommendations. Additional guidance related to clinical therapies provided by therapist/consolers, and support services provided by allied health professionals would be helpful.
5	Criteria in current addition is pretty well defined and accurately reflect needs of residential clients. Again adopting standardized regulations/criteria for managed care companies to utilize would be beneficial. Often we are tailoring treatment needs based off of managed care criteria as well ASAM criteria.
6	For Levels 3.5 and 3.7, include criteria for polysubstance stimulant use, particularly
7	Not qualified to say.
8	NONE
9	none
10	None
11	Similar to question 20, it would be highly beneficial to give more definition to what is expected or defined within various aspects of the criteria, which would also lend to more understanding for what will need to take place in order to make progress to a lower LOC.
12	as above
13	Best evidence-based therapy practices
14	NA
15	None.

16	as long as they are evidenced based I am fine with what ASAM recommends.
17	family education and involvement during care, and document why not doing so would be contraindicated. identify triggers to relapse identify healthy coping skills verify placement plan within 3-4 days of admit, as homelessness is common among this population aggressively pursue sober living placement if that is needed. address and treat comorbid MH and medical issues. strongly encourage MAT, especially Vivitrol.

Q47 Level 3: Documentation standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 16 Skipped: 208

#	RESPONSES
1	Providers are not always well trained in multidimensional assessment and information provided often not thorough enough to support need for a specific LOC in particular for this LOC as there is confusion between the various levels of residential.
2	Standard templates or documentation to submit for a Med Necessity claim would be
3	See answer in #41
4	In our organization, the amount of time and resources dedicated to documentation frequently negatively impacts the clinical care we provide. Hence I would hope for a conservative approach to mandating specific documentation standards in the next edition.
5	Clarification is needed that the documentation to relate back to the treatment plan. Additionally that the group note should not be the same for every person receiving services as a standard note.
6	Address treatment plan update requirements to correlate with state/Medicaid requirements. Again managed care companies are tending to dictate when treatment plan updates are needed based off the time approved for continued stay requests.
7	Not qualified to say.
8	None
9	none
10	None
11	It would be helpful to guide clinicians more on what topics, issues, areas, language within the domains are needed and considered by third party payors as well as accrediting bodies.
12	How the provider can document patient progress based on measurable goals and objectives.
13	Once again we use the DMC standards.
14	None.
15	This continues to be the biggest challenge , maybe clearly guidelines .
16	make them affordable and easily accessible online and on apps.

Q48 Level 3: Adult dimensional admission criteria: Do the dimensional admission criteria presented in the textbook support you in making Level of Care placement decisions? What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 15 Skipped: 209

#	RESPONSES
1	See answer in #41

2	They do support placement decisions. A more robust engagement of the interplay between trauma and addiction from assessment forward could make dimensional admission criteria more helpful.
3	If the risk level is retained, there needs to be more emphasis in the book about the importance of the risk level and clearly delineate the risk. Providers have been resistant with providing a risk level, including establishing a risk level. Some providers believe that everyone in residential treatment has the highest risk across all dimensions, justifying this as the need for residential placement, rather than using the risk to identify treatment needs and areas of focus that can be addressed at
4	Admission criteria is pretty well defined.
5	Take into consideration the Social Determinants of Health as they are critical factors that impact SUD individuals' potential for relapse. For example, homelessness, unemployment, lack of education or vocational skills, food insecurity, lack of childcare, environmental stressors etc. all play an important role in achieving and maintaining recovery. Consider including guidance relative to cultural diversity, non-English speaking populations, and LGBTQ+ populations.
6	Not qualified to say.
7	Yes the admission criteria supports our work; no recommendations
8	yes
9	None
10	YES!
11	Admission criteria are comprehensive and detailed. We sometimes have issues determining when an individual is ready for discharge because arguments can be made for meeting both level 2 and level 3 services.
12	NA
13	Yes.
14	Again, valuable information is presented within adult dimensional criteria to assess appropriate level of care but the way it is presented is complex and difficult to ascertain when comparing with the other levels. It is recommended to do a more comprehensive but more concise chart, as ASAM has on page 175 – 176 that is only for the Level 3.1 – 3.7 levels of care. It is also confusing for some, as mentioned in the previous level of care, to integrate the co-occurring enhanced versus capable programs within all the levels of care for 3.1 and greater. Streamlining these could assist greatly for those programs who are not strictly substance abuse providers but have a larger combination of those with SUD and MH.
15	yes . N/A

Q49 Level 3: Adolescent dimensional admission criteria: Do the dimensional admission criteria presented in the textbook support you in making Level of Care placement decisions? What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 14 Skipped: 210

#	RESPONSES
1	See answer in #41
2	Guidance is needed on the importance of the stages of change in treatment, as some residential providers report that adolescents remain in the precontemplation stage of change for six months or longer. Guidance on shifting focus from a person's illness to a person's progress. Guidance on determination of the effectiveness of the level of service and how to transition someone if the service is ineffective.
3	Expand it to younger age levels.
4	n/a

5	Consider pulling out adolescent-related admission criteria into their own dedicated section, as the current framework of having adolescent sections built into adult sections can be counter to adolescent service providers' ability to quickly/consistently using the Criteria (i.e. preventing the need to hunt and peck through multiple adult-focused sections for the adolescent-devoted
6	Not qualified to say.
7	n/a
8	yes
9	None
10	N/A-Our programs do not currently serve this population.
11	NA
12	N/a
13	N/A
14	N/A

Q51 Level 4: Overall: Is this level clearly delineated? If no, tell us how it could be clarified.

Answered: 14 Skipped: 210

#	RESPONSES
1	Yes, probably LOC for which need is most easily defined.
2	• Criteria are nebulous and poorly defined: Have to jump sections to pull together. Criteria are often not specific and ASAM itself notes that they are not for Medical Necessity. o Example – Level 4.0. Symptoms listed for medical necessity for inpatient withdrawal management are vague (i.e. severe vomiting, seizures and diarrhea) and lack medical specificity, where MCG might list specific signs. (Listing current vital signs of dehydration when discussing vomiting and diarrhea or specific history when discussing seizures). • No Guidance on Length of Stay (LOS): No listed expectation on any length of stay (LOS) or average LOS. MCO's are left to speculate on a reasonable timeframe. No research cited. • ASAM for Managed Care: There is current advocacy for using ASAM criteria for Managed Care and many states now require use of ASAM criteria for Medical Necessity determination which directly contradicts the ASAM book itself where it clearly states it was not designed for medical necessity decisions
3	n/a
4	Further clarification for staffing requirements and programming examples for level 4 programs. Title is confusing - seems to only apply to OTPs even though most OTPs are outpatient services. Is this only for withdrawal management services?
5	Can there be greater specification and clarity around the distinction between 3.7d and 4.0? Can there be more emphasis regarding supports to assist with the eventual step down? Could there be more standard protocols; insufficient use of induction vs detoxifying off opioids; evidence for 24/7 monitoring .
6	This level is clearly delineated however it often times means some patients do not qualify for this level of care that really need acute medical detox services.
7	No, it is too similar to 3.7. It is very difficult for payors to understand as well. The biggest issue is when a patient presents, prior to doing labs and observing them for a time, to know whether they will require 4.0 or 3.7, for both alcohol and opioid withdrawal. Until you have additional data, we put patients in 4.0 for safety, but payors look retrospectively and use that to deny care. 4.0 should specify risk of significant withdrawal as a reason for admission. Additionally, there should be mention of potential of need for not only IV fluids/medications but consults from specialists.
8	yes

9	Strongly suggest that ASAM consider changing inpatient level 3.7 numbering to 4.1 to minimize confusion with level 3.7 being referred to as "residential" when in fact it should be "inpatient"
10	NO - providers are not able to identify the stages of change and are not able to provide evidence to support their statements. I do believe it also needs to include more about motivational interviewing to assist the member of moving towards changing their lives and meeting the member where they are at in the process it is also important to not allow the member to become stagnant
11	Yes
12	Our agency does not have any contracts with Level 4 providers in our Provider Network. As such, we have littel to no experience with this level.
13	It would help to have better clarification of Level 4. Some states license what might be otherwise known as Levl 3 as Inpatient. It could help to clarify Inpatient vs. residential.
14	Many providers don't understand difference between 3.7 and 4.0. Need clear specification.

Q52 Level 4: Overall: What is working well?

Answered: 5 Skipped: 219

#	RESPONSES
1	Multidimensional assessment
2	The ASAM Criterial brings the medical presence back into SUD services, where it was missing in the past.
3	For those that are at this level it is about not only providing treatment for the individual but also being able to justify the level with their insurance company in order to get them to authorize treatment so the patient is not left with the entire bill to pay.
4	definitions are clearly stated
5	The process is working well.

Q53 Level 4: Overall: What challenges have you observed?

Answered: 6 Skipped: 218

#	RESPONSES
1	Hospital settings have little incentive to work with local providers to offer alternative community options for Inpatient stays. ASAM mentions the need to work on Collaborations in the community with provider groups but does not hold them accountable when they cite alternative options are not available in the community

2	Guidance is needed in terms of length of stay and elimination of program-driven care. Providers focus on length of stay, rather than emphasis of treatment required for the individual receiving services. There is no research behind the length of stay in residential settings, nonetheless, providers have created admission and treatment protocols around fixed episodes of care. Integrating measurement-based care would help residential and OP treatment programs in transitioning from fixed episode of care, based on historical funding protocols, to patient-centered care, based on reliable metrics of progress. We suggest including existing scales, such as the brief addiction measure (BAM) and other metrics, such as employment, housing stability or reductions in substance use via biomarkers or developing hybrid measures. The goal would be to use these tools across the continuum to assist providers in determining progress as well as tailoring lengths of stay within a level of care. Enhanced guidance is needed on the application of individualized treatment towards everyone receiving services, not only people that might fall into a specialty population. A related metric is continuum of pharmacological treatments across levels of care. Treatment providers in PA continue to view pharmacological interventions as separate from ASAM levels of care, instead of an essential element within all levels of care. We suggest emphasizing pharmacological interventions as essential elements within and across the four levels of care in the next edition. Notably, the menu of evidence-based medications for SUDs will likely expand before and after the next evolution of ASAM criteria. Treatment providers
3	Lack of standardization of assessment tools
4	none specifically
5	none
6	The length of the assessment is a challenge for the tis level of client.

Q54 Level 4: Overall: What are your recommendations for the 4th edition of The ASAM Criteria?

Answered: 7 Skipped: 217

#	RESPONSES
1	For both levels 4 and 3.7-WM it would be good to have some guidelines included on some of the newer drugs/substances being abused by members including ketamine, methamphetamine, “Bath salts", cough syrups, prescribed stimulants and other Club drugs as we know that these drugs can lead to significant medical and behavioral issues. Create or use some type of scale that measures the consequences of the use of these drugs. Some of these drugs may require
2	• Criteria are nebulous and poorly defined: Have to jump sections to pull together. Criteria are often not specific and ASAM itself notes that they are not for Medical Necessity. o Example– Level 4.0. Symptoms listed for medical necessity for inpatient withdrawal management are vague (i.e. severe vomiting, seizures and diarrhea) and lack medical specificity, where MCG might list specific signs. (Listing current vital signs of dehydration when discussing vomiting and diarrhea or specific history when discussing seizures)
3	• Need better reference to criteria: Info is not laid out in a way that references their opinion. Making it difficult to easily support determinations based on the criteria. For example, when referencing Withdrawal Management, you must go back and forth to multiple sections to combine relevant information to make a thorough determination. Another example would be determining medical necessity across substances. Very disjointed and often times, not specific or ill defined. Opinions do not cite the research info where they are referenced • Better defined Admission criteria: Criteria are nebulous and poorly defined: Have to jump sections to pull together. Criteria are often not specific and ASAM itself notes that they are not for Medical Necessity. o o Example #2 – Level 4.0. Symptoms listed for medical necessity for inpatient withdrawal management are vague (i.e. severe vomiting, seizures and diarrhea) and lack medical specificity, where MCG might list specific signs. (Listing current vital signs of dehydration when
4	Overall changes recommended include delineating clinical treatment time requirements for residential treatment levels of service, including induction as part of withdrawal management, more emphasis on family involvement in levels of care, and inclusion of measurement-based care.
5	none
6	Strongly suggest that ASAM consider changing inpatient level 3.7 numbering to 4.1 to minimize confusion with level 3.7 being referred to as "residential" when in fact it should be "inpatient" services.
7	NA

Q55 Level 4: Standards that relate to treatment setting: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 4 Skipped: 220

#	RESPONSES
1	Emphasis that OUD is often most appropriately treated in the outpatient setting Emphasis on MAT in the ED
2	Include clinical time requirements or recommendations for a treatment week of seven days, measurement-based care that can be used across all four levels to determine length of staff requirements for the continuum of pharmacotherapy at admission, during treatment and upon transfer to another level of care, family involvement, including a minimum of education and steps for more advance family interventions
3	none
4	NA

Q56 Level 4: Multidimensional assessment and treatment planning standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	Further guidance is needed on the definition of individualized treatment. Currently, individualized care is interpreted as needs of specialty populations (i.e. parents with children, LGBTQIA+, veterans), rather than looking at the individual receiving services that might not fall under a specialty population, but still needs an individualized treatment regimen. Additional guidance is needed on how to develop a treatment plan based off the assessment, especially as it relates to evidence-based practices. Additional guidance is needed on evidence-based practices as they relate to treatment of substance use disorders, as some providers are using multiple evidence-based practices on one individual receiving services, some of which are not evidence-based for substance use disorders or for the
2	none
3	NA

Q57 Level 4: Staffing standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	We support telehealth services but want to make sure physician is part of the treatment team and understands how to support treatment. There is bare minimum in-person time for physicians at some agencies. We do not want to create barriers to access, but we want to ensure physicians understand the culture at agency and monitoring processes. When physical exams are done at some agencies, people are not required to take off shirts or shoes. This led to the provider not being aware of infection sites and abscess sites, as common injection sites were not checked during the physical exam. Guidance in best practice in telehealth expectations for physical health examinations
2	none
3	NA

Q58 Level 4: Support system standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	Inclusion of certified recovery specialists across the continuum of care to ensure this service is offered in each level of care. Some residential programs believe having techs with lived experience is the same as having a certified recovery specialist, which is not the same.
2	none
3	NA

Q59 Level 4: Therapies standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	Guidance that a substance use disorder alone cannot be the justification for treatment. Providers need to identify problems (outside of substance use) and how the problems can be addressed during that level of care. Providers need a better understanding of evidence-based practices as they apply to levels of care and realistic expectations of what can be resolved during the treatment episode (i.e. trauma may be more effectively addressed in outpatient services, but groundwork can start in a residential program). Residential levels should have a clinical service hourly expectation, as providers are using the lack of expectation as justification that 1-2 hours of clinical services per day, 5 days per week, in residential treatment is sufficient.
2	none
3	NA

Q60 Level 4: Documentation standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	Clarification is needed that the documentation to relate back to the treatment plan. Additionally that the group note should not be the same for every person receiving services as a standard note.
2	none
3	NA

Q61 Level 4: Adult dimensional admission criteria: Do the dimensional admission criteria presented in the textbook support you in making Level of Care placement decisions? What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	If the risk level is retained, there needs to be more emphasis in the book about the importance of the risk level and clearly delineate the risk. Providers have been resistant with providing a risk level, including establishing a risk level. Some providers believe that everyone in residential treatment has the highest risk across all dimensions, justifying this as the need for residential placement, rather than using the risk to identify treatment needs and areas of focus that can be addressed at that level of care.
2	yes
3	NA

Q62 Level 4: Adolescent dimensional admission criteria: Do the dimensional admission criteria presented in the textbook support you in making Level of Care placement decisions? What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	Guidance is needed on the importance of the stages of change in treatment, as some residential providers report that adolescents remain in the precontemplation stage of change for six months or longer. Guidance on shifting focus from a person's illness to a person's progress. Guidance on determination of the effectiveness of the level of service and how to transition someone if the service is ineffective.
2	yes
3	NA

Q64 Level 1-WM: Overall: Is this level clearly delineated? If no, tell us how it could be clarified.

Answered: 5 Skipped: 219

#	RESPONSES
1	n/a
2	Needs to take into account advances in outpatient detoxification and induction into buprenorphine and Inj-NTX.
3	Delineating clearly between addressing acute withdrawal and Post Acute Withdrawal.
4	I agree this level is clearly delineated.
5	.

Q65 Level 1-WM: Overall: What is working well?

Answered: 3 Skipped: 221

#	RESPONSES
1	The ASAM Criterial brings the medical presence back into SUD services, where it was missing in the past.
2	Determining the risk level of withdrawals to determine if medical detox is needed which can be challenging for
3	.

Q66 Level 1-WM: Overall: What challenges have you observed?

Answered: 4 Skipped: 220

#	RESPONSES
1	Guidance is needed in terms of length of stay and elimination of program-driven care. Providers focus on length of stay, rather than emphasis of treatment required for the individual receiving services. There is no research behind the length of stay in residential settings, nonetheless, providers have created admission and treatment protocols around fixed episodes of care. Integrating measurement-based care would help residential and OP treatment programs in transitioning from fixed episode of care, based on historical funding protocols, to patient-centered care, based on reliable metrics of progress. We suggest including existing scales, such as the brief addiction measure (BAM) and other metrics, such as employment, housing stability or reductions in substance use via biomarkers or developing hybrid measures. The goal would be to use these tools across the continuum to assist providers in determining progress as well as tailoring lengths of stay within a level of care. Enhanced guidance is needed on the application of individualized treatment towards everyone receiving services, not only people that might fall into a specialty population. A related metric is continuum of pharmacological treatments across levels of care. Treatment providers in PA continue to view pharmacological interventions as separate from ASAM levels of care, instead of an essential element within all levels of care. We suggest emphasizing pharmacological interventions as essential elements within and across the four levels of care in the next edition. Notably, the menu of evidence-based medications for SUDs will likely expand before and after the next evolution of ASAM criteria. Treatment providers
2	Defining medical necessity for PAWS treatment.
3	Defining tolerability
4	.

Q67 Level 1-WM: Overall: What are your recommendations for the 4th edition of The ASAM Criteria?

Answered: 4 Skipped: 220

#	RESPONSES
1	Overall changes recommended include delineating clinical treatment time requirements for residential treatment levels of service, including induction as part of withdrawal management, more emphasis on family involvement in levels of care, and inclusion of measurement-based care.

2	That PAWS language be more prominent.
3	Having a clearer definition of tolerating withdrawal symptoms
4	.

Q68 Level 1-WM: Standards that relate to treatment setting: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 4 Skipped: 220

#	RESPONSES
1	n/a
2	That language where level 1WM integrates with other ASAM levels be added in.
3	Having a clearer definition of tolerating withdrawal symptoms which can be helpful for clinicians.
4	.

Q69 Level 1-WM: Multidimensional assessment and treatment planning standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 4 Skipped: 220

#	RESPONSES
1	Further guidance is needed on the definition of individualized treatment. Currently, individualized care is interpreted as needs of specialty populations (i.e. parents with children, LGBTQIA+, veterans), rather than looking at the individual receiving services that might not fall under a specialty population, but still needs an individualized treatment regimen. Additional guidance is needed on how to develop a treatment plan based off the assessment, especially as it relates to evidence-based practices. Additional guidance is needed on evidence-based practices as they relate to treatment of substance use disorders, as some providers are using multiple evidence-based practices on one individual receiving services, some of which are not evidence-based for substance use disorders or for the
2	Additional guidance regarding WM at this level and how it may be incorporated into an individuals overall care or whether WD is a stand alone service would be helpful.
3	NA
4	.

Q70 Level 1-WM: Staffing standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	We support telehealth services but want to make sure physician is part of the treatment team and understands how to support treatment. There is bare minimum in-person time for physicians at some agencies. We do not want to create barriers to access, but we want to ensure physicians understand the culture at agency and monitoring processes. When physical exams are done at some agencies, people are not required to take off shirts or shoes. This led to the provider not being aware of infection sites and abscess sites, as common injection sites were not checked during the physical exam. Guidance in best practice in telehealth expectations for physical health examinations

2	provide more specific criteria
3	.

Q71 Level 1-WM: Support system standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	Inclusion of certified recovery specialists across the continuum of care to ensure this service is offered in each level of care. Some residential programs believe having techs with lived experience is the same as having a certified recovery specialist, which is not the same.
2	NA
3	.

Q72 Level 1-WM: Therapies standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	Guidance that a substance use disorder alone cannot be the justification for treatment. Providers need to identify problems (outside of substance use) and how the problems can be addressed during that level of care. Providers need a better understanding of evidence-based practices as they apply to levels of care and realistic expectations of what can be resolved during the treatment episode (i.e. trauma may be more effectively addressed in outpatient services, but groundwork can start in a residential program). Residential levels should have a clinical service hourly expectation, as providers are using the lack of expectation as justification that 1-2 hours of clinical services per day, 5 days per week in residential treatment is sufficient.
2	see above
3	.

Q73 Level 1-WM: Documentation standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 2 Skipped: 222

#	RESPONSES
1	Clarification is needed that the documentation to relate back to the treatment plan. Additionally that the group note should not be the same for every person receiving services as a standard note.
2	.

Q74 Level 1-WM: Risk rating matrices: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 2 Skipped: 222

#	RESPONSES
1	If the risk level is retained, there needs to be more emphasis in the book about the importance of the risk level and clearly delineate the risk. Providers have been resistant with providing a risk level, including establishing a risk level. Some providers believe that everyone in residential treatment has the highest risk across all dimensions, justifying this as the need for residential placement, rather than using the risk to identify treatment needs and areas of focus that can be addressed at that level of care.
2	.

Q75 Level 1-WM: Withdrawal management dimensional admission criteria: Do the dimensional admission criteria presented in the textbook support you in making Level of Care placement decisions? What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 2 Skipped: 222

#	RESPONSES
1	Yes, the dimensional admission criteria presented were supportive of making a level of care placement.
2	.

Q77 Level 2-WM: Overall: Is this level clearly delineated? If no, tell us how it could be clarified.

Answered: 6 Skipped: 218

#	RESPONSES
1	Yes, it is
2	n/a
3	Excellent all
4	let providers know that can bill separately for the Residential treatment per diem and the additional billing for w/m
5	See previous comments which were actually on Level 2 outpatient services accidently
6	.

Q78 Level 2-WM: Overall: What is working well?

Answered: 4 Skipped: 220

#	RESPONSES
1	Facilities using appropriate interventions such as tapers and withdrawal protocols
2	The ASAM Criterial brings the medical presence back into SUD services, where it was missing in the past.
3	Excellent
4	.

Q79 Level 2-WM: Overall: What challenges have you observed?

Answered: 4 Skipped: 220

#	RESPONSES
1	The facility's ability to obtain all the necessary information related to criteria.
2	Guidance is needed in terms of length of stay and elimination of program-driven care. Providers focus on length of stay, rather than emphasis of treatment required for the individual receiving services. There is no research behind the length of stay in residential settings, nonetheless, providers have created admission and treatment protocols around fixed episodes of care. Integrating measurement-based care would help residential and OP treatment programs in transitioning from fixed episode of care, based on historical funding protocols, to patient-centered care, based on reliable metrics of progress. We suggest including existing scales, such as the brief addiction measure (BAM) and other metrics, such as employment, housing stability or reductions in substance use via biomarkers or developing hybrid measures. The goal would be to use these tools across the continuum to assist providers in determining progress as well as tailoring lengths of stay within a level of care. Enhanced guidance is needed on the application of individualized treatment towards everyone receiving services, not only people that might fall into a specialty population. A related metric is continuum of pharmacological treatments across levels of care. Treatment providers in PA continue to view pharmacological interventions as separate from ASAM levels of care, instead of an essential element within all levels of care. We suggest emphasizing pharmacological interventions as essential elements within and across the four levels of care in the next edition. Notably, the menu of evidence-based medications for SUDs will likely expand before and after the next evolution of ASAM criteria. Treatment providers
3	Excellent
4	.

Q80 Level 2-WM: Overall: What are your recommendations for the 4th edition of The ASAM Criteria?

Answered: 3 Skipped: 221

#	RESPONSES

1	Overall changes recommended include delineating clinical treatment time requirements for residential treatment levels of service, including induction as part of withdrawal management, more emphasis on family involvement in levels of care, and inclusion of measurement-based care.
2	Excellent
3	.

Q81 Level 2-WM: Standards that relate to treatment setting: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	n/a
2	Excellent
3	.

Q82 Level 2-WM: Multidimensional assessment and treatment planning standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 4 Skipped: 220

#	RESPONSES
1	Further guidance is needed on the definition of individualized treatment. Currently, individualized care is interpreted as needs of specialty populations (i.e. parents with children, LGBTQIA+, veterans), rather than looking at the individual receiving services that might not fall under a specialty population, but still needs an individualized treatment regimen. Additional guidance is needed on how to develop a treatment plan based off the assessment, especially as it relates to evidence-based practices. Additional guidance is needed on evidence-based practices as they relate to treatment of substance use disorders, as some providers are using multiple evidence-based practices on one individual receiving services, some of which are not evidence-based for substance use disorders or for the
2	Additional guidance regarding WM at this level and how it may be incorporated into an individuals overall care or whether WD is a stand alone service would be helpful.
3	Excellent
4	.

Q83 Level 2-WM: Staffing standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	We support telehealth services but want to make sure physician is part of the treatment team and understands how to support treatment. There is bare minimum in-person time for physicians at some agencies. We do not want to create barriers to access, but we want to ensure physicians understand the culture at agency and monitoring processes. When physical exams are done at some agencies, people are not required to take off shirts or shoes. This led to the provider not being aware of infection sites and abscess sites, as common injection sites were not checked during the physical exam. Guidance in best practice in telehealth expectations for physical health examinations

2	Excellent
3	.

Q84 Level 2-WM: Support system standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	Inclusion of certified recovery specialists across the continuum of care to ensure this service is offered in each level of care. Some residential programs believe having techs with lived experience is the same as having a certified recovery specialist, which is not the same.
2	Excellent
3	.

Q85 Level 2-WM: Therapies standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	Guidance that a substance use disorder alone cannot be the justification for treatment. Providers need to identify problems (outside of substance use) and how the problems can be addressed during that level of care. Providers need a better understanding of evidence-based practices as they apply to levels of care and realistic expectations of what can be resolved during the treatment episode (i.e. trauma may be more effectively addressed in outpatient services, but groundwork can start in a residential program). Residential levels should have a clinical service hourly expectation, as providers are using the lack of expectation as justification that 1-2 hours of clinical services per day, 5 days per week in residential treatment is sufficient.
2	Excellent
3	.

Q86 Level 2-WM: Documentation Standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	Clarification is needed that the documentation to relate back to the treatment plan. Additionally that the group note should not be the same for every person receiving services as a standard note.
2	Excellent
3	.

Q87 Level 2-WM: Risk rating matrices: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	If the risk level is retained, there needs to be more emphasis in the book about the importance of the risk level and clearly delineate the risk. Providers have been resistant with providing a risk level, including establishing a risk level. Some providers believe that everyone in residential treatment has the highest risk across all dimensions, justifying this as the need for residential placement, rather than using the risk to identify treatment needs and areas of focus that can be addressed at that level of care.
2	Excellent
3	.

Q88 Level 2-WM: Withdrawal management dimensional admission criteria: Do the dimensional admission criteria presented in the textbook support you in making Level of Care placement decisions? What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 3 Skipped: 221

#	RESPONSES
1	n/a
2	Excellent
3	.

Q90 Level 3-WM: Overall: Is this level clearly delineated? If no, tell us how it could be clarified.

Answered: 10 Skipped: 214

#	RESPONSES
1	The distinction between Level 3.7-WM and Level 4-WM is blurry at times --ie, “medically managed” versus “medically monitored” is one way to distinguish, but that is very nuanced language and open to interpretations. It would be helpful if it were more clearly delineated what makes a person appropriate for Level 3.7 -WM but not
2	It would be helpful if induction on opioid agonist treatment was included as part of this level, instead of using this level only to taper someone off substances.
3	Yes
4	Provide additional case examples. Recommend developing and including a severity index of withdrawal symptoms to help clarify.
5	Related to 3.2WM, I think there should be updated criteria related to a hybrid model as many 3.2WM don't provide the full services of a 3.7WM, but do utilize medication and detoxification techs as well as some nursing services. This would also support better payment for this level. I'm working with NV Medicaid on this as I write. Revising the criteria would support this endeavor.
6	Not clearly delineated. I can't get approval to buy the textbook/take the course as yet and can't find resources to

7	One of the LOCs that we offer is a 16 bed withdrawal management facility at 3.2WM or 3.7WM--it would be helpful to have a more clear definition of deciding if a client is more appropriate at 3.2 or 3.7. Typically for alcohol and benzos we initially admit at a 3.7WM LOC, but it would be helpful if there were a certain amount of withdrawal symptoms or certain COWs/CIWAs scores to decide which LOC so that we aren't basing it off of our gut feeling
8	yes
9	Some organizations will not recognize 3.2WM as a residential detoxification level of care and will attempt to require ASAM 3.7 which is intended for acute/hospital care and not sub-acute detox. Clarification on levels 3.7 and 3.2WM and how each relates to residential care would be highly beneficial.
10	Y

Q91 Level 3-WM: Overall: What is working well?

Answered: 3 Skipped: 221

#	RESPONSES
1	The ASAM Criterial brings the medical presence back into SUD services, where it was missing in the past.
2	Utilizing the ASAM criteria assessment tool is extremely helpful when attempting to get a Client qualified for this
3	see my comments for Level 3

Q92 Level 3-WM: Overall: What challenges have you observed?

Answered: 6 Skipped: 218

#	RESPONSES
1	For level 3.7-WM, there is some confusion with the use of "inpatient" and how it differs from level 4-WM as discussed in prior responses.
2	Providers use WM to take someone off medications, instead of moving towards induction. Guidance is needed in terms of length of stay and elimination of program-driven care. Providers focus on length of stay, rather than emphasis of treatment required for the individual receiving services. There is no research behind the length of stay in residential settings, nonetheless, providers have created admission and treatment protocols around fixed episodes of care. Integrating measurement-based care would help residential and OP treatment programs in transitioning from fixed episode of care, based on historical funding protocols, to patient-centered care, based on reliable metrics of progress. We suggest including existing scales, such as the brief addiction measure (BAM) and other metrics, such as employment, housing stability or reductions in substance use via biomarkers or developing hybrid measures. The goal would be to use these tools across the continuum to assist providers in determining progress as well as tailoring lengths of stay within a level of care. Enhanced guidance is needed on the application of individualized treatment towards everyone receiving services, not only people that might fall into a specialty population. A related metric is continuum of pharmacological treatments across levels of care. Treatment providers in PA continue to view pharmacological interventions as separate from ASAM levels of care, instead of an essential element within all levels of care. We suggest emphasizing pharmacological interventions as essential elements within and across the four levels of care in the next edition. Notably, the menu of evidence-based medications for SUDs will likely expand before and after the next evolution of ASAM criteria. Treatment
3	Medical staffing, the restrictions on the staff are confusing for providers. What level of staff can supply medications,
4	We have observed challenges for Clients who are incarcerated and some MCO's seeing this as an area that demonstrates the Client doesn't need a high level of care since they were incarcerated and not using a substance.
5	We are a start up. We have not purchased the textbook and are going on various other references. We are residential with a detox unit and it appears that we don't fit neatly into the withdrawal management criteria. The resources I have found go from withdrawal management levels 1 & 2 and then skip to inpatient withdrawal management. According to our state license we are ASAM withdrawal management level 3.2

6	See my comment for Level 3

Q93 Level 3-WM: Overall: What are your recommendations for the 4th edition of The ASAM Criteria?

Answered: 4 Skipped: 220

#	RESPONSES
1	Overall changes recommended include delineating clinical treatment time requirements for residential treatment levels of service, including induction as part of withdrawal management, more emphasis on family involvement in levels of care, and inclusion of measurement-based care.
2	My recommendations is to attempt to ensure that an assessment can also justify the high level of care need even if the Client was incarcerated.
3	Provide some kind of basic reference material free of charge to assist providers and facilities
4	See my comments for Level 3

Q94 Level 3-WM: Standards that relate to treatment setting: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	Define induction on opioid agonist during this level of care, including the harm that can occur from tapering individuals off of OATs during withdrawal management as well as the requirement to sustain pharmacological interventions during withdrawal management. Considering that an effective taper protocol from OATs may take many months, we suggest outlining an effective taper process that discourages rapid tapers, even when requested

Q95 Level 3-WM: Multidimensional assessment and treatment planning standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	Further guidance is needed on the definition of individualized treatment. Currently, individualized care is interpreted as needs of specialty populations (i.e. parents with children, LGBTQIA+, veterans), rather than looking at the individual receiving services that might not fall under a specialty population, but still needs an individualized treatment regimen. Additional guidance is needed on how to develop a treatment plan based off the assessment, especially as it relates to evidence-based practices. Additional guidance is needed on evidence-based practices as they relate to treatment of substance use disorders, as some providers are using multiple evidence-based practices on one individual receiving services, some of which are not evidence-based for such, to no medical benefit for the

Q96 Level 3-WM: Staffing standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	We support telehealth services but want to make sure physician is part of the treatment team and understands how to support treatment. There is bare minimum in-person time for physicians at some agencies. We do not want to create barriers to access, but we want to ensure physicians understand the culture at agency and monitoring processes. When physical exams are done at some agencies, people are not required to take off shirts or shoes. This led to the provider not being aware of infection sites and abscess sites, as common injection sites were not checked during the physical exam. Guidance in best practice in telehealth expectations for physical health examinations

Q97 Level 3-WM: Support system standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	Inclusion of certified recovery specialists across the continuum of care to ensure this service is offered in each level of care. Some residential programs believe having techs with lived experience is the same as having a certified recovery specialist, which is not the same.

Q98 Level 3-WM: Therapies standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 2 Skipped: 222

#	RESPONSES
1	Guidance that a substance use disorder alone cannot be the justification for treatment. Providers need to identify problems (outside of substance use) and how the problems can be addressed during that level of care. Providers need a better understanding of evidence-based practices as they apply to levels of care and realistic expectations of what can be resolved during the treatment episode (i.e. trauma may be more effectively addressed in outpatient services, but groundwork can start in a residential program). Residential levels should have a clinical service hourly expectation, as providers are using the lack of expectation as justification that 1-2 hours of clinical services per day, 5 days per week, in residential treatment is sufficient.
2	The staffing needed in these levels of care becomes challenging when dealing with DOH licensure and credentialing of licensed staff.

Q99 Level 3-WM: Documentation Standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	Clarification is needed that the documentation to relate back to the treatment plan. Additionally that the group note should not be the same for every person receiving services as a standard note.

Q100 Level 3-WM: Risk rating matrices: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	If the risk level is retained, there needs to be more emphasis in the book about the importance of the risk level and clearly delineate the risk. Providers have been resistant with providing a risk level, including establishing a risk level. Some providers believe that everyone in residential treatment has the highest risk across all dimensions, justifying this as the need for residential placement, rather than using the risk to identify treatment needs and areas of focus that can be addressed at that level of care.

Q101 Level 3-WM: Withdrawal management dimensional admission criteria: Do the dimensional admission criteria presented in the textbook support you in making Level of Care placement decisions? What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	n/a

Q103 Level 4-WM: Overall: Is this level clearly delineated? If no, tell us how it could be clarified.

Answered: 5 Skipped: 219

#	RESPONSES
1	Yes. Medically based. Clear.
2	Yes, it is
3	It would be helpful if induction on opioid agonist treatment was also included as part of this level, instead of using this level only to taper someone off substances.

4	Strongly suggest that ASAM consider changing inpatient level 3.7-WM numbering to 4.1-WM to minimize confusion with level 3.7-WM being referred to as "residential WM" when in fact it should be "inpatient WM" services.
5	The intensity of service is not clearly communicated to the provider to justfy this LOC.

Q104 Level 4-WM: Overall: What is working well?

Answered: 2 Skipped: 222

#	RESPONSES
1	Clarity.
2	The ASAM Criterial brings the medical presence back into SUD services, where it was missing in the past.

Q105 Level 4-WM: Overall: What challenges have you observed?

Answered: 3 Skipped: 221

#	RESPONSES
1	Some payors won't pay for it so pay at 3.5 or 3.7. Marijuana, meth, cocaine may not need it but then when you add Dim 3, 4, 5, 6 they meet residential.
2	We receive requests for 4-WM from out-of-network facilities that are licensed as detox but do not actually have the resources of a fully licensed hospital. When asked about this, they indicate that they would have to call an ambulance in the case of a medical emergency. There seems to be a disconnect between criteria and what licensing bodies approve/certify.
3	Providers use WM to take someone off medications, instead of moving towards induction. Guidance is needed in terms of length of stay and elimination of program-driven care. Providers focus on length of stay, rather than emphasis of treatment required for the individual receiving services. There is no research behind the length of stay in residential settings, nonetheless, providers have created admission and treatment protocols around fixed episodes of care. Integrating measurement-based care would help residential and OP treatment programs in transitioning from fixed episode of care, based on historical funding protocols, to patient-centered care, based on reliable metrics of progress. We suggest including existing scales, such as the brief addiction measure (BAM) and other metrics, such as employment, housing stability or reductions in substance use via biomarkers or developing hybrid measures. The goal would be to use these tools across the continuum to assist providers in determining progress as well as tailoring lengths of stay within a level of care. Enhanced guidance is needed on the application of individualized treatment towards everyone receiving services, not only people that might fall into a specialty population. A related metric is continuum of pharmacological treatments across levels of care. Treatment providers in PA continue to view pharmacological interventions as separate from ASAM levels of care, instead of an essential element within all levels of care. We suggest emphasizing pharmacological interventions as essential elements within and across the four levels of care in the next edition. Notably, the menu of evidence-based medications for SUDs will likely expand before and after the next evolution of ASAM criteria. Treatment

Q106 Level 4-WM: Overall: What are your recommendations for the 4th edition of The ASAM Criteria?

Answered: 3 Skipped: 221

#	RESPONSES
1	• Updated treatment perspective: Since the last ASAM edition was printed in 2013, a lot has happened in the treatment of addiction, especially with opioids. The newest edition would need an updated treatment perspective with the most updated research cited in its text. • ASAM for Managed Care: There is current advocacy for using ASAM criteria for Managed Care and many states now require use of ASAM criteria for Medical Necessity determination which directly contradicts the ASAM book itself where it clearly states it was not designed for medical necessity decisions. • Poor Inter-rater reliability. Consistent determinations are difficult for medical necessity – making providers having consistent expectations from the MCO's difficult. • Electronic Template is limited and cost prohibitive: The majority of providers are not submitting their Medical Necessity requests based on the tool, which makes it difficult to apply ASAM criteria. o Time to complete the electronic tool is prohibitive. o There is a lack of transparency in the electronic tool when a decision is rendered; You put in data and it outputs a decision. • Lack of evidence (in Levels of Care): Need better evidence to justify the designed levels of care. Need to go beyond expert or consensus opinion (least reliable method of evidence). Cite and list research. • Need better reference to criteria: Info is not laid out in a way that references their opinion. Making it difficult to easily support determinations based on the criteria. For example, when referencing Withdrawal Management, you must go back and forth to multiple sections to combine relevant information to make a thorough determination. Another example would be determining medical necessity across substances. Very disjointed and often times, not specific or ill defined. Opinions do not cite the research info where they are referenced • Criteria are nebulous and poorly defined: Have to jump sections to pull together. Criteria are often not specific and ASAM itself notes that they are not for Medical Necessity. o o Example #2 – Level 4.0. Symptoms listed for medical necessity for inpatient withdrawal management are vague (i.e. severe vomiting, seizures and diarrhea) and lack medical specificity, where MCG might list specific signs. (Listing current vital signs of dehydration when discussing vomiting and diarrhea or specific history when discussing seizures). • No Guidance on Length of Stay (LOS): No listed expectation on any length of stay (LOS) or average LOS. MCO's are left to speculate on a reasonable
2	Overall changes recommended include delineating clinical treatment time requirements for residential treatment levels of service, including induction as part of withdrawal management, more emphasis on family involvement in levels of care, and inclusion of measurement-based care.
3	Strongly suggest that ASAM consider changing inpatient level 3.7-WM numbering to 4.1-WM to minimize confusion with level 3.7-WM being referred to as "residential WM" when in fact it should be "inpatient WM" services.

Q107 Level 4-WM: Standards that relate to treatment setting: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	Define induction on opioid agonist during this level of care, including the harm that can occur from tapering individuals off of OATs during withdrawal management as well as the requirement to sustain pharmacological interventions during withdrawal management. Considering that an effective taper protocol from OATs may take many months, we suggest outlining an effective taper process that discourages rapid tapers, even when requested

Q108 Level 4-WM: Multidimensional assessment and treatment planning standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	Further guidance is needed on the definition of individualized treatment. Currently, individualized care is interpreted as needs of specialty populations (i.e. parents with children, LGBTQIA+, veterans), rather than looking at the individual receiving services that might not fall under a specialty population, but still needs an individualized treatment regimen. Additional guidance is needed on how to develop a treatment plan based off the assessment, especially as it relates to evidence-based practices. Additional guidance is needed on evidence-based practices as they relate to treatment of substance use disorders, as some providers are using multiple evidence-based practices on one individual receiving services, some of which are not evidence-based for substance use disorders or for the

Q109 Level 4-WM: Staffing standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	We support telehealth services but want to make sure physician is part of the treatment team and understands how to support treatment. There is bare minimum in-person time for physicians at some agencies. We do not want to create barriers to access, but we want to ensure physicians understand the culture at agency and monitoring processes. When physical exams are done at some agencies, people are not required to take off shirts or shoes. This led to the provider not being aware of infection sites and abscess sites, as common injection sites were not checked during the physical exam. Guidance in best practice in telehealth expectations for physical health examinations

Q110 Level 4-WM: Support system standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	Inclusion of certified recovery specialists across the continuum of care to ensure this service is offered in each level of care. Some residential programs believe having techs with lived experience is the same as having a certified recovery specialist, which is not the same.

Q111 Level 4-WM: Therapies standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	Guidance that a substance use disorder alone cannot be the justification for treatment. Providers need to identify problems (outside of substance use) and how the problems can be addressed during that level of care. Providers need a better understanding of evidence-based practices as they apply to levels of care and realistic expectations of what can be resolved during the treatment episode (i.e. trauma may be more effectively addressed in outpatient services, but groundwork can start in a residential program). Residential levels should have a clinical service hourly expectation, as providers are using the lack of expectation as justification that 1-2 hours of clinical services per day, 5 days per week in residential treatment is sufficient.

Q112 Level 4-WM: Documentation Standards: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	Clarification is needed that the documentation to relate back to the treatment plan. Additionally that the group note should not be the same for every person receiving services as a standard note.

Q113 Level 4-WM: Risk rating matrices: What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	If the risk level is retained, there needs to be more emphasis in the book about the importance of the risk level and clearly delineate the risk. Providers have been resistant with providing a risk level, including establishing a risk level. Some providers believe that everyone in residential treatment has the highest risk across all dimensions, justifying this as the need for residential placement, rather than using the risk to identify treatment needs and areas of focus that can be addressed at that level of care.

Q114 Level 4-WM: Withdrawal management dimensional admission criteria: Do the dimensional admission criteria presented in the textbook support you in making Level of Care placement decisions? What are your recommendations for the 4th edition of The ASAM Criteria and why?

Answered: 1 Skipped: 223

#	RESPONSES
1	n/a

Q116 Older adults: What is working well?

Answered: 28 Skipped: 196

#	RESPONSES
1	ASAM criteria works well to identify SUD treatment needs that are not always as clearly identifies within older adult population.
2	The support systems
3	There is a section for older adults. High risk group. Need more focus on outreach and treatment.
4	Lack of expertise of providers in working with older adults.
5	n/a
6	Thus far, the older adults in this LOC is working well as these clients are able to perform the treatment set for them.
7	none
8	Readiness to change considerations.
9	No comment
10	New strategies for manege symptoms
11	Not qualified to say.
12	We are able to place older adults appropriately and address their needs.
13	I really enjoy the section on Therapies to explain the psyche of older adults and the nuances that must be used when working with this population.
14	Not much experience here.
15	CASAT has assisted Nevada with training's related to providers being able to bill for Medicare. Progress is being made, but more has to be done. The older adult section could add enhancements related to Medicare.
16	n/a
17	great guidelines and things to consider when making recommendations.
18	The big problem here is not the Criteria, but Medicare!
19	n/a
20	Med identification and coordination
21	NA
22	Being in treatment
23	We do not distinguish older adults from other populations.
24	N/A
25	Overall admission criteria are working well.
26	Providing support measures of grouping adult populations together has been helpful and works well. It is recognized that someone with a substance use disorder who is 22 can present very different than an individual who has struggled with ETOH and is 67. Recognizing the difference in these populations and treating them from a biopsychosocial approach to address any concerns that are contributing to ongoing use is helpful and working well
27	N/A 3/30/2021
28	Just implementing

Q117 Older adults: What challenges have you observed?

Answered: 30 Skipped: 194

#	RESPONSES
1	Challenges include with higher level of care ASAM options acknowledgement of considerations in level of care with potential comorbidity of physical or cognitive considerations prevalent at higher consideration with OA population.
2	Consistent compliance
3	There are not most places that .5 ASAM or other lower levels that may be most helpful for older adults for intervention. By the time many get to treatment their medical needs are great yet medicare won't pay in most residential tx programs and in OP requires LCSW, other license.
4	In our residential program, at times clients' physical health challenges tend to interfere with addiction treatment interventions. (There's no 3.7 or 4.0 LOC in our county's system of care...)
5	Many older adults are not accessing services or programs equipped to address other complex medical needs.
6	n/a
7	the challenges I have witnesses with this population is there commitment to medical appointments that prevent them from attending. Other than this, this population is responsible and is committed to their treatment.
8	Maintaining treatment hour requirements, just like adolescents 3.5 requires fewer hours than 20 - considerations for older adults to require less hours per week - eg 15 or 17 treatment hours per week.
9	none
10	funding is a challenge with this population. Not many options for Levels of care for those who are only covered by Medicare
11	Their insurance does not cover the appropriate levels of care causing barriers for them to get the appropriate
12	None identified.
13	None identified
14	Intervention
15	Haven't worked extensively with the population.
16	The ambivalence sometimes shown by this population
17	I have observed difficulty in differentiating "Wet Brain" from dementia as well as determining if the presenting symptoms are the result of PAWS or other biomedical issues. Additionally, it is very difficult to assist patients with getting admitted to nursing homes because our medical providers are not perceived to be appropriate enough to make that medical referral as well as nursing homes not wanting to take in individuals with substance use disorders
18	Cognitive limitations posed by either substance abuse or co-morbidity.
19	reimbursement for Medicare is extremely low, Medicare does not recognize addiction credentials in someone who is not licensed.
20	None
21	Tend to have better Dimension 6 resources in place. This sometimes works to their disadvantage because health plans ask for them to be discharged before they are ready because they have a somewhat stable home. Unaccounted for is the fact that this person may have had a stable home for years and still lost control of life and entered residential treatment. A stable home without other supports is not enough for most older adults that are very set in their ways.
22	NA
23	None at this time
24	See above
25	N/A
26	We noticed some difficulty in clarifying specifics of failure to engage and how that could be used as rationale for transitioning treatment to a higher or lower LOC based on clinical information. There just isn't adequate information about appropriate treatment planning for reasonable guidance.
27	Awareness of balance between effective pain management and risks associated with opioid use.

28	The biggest challenge seen is the mentality of the substance use and how longevity can create new barriers to success. Difficulty relating to others can also be a concern as well as a recovery environment that has “always accepted” the individuals use patterns can be difficult. Some of the older populations will also present with concerns in dimensions 2 , 4, and 6 that make desired recovery difficult. The advancement of social media and electronics has also presented this population with its own challenges as an app for a phone that might cause excitement for a younger individual will create fear and resistance in some of the older population.
29	N/A
30	Just implementing

Q118 Older adults: What are your recommendations for the 4th edition of The ASAM Criteria?

Answered: 23 Skipped: 201

#	RESPONSES
1	Potentially adding under each LOC a box that indicates "any unique population considerations" with a yes or no box and comment box for further elaboration.
2	Weekly check-ins with the staff for self monitoring as well as participation in AA/ NA support groups.
3	More focus on detox needs and dangers for this population.
4	Provide section on working with older adults.
5	Older adults do not typically attend treatment. SUD rates are not decreasing, but the older generation is not entering treatment at any service (residential, outpatient, medication). There needs to be more focus on telehealth for this population. Additionally, guidance on how treatment might look different because of cross-age groups. Considerations for treatment protocols and additional assessment items that consider age and socioeconomic barriers. The range of substances for older adults is minimal—alcohol and prescription medications are typical for this population. Inclusion of clinical skills for these substances specifically with older adults. Guidance also requested regarding age of clinicians or others providing treatment with this population.
6	none
7	none
8	none
9	None identified
10	Mental Health themes
11	Not qualified to say.
12	none
13	I think having a discussion on the relationship between grief/loss and addiction among the pandemic. For example, losing friends/family and not being able to say goodbye to them in the hospital or be able to attend funerals.
14	more guidance in reimbursement
15	The Impact of racism.
16	None
17	NA
18	None at this time
19	See above
20	N/A
21	In the older world before managed care or before guidelines or criteria we knew when an individual was not receptive to treatment, despite several interventions. Now we do not know when enough is enough... While we seem to take a stance against 28 day programming, the overall thinking still seems to be crafted on the idea of giving lots of time to each individual to engage, probably too much, which ends up easily fitting within the 28 day.
22	N/A
23	Just implementing

Q119 Parents or prospective parents: What is working well?

Answered: 24 Skipped: 200

#	RESPONSES
1	Groups of cohorts focused on healthy children and deterring of Children's Services involvement as a motivating
2	We have a small number of programs targeted to work with pregnant women and women with children.
3	n/a
4	This is not working too well.
5	none
6	consider the challenges of parenting in the comprehensive assessment
7	No comment
8	Support Family
9	Not qualified to say.
10	Yes it is
11	Having a family services specialist be the designated contact for family members to provide education on addiction as a disease, boundaries, and ACOA.
12	Having the space and accommodations for pregnant and parenting women.
13	We have good services for expecting parents for OUD treatment.
14	None
15	NA
16	We use level 2.1. We have a day treatment model. It helps with the perinatal population.
17	None at this time
18	We do not incorporate ASAM recommendations into our programs tailored for parents.
19	N/A
20	The current dimension and the importance of the family involvement is well described.
21	Recommendations for withdrawal management for pregnant clients
22	Assisting parents on focusing on themselves during treatment while providing a balanced collaboration with family/children at home.
23	N/A
24	Just implementing

Q120 Parents or prospective parents: What challenges have you observed?

Answered: 25 Skipped: 199

#	RESPONSES
1	Addiction due to childhood trauma is powerful and when not fully explored, leads to repetition and relapse.
2	It's been difficult to adapt county expectations about residential levels of care to meet the real needs of parents in early recovery. Excessive service hour requirements and underestimation of the challenges that arise when parents engage fully with their children.
3	Child care and opportunities for women with children to participate in residential treatment programs. Limited programs who understand or provide withdrawal management for pregnant women.
4	n/a

5	the parent's time to attend due to their employment, caring for other children, and the conflictual relationship between the parent and child.
6	none
7	Parents (both men and women) could benefit from more options to facilitate a family. Specifically a family with a primary parent as a father.
8	none
9	No comment
10	New strategies
11	Not qualified to say.
12	Nothing directly connected to ASAM
13	A lot of guilt and shame for "traumatizing" their children or passing down the addiction gene to their children. Also, lack of childcare greatly affects their ability to be able to participate in treatment. Also, parents having a fear of their children being taken away by CPS if they disclose how their substance use has negatively affected their children.
14	There needs to be more focus on families in engagement with those in recovery and how important the impact of the addiction reaches the family members.
15	Pregnant and parenting moms may need higher levels of care for a longer length of stay than other people. The pillars of gender-responsive treatment highlight the unique biology of women and the way substances disrupt their hormones and biological processes in a different way than male counterparts. It takes time to coordinate family planning and reproductive care and education for women, and it is essential that this is done in conjunction with SUD treatment as 80% of pregnancies in women w/ SUD are unplanned. In addition, women in early treatment are almost instantly more fertile than they were while in addiction, so it is essential to coordinate family planning care before she discharges from treatment. Women are much more likely than their male counterparts to have experienced interpersonal trauma perpetrated by someone they knew and trusted. In addition to their higher rates of PTSD, women may take longer than their male counterparts to develop trusting relationships with staff and other people. Most preg/parenting women w/ SUD have extensive trauma histories which are intricately tied up with their substance use disorders. Without addressing trauma in a safe, stable and supportive environment and with the coping skills to handle it, mothers are at high risk for relapse due to trauma-related triggers and responses. In addition, relationships are of central importance and influence in women's lives (for better or families are at high risk for entry/ re-entry into the Child Welfare system. Managed Care Organizations all interpret ASAM differently, with many giving more weight (medical necessity) to ASAM dimensions 1-3 versus 4-6. The ASAM Criteria don't explicitly take into account the perinatal needs and/or risk factors of the pregnant/postpartum person or the mother/infant dyad, which leaves level of care and length of stay determinations dependent on the perinatal training (or lack thereof) of those completing utilization management. Another concern is the way in which ASAM can or cannot take into account the unique risk factors faced by a Black/ Indigenous pregnant/postpartum dyad. The maternal and infant mortality rates of Black mothers and infants is 4-5x higher than their white counterparts. Fifty percent of Black birthing individuals experience postpartum depression (compared to 20% of their white counterparts), but the risk factors associated with experiences of discrimination and systemic racism aren't captured by ASAM as it stands. I'll use the same example from earlier in the survey, but this time, imagine this client is Black. Her risk for poor maternal/child health outcomes, including maternal and infant mortality just increased 5-fold. As an example: a woman who is 31 weeks pregnant with history of bipolar disorder and concurrent maternal opioid use disorder enters treatment at the 3.5 level of care. She begins MAT, and within 2-3 weeks, her symptoms have stabilized. She will be induced at 36 weeks due to pre-ecclampsia, but because she is currently stable, she is discharged from treatment. What isn't taken into account is the likelihood that her infant will be in the NICU due to pre-term delivery and NAS. Mother's with infants in the NICU are much more likely to develop perinatal mood and anxiety disorders, including PTSD, which are correlated with poor maternal/ infant health outcomes. Her bipolar disorder also makes her much more likely to experience postpartum psychosis, due to rapidly fluctuating hormone
16	None
17	NA
18	None at this time
19	See above
20	N/A
21	Parents (or family) involvement in treatment is not sufficiently advocated as a treatment mandate from start of treatment. Many facilities will say that they do not involve family in Treatment till the 3rd week of RTC under the faulty premise that it may detract from engagement or concentration on recovery at early stages of treatment.
22	My understanding of gender identity has changed considerably since 2013. I would suspect that the ASAM language needs to be changed similarly - and this may already be in process given the Parents or prospective parents as opposed to "pregnant women" reference.
23	Parents who come to treatment and have difficulty with being away from their children so they leave early or are unable to focus on treatment goals. Difficulty with assisting parents that not focusing on themselves hinders their ability to parent effectively can also present barriers to success.
24	N/A

25	Just implementing

Q121 Parents or prospective parents: What are your recommendations for the 4th edition of The ASAM Criteria?

Answered: 20 Skipped: 204

#	RESPONSES
1	Include some mention of the above.
2	When children join parents in residential programs, they may attend treatment, but there is no programming specifically for children in the facilities. Guidance is requested for the emphasis on age and developmental level of the child when determining appropriate treatment interventions. Guidance surrounding which child interventions should occur onsite versus being referred out to specialized providers when the parent is in a residential program. Assessments of family members should occur in the process of treatment and determine what interventions may be
3	None. the book provides excellent problem-solving solutions.
4	Additional guidance whether pregnant women population are covered under Level 3.3: Clinically Managed, Population Specific, High Intensity Residential Services
5	none
6	none
7	No comment
8	Developed new knowledge
9	Not qualified to say.
10	none
11	Discussion of how their children not going to school as the result of the pandemic has played a role in their substance use and mental health. Mentioning how to work with the guilt of "leaving" their children to go to treatment. Recommendations for parenting skills that can be taught in group settings. Also, how parents of different socioeconomic statuses and races, have been impacted by COVID
12	Overall, I'd like to see more gender-responsive criteria inclusion. I'd recommend inclusion of language which captures the intersectionality of risk related tothe social determinant's of health, racial identity, sexual orientation and gender-expression. I'd recommend a gender- responsive component assessment for intersectional risks posed to the pregnancy AND the mother/infant dyad
13	None
14	NA
15	None at this time
16	See above
17	N/A
18	More considerations around family planning/parenting within the dimensions can assist with determining level of care. For instance, a parent who returns home and continues to use ETOH while driving their children around might need that 24/7 care to not just keep themself safe but keep others safe as well.
19	N/A
20	Just implementing

Q122 Persons in safety sensitive occupations: What is working well?

Answered: 18 Skipped: 206

#	RESPONSES
1	Enforcement of the "NO DRUG" policies in both Federal jobs and private industry to avoid both Worker's Compensation issues , and osha Health and Safety standards.

2	It's listed! That's great!
3	n/a
4	have not come across this population yet.
5	none
6	currently working well
7	No comment
8	Mental Health Assistance
9	Not qualified to say.
10	Yes we are able to serve this population but usually this population has commercial insurance and our admission numbers are not high with this population.
11	Having the executive team (Executive Director, Clinical Director, Medical Director, etc.) build a one-on-one rapport with the patient to emphasize our commitment to confidentiality and provide education on 42CFR. Assigning these patients to therapists who have been in the field longer gives the patients more confidence that the treatment they will receive is backed by years of ethics and experience. Giving the patients very clear directions and assignments provides them with a set of structure that is very familiar to them.
12	None
13	NA
14	None at this time
15	not applicable to the indigent client base we serve
16	N/A
17	N/A
18	Just implementing

Q123 Persons in safety sensitive occupations: What is posing challenges?

Answered: 22 Skipped: 202

#	RESPONSES
1	Airline pilots who use O2 for quick relief of hangovers.
2	Their work hours sometimes. They can't participate in IOP or OP with the 24 on 24 off schedules or while trucking or other safety sensitive positions. Hard to get into "traditional tx" groups. Setting up ongoing care is difficult.
3	Challenges with ongoing treatment in prisons and correctional facilities.
4	n/a
5	n/a
6	none
7	Linking with other professionals who are struggling with the same concerns or issues as it relates to occupations or licensing concerns.
8	none
9	No comment
10	First Responders
11	Not qualified to say.
12	none
13	Pilots especially cannot be diagnosed with a mental health disorder other than Adjustment Disorder. Patients who are nurses or doctors trying to provide medical opinions to other patients. Patients with high profile careers (e.g., doctors, lawyers, executives) not thinking that the group schedule or other treatment rules apply to them. Experiencing increased PTSD symptoms from their jobs as the result of not using their drug of choice anymore. High overconfidence in their ability to stay sober on their own. Denial that their EAP will not allow them to return to work if they don't successfully complete treatment.
14	When agencies like DOC are partnering with us to release clients into treatment to STOP calling them inmates. They are clients, they are people suffering with the disease of addiction. That is so dehumanizing when they hear that.
15	None
16	NA

17	None at this time
18	not applicable
19	N/A
20	There are lax guidelines about the duration of treatment for this population. There is a tendency for these programs to claim that impaired professionals require far more intensive treatment than the rest of the population that is not evidence based knowledge. There is little information about the importance of specialized staffing for addressing working with professionals
21	N/A
22	Just implementing

Q124 Persons in safety sensitive occupations: What are your recommendations for the 4th edition of The ASAM Criteria?

Answered: 20 Skipped: 204

#	RESPONSES
1	Please enumerate what professions are acutely aware.
2	n/a
3	n/a
4	none
5	none
6	No comment
7	Developed new strategies
8	Not qualified to say.
9	none
10	Again, just a special look at how the pandemic has impacted these individuals. Discussion on how to navigate stigma against police officers in light of the racial tension over the last year.
11	Encourage partners with healthcare facilities where they have those incarcerated to have universal language for how their personhood is referred to.
12	None
13	NA
14	None at this time
15	not applicable
16	N/A
17	There are lax guidelines about the duration of treatment for this population. There is a tendency for these programs to claim that impaired professionals require far more intensive treatment than the rest of the population that is not evidence based knowledge. There is little information about the importance of specialized staffing for addressing working with professionals
18	I am not sure if this is well integrated into ASAM 3rd, but certainly a section on licensed healthcare professionals is needed; and perhaps something about implementing ASAM Criteria for safety sensitive occupations using remote nd telehealth resources.
19	N/A
20	Just implementing

Q125 Persons in criminal justice settings: What is working well?

Answered: 21 Skipped: 203

#	RESPONSES
1	Better
2	We have some MAT programs in local detentions.
3	n/a
4	For the most part, this is working well.
5	none
6	current criteria works really well
7	No comment
8	New strategies and knowledge
9	Not qualified to say.
10	Yes working very well
11	Strengths based counseling and including family and PO in their treatment. Psychoeducation on PTSD, how childhood trauma may have played a role in their addiction and subsequent criminal history, and how to cope with the trauma they have experienced in active addiction and/or jail/prison without using substances.
12	focus on strengths as well as problems or needs
13	NA
14	Assessing appropriateness of inpatient vs outpatient
15	None at this time
16	We do not oversee programs directly for CJ populations
17	N/A
18	When probation or legal levers are used, there is a chance for the external motivators to contribute to engagement in recovery.
19	Some of the withdrawal management interventions routinely integrated into SUD treatment for individual in CJ
20	N/A
21	N/A

Q126 Persons in criminal justice settings: What challenges have you observed?

Answered: 27 Skipped: 197

#	RESPONSES
1	Continued sobriety after discharge
2	Seems to cover the legal system too much. We can't really control for that as the scope is to determine if the service is medically necessary.
3	Courts expect lengthy treatment episodes in a manner inconsistent with the ASAM criteria.
4	Challenges with setting up OTPs in correctional settings due to stringent DEA requirements. Challenges with ongoing treatment in prisons and correctional facilities.
5	n/a
6	The challenges I have observed is readiness to change, limited resource4s to meet the client's needs, and lack of support systems.
7	none
8	Individuals with long standing addiction and criminal justice involvement often need additional time to help shift motivation to change from external consequences to internal personal motivation. These individuals often have a higher relapse and recidivism rate. Often court mandates are considered when additional time is needed and
9	none
10	No comment
11	Treatment
12	Not qualified to say.
13	Biggest challenge is explaining to criminal justice system that their recommendations are not always the same as clinical recommendations per ASAM.

14	Patients who would prefer to go to prison over staying in treatment, finishing probation, and staying sober. Patients who worked in prisons being triggered by patients who were inmates. Patients revoking the ROI for their probation officer and/or family.
15	criminal justice makes the recommendations for length of time or hours instead of following professional and using ASAM guidelines - they don't understand the criteria
16	Persons with high criminogenic needs may need longer length of stay/ higher level of care in order to address their multidimensional needs. ASAM and medical necessity do not lend themselves toward these needs.
17	Judges are ordering higher levels of care then assessed or for longer lengths of stay then needed. MCOs won't reimburse which leave the provider in the middle. Advocacy and education to the criminal justice system seems have little effect. Certain MCOs won't cover certain levels of care if diagnosis indicates that they were in remission (even if this is only due to a controlled environment)
18	None
19	There is often great discrepancy between the duration a court would like to see an individual in treatment and the duration that health plans would like to see an individual in treatment. Usually, the correct amount of treatment is somewhere in between the courts expectation and the health plans expectation but it can be difficult to manage the expectations when they are so far apart.
20	NA 4/13/2021
21	None at this time
22	not applicable
23	N/A
24	Lack of understanding from the criminal justice system, specifically the judicial system.
25	Most frequently SUD treatment facilities do not seek release of information and do not mandate direct involvement of the criminal justice system in the treatment, even when it is a major determinant of the outcome.
26	N/A
27	N/A

Q127 Persons in criminal justice settings: What are your recommendations for the 4th edition of The ASAM Criteria?

Answered: 22 Skipped: 202

#	RESPONSES
1	n/a
2	n/a
3	none
4	Collaborate criteria to define compliance with criminal justice mandates.
5	none
6	No comment
7	Treatment and strategies
8	Not qualified to say.
9	none
10	None
11	Suggest including clarifications for how to address medical necessity for criminal justice populations that may not have used prior to their incarceration and abstinent due to incarceration.
12	None
13	More applications and use for court systems (e.g., ASAM Criteria could be utilized for sentencing purposes to a
14	NA
15	None at this time
16	not applicable
17	N/A
18	Trainings for the judicial system
19	Most frequently SUD treatment facilities do not seek release of information and do not mandate direct involvement of the criminal justice system in the treatment, even when it is a major determinant of the outcome.

20	ASAM needs to take a clear policy stance on the absurdity of rates of incarceration by people with SUDs, and that this incarceration is not evenly distributed by race. ASAM has the opportunity to engage in the 4th edition in anti-racism practices by calling this out, and aligning with the Center for Behavioral Health and Justice at Wayne State University in policy recommendations.
21	N/A
22	N/A

Q128 Are there additional subpopulations the 4th edition of The ASAM Criteria should focus on?

Answered: 30 Skipped: 194

#	RESPONSES
1	Cultural considerations, particularly relevant to "Recovery Environment" second of each level of care.
2	Black people and Latino people and the inordinate amount of abuse and punishment those populations receive.
3	Other subpopulations to consider are individuals who are homeless and individuals with special needs. Specific Guidelines for Pregnant women who are requiring withdrawal management would also be useful.
4	Realistically most of our clients fall within the criteria for multiple subpopulations. The next edition should lean into an intersectional lens.
5	Homeless populations
6	The following subpopulations are recommended: specialty section on families, People of Color (Racial and Ethnic), and LGBTQIA+.
7	HIV populations, PPW, pre-teen.
8	n/a
9	LGBTQ - trans population in residential settings Young adults - 18-24 - seems to have different needs - so much energy, challenges in co-ed program, sexual encounters etc.
10	none
11	Non-English speaking, and LGBTQ+
12	covers all the issues we are concerned about
13	None identified
14	Adolescents
15	Not qualified to say.
16	most of my clients are covered in ASAM
17	Trauma, borderline personality disorder, LGBTQIA, chronic pain, and eating disorders.
18	More guidelines on level .5. what that looks like
19	Clients with Gambling Disorder.
20	LGBTQ+ All he/her pronouns should be replaced with appropriately inclusive pronouns
21	None
22	Foster Children.
23	LGBTQ
24	LGBTQ+
25	NA
26	None at this time
27	trans and non-binary gender identity populations experiencing insecurity for basic needs like housing and food
28	No
29	N/A
30	Just implementing

Q129 Are there other topics that the 4th edition of The ASAM Criteria should cover that are not covered in the 3rd edition?

Answered: 44 Skipped: 180

#	RESPONSES
1	N/A
2	Revision of the ASAM criteria offers the opportunity to further improve the capture of the standard of care and integrate into the broader world of guidelines that inform practitioners, patients and their families about the treatment of substance use disorders by: 1) Endorsing and adopting the National Academy of Science, Engineering and Medicine/Institute Of Medicine standards found in Clinical Guidelines We Can Trust. A key element in the revised ASAM criteria will be meeting the regular review standard. For example, the American Academy of Pediatrics endorses the review cycle standard: All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publications unless reaffirmed, revised, or retired at or before that time. 2) Survey state management of substance use disorder treatment, especially to identify ways in which state Medicaid criteria deviate from ASAM criteria. Individual states are setting the standard of care. Acknowledge and adopt when supported by evidence. 3) Acknowledge and incorporate Federal clinical guidelines, especially if ASAM uses a systematic data evaluation approach. 4) Systematically acknowledge effective treatment by condition. The behavioral health field has moved to treatment algorithms like much of the rest of medicine. Individuals with substance use disorders should access treatment based on the best available evidence, a standard the organization can provide using the RAM methodology. 5) Create criteria that incorporate patient report. Provide meaningful
3	Criminal Justice
4	Make it available on-line.
5	None at this time.
6	No
7	We recommend addressing disparity and racial inequality with services, discussing how to address disparities at the assessment and as part of the engagement process.
8	none
9	Evidence around specific populations that do better in residential or in outpatient settings, eg consumers with diagnoses of bipolar, personality disorders, history of sex offenses etc. Exclusion criteria for residential and outpatient services? How to determine when to admit a consumer with a history of sexual offenses and/or 1st degree assaults, what screening tools are recommended, and who to perform
10	In light of the Public Health Emergency, guidance related to telehealth services along the continuum would be greatly appreciated. Ever prior to the PHE, we have often seen that one provider who may have more than one facility/program/location, often times share staffing among these facilities/location or services are provided via telehealth; this is especially concerning at the higher levels of residential care
11	Incorporating criminal justice issues in outpatient levels of care for community-based treatment facilities that have to prove that are addressing criminogenic risk. Specialized population for people with chronic pain or a TBI
12	More about how diagnosis plays into level of care determination.
13	Intensive ASAM training provided to staff. Less Subjective
14	Social determinants of health, caring for LGBTQ+ and non-English speaking populations 5/7/2021
15	Assertive outreach has to be categorized as a type Level One Tx.
16	none identified
17	None identified
18	The 3rd edition did a nice job in disavowing "predetermined minimum lengths of stay" but more need to be said about this since the provider community is still oriented to 'time in treatment' as the end goal. Although we know that total time in treatment is critical, the research does not support of of that time being dedicated to residential treatment. The 3rd edition only touches on the critical "dose-response relationship for residential treatment" by saying "there is little data and knowledge on the dose-response relationship for residential treatment, and further research is needed to clarify these matters". I hope the 4th edition puts some meat on these bones; the field needs it
19	Anxiety in Adolescents
20	Not qualified to say.
21	none comes to mind
22	The Pandemic!

23	n/a
24	Frequency of something should not be the driver of the level.
25	N/A
26	N/A
27	no
28	NO
29	Trauma
30	The intersectionality of risk related to racism and substance use disorders.
31	ASAM Dimension 1: need to cover the history of overdoses of a client
32	Incorporate ACE study questions and an ACE score into the assessment
33	There were too many questions asked in the survey.
34	NA
35	Need to elaborate more on the Recovery Support Services
36	None at this time
37	No
38	It would be helpful if the 4th edition includes a ASAM to HCPCS crosswalk like DSM offers a DSM to ICD crosswalk.
39	No
40	Different substances of abuse that are not fitting the usual pattern and where evidence based information is not widely available. Evidence based treatment of other forms of addiction that are not substance based.
41	Certainly pain and opiates, and a broader understanding of the relationship, alternatives, and overdose prevention and harm reduction strategies that are regularly implemented; in addition to ACT, should incorporate understanding of Integrated Dual Disorder Treatment (IDDT) for individuals with severe COD.
42	ASAM would benefit from greater consideration of mental health populations and the correlation between both substance use and mental health. Though they are covered, they can be covered in more depth and with increased consideration for level of care.
43	The only thing I would add is ASAM has guidelines which are very good and they overall cover a very thorough thoughtful criteria on recovery. I would like to see more support on long term recovery and how important it is that the continued message is longer you stay in treatment the better and more solid your recovery is.
44	Just implementing

Q130 Should ASAM consider any changes to the six dimensions?

Answered: 46 Skipped: 178

#	RESPONSES
1	Yes
2	Multidimensional assessment is key, there is at times some confusion in how dimensions 4 and 5 differ.
3	See answer on item #41
4	No
5	The only change we recommend is a movement towards measurement based criteria to determine the level of service and the effectiveness of that level.
6	none
7	Specifically call out cultural considerations and family history in dimension 3 or 6.
8	none
9	The dimensions can be interpreted very broadly, it would be helpful to provide examples of what is meant by "Mild," "Moderate," and "Severe."
10	include assertive outreach
11	none
12	No
13	New Strategies and Knowledge

14	Not qualified to say.	
15	I love the 6 dimensions	
16	No	
17	No.	
18	No	
19	Eliminate dimensions 4-6	
20	No	
21	NO	
22	None	
23	Family mental health and health history under Dimension 2.	
24	None that I can think of.	
25	I worry that changing the six dimensions (adding more) will produce chaos.	
26	n/a	
27	No	
28	dimension 1 and 4	
29	Perhaps adding some sort of specific interpersonal relationship risk dimension?	
30	NO	
31	Yes. An additional dimension for "Gender-specific & family based" and another for "criminogenic".	4/16/2021
32	No changes are recommended	
33	Mo	
34	An addition or inclusion of spirituality. An addition or inclusion of harm reduction.	
35	Combine and limit dimensions, be CONCISE	
36	Yes. The entire process needs simplified.	
37	NA	
38	None at this time	
39	No, it needs to not get more complex or it will be too cumbersome. It is already difficult to use without the software, which is not stand alone. If any changes are undertaken, they should promote simplicity and ease of use	
40	Revise or eliminate the Motivation Dimension to allow for more nuanced assessment of motivation and readiness and dynamic interaction within a person's internal motivation and other factors.	
41	No	
42	no	
43	No - good as is.	
44	Not at this time, they provided a strong comprehensive approach to the individual.	
45	Maybe the sixth on defining sober living and this a important step and key to recovery for some patients.	
46	Just implementing	

Q131 Should ASAM consider any changes to the current continuum of care (for example adding a new level, removing a level, or combining two levels)?

Answered: 50 Skipped: 174

#	RESPONSES
1	N/A
2	As noted above, level 3 residential/inpatient services would benefit from being revised.
3	Adding a level between 3.7 and 4.0. Many communities will push individuals with OUD into the Hospital setting when an outpatient setting would be best served Emphasis on the use of observation level of care. Especially for individuals who present as suicidal in the ED
4	Consider combining the residential levels of care. Re-evaluate the criteria around partial hospitalization. The duration of care, 20 hours or more and a minimum of 4 hours day, is strenuous for a person receiving services on an outpatient basis and for clinicians who have to delivery the service.
5	None at this time.

6	In practice, there's been limited differentiation between 3.1 and 3.5 for our organization.
7	More discussion on co-occurring enhanced services.
8	We recognize a need protocol for recovery management checkup, which includes a recovery track. Consider changing 0.5 to include prevention and long-term monitoring. Early intervention speaks to the beginning of the continuum, but there's nothing that addresses the end of the continuum once a person is stabilized. We recommend a long-term stabilization of care for stable individuals. For 3.3 level of care, we recommend clarification for the appropriate populations for this level of service, such as traumatic brain injury, parents with children, criminal justice population within a jail setting, etc. Reword "withdrawal management" so that it is inclusive of induction across these
9	no. the ASAM covers an array of LOC that allows the counselor to gather the needs of the client to provide services as needed.
10	Adding more transitions to other levels of care during later stages of treatment - eg 3.1 to 1.0 while in residential, 2.1 - 1.0 while in IOP, 3.7WM to 3.5 while in WM program; so many consumers get lost in between programs
11	Additional guidance around Level 3.3 would be helpful to clearly define if "Population Specific", and whether is may include female, male, pregnant women or LGBTQ+.
12	none
13	Add a new section to Level 1 to recognize and formalize criteria and recommendations for stimulant use, and the need for structured sober living.
14	none
15	No
16	Excellent all
17	Not qualified to say.
18	the levels seem appropriate
19	No
20	more details on .5 what does that cover
21	There are too many residential levels of care, makes it too confusing for clients, providers, & payors
22	No, the only thing i can say here is maybe more information about what to do if a level of care does not exist that is recommended after utilizing the ASAM Criteria.
23	I recommend adding a Transitional Housing level of care where treatment is required as part of this. With this said, this would be a separate level of care than 3.1. We developed a Transitional Housing Level of care with specific requirements that ASAM does not address. I also recommend developing a Sober Living Level of Care as this would add states in funding these type of services with clear requirements.
24	NO
25	None
26	put medically monitored and managed in the same level of care
27	Recovery Support Services should be added.
28	More granularity in Level 1. Clarification of need for community healing as a criterion for Level 3.
29	n/a
30	None
31	N/A
32	no
33	NO
34	NO
35	No
36	We still experience some confusion about the 1.0 Opiate Services loc and when to appropriately choose that over, for example, IOP, if a client is in the MAT program, but doing IOP.
37	No
38	see previous input
39	Additional guidance as to when long-term (e.g., 30 days +) and short-term (less than 30 days) treatment is appropriate. In our experience, individuals struggling with addiction, especially heroin, meth, and other highly addictive substances, require much longer than 30 days. Even if skills are in place, a longer time is needed away from the substance for the person to actually apply the skill. Clarification/guidance on when a longer term high intensity (3.5) treatment may be needed would be helpful given the growing intensity of addictive substances today.
40	The community needs to support all level of care. More levels of care will not make a difference if there are no services in the community of the existing levels.
41	None at this time
42	Halfway House, supported living could be more easily identified. It could be helpful if level 3 was simplified by perhaps combining some levels .
43	OTP levels do not seem well-integrated with the others and does not adequately address OBOT settings.

44	Residential levels of care don't align with some states. NY has community inpatient (short- term) and stabilization in residential care that overlap with ASAM levels.	
45	No	
46	no	
47	Just clarify that Level 1 can include bundles of care less than 9 hours/week	
48	As mentioned before, levels within level 3.1 and above need to be looked at. Maybe not group all of those together as a level 3.1 but provide different names? I think that the common factor of 24/7 is not enough to decipher between the levels and have seen a lot of confusion around these.	3/31/2021
49	maybe removing .5 early intervention. difficult to measure and not sure outcomes from this level.	
50	Just implementing	

Q132 Are there other tools, products, or services that would help you use The ASAM Criteria more effectively?

Answered: 48 Skipped: 176

#	RESPONSES
1	As noted above, many providers have limited knowledge of ASAM Criteria and how to use them effectively. Access to criteria may be hindered by cost and having low-cost and/or free access to criteria would highly benefit the field.
2	ASAM App that allows access to the criteria and where a clinician can ask for help or submit questions.
3	Training tools that are more widely distributed for providers to use in training new staff and supporting ongoing learning for clinicians is a need. The cost of training and materials is high and while OMHAS has sponsored some trainings they do not occur frequently enough to keep up with the work-force need.
4	None that I can think of at this time.
5	Web-based assessment tools for providers to use to determine ASAM criteria.
6	n/a
7	Cheat- sheet, and pocket guides for all levels of care/ages.
8	Perhaps a cross reference guide that will provide a 'this or that LOC' sheet so that the counselor can make an decision that will serve the client well..
9	Continuum and triage tools more accessible, written in ASAM criteria
10	Standardized assessment and level of care placement determination criteria. More examples of appropriate LOC determination using all 6 dimensions.
11	Intensive training
12	Having access to free educational resources, since this mandated criteria that has to be met in order to be appropriately reimbursed.
13	Increased training on front-line application of the Criteria, and "train the trainer" programs to increase the capacity of in-state training.
14	none
15	No
16	Excellent all
17	Not qualified to say.
18	n/a
19	No
20	A web-based tool for payors to determine level of care
21	A decision chart on the levels that can be used independently of the book/ posted in an office.
22	Anything print, online that would assist with enhancing job aids. Further definition of the levels. Training webinars.
23	how to work with insurance companies have insurance companies follow the same guidelines
24	n/a
25	No
26	N/A
27	No
28	more ASAM criteria trainings
29	NO

30	Needs another tool to better assess readiness for change
31	Incorporate ACE screening tool and ACE score into Assessment
32	Standardized forms.
33	More affordable trainings!
34	A general scoring reference. My staff still struggle with not having a definitive cross- reference of the ASAM risk ratings and which level to place a client in, mostly between 1.0 and 2.1. I guess a more clearly defined "cheat sheet" of when to place someone in outpatient vs IOP.
35	Yes, support services
36	any quick references would be appreciated differentials
37	Simplification and ensuring continuity for implementation.
38	NA
39	None at this time
40	Stand alone software that is inexpensive and easy to access - like open source software. Online networking and support for providers, moderated forums, etc.
41	There is a lot of information in the ASAM. Additional resources provided at no charge to help digest the information would be helpful (e.g. pocket guides, free trainings, cheat sheets).
42	No
43	Since more and more people will access the 4th Edition digitally, make sure all of the tools that are incorporated have active links, and that they are editable by practitioners, so that ASAM can track how they are being used.
44	It would be helpful to provide more examples and algorithms for determining level of care. I am aware there is a computer product available by ASAM but am also aware that the very best determination of level of care will be made by the multidisciplinary team and the pt. it is difficult to find examples of how levels of care should be determined by ASAM Standards. Again, the subjectivity of the questions and some of the standards can create for different scenarios! I was made aware of this during an ASAM Training I attended when my determination of level of care was different than the
45	maybe training that wasn't so costly.
46	Simple, easy to read, uncluttered "wallet card" type references that staff and providers can have handy without having to pull up a huge document or book to refer to.
47	An index with relevant terms and the pages on which they can be found would be helpful eg. "treatment plan" pages 110 etc.
48	Just implementing

Q133 What is the most important change ASAM should consider for the 4th edition of The ASAM Criteria?

Answered: 44 Skipped: 180

#	RESPONSES
1	Revising Level 3.
2	More specific criteria for OUD for inpatient withdrawal management. It is too vague to make medical necessity determinations
3	Make it available on-line.

4	Guidance is needed in terms of length of stay and elimination of program-driven care. Providers focus on length of stay, rather than emphasis of treatment required for the individual receiving services. There is no research behind the length of stay in residential settings, nonetheless, providers have created admission and treatment protocols around fixed episodes of care. Integrating measurement-based care would help residential and OP treatment programs in transitioning from fixed episode of care, based on historical funding protocols, to patient-centered care, based on reliable metrics of progress. We suggest including existing scales, such as the brief addiction measure (BAM) and other metrics, such as employment, housing stability or reductions in substance use via biomarkers or developing hybrid measures. The goal would be to use these tools across the continuum to assist providers in determining progress as well as tailoring lengths of stay within a level of care. Enhanced guidance is needed on the application of individualized treatment towards everyone receiving services, not only people that might fall into a specialty population. A related metric is continuum of pharmacological treatments across levels of care. Treatment providers in PA continue to view pharmacological interventions as separate from ASAM levels of care, instead of an essential element within all levels of care. We suggest emphasizing pharmacological interventions as essential elements within and across the four levels of care in the next edition. Notably, the menu of evidence-based medications for SUDs will likely expand before and after the next evolution of ASAM criteria. Treatment providers
5	Including of Peers.
6	n.a
7	Implementing telehealth guidance at various levels of care.
8	Strongly consider revising for plain language (e.g. 8th grade reading level).
9	less subjective
10	Direct connections to evidence-based practices.
11	no other recommendations
12	None identified
13	Rimrock utilizes everything ASAM and has no problems with any of it. Great job!
14	New Strategies for intervention
15	Not qualified to say.
16	to continue to make it clear and concise while keeping it clinically sound
17	COVID and telehealth.
18	Make it more simple to use
19	The length and time it takes to complete so any ways to reduce and make it more cognizant of a patient seeking treatment. Maybe, consider making a 2 step to break up the time it takes; initial VS established.
20	To look at the impact of racism on individuals. There is plenty information and research that shows the negative impact on health and mental health. This has treatment implications for people in treatment.
21	n/a
22	None
23	N/A
24	Dimensions
25	The language needs to be consistent with the typical staff provider that has a highschool or assocates or bachelors degree. Most of the providers do not understand how to interpret The ASAM Criteria from reading the book. I am suprised and dismayed that the large majority of providers know very little or nothing about the ASAM Decisional Flow (process) in determining the Intensity of Service and LOC Placement
26	NONE
27	Adding descriptions for risk ratings that more comprehensively reflect challenges in recovery, such as PWS, LGBTQ issues and how those are intertwined with addiction, and impulsivity.
28	Adding more details in residential services. I appreciate flexibility but the decisional flow is too vague and subjective.
29	Needs another tool to better assess readiness for change
30	Incorporate ACE score
31	Place more emphasis on outcome criteria in addition to inclusion criteria. For non-SUD medical criteria we are able to review outcomes and determine if continued treatment at a given LOC is warranted. This is very difficult, if not impossible to do with ASAM.
32	Shorten and be concise
33	Simplification.
34	NA
35	Clear instructions on how to use the ASAM tool, to those not familiar with it.
36	None at this time
37	Make the software available as a stand alone package. incorporate the needs of trans and non- binary individuals. Also ensure that the criteria are tailored to different cultures and communities.

38	ASAM is both an assessment tool and a tool for making level of care determinations, with an emphasis on assessment which gives it a very rich ability as a treatment planning tool and a tool that could provide guidance to clinicians for providing care consistent with science. It is more complex than needed for making level of care decisions in the way that real world LOC decision making needs to be made. If the continuum tool could be adapted for the narrowest number of questions needed to make the LOC decisions, and the more complexity also available for longer assessment with clinical guidance for treatment planning it would be more practical. Consider revisiting	
39	No	
40	Incorporate increased knowledge of opioid needs and pain management, and add materials regarding harm	
41	A more concise layout of already provided strong data to assist with agencies making their own determination for level of care. Second would be a stronger introduction of co-occurring information for each level of care and better definitions of staff requirements when it comes to addiction training and credentials.	
42	ease to understand. Although the language is clear there is a lot to absorb on so many levels.	
43	Organizing the text in a more user friendly way. Making it so non-clinicians can easily use it.	3/30/2021
44	Just implementing	

Q134 How could The ASAM Criteria be more sensitive to demographic or sociocultural disparities among the population your organization serves?

Answered: 35 Skipped: 189

#	RESPONSES
1	Have doctors from those populations address the issues from an INSIDERS View!
2	More about Native Americans
3	By incorporating various stakeholders feedback and in particular patient feedback.
4	See response to #41
5	Typically our clients identify as members of multiple underserved communities and face numerous barriers to accessing and remaining engaged w/ care that are outside of our control as providers.
6	ASAM should discuss more about the impact of trauma, the social determinants of health and cultural
7	n/a
8	Culturally and linguistically appropriate services (CILAS). Updated research on diverse groups of people.
9	Strongly consider revising for plain language (e.g. 8th grade reading level). Including more BIPOC voices in future
10	none
11	covers social determinants of health consider the effects racial discrimination, health disparities, effects of sexual harassments.
12	Not sure
13	Excellent all
14	Not qualified to say.
15	by acknowledging that different cultures are effected in different ways.
16	Not sure
17	None.
18	addressing transportation in a lower level of care - the ability to "bump up' the level due to no or unreelable
19	See response to 36
20	n/a
21	None
22	N/A
23	N/A
24	IT'S APPROPRIATE AS IS
25	Making sure that LGBTQ trauma is addressed.
26	Sexual preference, gender identity and non-binary considerations
27	N/A
28	NA
29	None at this time

30	Addressing the issues of homelessness and food insecurity. Acknowledge and address unique issues faced by non-binary and trans individuals.
31	Integrate information and guidance about sociocultural and social determinants of health factors into the assessment as well as guidance for clinicians in assessing their own beliefs, values and cultural context that may impact their assessment of clients.
32	No
33	Take a clear stance on mass incarceration of Black, Brown, and Indigenous individuals with SUDs; Incorporate non-Western support resources (e.g. Wellbriety) and how they are conceptualized in communal as opposed to individual ways; Language changes related to reference to gender and sexual orientation that are updated, and incorporate treatment needs for trans and non-binary individuals
34	not sure the criteria could be more sensitive but I do think health plans and providers could be more sensitive.
35	Just implementing