Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid

Residential Levels of Care

All Providers must adhere to state licensing requirements for their respective level(s) of care. As set forth in the Connecticut Medical Assistance Program (CMAP) provider enrollment agreement, providers must comply with all applicable federal and state statutes, regulation, and other requirements. All treatment services and interventions outlined within are included in the all-inclusive rates unless otherwise specified.

Qualified practitioners must operate within their scope of practice as applicable under state law, ensuring appropriate licensure and supervision as applicable. Qualified practitioners whose credentials exceed the minimum expectations outlined in this document may provide the services identified so long as they continue to operate within their scope of practice as applicable under state law.

***For programs serving JBCSSD clients, see p. 75 for additional contractor requirements.**

	Clinically Managed Low-Intensity Residential Services (ASAM 3.1)	Clinically Managed, High-Intensity Residential Population Specific (ASAM 3.3)
Ages Served	Age 18 and older	Age 18 and older
Brief Service Description	Level 3.1 residential programs provide a structured recovery residence environment, staffed 24 hours a day, which provides sufficient stability to prevent or minimize relapse or continued use and continued problem potential. • Residential programs offer at least five (5) hours per week of a combination of low-intensity clinical and recovery-focused services. These programs provide at least five (5) hours a week of individual, group, family therapy, medication management, and psychoeducation. At least two (2) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern, at least one (1) hour of which must include individual/family therapy.	Level 3.3 residential programs provide a structured recovery residence environment, staffed 24 hours a day, which provides sufficient stability to prevent or minimize relapse or continued use and continued problem potential. • Residential programs offer at least twenty (20) hours per week of a combination of high-intensity clinical and recovery-focused services provided in a manner to meet the functional limitations of individuals to support recovery from substance-related disorders. These programs provide at least twenty (20) hours a week of individual, group, family therapy, medication management, and psychoeducation. At least five (5) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern,

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	• Level 3.1 programs often are considered appropriate for individuals who need time and structure to practice and integrate their recovery and coping skills in a residential, supportive environment. The functional limitations found in individuals typically treated at Level 3.1 include problems in the application of recovery skills, self-efficacy, or lack of connection to the community systems of work, education, or family life. Individuals have an opportunity to develop and practice their interpersonal and group living skills, strengthen their recovery skills, reintegrate into the community and family, and begin or resume employment or academic pursuits. • Treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual into the worlds of work, education, and family life. • Mutual/self-help meetings usually are available onsite or are easily accessible in the community and are not included in the five hours of weekly programming provided by the facility. • Does not include sober houses, boarding houses, or group homes where treatment services are not provided (e.g., halfway house, group home or other supportive living environment with 24-hour staff and close integration with clinical services is not an ASAM 3.1 facility). • All facilities are licensed by the State of Connecticut (Connecticut or State) licensure agency.	at least one (1) hour of which must include individual/family therapy. • For individuals in Level 3.3 programs, the effects of the substance use disorder (SUD) or a co-occurring disorder resulting in cognitive impairment on the individual's life are so significant, and the resulting level of impairment so great, that outpatient motivational and/or relapse prevention strategies are not feasible or effective. Similarly, the individual's cognitive limitations make it unlikely that they could benefit from other levels of residential care. • The functional limitations exhibited by the individual can be either temporary or permanent and may result in problems in interpersonal relationships, emotional coping skills, and/or comprehension. Some individuals have such severe limitations that the treatment process is one of habilitation rather than rehabilitation. • Services may be provided in a deliberately repetitive fashion to address the special needs of these individuals. • Mutual/self-help meetings usually are available onsite or are easily accessible in the community and are not included in the twenty hours of weekly programming provided by the facility. • All facilities are licensed by the State of Connecticut (Connecticut or State) licensure agency.
Admission criteria	Level 3.1 programs are expected to accept admissions at least 16 hours per day, 7 days per week. Individuals meeting the below criteria shall be admitted regardless of the environment they are coming from (e.g., the community, other levels of care). The individual who is appropriately placed in a Level 3.1 program meets the diagnostic criteria for a moderate or severe substance use disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association	Level 3.3 programs are expected to accept admissions at least 16 hours per day, 7 days per week. Individuals meeting the below criteria shall be admitted regardless of the environment they are coming from (e.g., the community, other levels of care). The individual who is appropriately placed in a Level 3.3 program meets the diagnostic criteria for a moderate or severe SUD, as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized

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	or other standardized and widely accepted criteria, as well as the American Society of Addiction Medicine (ASAM) dimensional criteria for admission. If the individual's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (such as family members, legal guardians, and significant others). **Note**: Individuals in Level 3.1 programs may have co-occurring mental health disorders; or difficulties with mood, behavior, or cognition related to a substance use, other addictive, or mental health disorder; or emotional, behavioral, or cognitive symptoms that are troublesome but do not meet the DSM criteria for a mental health disorder. Therefore, all Level 3.1 programs are expected to be co-occurring capable. **DIMENSION 1: Acute Intoxication and/or Withdrawal Potential** The individual has no signs or symptoms of withdrawal, or their withdrawal needs can be safely managed in a Level 3.1 setting **DIMENSION 2: Biomedical Conditions and Complications** None, or stable. • The individual's biomedical conditions, if any, are stable do not require medical monitoring. Individuals are capable of self-administering any prescribed medications. **OR** • The individual's biomedical condition is not severe enough to warrant inpatient treatment but is sufficient to distract from treatment or recovery efforts and requires medical monitoring (can be arranged by the program or through an established arrangement with another provider). **DIMENSION 3: Emotional, Behavioral or Cognitive Conditions and Complications** A) Dangerousness/Lethality, B) Interference with Addiction and/or Mental Health Recovery Efforts, C) Social Functioning, D) Ability for Self-Care, E) Course of Illness	and widely accepted criteria, as well as the American Society of Addiction Medicine (ASAM) dimensional criteria for admission. If the individual's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (such as family members, legal guardians, and significant others). **Note**: Individuals in Level 3.3 programs may have co-occurring mental health disorders; or difficulties with mood, behavior, or cognition related to a substance use, other addictive, or mental health disorder; or emotional, behavioral, or cognitive symptoms that are troublesome but do not meet the DSM criteria for a mental health disorder. Therefore, all Level 3.3 programs are expected to be co-occurring capable. **DIMENSION 1: Acute Intoxication and/or Withdrawal Potential** Minimal risk of severe withdrawal, manageable withdrawal**.** • Individuals have no signs or symptoms of withdrawal, or their withdrawal needs can be managed in a Level 3.3 setting **DIMENSION 2: Biomedical Conditions and Complications** None, or stable • The individual's biomedical conditions, if any, are stable do not require medical monitoring. Individuals are capable of self-administering any prescribed medications. **OR** • The individual's biomedical condition is not severe enough to warrant inpatient treatment but is sufficient to distract from treatment or recovery efforts and requires medical monitoring (can be arranged by the program or through an established arrangement with another provider). **DIMENSION 3: Emotional, Behavioral or Cognitive Conditions and Complications** A) Dangerousness/Lethality, B) Interference with Addiction and/or Mental Health Recovery Efforts, C) Social Functioning, D) Ability for Self-Care, E) Course of Illness Adult 3.3: Mild to moderate

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	None or minimal. • **All 3.1 programs are co-occurring capable** such that those who have any Dimension 3 conditions are not excluded from admission. • The individual's mental status (including emotional stability and cognitive functioning) is assessed as sufficiently stable to participate and benefit from treatment **AND** one of the following: • The individual's psychiatric condition is stable, and they are assessed as having minimal problems in this area • The individual's symptoms and functional limitations, when considered in the context of their home environment, are sufficiently severe that they are assessed as not likely to maintain mental stability and/or abstinence if treatment is provided in a nonresidential setting • The individual demonstrates (through distractibility, negative emotions, or generalized anxiety) an inability to maintain stable behavior over a 24-hour period without the structure and support of a 24-hour setting • The individual's co-occurring psychiatric, emotional, behavioral, or cognitive conditions are being addressed concurrently through appropriate psychiatric services. **DIMENSION 4: Readiness to change** Adult 3.1: Open to recovery, needs structured environment. • Readiness to Change: The individual may acknowledge the existence of a psychiatric condition and/or substance use problem, recognizes specific negative consequences and dysfunctional behaviors and is ready to change. The individual may be at an early stage of readiness to change and thus in need of engagement and motivational strategies. The individual may require a 24-hour structured milieu to promote treatment progress and recovery. The individual's perspective may impair their ability to make behavior changes without the support of a structured environment. Interventions may be assessed as not likely to succeed in an outpatient setting.	• **All 3.3 programs to be co-occurring capable** such that those who have any Dimension 3 conditions are not excluded from admission. • The individual's mental status (including emotional stability and cognitive functioning) is assessed as sufficiently stable to participate and benefit from treatment **AND** one of the following: • In need of a 24-hour structured environment • Symptoms and functional limitations are sufficiently severe that the individual is not likely to maintain mental stability and/or abstinence if treatment is provided in a non-residential setting • The individual is at mild risk of behaviors endangering self, others or property and is in imminent danger of relapse without the 24-hour support and structure **DIMENSION 4: Readiness to change** Needs interventions to engage and stay in treatment • Individuals' readiness to change may be impacted by limited problem awareness and/or difficulty understanding the relationship between their disorder(s) and level of functioning, despite experiencing serious consequences. Individuals' continued use may pose a harm to themselves or others. Behavior changes may be unlikely without the interventions delivered in a 24-hour milieu. **DIMENSION 5: Relapse, Continued Use or Continued Problem Potential** Needs intervention to prevent relapse • The individual may not recognize relapse triggers and is in imminent danger of continued substance use or mental health problems with serious consequences. The individual may be experiencing an intensification of symptoms and deteriorating level of functioning. The individual's cognitive impairment may require relapse prevention activities that are delivered at a slower pace, more concretely, and more repetitively, in a setting that provides 24-hour structure and support to prevent imminent consequences. For mandated individuals, serious consequences may be criminal.

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	DIMENSION 5: Relapse, Continued Use or Continued Problem Potential Understands relapse, needs structure. • The individual may demonstrate limited coping skills to address relapse triggers and urges and/or deteriorating mental functioning. The individual may understand their disorder(s) but is unable to consistently address it (them) such that there is risk of relapse. The individual may need staff support to maintain engagement in recovery while transitioning to the community. The individual may be at high risk of substance use, addictive behavior, or deteriorated mental functioning, with dangerous emotional, behavioral, or cognitive consequences, in the absence of close 24-hour structured support **DIMENSION 6: Recovery/Living Environment** Dangerous environment, 24-hour structure needed. • The individual is able to cope, for limited periods of time, outside the 24-hour structure of a Level 3.1 program in order to pursue clinical, vocational, educational, and community activities **AND** one of the following: • The individual has been living in an environment that has a high risk of compromising recovery • The individual lacks social contacts or has high-risk social contact that jeopardize their recovery • Continued exposure to the individual's school, work, or living environment makes recovery unlikely, and the individual has insufficient resources and skills to maintain an adequate level of functioning outside of a 24-hour supportive environment; • The individual is in danger of victimization by another and thus requires 24-hour supervision **Transfer to another LOC** • When assessment indicates that an individual no longer meets the placement criteria noted above, they can be transferred to the next appropriate level of	**DIMENSION 6: Recovery/Living Environment** Dangerous environment, 24-structure needed • An individual's recovery environment interferes with recovery and is characterized by a moderately high risk of victimization and/or abuse and/or a social network with prominent triggers to use. The individual may be unable to cope, for even limited periods of time, outside of a 24-hour program structure. **Transfer to another LOC** • When assessment indicates that an individual no longer is cognitively impaired, they can be transferred to another level of care (such as a Level 3.5 program) or a less intensive level of care (such as a Level 1, 2.1, 2.5 or 3.1 program), based on a reassessment of their severity of illness and rehabilitative needs.

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	care based on a reassessment of their severity of illness and rehabilitative needs.	

Interventions	• A toxicology screen and a tuberculosis screen are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider. Random drug screening as clinically necessary to reinforce treatment gains and as appropriate to the individual's treatment plan.
	  ○ Note: DSS will establish upper limit on number of lab tests that can be sent out. Refer to associated lab policy for additional guidance.
	• An individualized, comprehensive biopsychosocial assessment of the individual is completed or updated within 72 hours of admission which substantiates appropriate placement at Level 3.1. This assessment also helps to guide the individualized treatment planning process, which is focused on the individual's strengths, needs, abilities, preferences, and desired goals.
	  ○ Staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders.
	  ○ Credentials of the completing practitioner must be documented on the assessment.
	  ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.
	• A documented physical exam one month prior to admission or an appointment scheduled no later than five days after admission and the appointment for the physical cannot be more than 30 days from the date of admission. Any individual receiving uninterrupted treatment or care in a licensed facility shall require only the documentation of the initial physical examination.
		• A toxicology screen and a tuberculosis screen are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider. Random drug screening as clinically necessary to reinforce treatment gains and as appropriate to the individual's treatment plan.
		  ○ Note: DSS will establish upper limit on number of lab tests that can be sent out. Refer to associated lab policy for additional guidance.
		• An individualized, comprehensive biopsychosocial assessment of the individual is completed or updated within 72 hours of admission which substantiates appropriate placement at Level 3.3. This assessment also helps to guide the individualized treatment planning process, which is focused on the individual's strengths, needs, abilities, preferences, and desired goals.
		  ○ Staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders.
		  ○ Credentials of the completing practitioner must be documented on the assessment.
		  ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.
		• A documented physical exam one month prior to admission or an appointment scheduled no later than five days after admission and the appointment for the physical cannot be more than 30 days from the date of admission. Any individual receiving uninterrupted treatment or care in a licensed facility shall require only the documentation of the initial physical examination.
		• An individualized treatment plan which includes problem formulation, needs, strengths, skills and articulation of short-

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	• An individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals. ○ The plan is initiated at the time of admission, is developed in collaboration with the individual and is completed within 72 hours of admission. The plan reflects the individual's personal goals while considering the individual's strengths, capabilities, and existing recovery resources available to achieve the individual's personal goals. ○ The treatment plan reflects case management conducted by on-site staff; coordination of related addiction treatment, health care, mental health, recovery support services, social, vocational, or housing services (provided concurrently); and the integration of services at this and other levels of care. ○ Because treatment plans are individualized, fixed lengths of stay are inappropriate. ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the treatment plan. ○ The treatment plan must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. ○ Complete and document a review of the treatment plan and determine the appropriateness of the individual's continued placement every 30 days and revise accordingly to reflect the individual's clinical progress. • Discharge/transfer planning begins at admission and is documented in the individual's record. ○ The duration of treatment always depends on individual progress and outcome. Because treatment plans should be individualized, lengths of stay should be flexible and individualized to	term, measurable treatment goals and activities designed to achieve those goals. ○ The plan is initiated at the time of admission, is developed in collaboration with the individual and is completed within 72 hours of admission. The plan reflects the individual's personal goals, while considering the individual's strengths, capabilities and existing recovery resources available to achieve the individual's personal goals. ○ The treatment plan reflects case management conducted by onsite staff; coordination of related addiction treatment, health care, mental health, recovery support services, social, vocational, or housing services (provided concurrently); and the integration of services at this and other levels of care. ○ Because treatment plans are individualized, fixed lengths of stay are inappropriate. ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the treatment plan. ○ The treatment plan must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. ○ Complete and document a review of the treatment plan and determine the appropriateness of the individual's continued placement every 30 days and revise accordingly to reflect the individual's clinical progress, as assessed by the interdisciplinary team. • Discharge/transfer planning begins at admission and is documented in the individual's record. ○ The duration of treatment always depends on individual progress and outcome. Because treatment plans should be individualized, lengths of stay should be flexible and individualized to meet the needs of each individual, not based on predetermined lengths of stay.

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	meet the needs of each individual, not based on predetermined lengths of stay. ○ Transfer or Discharge Plan required except in an emergency, or when a client leaves of their own accord or against program advice. Discharge plans include obtaining necessary release(s) of information to refer to appropriate aftercare services, including clinical recovery supports. Plans are written in conjunction with the individual and their primary counselor and service coordinator. ○ There are concrete plans for community reintegration and transition to the next appropriate level of care and treatment support and services documented including the aftercare the individual is being discharged to. • Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services. ○ Provide an orientation to and facilitate connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment.	○ Transfer or Discharge Plan required except in an emergency, or when a client leaves of their own accord or against program advice. Discharge plans include obtaining necessary release(s) of information to refer to appropriate aftercare services, including clinical recovery supports. Plans are written in conjunction with the client and their primary counselor. ○ There are concrete plans for community reintegration and transition to the next appropriate level of care and treatment support and services documented including the aftercare the individual is being discharged to. • Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services. ○ Provide an orientation to and facilitate connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment.
Treatment Services	Level 3.1 residential programs offer 24-hour direct care and delivers low-intensity services. Treatment services facilitate the application of recovery skills, relapse prevention, and emotional coping strategies. They promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life. • Provide SUD services, in accordance with the individual's treatment plan, for a minimum of five (5) hours per week. At least two (2) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern, at least one (1) hour of which must include individual/family therapy.	Level 3.3 residential programs offer 24-hour direct care and delivers high-intensity services, which may be provided in a deliberately repetitive fashion to address the special needs of individuals in the program. • Daily programming in accordance with the individual's treatment plan, which shall include a minimum of twenty (20) hours of SUD services per week. At least five (5) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern, at least one (1) hour of which must include individual/family therapy. • Some individuals have such severe limitations in interpersonal and coping skills

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	• In Level 3.1, the treatment services are focused on improving the individual's readiness to change (Dimension 4) and/or functioning and coping skills in Dimensions 5 and 6. Services may include individual, group, and family therapy; medication management and medication education; mental health evaluation and treatment; vocational rehabilitation and job placement; and either introductory or remedial life skills workshops. • The program offers a range of evidence-based cognitive, behavioral, and other therapies administered on an individual and group basis, medication education and management, medication for addiction treatment, educational skill building groups, and occupational or recreational activities, adapted to the individual's developmental stage and level of comprehension, understanding, and physical abilities. • Services designed to improve the individual's ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance, and punctuality. • Motivational enhancement and engagement strategies appropriate to the individual's stage of readiness to change, which are used in preference to confrontational approaches. • Counseling and clinical monitoring to promote successful initial involvement or re-involvement in regular, productive daily activity, such as work or school and, as indicated, successful reintegration into family living. • Direct affiliations with other levels of care (such as IOP for purposes of discharge planning) and other services (such as supported employment, literacy training, and adult education). • Promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life. • Provide onsite peer support, including at a minimum, alumni groups and recovery groups or linkage to 12-step groups that ideally are welcoming to people with	that the treatment process is one of habilitation rather than rehabilitation. • Such individuals require a program that allows sufficient time and a slower pace to integrate the lessons and experiences of treatment into their daily lives. • Treatment and educational sessions, inclusive of evidence-based practices, relevant to individuals receiving services and directed toward increasing awareness, enhancing readiness to change, preventing relapse and continued problems and promoting the eventual reintegration into the community. • The program offers a range of evidence-based cognitive, behavioral, and other therapies administered on an individual and group basis, medication education and management, medication for addiction treatment, educational skill building groups, and occupational or recreational activities, adapted to the individual's developmental stage and level of comprehension, understanding, and physical abilities. • Motivational enhancement and engagement strategies appropriate to the individual's stage of readiness and desire to change. Motivational therapies and other evidence-based practices are used in preference to confrontational strategies. • For individuals with significant cognitive deficits (such as chronic brain syndrome, intellectual disabilities, or traumatic brain injury), therapies are delivered in a manner that is slower paced, more concrete, and more repetitive. • Counseling and clinical monitoring to promote successful initial involvement or re-involvement in regular, productive daily activity, such as work or school and, as indicated, successful reintegration into family living. • Provide onsite peer support, including at a minimum, alumni groups and recovery groups or linkage to 12-step groups that ideally are welcoming to people with co-occurring disorders. Note: these meetings do not count toward the 20 hours of weekly programming each individual receives.

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	co-occurring disorders. Note: these meetings do not count toward the five hours of weekly programming each individual receives. • Facilitate connections to recovery resources and community supports. • Monitoring of the individual's adherence in self-administering any prescribed medications, including medication for addiction treatment (MAT), and/or any permitted over-the-counter (OTC) medications or supplements. • Opportunities for the individual to be introduced to the potential benefits of medication for addiction treatment as a tool to manage their substance use disorder(s). • Access to medication for addiction treatment. The program does not preclude admission of individuals based on MAT profile and active medication prescriptions. If agency cannot support a medication need internally, they have policies in place to ensure communication with prescribing physician is ongoing. • Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g., HIV, hepatitis C, sexually transmitted diseases) • Services, as appropriate and whenever possible with the individual's consent, for the individual's family and significant others to promote positive contribution to the individual's treatment and recovery.	• Planned community reinforcement designed to foster prosocial values, a prosocial milieu, and community living skills. • Facilitate connections to recovery resources and community supports. • Activities directed toward networking individuals into community-based ancillary or "wrap-around" services such as housing, vocational services, or transportation assistance so that they are able to attend mutual/self-help meetings or vocational activities after discharge. • Monitoring of the individual's adherence in self-administering any prescribed medications, including medication for addiction treatment (MAT), and/or any permitted over-the-counter (OTC) medications or supplements. • Opportunities for the individual to be introduced to the potential benefits of medication for addiction treatment as a tool to manage their substance use disorder(s). • Access to medication for addiction treatment. The program does not preclude admission of individuals based on MAT profile and active medication prescriptions. If agency cannot support a medication need internally, they have policies in place to ensure communication with prescribing physician is ongoing. • Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g., HIV, hepatitis C, sexually transmitted diseases) • Services, as appropriate and whenever possible with the individual's consent, for the individual's family and significant others to promote positive contribution to the individual's treatment and recovery.
Documentation	Level 3.1 programs will maintain individualized records which shall include: • The individual's Medicaid eligibility status • A physical exam one month prior to admission or an appointment scheduled no later than five days after admission. Any individual receiving uninterrupted treatment or care in a licensed facility shall require only the documentation of the initial physical examination.	Level 3.3 programs will maintain individualized records which shall include: • The individual's Medicaid eligibility status • Initial intake evaluation, including screening for a co-occurring psychiatric disorder. • A physical exam one month prior to admission or an appointment scheduled no later than five days after admission. Any individual receiving uninterrupted treatment or care in a licensed facility shall require only

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	• Initial intake evaluation, including screening for a co-occurring psychiatric disorder. A physician (or PA/NP) should review all admissions, indicate agreement with the level of care recommended and document this in the individual's medical record. • Information regarding the individual meeting ASAM placement criteria for the purpose of authorization and continued eligibility. ASAM 6 dimensions of care assessment tool score upon entry and documentation in the treatment plan for continued stay at each reassessment. • An individualized, comprehensive biopsychosocial assessment which includes assessment in each of the ASAM six dimensions; this assessment must be compliant with the most recent edition of ASAM. ○ Documentation of any mental health and SUD diagnoses as well as any cognitive limitations ○ Completion within 72 hours of admission ○ Staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders. ○ Credentials of the completing practitioner must be documented on the assessment. ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • Individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals. ○ Discharge planning is integrated into the treatment plan. ○ Initiated at the time of admission and completed within 72 hours of admission ○ Staff developing the treatment plan shall be an independently licensed or	the documentation of the initial physical examination. • Initial intake evaluation, including screening for a co-occurring psychiatric disorder. • Information regarding the individual meeting ASAM placement criteria for the purpose of authorization and continued eligibility. ASAM 6 dimensions of care assessment tool score upon entry and documentation in the treatment plan for continued stay at each reassessment. • An individualized, comprehensive biopsychosocial assessment which includes assessment in each of the ASAM six dimensions; this assessment must be compliant with the most recent edition of ASAM. ○ Documentation of any mental health and SUD diagnoses as well as any cognitive limitations ○ Completion within 72 hours of admission ○ Staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders. ○ Credentials of the completing practitioner must be documented on the assessment. ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • Individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals. ○ Discharge planning is integrated into the treatment plan. ○ Initiated at the time of admission and completed within 72 hours of admission ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern.

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	associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the treatment plan. ○ Plans must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. ○ Review of the treatment plan and determine the appropriateness of the individual's continued placement every 30 days and revise accordingly to reflect the individual's clinical progress • Individualized progress notes that clearly reflect implementation of the treatment plan and the individual's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. ○ Credentials of the practitioner completing ○ Notes for clinical services provided by an associate licensed practitioner or graduate-level intern shall have the review and signature of an independently licensed behavioral health practitioner/clinical supervisor. • Administration of toxicology screens and the test results. • Discharge summary which has been written within 15 working days of the individual leaving the program. This summary shall: ○ Address original reason for referral. ○ Indicate the individual's progress towards the established plan. ○ Describe the type, frequency and duration of treatment or services. ○ Specify reason(s) for discharge ○ Indicate the individual's participation in discharge planning. ○ Includes information regarding release(s) of information obtained and aftercare services referred to. ○ Staff completing the discharge summary shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern.	○ Credentials of the completing practitioner must be documented on the treatment plan. ○ Plans must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. ○ Review of the treatment plan and determine the appropriateness of the individual's continued placement every 30 days and revise accordingly to reflect the individual's clinical progress • Individualized progress notes that clearly reflect implementation of the treatment plan and the individual's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. ○ Credentials of the practitioner completing ○ Notes for clinical services provided an associate licensed practitioner or graduate-level intern shall have the review and signature of an independently licensed behavioral health practitioner/clinical supervisor. • Administration of toxicology screens and the test results. • Discharge summary which has been written within 15 working days of the individual leaving the program. This summary shall: ○ Address original reason for referral. ○ Indicate the individual's progress towards the established plan. ○ Describe the type, frequency and duration of treatment or services. ○ Specify reason(s) for discharge ○ Indicate the individual's participation in discharge planning. ○ Includes information regarding release(s) of information obtained and aftercare services referred to. ○ Staff completing the discharge summary shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the discharge summary. ○ The discharge summary must be reviewed and signed by an

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	○ Credentials of the completing practitioner must be documented on the discharge summary. ○ The discharge summary must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.	independently licensed behavioral health practitioner/clinical supervisor.
Provider Qualifications/ Staffing	Level 3.1 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified peers and technicians operating within their scope of practice to provide services appropriate to the biopsychosocial needs of individuals being admitted to the program. Facility's staffing pattern is gender responsive and trauma informed. • Minimum on-site staffing requirements (not counting on-call hours) shall be maintained 24 hours per day, 7 days per week as outlined below: ○ 0-24 beds: 2 staff minimum at all times ○ 25-64 beds: 3 staff minimum at all times ○ 65-99 beds: 4 staff minimum at all times ○ 100+ beds: 5 staff minimum at all times - For facilities with multiple levels of care at the same physical address and within the same building and floor, minimum staff ratios can be shared between programs. - If programs share the same address and are separated on different floors or different buildings, the minimum staff requirement shall apply to each floor and building. An exception to this is a 0-24 bed program located in one building in which there are resident rooms on multiple levels of the building (e.g. a house-like setting); only the minimum staffing of two persons would be required. - Any requests to waive the above criteria must be submitted to The Departments for review and approval. • Level 3.1 programs must be able to provide 24-hour staff support. Ensure staff who have client contact receive training on cooccurring mental health and substance	Level 3.3 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified peers and technicians operating within their scope of practice to provide services appropriate to the biopsychosocial needs of individuals being admitted to the program. Facility's staffing pattern is gender responsive and trauma informed. • Minimum on-site staffing requirements (not counting on-call hours) shall be maintained 24 hours per day, 7 days per week as outlined below: ○ 0-24 beds: 2 staff minimum at all times ○ 25-64 beds: 3 staff minimum at all times ○ 65-99 beds: 4 staff minimum at all times ○ 100+ beds: 5 staff minimum at all times ○ For facilities with multiple levels of care at the same physical address and within the same building and floor, minimum staff ratios can be shared between programs. ○ If programs share the same address and are separated on different floors or different buildings, the minimum staff requirement shall apply to each floor and building. An exception to this is a 0-24 bed program located in one building in which there are resident rooms on multiple levels of the building (e.g. a house-like setting); only the minimum staffing of two persons would be required. ○ Any requests to waive the above criteria must be submitted to The Departments for review and approval. • Level 3.3 programs must be able to provide 24-hour staff support. Ensure staff who have client contact receive training on co-occurring mental health and substance use disorders, including prevalence, signs/symptoms,

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	use disorders, including prevalence, signs/symptoms, assessment, treatment and the impact of one's own attitudes/beliefs on the delivery of services and the use of naloxone in response to an opioid overdose.
	• Where on-call coverage is indicated for any of the below positions, such coverage can be combined across programs within the same agency.
	• Medical, psychiatric, psychological, laboratory and toxicology services, available through consultation or referral, as appropriate to the severity and urgency of the individual's condition.
	• Psychiatric services are available on-site or through telemedicine per the state's telemedicine policy, as appropriate to the severity and urgency of the individual's condition.
	  ○ Such services include medication for addiction treatment (e.g., buprenorphine, naltrexone, acamprosate, disulfiram).
	• Physician (or NP/PA): Although they are not required to provide direct services, the physician is part of the interdisciplinary team either through employment or contractual arrangement.
	  ○ A physician (or NP/PA) shall review all admissions, indicate agreement with the level of care recommended and document this in the individual's medical record.
	  ○ Telephone or in person consultation with a physician, physician assistant or nurse practitioner and emergency services is available 24/7.
	• Executive Director: Each facility shall have an executive director who is accountable to the governing authority. The executive director shall be responsible for the management of the facility
	• Employs a clinical supervisor with authority over all behavioral health treatment services, who shall have a minimum of a master's degree in a behavioral health treatment services field, at least three years of full-time work experience in SUD services
		assessment, treatment and the impact of one's own attitudes/beliefs on the delivery of services and the use of naloxone in response to an opioid overdose.
		• Where on-call coverage is indicated for any of the below positions, such coverage can be combined across programs within the same agency.
		• Medical, psychiatric, psychological, laboratory and toxicology services, available through consultation or referral, as appropriate to the severity and urgency of the individual's condition.
		• Psychiatric services are available on-site or through telemedicine per the state's telemedicine policy.
		  ○ Such services include medication for addiction treatment (e.g., buprenorphine, naltrexone, acamprosate, disulfiram).
		• A physician (or NP/PA) provides oversight to the nursing staff who carry out the medical orders. Orders should not exceed the nurse or ordering practitioner's scope of practice.
		  ○ Telephone or in-person consultation with a physician (or NP/PA) and emergency services are available 24/7.
		• Executive Director: Each facility shall have an executive director who is accountable to the governing authority. The executive director shall be responsible for the management of the facility.
		• Nursing staff (RN or LPN) onsite 20 hours per week per 16 residents. Facilities greater than 64 residents will not be required to have more than two (2) total nurses.
		  ○ At least one nurse shall be an RN
		  ○ The RN works under the direction and orders of a licensed physician (or NP/PA). Orders should not exceed the nurse or ordering practitioner's scope of practice.
		• Employs a clinical supervisor with authority over all behavioral health treatment services, who shall have a minimum of a master's degree in a behavioral health treatment services field, at least three years of full-time work experience in SUD services and be independently licensed by the State in their respective discipline.

	Clinically Managed Low-Intensity Residential Services (ASAM 3.1)	Clinically Managed, High-Intensity Residential Population Specific (ASAM 3.3)
	and be independently licensed by the State in their respective discipline. ○ The Clinical Supervisor must be on-site at least 40 hours per week with at least one evening shift per week. Larger programs may require additional clinical supervisor hours to ensure all supervision requirements are met as detailed in the "Supervision Requirements" section below. ○ The Clinical Supervisor conducts and documents face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month. ○ There shall be 24-hour on-call coverage by telephone during those hours when the clinical supervisor is not physically present. • An independently licensed or associate licensed behavioral health practitioner is available to provide a minimum of two (2) hours (out of the total five hours of weekly programming) of clinical treatment per week. At least one (1) of these hours includes individual/family therapy. ○ Up to 25 percent of clinical treatment hours may be provided by a graduate-level intern whose accredited graduate degree program requires their students to participate in intern placements for clinical training in the provision of behavioral health services. ○ At least one behavioral health practitioner per 16 residents is on-site 40 hours per week. ○ Any behavioral health practitioner who is not independently licensed must be working under a licensed independent behavioral health practitioner who must sign off on clinical documentation and provide supervision. ○ Clinical staff should be knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment. Clinical staff should be able to identify the signs and symptoms of	○ The Clinical Supervisor must be on-site at least 40 hours per week with at least one evening shift per week. Larger programs may require additional clinical supervisor hours to ensure all supervision requirements are met as detailed in the "Supervision Requirements" section below. ○ The Clinical Supervisor conducts and documents face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month. ○ There shall be 24-hour on-call coverage by telephone during those hours when the clinical supervisor is not physically present. • An independently licensed or associate licensed behavioral health practitioner is available to provide a minimum of five (5) hours (out of the total 20 hours of weekly programming) of clinical treatment per week. At least one (1) of these hours include individual/family therapy. ○ Up to 25 percent of clinical treatment hours may be provided by a graduate-level intern whose accredited graduate degree program requires their students to participate in intern placements for clinical training in the provision of behavioral health services. ○ At least one behavioral health practitioner per 16 residents is on-site 40 hours per week. ○ Any behavioral health practitioner who is not independently licensed must be working under a licensed independent behavioral health practitioner who must sign off on clinical documentation and provide supervision. ○ Clinical staff should be knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment. Clinical staff should be able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation. ○ Clinical groups should be limited to no more than 12 group members regardless

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	acute psychiatric conditions, including psychiatric decompensation. ○ Clinical groups should be limited to no more than12 group members regardless of payer. Psychoeducational and non-clinical groups should be limited to no more than 25 group members. ○ At least one behavioral health practitioner with competence in the treatment of substance use and mental health disorders is available by telephone 24 hours a day, seven days a week when not on-site. • House manager awake and on-site during evenings, weekends and overnight to supervise activities of the facility. This person is required to have adequate orientation and skills to assess situations related to relapse and to provide access to appropriate medical care when needed • Technicians are available onsite, as needed, to ensure minimum staffing requirements are met and are awake and monitoring individuals' needs at all times. ○ Technicians may provide the additional remaining hours of weekly programming ○ Technicians report to a Tech Supervisor (or other leadership position) with at least 6 months experience in residential SUD programs. • Certified Peers may provide the additional remaining hours of weekly programming and may meet with residents individually and/or in group formats to support their ongoing engagement, retention and progress in treatment. ○ Certification must be obtained by one of the state-approved certification boards. ○ Certified Peers should be onsite while residents are awake, including presence on evenings and weekends. Number of Certified Peers required depends on the size of the program: ▪ 0-32 beds: 1 peer onsite at least 40 hours per week ▪ 33-64 beds: 2 peers onsite at least 40 hours per week each	of payer. Psychoeducational and non-clinical groups should be limited to no more than 25 group members. ○ At least one behavioral health practitioner with competence in the treatment of substance use and mental health disorders is available by telephone 24 hours a day, seven days a week when not on-site. At least one behavioral health practitioner with competence in the treatment of substance use disorders is available by telephone 24 hours a day, seven days a week when not on-site. • Technicians are available on-site, as needed, to ensure minimum staffing requirements are met and are awake and monitoring individuals' needs at all times. ○ Technicians may provide the additional remaining hours of weekly programming ○ Technicians report to a Tech Supervisor (or other leadership position) with at least 6 months experience in residential SUD programs. • Certified Peers may provide the additional remaining hours of weekly programming and may meet with residents individually and/or in group formats to support their ongoing engagement, retention and progress in treatment. ○ Certification must be obtained by one of the state-approved certification boards. ○ Certified Peers should be onsite while residents are awake, including presence on evenings and weekends. Number of Certified Peers required depends on the size of the program: ▪ 0-32 beds: 1 peer onsite at least 40 hours per week ▪ 33-64 beds: 2 peers onsite at least 40 hours per week each ▪ 65+ beds: 3 peers onsite at least 40 hours per week each ○ Certified peers receive one hour of clinical supervision weekly, of which group supervision may be utilized once a month. This supervision can be provided by: ▪ The Clinical Supervisor (as defined above);

	Clinically Managed Low-Intensity Residential Services (ASAM 3.1)	Clinically Managed, High-Intensity Residential Population Specific (ASAM 3.3)
	▪ 65+ beds: 3 peers onsite at least 40 hours per week each ○ Certified peers receive one hour of clinical supervision weekly, of which group supervision may be utilized once a month. This supervision can be provided by: ▪ The Clinical Supervisor (as defined above); ▪ An independently licensed or associate licensed behavioral health practitioner with at least 2 years of full-time work experience in SUD services; or ▪ A Certified Peer with at least 2 years of full-time experience in providing peer support services. • A dedicated Service Coordinator that manages incoming referrals and discharge plans is required for each facility. The purpose of the Service Coordinator is to promote engagement and retention in treatment and facilitate an effective discharge plan whereby the individual successfully connects to the next level of care. The service coordinator facilitates referral arrangements and coordination with aftercare. ○ The Service Coordinator can also assist in networking individuals into community-based ancillary or "wrap-around" services to build/maintain recovery capital. ○ The service coordinator shall be on-site weekdays during 1st shift for at least 80% of the time. The other 20% may be done second, third or weekend shifts. ○ The Service Coordinator may be a licensed practitioner, unlicensed counselor, or certified peer. • Each facility shall have at least one staff person in each building, when a resident is known to be present and who shall have immediate access to back up staff, for urgent or emergency situations. This is inclusive of the positions described above.	▪ An independently licensed or associate licensed behavioral health practitioner with at least 2 years of full-time work experience in SUD services; or ▪ A Certified Peer with at least 2 years of full-time experience in providing peer support services. • A dedicated Service Coordinator that manages incoming referrals and discharge plans is required for each facility. The purpose of the Service Coordinator is to promote engagement and retention in treatment and facilitate an effective discharge plan whereby the individual successfully connects to the next level of care. The service coordinator facilitates referral arrangements and coordination with aftercare. ○ The Service Coordinator can also assist in networking individuals into community-based ancillary or "wrap-around" services to build/maintain recovery capital. ○ The service coordinator shall be on-site weekdays during 1st shift for at least 80% of the time. The other 20% may be done second, third or weekend shifts. ○ The Service Coordinator may be a licensed practitioner, unlicensed counselor, or certified peer. • Each facility shall have at least one staff person in each building, when a resident is known to be present and who shall have immediate access to back up staff, for urgent or emergency situations. This is inclusive of the positions described above.
Length of Stay	As medically necessary, or dependent on time needed to sustain and further therapeutic gains and master the application of coping and recovery skills	As medically necessary, or dependent on time needed to sustain and further therapeutic gains and master the application of coping and recovery skills

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Supervision Requirements	Supervisors conduct and document face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month. Certified peers with lived experience receive clinical supervision 1 hour weekly, of which group supervision may be utilized once a month – this can be from: the Clinical Supervisor; an independently licensed or associate licensed behavioral health practitioner with at least 2 years of full-time work experience in SUD services; or a Certified Peer with at least 2 years of full-time experience in providing peer support services. Technicians receive supervision 30 minutes for every 40 hours worked – this can be from the House Manager/Tech supervisor. Tech administrative supervision can be in a group setting for all but one time a month. Techs must receive monthly group clinical supervision with a potential shift overlap (All staff meeting at least once a month). There should be a shift report or hand off for every shift or staggered starts.	

	Clinically Managed High-Intensity Residential (ASAM 3.5)	Clinically Managed High-Intensity Residential (ASAM 3.5) Pregnant and Parenting Women (PPW)
Ages Served	Age 18 and older[1]	Age 18 and older
Brief Service Description	Level 3.5 programs provide a structured recovery residence environment, staffed 24 hours a day, which provides sufficient stability to prevent or minimize relapse or continued use and continued problem potential. • Residential programs offer at least twenty (20) hours per week of a combination of high-intensity clinical and recovery-focused services specifically focused on individuals who have significant social and psychological problems. These programs provide at least twenty (20) hours a week of individual, group, family therapy, medication management, and psychoeducation. At least ten (10) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern, at least one (1) hour of which must include individual/family therapy. • Level 3.5 programs are designed to serve individuals who, because of specific functional limitations, need safe and stable living environments in order to develop and/or demonstrate sufficient recovery skills so that they do not immediately relapse or continue to use in an imminently dangerous	Level 3.5PPW programs include the standards outlined for the Level 3.5 programs. In addition, 3.5PPW specializes in Pregnant and Parenting Women which affords women the opportunity to have at least one of their children accompany them while they reside at the program and receive gender-specific treatment services. 3.5PPW programs also assist women in accessing resources to provide safe, nurturing homes for their children and themselves as they prepare to transition back to the community.

[1] See *SUD Demo CT Clinical Assumptions Grid – Adolescent Considerations* for adolescent-specific standards and considerations for ages 13+

	Clinically Managed High-Intensity Residential (ASAM 3.5)	Clinically Managed High-Intensity Residential (ASAM 3.5) Pregnant and Parenting Women (PPW)
	manner upon transfer to a less intensive level of care. • SUD residential programs are characterized by their utilization of the treatment community as a therapeutic agent. • Treatment goals are to stabilize a person who is in imminent danger if not in a 24-hour treatment setting. It is also to promote abstinence from substance use and antisocial behavior and to effect a global change in individuals' lifestyles, attitudes, and values. Individuals typically have multiple deficits, which include SUDs and may include criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values. Their mental health conditions may involve those which are serious and chronic. • Mutual/self-help meetings usually are available onsite or are easily accessible in the community and are not included in the twenty hours of weekly programming provided by the facility. • All facilities are licensed by the State licensure agency.	
Admission criteria	Level 3.5 programs are expected to accept admissions at least 16 hours per day, 7 days per week. Individuals meeting the below criteria shall be admitted regardless of the environment they are coming from (e.g., the community, other levels of care). The individual who is appropriately placed in a Level 3.5 program meets the diagnostic criteria for a substance use of moderate to high severity as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the American Society of Addiction Medicine (ASAM) dimensional criteria for admission. If the individual's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (such	Level 3.5 PPW programs are expected to accept admissions at least 16 hours per day, 7 days per week. Individuals meeting the below criteria shall be admitted regardless of the environment they are coming from (e.g., the community, other levels of care). The individual who is appropriately placed in a Level 3.5 program meets the diagnostic criteria for a substance use of moderate to high severity as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the American Society of Addiction Medicine (ASAM) dimensional criteria for admission. If the individual's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (such as family members, legal guardians, and significant others).

	Clinically Managed High-Intensity Residential (ASAM 3.5)	Clinically Managed High-Intensity Residential (ASAM 3.5) Pregnant and Parenting Women (PPW)
	as family members, legal guardians, and significant others). **Note:** Individuals in Level 3.5 programs may have co-occurring mental health disorders; or difficulties with mood, behavior, or cognition related to a substance use, other addictive, or mental health disorder; or emotional, behavioral, or cognitive symptoms that are troublesome but do not meet the DSM criteria for a mental health disorder. Therefore, all Level 3.5 programs are expected to be co-occurring capable. **DIMENSION 1: Acute Intoxication and/or Withdrawal Potential** Minimal severe withdrawal risk, manageable withdrawal • Individuals who are appropriately placed in the clinically managed levels of care have minimal problems with intoxication or withdrawal **DIMENSION 2: Biomedical Conditions and Complications** None, or stable • Individuals who are appropriately placed in the clinically managed levels of care have few biomedical complications, so onsite physician services are not required. Do not warrant the availability of 24-hour medical or nursing interventions **DIMENSION 3: Emotional, Behavioral or Cognitive Conditions and Complications** A) Dangerousness/Lethality, B) Interference with Addiction and/or Mental Health Recovery Efforts, C) Social Functioning, D) Ability for Self-Care, E) Course of Illness **All 3.5 programs are co-occurring capable** such that those who have any Dimension 3 conditions are not excluded from admission. 24-hour setting for stabilization • Individuals who may have relatively stable problems in emotional, behavioral, and cognitive conditions, meeting the diagnostic criteria of the DSM of the American Psychiatric Association.	**Note:** Individuals in Level 3.5 programs may have co-occurring mental health disorders; or difficulties with mood, behavior, or cognition related to a substance use, other addictive, or mental health disorder; or emotional, behavioral, or cognitive symptoms that are troublesome but do not meet the DSM criteria for a mental health disorder. Therefore, all Level 3.5 programs are expected to be co-occurring capable. Pregnant and/or Parenting women who meet the diagnostic criteria and placement criteria for a Level 3.5 Program will receive same-day priority admission, whenever possible. **Priority populations (in order of priority):** 1. Pregnant women whose mode of substance use is by way of injection 2. Pregnant women who use substances in other ways 3. Other women who inject substances Interim services shall be arranged for priority populations within 48 hours when unable to admit or refer to other programs with sufficient capacity. Interim services include at a minimum: • Referral to treatment provider offering PHP or IOP services • Connection to a Recovery Navigator • Referral for prenatal care • Counseling on the effects of alcohol and drug use on the fetus • HIV and TB services • The risk of needle-sharing, if applicable **DIMENSION 1: Acute Intoxication and/or Withdrawal Potential** Minimal severe withdrawal risk, manageable withdrawal • Individuals who are appropriately placed in the clinically managed levels of care have minimal problems with intoxication or withdrawal **DIMENSION 2: Biomedical Conditions and Complications** None, or stable

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	DIMENSION 4: Readiness to change Has significant difficulty with treatment, with negative consequences • Individuals who may have significant limitations in the areas of readiness to change. Recovery may be perceived by the individual as providing a lesser return for the effort. **DIMENSION 5: Relapse, Continued Use or Continued Problem Potential** Needs skills to prevent continued use • Individuals who may have relapse, continued use, or continued problem potential **DIMENSION 6: Recovery/Living Environment** Dangerous environment, highly structured 24-hour setting needed • Individuals who may have significant limitations in the areas of recovery environment. Includes a living environment in which substance use, crime, and unemployment are endemic. These social influences may represent a sense of hopelessness or an acceptance of deviance as normative **Transfer to another LOC** When assessment indicates that an individual no longer meets the placement criteria noted above, they can be transferred to the next appropriate level of care based on a reassessment of their severity of illness and rehabilitative needs.	• Individuals who are appropriately placed in the clinically managed levels of care have few biomedical complications, so onsite physician services are not required. Do not warrant the availability of 24-hour medical or nursing interventions **DIMENSION 3: Emotional, Behavioral or Cognitive Conditions and Complications** A) Dangerousness/Lethality, B) Interference with Addiction and/or Mental Health Recovery Efforts, C) Social Functioning, D) Ability for Self-Care, E) Course of Illness **All 3.5PPW programs are co-occurring capable** such that those who have any Dimension 3 conditions are not excluded from admission. 24-hour setting for stabilization • Individuals who may have relatively stable problems in emotional, behavioral, and cognitive conditions, meeting the diagnostic criteria of the DSM of the American Psychiatric Association. **DIMENSION 4: Readiness to change** Has significant difficulty with treatment, with negative consequences • Individuals who may have significant limitations in the areas of readiness to change. Recovery may be perceived by the individual as providing a lesser return for the effort. **DIMENSION 5: Relapse, Continued Use or Continued Problem Potential** Needs skills to prevent continued use • Individuals who may have relapse, continued use, or continued problem potential **DIMENSION 6: Recovery/Living Environment** Dangerous environment, highly structured 24-hour setting needed • Individuals who may have significant limitations in the areas of recovery environment. Includes a living environment in which substance use, crime, and unemployment are endemic. These social

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		influences may represent a sense of hopelessness or an acceptance of deviance as normative **Transfer to another LOC** • When assessment indicates that an individual no longer meets the placement criteria noted above, they can be transferred to the next appropriate level of care based on a reassessment of their severity of illness and rehabilitative needs.
Interventions	• A toxicology screen and a tuberculosis screen are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider. Random drug screening as clinically necessary to reinforce treatment gains and as appropriate to the individual's treatment plan. ○ Note: DSS will establish upper limit on number of lab tests that can be sent out. Refer to associated lab policy for additional guidance. • An alcohol or other drug-focused nursing assessment is completed by a registered nurse within 72 hours of admission. • An individualized, comprehensive biopsychosocial assessment of the individual is completed or updated within 48 hours of admission which substantiates appropriate placement at Level 3.5. This assessment also helps to guide the individualized treatment planning process, which is focused on the individual's strengths, needs, abilities, preferences, and desired goals. ○ Staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders. ○ Credentials of the completing practitioner must be documented on the assessment. ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.	• A toxicology screen and a tuberculosis screen are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider. Random drug screening as clinically necessary to reinforce treatment gains and as appropriate to the individual's treatment plan. ○ Note: DSS will establish upper limit on number of lab tests that can be sent out. Refer to associated lab policy for additional guidance. • An alcohol or other drug-focused nursing assessment is completed by a registered nurse within 24 hours of admission for any women who are pregnant and within 72 hours of admission for all non-pregnant individuals. • An individualized, comprehensive biopsychosocial assessment of the individual is completed or updated within 48 hours of admission which substantiates appropriate placement at Level 3.5. This assessment also helps to guide the individualized treatment planning process, which is focused on the individual's strengths, needs, abilities, preferences, and desired goals. ○ Staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders. ○ Credentials of the completing practitioner must be documented on the assessment. ○ The assessment must be reviewed and signed by an independently licensed

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	• A documented physical exam one month prior to admission or an appointment scheduled no later than five days after admission and the appointment for the physical cannot be more than 30 days from the date of admission. Any individual receiving uninterrupted treatment or care in a licensed facility shall require only the documentation of the initial physical examination. • An individualized treatment plan, which includes problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. ○ The plan is initiated at the time of admission, is developed in collaboration with the individual and is completed within 72 hours of admission. The plan reflects the individual's personal goals, while considering the individual's strengths, capabilities and existing recovery resources available to achieve the individual's personal goals. ○ The treatment plan reflects case management conducted by onsite staff; coordination of related addiction treatment, health care, mental health, recovery support services, social, vocational, or housing services (provided concurrently); and the integration of services at this and other levels of care. ○ Because treatment plans are individualized, fixed lengths of stay are inappropriate. The intensity and duration of clinical and habilitative or rehabilitative services, rather than medical services, are the defining characteristics of Level 3.5 programs. ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the treatment plan. ○ The clinical supervisor has reviewed and signed the individual's treatment plan.	behavioral health practitioner/clinical supervisor. • A documented physical exam one month prior to admission or an appointment scheduled no later than five days after admission and the appointment for the physical cannot be more than 30 days from the date of admission. Any individual receiving uninterrupted treatment or care in a licensed facility shall require only the documentation of the initial physical examination. • An individualized treatment plan, which includes problem formulation, needs, strengths, skills and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. ○ The plan is initiated at the time of admission, is developed in collaboration with the individual and is completed within 72 hours of admission. The plan reflects the individual's personal goals, while considering the individual's strengths, capabilities and existing recovery resources available to achieve the individual's personal goals. ○ The treatment plan reflects case management conducted by onsite staff; coordination of related addiction treatment, health care, mental health, recovery support services, social, vocational, or housing services (provided concurrently); and the integration of services at this and other levels of care. ○ Because treatment plans are individualized, fixed lengths of stay are inappropriate. The intensity and duration of clinical and habilitative or rehabilitative services, rather than medical services, are the defining characteristics of Level 3.5 programs. ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the treatment plan.

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	• Complete and document a review of the treatment plan and determine the appropriateness of the individual's continued placement every 30 days and revise accordingly to reflect the individual's clinical progress. ○ Staff conducting the treatment plan reviews shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the treatment plan. ○ The clinical supervisor has reviewed and signed off on all treatment plan reviews and updates. • Discharge/transfer planning begins at admission and is documented in the individual's record. ○ The duration of treatment always depends on individual progress and outcome. Because treatment plans should be individualized, lengths of stay should be flexible and individualized to meet the needs of each individual, not based on predetermined lengths of stay. ○ Transfer or Discharge Plan required except in an emergency, or when an individual leaves of their own accord or against program advice. Discharge plans include obtaining necessary release(s) of information to refer to appropriate aftercare services, including clinical recovery supports. Plans are written in conjunction with the individual and their primary counselor and service coordinator. ○ There are concrete plans for community reintegration and transition to the next appropriate level of care and treatment support and services documented including the aftercare the individual is being discharged to. • Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services. ○ Provide an orientation to and facilitate connections to recovery resources and	○ The clinical supervisor has reviewed and signed the individual's treatment plan • Complete and document a review of the treatment plan and determine the appropriateness of the individual's continued placement every 30 days and revise accordingly to reflect the individual's clinical progress. ○ Staff conducting the treatment plan reviews shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the treatment plan. ○ The clinical supervisor has reviewed and signed off on all treatment plan reviews and updates. • Discharge/transfer planning begins at admission and is documented in the individual's record. ○ The duration of treatment always depends on individual progress and outcome. Because treatment plans should be individualized, lengths of stay should be flexible and individualized to meet the needs of each individual, not based on predetermined lengths of stay. ○ Transfer or Discharge Plan required except in an emergency, or when an individual leaves of their own accord or against program advice. Discharge plans include obtaining necessary release(s) of information to refer to appropriate aftercare services, including clinical recovery supports. Plans are written in conjunction with the individual and their primary counselor and service coordinator. ○ There are concrete plans for community reintegration and transition to the next appropriate level of care and treatment support and services documented including the aftercare the individual is being discharged to.

	Clinically Managed High-Intensity Residential (ASAM 3.5)	Clinically Managed High-Intensity Residential (ASAM 3.5) Pregnant and Parenting Women (PPW)
	community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment.	• Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services. ○ Provide an orientation to and facilitate connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment.
Documentation	Level 3.5 programs will maintain individualized records which shall include: • The individual's Medicaid eligibility status • A physical exam one month prior to admission or an appointment scheduled no later than five days after admission. Any individual receiving uninterrupted treatment or care in a licensed facility shall require only the documentation of the initial physical examination. • Initial intake evaluation, including screening for a cooccurring psychiatric disorder. • Information regarding the individual meeting ASAM placement criteria for the purpose of authorization and continued eligibility. ASAM 6 dimensions of care assessment tool score upon entry and documentation in the treatment plan for continued stay at each reassessment. • An individualized, comprehensive bio-psychosocial assessment which includes assessment in each of the ASAM six dimensions; this assessment must be compliant with the most recent edition of ASAM. ○ Documentation of any mental health and SUD diagnoses as well as any cognitive limitations ○ Completion within 48 hours of admission ○ Minimum credentials for the staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders.	Level 3.5 PPW programs will maintain individualized records which shall include: • The individual's Medicaid eligibility status • A physical exam one month prior to admission or an appointment scheduled no later than five days after admission. Any individual receiving uninterrupted treatment or care in a licensed facility shall require only the documentation of the initial physical examination. • Initial intake evaluation, including screening for a cooccurring psychiatric disorder. • Information regarding the individual meeting ASAM placement criteria for the purpose of authorization and continued eligibility. ASAM 6 dimensions of care assessment tool score upon entry and documentation in the treatment plan for continued stay at each reassessment. • An individualized, comprehensive bio-psychosocial assessment which includes assessment in each of the ASAM six dimensions; this assessment must be compliant with the most recent edition of ASAM. ○ Documentation of any mental health and SUD diagnoses as well as any cognitive limitations ○ Completion within 48 hours of admission ○ Minimum credentials for the staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders. ○ Credentials of the completing practitioner must be documented on the assessment.

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	○ Credentials of the completing practitioner must be documented on the assessment. ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • Individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals. ○ Discharge planning is integrated into the treatment plan. ○ Initiated at the time of admission and completed within 72 hours of admission ○ Minimum credentials for staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the practitioner must be documented on the treatment plan. ○ The treatment plan must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. ○ Review of the treatment plan and determine the appropriateness of the individual's continued placement every 30 days and revise accordingly to reflect the individual's clinical progress. • Individualized progress notes that clearly reflect implementation of the treatment plan and the individual's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. ○ Credentials of the practitioner completing ○ Notes for clinical services provided by an associate licensed practitioner or graduate-level intern shall have the review and signature of an independently licensed behavioral health practitioner/clinical supervisor.	○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • Individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals. ○ Discharge planning is integrated into the treatment plan. ○ Initiated at the time of admission and completed within 72 hours of admission ○ Minimum credentials for staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the practitioner must be documented on the treatment plan. ○ The treatment plan must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. ○ Review of the treatment plan and determine the appropriateness of the individual's continued placement every 30 days and revise accordingly to reflect the individual's clinical progress • A Plan of Safe Care (POSC) shall be maintained for each individual. The POSC is updated as needed as additional needs and referrals for services are identified.[2] The POSC shall be up-to-date at the time an individual discharges from the program to reflect any ongoing needs and aftercare plans. • Individualized progress notes that clearly reflect implementation of the treatment plan and the individual's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. ○ Credentials of the practitioner completing ○ Notes for clinical services provided by an associate licensed practitioner or

[2] https://www.childwelfare.gov/pubPDFs/safecare.pdf

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	• Administration of toxicology screens and the test results. • Discharge summary which has been written within 15 working days of the individual leaving the program. This summary shall: ○ Address original reason for referral. ○ Indicate the individual's progress towards the established plan. ○ Describe the type, frequency and duration of treatment or services. ○ Specify reason(s) for discharge ○ Indicate the individual's participation in discharge planning. ○ Includes information regarding release(s) of information obtained and aftercare services referred to. ○ Staff completing the discharge summary shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the discharge summary. ○ The discharge summary must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.	graduate-level intern shall have the review and signature of an independently licensed behavioral health practitioner/clinical supervisor. • Administration of toxicology screens and the test results. • Discharge summary which has been written within 15 working days of the individual leaving the program. This summary shall: ○ Address original reason for referral. ○ Indicate the individual's progress towards the established plan. ○ Describe the type, frequency and duration of treatment or services. ○ Specify reason(s) for discharge ○ Indicate the individual's participation in discharge planning. ○ Includes information regarding release(s) of information obtained and aftercare services referred to. ○ Staff completing the discharge summary shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the practitioner must be documented on the discharge summary. ○ The discharge summary must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • A separate file shall be maintained for child-specific health information for each child residing in the program with their parent.
Treatment Services	Level 3.5 residential programs offer 24-hour direct care and delivers high-intensity services. Programs are characterized by their reliance on the treatment community as a therapeutic agent. Treatment is directed toward ameliorating individuals' limitations through targeted interventions and is accomplished by providing specialty modalities and skills training while the individual is in a safe and structured environment, thus providing an opportunity for continued improvement. • Treatment goals are to stabilize the individual who is in imminent danger if not in a 24-hour treatment setting. It is also to promote abstinence from substance use and	Level 3.5PPW residential programs offer 24-hour direct care and delivers high-intensity services. Programs are characterized by their reliance on the treatment community as a therapeutic agent. Treatment is directed toward ameliorating individuals' limitations through targeted interventions and is accomplished by providing specialty modalities and skills training while the individual is in a safe and structured environment, thus providing an opportunity for continued improvement. Treatment should also be family-centered; families should be treated as a unit. • Treatment goals are to stabilize the individual who is in imminent danger if not in a 24-hour treatment setting. It is also to promote

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	antisocial behavior and to effect a global change in individuals' lifestyles, attitudes, and values.
	• Individuals typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values.
	• Daily programming in accordance with the individual's treatment plan, which shall include a minimum of twenty (20) hours of SUD services per week. At least ten (10) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or graduate-level intern, at least one (1) hour of which must include individual/family therapy.
	  ○ Up to 25 percent of clinical hours may be provided by a graduate-level intern whose accredited graduate degree program requires their students to participate in intern placements for clinical training in the provision of behavioral health services.
	• Daily programming includes a combination of clinical and recovery-focused education services to improve the individual's ability to structure and organize the tasks of daily living and recovery and to develop and practice prosocial behaviors.
	• The program offers a range of evidence-based cognitive, behavioral, and other therapies administered on an individual and group basis, medication education and management, medication for addiction treatment, educational skill building groups, and occupational or recreational activities, adapted to the individual's developmental stage and level of comprehension, understanding, and physical abilities.
	• Motivational enhancement and engagement strategies appropriate to the individual's stage of readiness and desire to change. Motivational therapies and other evidence-based practices are used in preference to confrontational strategies.
	• Counseling and clinical monitoring to promote successful initial involvement or re-involvement in regular, productive daily
		abstinence from substance use and antisocial behavior and to effect a global change in individuals' lifestyles, attitudes, and values.
		• Individuals typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values. Individuals may also have varying understanding on the impact their substance use and/or co-occurring disorders have on their child(ren) and family system.
		• The adult treatment plan should align with the Plan of Safe Care (POSC).
		• Daily programming in accordance with the individual's treatment plan, which shall include a minimum of twenty (20) hours of SUD services per week. At least ten (10) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or graduate-level intern, at least one (1) hour of which must include individual/family therapy.
		  ○ Up to 25 percent of clinical hours may be provided by a graduate-level intern whose accredited graduate degree program requires their students to participate in intern placements for clinical training in the provision of behavioral health services.
		• Daily programming includes a combination of clinical and recovery-focused education services to improve the individual's ability to structure and organize the tasks of daily living and recovery and to develop and practice prosocial behaviors.
		• Programs must arrange for gender-specific SUD treatment and other therapeutic interventions for women.
		• The program offers a range of evidence-based cognitive, behavioral, and other therapies administered on an individual and group basis, medication education and management, medication for addiction treatment, educational skill building groups, and occupational or recreational activities, adapted to the individual's developmental stage and level of comprehension, understanding, and physical abilities.

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	activity, such as work or school and, as indicated, successful reintegration into family living. ○ Activities related to community reintegration must be specific to the individual's needs and outlined in the individual's treatment plan. ○ Up to two (2) hours of educational and/or vocational activities can be counted towards the 20 hours of weekly programming if such activities are curriculum based. Programs should refer to the standards outlined by the curriculum(s) used to ensure appropriately credentialed staff are administering; if not indicated by the curriculum, any trained staff can administer. • Planned community reinforcement designed to foster prosocial values, a prosocial milieu, and community living skills. • Monitoring of the individual's adherence in self-administering any prescribed medications, including medication for addiction treatment (MAT), and/or any permitted over-the-counter (OTC) medications or supplements. • Opportunities for the individual to be introduced to the potential benefits of medication for addiction treatment as a tool to manage their substance use disorder(s). • Access to medication for addiction treatment. The program does not preclude admission of individuals based on MAT profile and active medication prescriptions. If agency cannot support a medication need internally, they have policies in place to ensure communication with prescribing physician is ongoing. • Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g., HIV, hepatitis C, sexually transmitted diseases). • Services, as appropriate and whenever possible with the individual's consent, for the individual's family and significant others to promote positive contribution to the individual's treatment and recovery.	• Motivational enhancement and engagement strategies appropriate to the individual's stage of readiness and desire to change. Motivational therapies and other evidence-based practices are used in preference to confrontational strategies. • Counseling and clinical monitoring to promote successful initial involvement or re-involvement in regular, productive daily activity, such as work or school and, as indicated, successful reintegration into family living. ○ Activities related to community reintegration must be specific to the individual's needs and outlined in the individual's treatment plan. ○ Up to two (2) hours of educational and/or vocational activities can be counted towards the 20 hours of weekly programming if such activities are curriculum based. Programs should refer to the standards outlined by the curriculum(s) used to ensure appropriately credentialed staff are administering; if not indicated by the curriculum, any trained staff can administer. • Planned community reinforcement designed to foster prosocial values, a prosocial milieu, and community living skills. • Monitoring of the individual's adherence in self-administering any prescribed medications, including medication for addiction treatment (MAT), and/or any permitted over-the-counter (OTC) medications or supplements. ○ For any child residing in the program who receives medication (OTC or prescribed), the mother administers the child in taking the medication. Program staff supervise and document in the child's file. • Opportunities for the individual to be introduced to the potential benefits of medication for addiction treatment as a tool to manage their substance use disorder(s). • Access to medication for addiction treatment. The program does not preclude admission of individuals based on MAT profile and active medication prescriptions. If agency cannot

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	• Provide onsite peer support, including at a minimum, alumni groups and recovery groups or linkage to 12-step groups that ideally are welcoming to people with co-occurring disorders. Note: these meetings do not count toward the 20 hours of weekly programming each individual receives. • Case management services to facilitate individuals' reintegration into the larger community.	support a medication need internally, they have policies in place to ensure communication with prescribing physician is ongoing. • Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g., HIV, hepatitis C, sexually transmitted diseases). ○ Currently approved DMHAS curriculums on Comprehensive Reproductive Health Care, which may include but may not be limited to: One Key Question Curriculum; weekly reproductive health group; partnership with Planned Parenthood for kits, education and resources. • Provide education on the Child Abuse Prevention and Treatment Act (CAPTA) to facilitate collaboration in developing, updating, implementing, and monitoring Plans of Safe Care (POSC). • Provide or arrange for primary medical care, including prenatal care. • Provide or arrange for primary pediatric care, including immunizations, for the women's child(ren). Coordination and consultation with the child(ren)'s pediatrician for well-child visits consistent with EPSDT and for any non-routine medical care. • Arrange for therapeutic interventions for the child(ren) in the custody of women in treatment. These might address issues such as: developmental needs; sexual and physical abuse; neglect and include: ○ Screenings regarding the physical and mental health development of infants and children ○ Treatment for any perinatal effects of a maternal substance use disorder ○ Counseling and other mental health services ○ Comprehensive social services • Services, as appropriate and whenever possible with the individual's consent, for the individual's family and significant others to promote positive contribution to the individual's treatment and recovery. • Provide onsite peer support, including at a minimum, alumni groups and recovery groups

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		or linkage to 12-step groups that ideally are welcoming to people with cooccurring disorders. Note: these meetings do not count toward the 20 hours of weekly programming each individual receives. • Case management services to facilitate individuals' reintegration into the larger community. Sufficient case management and transportation to ensure that women and their child(ren) can access the other services. • Provide or arrange for supervision of their child(ren) while women are receiving services and employment/educational needs. • Parenting training; Note: Parenting services do not count toward the 20 hours of weekly programming each individual receives.
Provider Qualifications/ Staffing	Level 3.5 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified peers and technicians operating within their scope of practice to provide services appropriate to the biopsychosocial needs of individuals being admitted to the program. Facility's staffing pattern is gender responsive and trauma informed. • Minimum on-site staffing requirements (not counting on-call hours) shall be maintained 24 hours per day, 7 days per week as outlined below: ○ 0-24 beds: 2 staff minimum at all times ○ 25-64 beds: 3 staff minimum at all times ○ 65-99 beds: 4 staff minimum at all times ○ 100+ beds: 5 staff minimum at all times – For facilities with multiple levels of care at the same physical address and within the same building and floor, minimum staff ratios can be shared between programs. – If programs share the same address and are separated on different floors or different buildings, the minimum staff requirement shall apply to each floor and building. An exception to this is a 0-24 bed program located in one building in which there are resident rooms on multiple levels of the building (e.g. a house-like setting); only the minimum	Level 3.5 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified peers and technicians operating within their scope of practice to provide services appropriate to the biopsychosocial needs of individuals being admitted to the program. Facility's staffing pattern is gender responsive and trauma informed. • Minimum on-site staffing requirements (not counting on-call hours) shall be maintained 24 hours per day, 7 days per week as outlined below: ○ 0-24 beds: 2 staff minimum at all times ○ 25-64 beds: 3 staff minimum at all times ○ 65-99 beds: 4 staff minimum at all times ○ 100+ beds: 5 staff minimum at all times – Minimum staff requirements for 3.5PPW Programs cannot be shared with other programs or levels of care even if contained within the same building and floor. – If programs share the same address and are separated on different floors or different buildings, the minimum staff requirement shall apply to each floor and building. An exception to this is a 0-24 bed program located in one building in which there are resident rooms on multiple levels of a building (e.g. a house-like setting); only the minimum staffing of two persons would be required.

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	staffing of two persons would be required. – Any requests to waive the above criteria must be submitted to The Departments for review and approval. • Level 3.5 programs must be able to provide 24-hour staff support. Ensure staff who have client contact receive training on cooccurring mental health and substance use disorders, including prevalence, signs/symptoms, assessment, treatment and the impact of one's own attitudes/beliefs on the delivery of services and the use of naloxone in response to an opioid overdose. • Where on-call coverage is indicated for any of the below positions, such coverage can be combined across programs within the same agency. • Executive Director: Each facility shall have an executive director who is accountable to the governing authority. The executive director shall be responsible for the management of the facility. • Psychiatric services must be made available on-site or via telemedicine per the state's telemedicine policy as needed and as appropriate to the severity and urgency of the individual's condition. ○ Such services include medication for addiction treatment (e.g., buprenorphine, naltrexone, acamprosate, disulfiram). • A physician (or NP/PA) is available on-site or via telemedicine per the state's telemedicine policy to review, identify, and manage risk factors that may contribute to adverse health outcomes for the individual. ○ The physician (or NP/PA) shall participate in treatment team meetings and case consultations to review the individual's care and provide guidance on identifying risk factors while in treatment. ○ The physician (or NP/PA) provides oversight to the nursing staff who carry out the medical orders. Orders should not exceed the nurse or ordering practitioner's scope of practice. ○ Telephone or in-person consultation with a physician, a physician assistant or	– Any requests to waive the above criteria must be submitted to The Departments for review and approval. • Level 3.5-PPW programs must be able to provide 24-hour staff support. Ensure all technicians and non-technicians who have client contact receive training on cooccurring disorders, including prevalence, signs/symptoms, assessment, treatment and the impact of one's own attitudes/beliefs on the delivery of services and the use of naloxone in response to an opioid overdose. • Where on-call coverage is indicated for any of the below positions, such coverage can be combined across programs within the same agency. • Executive Director: Each facility shall have an executive director who is accountable to the governing authority. The executive director shall be responsible for the management of the facility. • Psychiatric services must be made available on-site or via telemedicine per the state's telemedicine policy as needed and as appropriate to the severity and urgency of the individual's condition. ○ Such services include medication for addiction treatment (e.g., buprenorphine, naltrexone, acamprosate, disulfiram). • A physician (or NP/PA) is available on-site or via telemedicine per the state's telemedicine policy to review, identify, and manage risk factors that may contribute to adverse health outcomes for the woman and/or child(ren). ○ The physician (or NP/PA) shall participate in treatment team meetings and case consultations to review the individual's care while in treatment and provide guidance on identifying risk factors for both mother and child that shall be addressed while in treatment. ○ The physician (or NP/PA) provides oversight to the nursing staff who carry out the medical orders. Orders should not exceed the nurse or ordering practitioner's scope of practice. ○ Telephone or in-person consultation with a physician, a physician assistant or

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	nurse practitioner and emergency services are available 24/7.
	• Nursing staff (RN or LPN) onsite 40 hours per week per 16 residents. Facilities greater than 64 residents will not be required to have more than four (4) total nurses.
	  ○ At least one nurse shall be an RN
	  ○ The RN works under the direction and orders of a licensed physician (or NP/PA). Orders should not exceed the nurse or ordering practitioner's scope of practice.
	• Employs a clinical supervisor with authority over all behavioral health treatment services, who shall have a minimum of a master's degree in a behavioral health treatment services field, at least three years of full-time work experience in SUD services and be independently licensed by the State in their respective discipline.
	  ○ The Clinical Supervisor must be on-site at least 40 hours per week with at least one evening shift per week. Larger programs may require additional clinical supervisor hours to ensure all supervision requirements are met as detailed in the "Supervision Requirements" section below.
	  ○ The Clinical Supervisor conducts and documents face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month.
	  ○ There shall be 24-hour on-call coverage by telephone during those hours when the clinical supervisor is not physically present.
	• An independently licensed or associate licensed behavioral health practitioner is available to provide a minimum of ten (10) hours (out of the total 20 hours of weekly programming) of clinical treatment per week. At least one (1) of these hours include individual/family therapy.
	  ○ Up to 25 percent of clinical treatment hours may be provided by a graduate-level intern whose accredited graduate degree program requires their students
		nurse practitioner and emergency services are available 24/7.
		• Nursing staff (RN or LPN) onsite 40 hours per week per 16 residents. Facilities greater than 64 residents will not be required to have more than four (4) total nurses.
		  ○ At least one nurse shall be an RN
		  ○ The RN works under the direction and orders of a licensed physician (or NP/PA). Orders should not exceed the nurse or ordering practitioner's scope of practice.
		• Employs a clinical supervisor with authority over all behavioral health treatment services, who shall have a minimum of a master's degree in a behavioral health treatment services field, at least three years of full-time work experience in SUD services, at least one year experience working with children and families and be independently licensed by the State in their respective discipline.
		  ○ The Clinical Supervisor must be on-site at least 40 hours per week with at least one evening shift per week. Larger programs may require additional clinical supervisor hours to ensure all supervision requirements are met as detailed in the "Supervision Requirements" section below.
		  ○ The Clinical Supervisor conducts and documents face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month.
		  ○ There shall be 24-hour on-call coverage by telephone during those hours when the clinical supervisor is not physically present.
		• An independently licensed or associate licensed behavioral health practitioner is available to provide a minimum of ten (10) hours (out of the total 20 hours of weekly programming) of clinical treatment per week. At least one (1) of these hours include individual/family therapy.
		  ○ Up to 25 percent of clinical treatment hours may be provided by a graduate-level intern whose accredited graduate degree program requires their students to

	Clinically Managed High-Intensity Residential (ASAM 3.5)	Clinically Managed High-Intensity Residential (ASAM 3.5) Pregnant and Parenting Women (PPW)
	to participate in intern placements for clinical training in the provision of behavioral health services. ○ At least one behavioral health practitioner per 16 residents is on-site 40 hours per week. ○ Any behavioral health practitioner who is not independently licensed must be working under a licensed independent behavioral health practitioner who must sign off on clinical documentation and provide supervision. ○ Clinical staff should be knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment. Clinical staff should be able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation. ○ Clinical groups should be limited to no more than 12 group members regardless of payer. Psychoeducational and non-clinical groups should be limited to no more than 25 group members. ○ At least one behavioral health practitioner with competence in the treatment of substance use and mental health disorders is available by telephone 24 hours a day, seven days a week when not on-site. • Technicians are available onsite, as needed, to ensure minimum staffing requirements are met and are awake and monitoring individuals' needs at all times. ○ Technicians may provide the additional remaining hours of weekly programming ○ Technicians report to a Tech Supervisor (or other leadership position) with at least 6 months experience in residential SUD programs. • Certified Peers may provide the additional remaining hours of weekly programming and may meet with residents individually and/or in group formats to support their ongoing engagement, retention and progress in treatment. ○ Certification must be obtained by one of the state-approved certification boards.	participate in intern placements for clinical training in the provision of behavioral health services. ○ Clinician assignment considerations may be indicated for the residents of 3.5PPW programs to ensure emotional safety given potential traumatic histories. ○ At least one behavioral health practitioner per 16 residents is on-site 40 hours per week. ○ Any behavioral health practitioner who is not independently licensed must be working under a licensed independent behavioral health practitioner who must sign off on clinical documentation and provide supervision. ○ Clinical staff should be knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment. Clinical staff should be able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation. ○ Clinical groups should be limited to no more than 12 group members regardless of payer. Psychoeducational and non-clinical groups should be limited to no more than 25 group members. ○ At least one behavioral health practitioner with competence in the treatment of substance use disorders is available by telephone 24 hours a day, seven days a week when not on-site. • Technicians are available onsite, as needed, to ensure minimum staffing requirements are met and are awake and monitoring individuals' needs at all times. ○ Technicians may provide the additional remaining hours of weekly programming ○ Technicians report to a Tech Supervisor (or other leadership position) with at least 6 months experience in residential SUD programs. • Certified Peers may provide the additional remaining hours of weekly programming and may meet with residents individually and/or in group formats to support their ongoing

	Clinically Managed High-Intensity Residential (ASAM 3.5)	Clinically Managed High-Intensity Residential (ASAM 3.5) Pregnant and Parenting Women (PPW)
	○ Certified Peers should be onsite while residents are awake, including presence on evenings and weekends. Number of Certified Peers required depends on the size of the program: ▪ 0-32 beds: 1 peer onsite at least 40 hours per week ▪ 33-64 beds: 2 peers onsite at least 40 hours per week each ▪ 65+ beds: 3 peers onsite at least 40 hours per week each ○ Certified peers receive one hour of clinical supervision weekly, of which group supervision may be utilized once a month. This supervision can be provided by: ▪ The Clinical Supervisor (as defined above); ▪ An independently licensed or associate licensed behavioral health practitioner, with at least 2 years of full-time work experience in SUD services; or ▪ A Certified Peer with at least 2 years of full-time experience in providing peer support services. • A dedicated Service Coordinator that manages incoming referrals and discharge plans is required for each facility. The purpose of the Service Coordinator is to promote engagement and retention in treatment and facilitate an effective discharge plan whereby the individual successfully connects to the next level of care. The service coordinator facilitates referral arrangements and coordination with aftercare. ○ The Service Coordinator can also assist in networking individuals into community-based ancillary or "wrap-around" services to build/maintain recovery capital. ○ The service coordinator shall be on-site weekdays during 1st shift for at least 80% of the time. The other 20% may be done second, third or weekend shifts. ○ The Service Coordinator may be a licensed practitioner, unlicensed counselor, or certified peer.	engagement, retention and progress in treatment. ○ Certification must be obtained by one of the state-approved certification boards. ○ Certified Peers should be onsite while residents are awake, including presence on evenings and weekends. Number of Certified Peers required depends on the size of the program: ▪ 0-32 beds: 1 peer onsite at least 40 hours per week ▪ 33-64 beds: 2 peers onsite at least 40 hours per week each ▪ 65+ beds: 3 peers onsite at least 40 hours per week each ○ Certified peers receive one hour of clinical supervision weekly, of which group supervision may be utilized once a month. This supervision can be provided by: ▪ The Clinical Supervisor (as defined above); ▪ An independently licensed or associate licensed behavioral health practitioner, with at least 2 years of full-time work experience in SUD services; or ▪ A Certified Peer with at least 2 years of full-time experience in providing peer support services. • A dedicated Service Coordinator that manages incoming referrals and discharge plans is required for each facility. The purpose of the Service Coordinator is to promote engagement and retention in treatment and facilitate an effective discharge plan whereby the individual successfully connects to the next level of care. The service coordinator facilitates referral arrangements and coordination with aftercare. ○ The Service Coordinator can also assist in networking individuals into community-based ancillary or "wrap-around" services to build/maintain recovery capital. ○ The service coordinator shall be on-site weekdays during 1st shift for at least 80% of the time. The other 20% may be done second, third or weekend shifts.

	Clinically Managed High-Intensity Residential (ASAM 3.5)	Clinically Managed High-Intensity Residential (ASAM 3.5) Pregnant and Parenting Women (PPW)
	• Each facility shall have at least one staff person in each building, when a resident is known to be present and who shall have immediate access to back up staff, for urgent or emergency situations. This is inclusive of the positions described above.	○ The Service Coordinator may be a licensed practitioner, unlicensed counselor, or certified peer. • Each facility shall have at least one staff person in each building, when a resident is known to be present and who shall have immediate access to back up staff, for urgent or emergency situations. This is inclusive of the positions described above.
Supervision Requirements	Supervisors conduct and document face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month. Certified peers with lived experience receive clinical supervision 1 hour weekly, of which group supervision may be utilized once a month – this can be from: the Clinical Supervisor; an independently licensed or associate licensed behavioral health practitioner with at least 2 years of full-time work experience in SUD services; or a Certified Peer with at least 2 years of full-time experience in providing peer support services. Technicians receive supervision from the Tech Supervisor or other leadership position for 30 minutes for every 40 hours worked. Tech administrative supervision can be in a group setting for all but one time a month. Techs must receive monthly group clinical supervision with a potential shift overlap (All staff meeting at least once a month). There should be a shift report or hand off for every shift or staggered starts.	
Target Length of Stay	As medically necessary, or dependent on time needed to sustain and further therapeutic gains and master the application of coping and recovery skills	As medically necessary, or dependent on time needed to sustain and further therapeutic gains and master the application of coping and recovery skills

	Medically-Monitored Intensive Inpatient (ASAM 3.7 (R))	Medically-Monitored Intensive Inpatient (ASAM 3.7 Enhanced (RE))
Ages Served	Age 18 and older	
Brief Service Description	Level 3.7 programs provide a structured recovery residence environment, staffed 24 hours a day, which provides sufficient stability to prevent or minimize relapse or continued use and continued problem potential. • Medically-monitored intensive inpatient programs offer at least thirty (30) hours per week of a combination of high-intensity clinical and recovery-focused services. These programs provide at least thirty (30) hours a week of individual, group, family therapy, medication management, and psychoeducation. At least fifteen (15) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern, at least one (1) hour of which must include individual/family therapy. • Level 3.7 programs often are appropriate for individuals whose subacute biomedical and emotional, behavioral, or cognitive problems are so severe that they require monitoring at inpatient/intensive residential treatment, but who do not need the full resources of an acute care general hospital or a medically managed inpatient treatment program. • Mutual/self-help meetings usually are available onsite or are easily accessible in the community and are not included in the thirty hours of weekly programming provided by the facility. • All facilities are licensed by the State of Connecticut (Connecticut or State) licensure agency.	Level 3.7RE programs include the standards outlined for the Level 3.7 programs. In addition, Level 3.7RE (co-occurring enhanced) programs offer planned clinical activities designed to promote stabilization of the individual's behavioral health needs and psychiatric symptoms. • The goals of therapy apply to both the substance use disorder and any co-occurring mental health disorder. Specific attention is given to medication education and management. Motivational and engagement strategies and other evidence-based practices are used in preference to confrontational approaches. • Medically-monitored intensive inpatient programs that are co-occurring enhanced offer at least thirty (30) hours per week of a combination of high-intensity clinical and recovery-focused services. These programs provide at least thirty (30) hours a week of individual, group, family therapy, medication management, and psychoeducation. ***At least twenty (20) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern, at least one (1) hour of which must include individual/family therapy.*** • Level 3.7RE programs often are appropriate for individuals whose subacute biomedical and emotional, behavioral, or cognitive problems are so severe that they require monitoring at inpatient/intensive residential treatment, but who do not need the full resources of an acute care general hospital or a medically managed inpatient treatment program. • Mutual/self-help meetings usually are available onsite or are easily accessible in the community and are not included in the thirty hours of weekly programming provided by the facility. • All facilities are licensed by the State of Connecticut (Connecticut or State) licensure agency.
Admission criteria	Level 3.7 programs are expected to accept admissions at least 16 hours per day, 7 days per week. Individuals meeting the below criteria shall be admitted regardless of the environment they are coming from (e.g., the community, other levels of care).	Level 3.7RE programs are expected to accept admissions at least 16 hours per day, 7 days per week. Individuals meeting the below criteria shall be admitted regardless of the environment they are coming from (e.g., the community, other levels of care).

	Medically-Monitored Intensive Inpatient (ASAM 3.7 (R))	Medically-Monitored Intensive Inpatient (ASAM 3.7 Enhanced (RE))
	Level 3.7 programs are appropriate for individuals who have functional limitations in Dimensions 1 (Acute Intoxication and/or Withdrawal Potential), 2 (Biomedical Conditions and Complications) and/or 3 (Emotional, Behavioral or Cognitive Conditions and Complications) and thus require the availability of 24-hour nursing and medical interventions. Because physical and mental health problems exist on a continuum of severity, problems that exist in Dimensions 2 or 3 may fall short of reaching the threshold to meet diagnostic criteria, but still require treatment in a Level 3.7 program. Requirements for admission to 3.7 indicate that the individual meets specifications in at least *two* of the six dimensions and at least one of the two specifications must be in Dimensions 1, 2, or 3. • If any of the Dimension 3 conditions are present, the individual must be admitted to a co-occurring capable or co-occurring enhanced program (depending on the individual's level of function, stability and degree of impairment). • Individual meets the diagnostic criteria for a moderate or severe substance use disorder as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the American Society of Addiction Medicine (ASAM) dimensional criteria for admission. If the individual's presenting history is conflicting or inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information provided by collateral parties (e.g., family members, legal guardians and significant others). • This level of care is appropriate for individuals whose subacute biomedical and emotional, behavioral or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute general hospital or a medically managed inpatient treatment program.	Level 3.7RE programs are appropriate for individuals who have functional limitations in Dimensions 1 (Acute Intoxication and/or Withdrawal Potential), 2 (Biomedical Conditions and Complications) and/or 3 (Emotional, Behavioral or Cognitive Conditions and Complications) and thus require the availability of 24-hour nursing and medical interventions. Because physical and mental health problems exist on a continuum of severity, problems that exist in Dimensions 2 or 3 may fall short of reaching the threshold to meet diagnostic criteria, but still require treatment in a Level 3.7 program. Requirements for admission to 3.7 indicate that the individual meets specifications in at least *two* of the six dimensions and at least one of the two specifications must be in Dimensions 1, 2, or 3. • ***The individual also meets the diagnostic criteria for a mental health disorder as defined in the DSM or other standardized and widely accepted criteria. Similarly, collateral information can be utilized to assist in determining the probability of such a diagnosis.*** • The individual meets the diagnostic criteria for a moderate or severe substance use or addictive disorder as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the American Society of Addiction Medicine (ASAM) dimensional criteria for admission. If the individual's presenting history is conflicting or inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information provided by collateral parties (e.g., family members, legal guardians and significant others). • This level of care is appropriate for individuals whose subacute biomedical and emotional, behavioral or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute general hospital or a medically managed inpatient treatment program. **DIMENSION 1: Acute Intoxication and/or Withdrawal Potential**

	Medically-Monitored Intensive Inpatient (ASAM 3.7 (R))	Medically-Monitored Intensive Inpatient (ASAM 3.7 Enhanced (RE))
	Note: Individuals in Level 3.7 programs may have co-occurring mental health disorders; or difficulties with mood, behavior, or cognition related to a substance use, other addictive, or mental health disorder; or emotional, behavioral, or cognitive symptoms that are troublesome but do not meet the DSM criteria for a mental health disorder. Therefore, all Level 3.7 programs are expected to be co-occurring capable. **DIMENSION 1: Acute Intoxication and/or Withdrawal Potential** High withdrawal risk, manageable withdrawal risk; the individual does not require the full resources of an acute care hospital. **DIMENSION 2: Biomedical Conditions and Complications** Requires 24-hour medical monitoring Individual's status is characterized by one of the following: • The interaction of the individual's biomedical condition and continued alcohol and/or other drug use places the individual at significant or serious damage to physical health or concomitant biomedical conditions **OR** • A current biomedical condition requires 24hour nursing and medical monitoring or active treatment, but not the full resources of an acute care hospital **DIMENSION 3: Emotional, Behavioral or Cognitive Conditions and Complications** A) Dangerousness/Lethality, B) Interference with Addiction and/or Mental Health Recovery Efforts, C) Social Functioning, D) Ability for Self-Care, E) Course of Illness **All 3.7 programs are co-occurring capable** such that those who have any Dimension 3 conditions are not excluded from admission. Moderate severity, requires 24-hour structured setting • If any of the Dimension 3 conditions are present, the individual must be admitted to a co-occurring capable or co-occurring enhanced program (depending on the	High withdrawal risk, manageable withdrawal risk; the individual does not require the full resources of an acute care hospital. Moderate to severe withdrawal, or at risk **DIMENSION 2: Biomedical Conditions and Complications** Requires 24-hour medical monitoring Individual's status is characterized by one of the following: • The interaction of the individual's biomedical condition and continued alcohol and/or other drug use places the individual at significant or serious damage to physical health or concomitant biomedical conditions **OR** • A current biomedical condition requires 24-hour nursing and medical monitoring or active treatment, but not the full resources of an acute care hospital **DIMENSION 3: Emotional, Behavioral or Cognitive Conditions and Complications** A) Dangerousness/Lethality, B) Interference with Addiction and/or Mental Health Recovery Efforts, C) Social Functioning, D) Ability for Self-Care, E) Course of Illness Moderate severity, requires 24-hour structured setting The individual's status in Dimension 3 is characterized by a range of psychiatric symptoms that require active monitoring, such as low anger management skills. These are assessed as posing a risk of harm to self or others if the individual is not contained in a 24-hour structured environment. Although such individuals do not require specialized psychiatric nursing and close observation, they do need monitoring and interventions by mental health staff to limit and de-escalate their behaviors, develop a therapeutic alliance, and process events that trigger symptomatology and identify and utilize appropriate coping techniques and medical interventions or relaxation. A 24-hour milieu is sufficient to contain such impulses in most cases, but enhanced staff and therapeutic interventions are required to manage unpredictable losses of impulse control. • The individual's status is characterized by at least one of the following:

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	individual's level of function, stability and degree of impairment). • The individual's status is characterized by one of the following: ○ The individual's psychiatric condition is unstable and presents with symptoms that are interfering with abstinence, recovery, and stability to such a degree that the individual needs a structured 24-hour medically monitored environment to address recovery efforts **OR** ○ The individual exhibits stress behaviors associated with recent or threatened losses in work, family, or social domains; or there is a reemergence of feelings and memories of trauma and loss one the individual achieves abstinence, to a degree that their ability to manage the activities of daily living is significantly impaired. The individual thus requires a secure, medically monitored environment in which to address self-care problems and to focus on their substance use or behavioral health problems **OR** ○ The individual has significant functional limitations that require active psychiatric monitoring. They may include, but are not limited to, problems with: ADLs; self-care, lethality, or dangerousness; social functioning **OR** ○ The individual is at moderate risk of behaviors endangering self, others or property, likely to result in imminent danger of relapse (with dangerous emotional, behavioral or cognitive consequences) without 24-hours support and structure **OR** ○ The individual is actively intoxicated with resulting violent or disruptive behavior that poses imminent danger to self or others **OR** ○ The individual is psychiatrically unstable or has cognitive limitations that require	○ The individual has a history of moderate psychiatric decompensation or symptoms occur during discontinuation of addictive drugs or when experiencing post-acute withdrawal symptoms, and such decompensation is present **OR** ○ The individual is assessed as at moderate to high risk of behaviors endangering self, others or property, or is in imminent danger of relapse (with dangerous emotional, behavioral or cognitive consequences) without 24-hour structure and support **OR** ○ The individual is severely depressed, with suicidal urges and a plan. However, they are able to reach out for help as needed and do not require one-on-one suicide watch **OR** ○ The individual has a co-occurring psychiatric disorder that is interfering with their addiction treatment or ability to participate in a less intensive LOC and thus requires stabilization with psychotropic medications **OR** ○ The individual has a co-occurring psychiatric disorder of moderate to high severity that is marginally and tenuously stable and requires care to prevent further decompensation **DIMENSION 4: Readiness to change** Low interest in treatment, needs motivational strategies in 24-hour structured setting • The individual's status is characterized by at least one of the following: ○ Despite experiencing serious consequences or effects of the addictive disorder and/or behavioral health problem, the individual does not accept or relate the addictive disorder to the severity of the presenting problem. **OR** ○ The individual is in need of intensive motivating strategies, activities and processes available only in a 24-hour structured, medically monitored setting. **OR** ○ The individual needs ongoing 24-hour psychiatric monitoring to assure follow through with the treatment regimen, and to deal with

	Medically-Monitored Intensive Inpatient (ASAM 3.7 (R))	Medically-Monitored Intensive Inpatient (ASAM 3.7 Enhanced (RE))
	stabilization but not medical management **DIMENSION 4: Readiness to change** Low interest in treatment, needs motivational strategies in 24-hour structured setting • The individual's status is characterized by at least one of the following: ○ Despite experiencing serious consequences or effects of the addictive disorder and/or behavioral health problem, the individual does not accept or relate the addictive disorder to the severity of the presenting problem. **OR** ○ The individual is in need of intensive motivating strategies, activities and processes available only in a 24-hour structured, medically monitored setting. **OR** ○ The individual needs ongoing 24-hour psychiatric monitoring to assure follow through with the treatment regimen, and to deal with issues such as ambivalence about adherence to psychiatric medication and a recovery program. **DIMENSION 5: Relapse, Continued Use or Continued Problem Potential** Challenges controlling use at less intensive care levels • The individual's status is characterized by at least one of the following: ○ The individual is experiencing an acute psychiatric or substance use crisis, marked by intensification of symptoms of their addictive or mental health disorder. This situation poses a serious risk of harm to self or others in the absence of 24-hour monitoring and structured support. **OR** ○ The individual is experiencing an escalation of relapse behaviors and/or reemergence of acute symptoms, which places the individual at serious risk to self or others in the absence of the type of 24-hour monitoring and structured support (e.g., Driving Under the	issues such as ambivalence about adherence to psychiatric medication and a recovery program ○ ***The individual's status is characterized by a lack of commitment to change and reluctance to engage in activities necessary to address a co-occurring psychiatric disorder. Similarly, the individual is not consistently able to follow through with treatment, demonstrates minimal awareness of a problem or is unaware of the need to change behaviors related to behavioral or health problems. Such an individual requires active interventions with family, significant others, and/or external systems to create leverage and align incentives so as to promote engagement in treatment.*** **DIMENSION 5: Relapse, Continued Use or Continued Problem Potential** Challenges controlling use at less intensive care levels ○ The individual's status is characterized by at least one of the following: ○ The individual is experiencing an acute psychiatric or substance use crisis, marked by intensification of symptoms of their addictive or mental health disorder. This situation poses a serious risk of harm to self or others in the absence of 24-hour monitoring and structured support. **OR** ○ The individual is experiencing an escalation of relapse behaviors and/or reemergence of acute symptoms, which places the individual at serious risk to self or others in the absence of the type of 24-hour monitoring and structured support (e.g., Driving Under the Influence; not taking life-sustaining medications) **OR** ○ The modality or intensity of treatment protocols to address relapse require that the individual receive care in a Level 3.7 program to safely and effectively initiate medication-assisted treatments. ○ The individual's status is characterized by psychiatric symptoms that pose a moderate to high risk of relapse to a substance use or mental

	Medically-Monitored Intensive Inpatient (ASAM 3.7 (R))	Medically-Monitored Intensive Inpatient (ASAM 3.7 Enhanced (RE))
	Influence; not taking life-sustaining medications). **OR** ○ The modality or intensity of treatment protocols to address relapse require that the individual receive care in a Level 3.7 program to safely and effectively initiate medication-assisted treatments. **DIMENSION 6: Recovery/Living Environment** Dangerous environment • The individual's status is characterized by at least of the following: ○ The individual requires continuous medical monitoring, while addressing their substance use and/or psychiatric symptoms because their current living situation is characterized by a high risk of initiation or repetition of physical, sexual, or emotional abuse, or active substance use, such that the individual is assessed as being unable to achieve or maintain recovery at a less intensive level of care. For example, the individual is involved in an abusive relationship with an actively using significant other. **OR** ○ Family members or significant others living with the individual are not supportive of their recovery goals and are actively sabotaging treatment, or their behavior jeopardizes recovery efforts. This situation requires structured treatment services and relief from the home environment in order for the individual to focus on recovery. **OR** ○ The individual is unable to cope, for even limited periods of time, outside of 24-hour care. The individual needs staff monitoring to learn to cope with Dimension 6 problems before they can be transferred safely to a less intensive setting. **Transfer to another LOC** • When assessment indicates that an individual no longer meets the placement criteria noted above, they can be transferred to the next appropriate level of	health disorder. Such an individual demonstrates limited ability to apply relapse prevention skills, as well as demonstrating poor skills in coping with psychiatric disorders and/or avoiding or limiting relapse, with imminent serious consequences. The individual's follow through in treatment is limited or inconsistent, and their relapse problems are escalating to such a degree that treatment at a less intensive level of care is not successful or feasible. **DIMENSION 6: Recovery/Living Environment** Dangerous environment • The individual's status is characterized by at least of the following: ○ The individual requires continuous medical monitoring, while addressing their substance use and/or psychiatric symptoms because their current living situation is characterized by a high risk of initiation or repetition of physical, sexual, or emotional abuse, or active substance use, such that the individual is assessed as being unable to achieve or maintain recovery at a less intensive level of care. For example, the individual is involved in an abusive relationship with an actively using significant other. **OR** ○ Family members or significant others living with the individual are not supportive of their recovery goals and are actively sabotaging treatment, or their behavior jeopardizes recovery efforts. This situation requires structured treatment services and relief from the home environment in order for the individual to focus on recovery. **OR** ○ The individual is unable to cope, for even limited periods of time, outside of 24-hour care. The individual needs staff monitoring to learn to cope with Dimension 6 problems before they can be transferred safely to a less intensive setting. • The individual's status is characterized by severe psychiatric symptoms. They may be too compromised to benefit from skills training to learn to cope with problems in the recovery environment. Such an individual requires planning for assertive community treatment, intensive case

	Medically-Monitored Intensive Inpatient (ASAM 3.7 (R))	Medically-Monitored Intensive Inpatient (ASAM 3.7 Enhanced (RE))
	care based on a reassessment of their severity of illness and rehabilitative needs.	management, or other community outreach and support services. Such an individual's living, working, social, and/or community environment is not supportive of addiction and/or psychiatric recovery. They have insufficient resources and skills to deal with this situation. **Transfer to another LOC** • When assessment indicates that an individual no longer meets the placement criteria noted above, they can be transferred to the next appropriate level of care based on a reassessment of their severity of illness and rehabilitative needs.

Interventions	• A toxicology screen and a tuberculosis screen are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider. Random drug screening as clinically necessary to reinforce treatment gains and as appropriate to the individual's treatment plan.
	  ○ Note: DSS will establish upper limit on number of lab tests that can be sent out. Refer to associated lab policy for additional guidance.
	• An alcohol or other drug-focused nursing assessment completed by a registered nurse at the time of admission (no later than 24 hours after admission).
	• A physician (or NP/PA) is available to assess the individual in person within 24 hours of admission or is available to review and update within 24 hours of admission the record of a physical examination conducted within the seven days prior to admission. A physician (or NP/PA) is available to assess the individual thereafter as medically necessary.
	  ○ Additional medical specialty consultation, psychological, laboratory, and toxicology services, are available onsite, through consultation or referral.
	• An individualized, comprehensive biopsychosocial assessment of the individual is completed or updated within 48 hours of admission which substantiates appropriate placement at Level 3.7. This assessment also helps to guide the individualized treatment planning process,
		• A toxicology screen and a tuberculosis screen are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider. Random drug screening as clinically necessary to reinforce treatment gains and as appropriate to the individual's treatment plan.
		  ○ Note: DSS will establish upper limit on number of lab tests that can be sent out. Refer to associated lab policy for additional guidance.
		• An alcohol or other drug-focused nursing assessment completed by a registered nurse at the time of admission (no later than 24 hours after admission).
		• A physician (or NP/PA) is available to assess the individual in person within 24 hours of admission or is available to review and update within 24 hours of admission the record of a physical examination conducted within the seven days prior to admission. A physician (or NP/PA) is available to assess the individual thereafter as medically necessary.
		  ○ Additional medical specialty consultation, psychological, laboratory, and toxicology services, are available onsite, through consultation or referral.
		• An individualized, comprehensive biopsychosocial assessment of the individual is completed or updated within 48 hours of admission which substantiates appropriate placement at Level 3.7RE. This assessment also helps to guide the individualized treatment planning process, which is focused on the individual's strengths, needs, abilities, preferences, and desired goals.
		  ○ Staff conducting or updating the assessment shall be an independently licensed or

	Medically-Monitored Intensive Inpatient (ASAM 3.7 (R))	Medically-Monitored Intensive Inpatient (ASAM 3.7 Enhanced (RE))
	which is focused on the individual's strengths, needs, abilities, preferences, and desired goals. ○ Staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders. ○ Credentials of the completing practitioner must be documented on the assessment. ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • An individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals. ○ The plan is initiated at the time of admission, is developed in collaboration with the individual and is completed within 48 hours of admission. The plan reflects the individual's personal goals while considering the individual's strengths, capabilities and existing recovery resources available to achieve the individual's personal goals. ○ The treatment plan reflects case management conducted by onsite staff; coordination of related addiction treatment, health care, mental health, recovery support services, social, vocational, or housing services (provided concurrently); and the integration of services at this and other levels of care. ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the treatment plan. ○ The treatment plan must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.	associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders. ○ Credentials of the completing practitioner must be documented on the assessment. ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • An individualized treatment plan which involves problem formulation, needs, strengths, skills and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals. ○ The plan is initiated at the time of admission, is developed in collaboration with the individual and is completed within 48 hours of admission. The plan reflects the individual's personal goals and incorporates the individual's strengths while considering the individual's strengths, capabilities and existing recovery resources available to achieve the individual's personal goals. ○ The treatment plan also reflects case management conducted by onsite staff; coordination of related addiction treatment, health care, mental health, social, vocational, or housing services (provided concurrently); and the integration of services at this and other levels of care. ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the treatment plan. ○ The treatment plan must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. ○ ***In addition to the above, provide a review of the individual's recent psychiatric history and mental status examination (if necessary, this review is conducted by a psychiatrist). A comprehensive examination and psychodiagnostic assessment are performed within a reasonable time, as determined by the individual's needs and progress in treatment.***

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	○ There is evidence in the clinical record that the treatment plan is reviewed and updated weekly to reflect the individual's clinical progress. There is evidence in the clinical record that continued placement is assessed dimensionally utilizing the ASAM Continued Service Criteria. • Discharge/transfer planning begins at admission and is documented in the individual's record. ○ The duration of treatment always depends on individual progress and outcome. Because treatment plans should be individualized, lengths of stay should be flexible and individualized to meet the needs of each individual, not based on predetermined lengths of stay. ○ Transfer or Discharge Plan required except in an emergency, or when an individual leaves of their own accord or against program advice. Discharge plans include obtaining necessary release(s) of information to refer to appropriate aftercare services, including clinical recovery supports. Plans are written in conjunction with the individual and their primary counselor and service coordinator. ○ There are concrete plans for community reintegration and transition to next appropriate level of care and treatment support and services documented including the aftercare the client is being discharged to. • Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services. ○ Provide an orientation to and facilitate connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment.	○ ***Level 3.7RE programs are able to provide a psychiatric assessment within 4 hours of admission by telephone and within 24 hours following admission in person, or sooner, as appropriate to the individual's behavioral health condition, and thereafter as medically necessary. When an in-person assessment is not available within 24 hours, use of telehealth (video AND audio; audio only is not permitted) is permitted to ensure assessment within this timeframe.*** ○ ***The individual's history of follow through with behavioral health treatment and adherence with psychotropic medications is assessed and addressed in the treatment plan.*** ○ There is evidence in the clinical record that the treatment plan is reviewed and updated weekly to reflect the individual's clinical progress. There is evidence in the clinical record that continued placement is assessed dimensionally utilizing the ASAM Continued Service Criteria. • ***Provide active reassessments of the individual's mental status, at a frequency determined by the urgency of the individual's psychiatric condition. The treatment plan will be adjusted accordingly.*** • Discharge/transfer planning begins at admission and is documented in the individual's record. ○ The duration of treatment always depends on individual progress and outcome. Because treatment plans should be individualized, lengths of stay should be flexible and individualized to meet the needs of each individual, not based on predetermined lengths of stay. ○ Transfer or Discharge Plan required except in an emergency, or when an individual leaves of their own accord or against program advice. Discharge plans include obtaining necessary release(s) of information to refer to appropriate aftercare services, including clinical recovery supports. Plans are written in conjunction with the individual and their primary counselor and service coordinator. ○ There are concrete plans for community reintegration and transition to next appropriate level of care and treatment support and

	Medically-Monitored Intensive Inpatient (ASAM 3.7 (R))	Medically-Monitored Intensive Inpatient (ASAM 3.7 Enhanced (RE))
		services documented including the aftercare the client is being discharged to. • Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services. ○ Provide an orientation to and facilitate connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment.
Documentation	Level 3.7 residential programs will maintain individualized records which shall include: • The individual's Medicaid eligibility status • Initial intake evaluation, including screening for a cooccurring psychiatric disorder**.** • Information regarding the individual meeting ASAM placement criteria for the purpose of authorization and continued eligibility. ASAM 6 dimensions of care assessment tool score upon entry and documentation in the treatment plan for continued stay at each reassessment. • Alcohol or other drug-focused nursing assessment by an RN ○ Initiated at the time of admission and completion within 24 hours ○ Nurse credentials documented on the assessment • Physician (or NP/PA) assessment or physician review and update of the record of a physical examination completed within the seven days prior to admission ○ Completion within 24 hours ○ Credentials of medical professional completing documented on assessment or review • An individualized, comprehensive bio-psychosocial assessment which includes assessment in each of the ASAM six dimensions; this assessment must be compliant with the most recent edition of ASAM. ○ Documentation of any mental health and SUD diagnoses as well as any cognitive limitations ○ Completion within 48 hours of admission	Level 3.7 residential enhanced programs will maintain individualized records which shall include: • The individual's Medicaid eligibility status • Initial intake evaluation, including screening for a cooccurring psychiatric disorder**.** • Information regarding the individual meeting ASAM placement criteria for the purpose of authorization and continued eligibility. ASAM 6 dimensions of care assessment tool score upon entry and documentation in the treatment plan for continued stay at each reassessment. • Alcohol or other drug-focused nursing assessment by an RN ○ Initiated at the time of admission and completion within 24 hours ○ Nurse credentials documented on the assessment • Physician (or NP/PA) assessment or physician review and update of the record of a physical examination completed within the seven days prior to admission ○ Completion within 24 hours ○ Credentials of medical professional completing documented on assessment or review • An individualized, comprehensive bio-psychosocial assessment which includes assessment in each of the ASAM six dimensions; this assessment must be compliant with the most recent edition of ASAM. ○ Documentation of any mental health and SUD diagnoses as well as any cognitive limitations ○ ***Review of the individual's recent psychiatric history and mental status examination (if necessary, this review is conducted by a psychiatrist).*** ○ Completion within 48 hours of admission

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	○ Staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders. ○ Credentials of the completing practitioner must be documented on the assessment. ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • Individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals. ○ Discharge planning is integrated into the treatment plan. ○ Initiated at the time of admission and completed within 48 hours of admission ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the treatment plan. ○ The treatment plan must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. ○ There is evidence in the clinical record that the treatment plan is reviewed and updated weekly to reflect the individual's clinical progress. There is evidence in the clinical record that continued placement is assessed dimensionally utilizing the ASAM Continued Service Criteria. • Individualized progress notes that clearly reflect implementation of the treatment plan and the individual's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. ○ Credentials of the practitioner completing	○ Staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders. ○ Credentials of the completing practitioner must be documented on the assessment. ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • Individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals. ○ Discharge planning is integrated into the treatment plan. ○ ***Includes the individual's history of follow through with behavioral health treatment and adherence with psychotropic medications*** ○ Initiated at the time of admission and completed within 48 hours of admission ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the treatment plan. ○ The treatment plan must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. ○ There is evidence in the clinical record that the treatment plan is reviewed and updated weekly ***including active reassessments of the individual's mental status*** to reflect the individual's clinical progress. There is evidence in the clinical record that continued placement is assessed dimensionally utilizing the ASAM Continued Service Criteria. • Individualized progress notes that clearly reflect implementation of the treatment plan and the individual's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. ○ ***Includes active reassessments of the individual's mental status, at a frequency***

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	○ Notes for clinical services provided by an associate licensed practitioner or graduate-level intern shall have the review and signature of an independently licensed behavioral health practitioner/clinical supervisor. • Administration of toxicology screens and the test results. • Discharge summary which has been written within 15 working days of the individual leaving the program. This summary shall: ○ Address original reason for referral. ○ Indicate the individual's progress towards the established plan. ○ Describe the type, frequency and duration of treatment or services. ○ Specify reason(s) for discharge ○ Indicate the individual's participation in discharge planning. ○ Includes information regarding release(s) of information obtained and aftercare services referred to. ○ Staff completing the discharge summary shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the discharge summary. ○ The discharge summary must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.	***determined by the urgency of the individual's psychiatric condition.*** ○ Credentials of the practitioner completing ○ Notes for clinical services provided by an associate licensed practitioner or graduate-level intern shall have the review and signature of an independently licensed behavioral health practitioner/clinical supervisor. • Administration of toxicology screens and the test results. • Discharge summary which has been written within 15 working days of the individual leaving the program. This summary shall: ○ Address original reason for referral. ○ Indicate the individual's progress towards the established plan. ○ Describe the type, frequency and duration of treatment or services. ○ Specify reason(s) for discharge ○ Indicate the individual's participation in discharge planning. ○ Includes information regarding release(s) of information obtained and aftercare services referred to and aftercare services referred to. ○ Staff completing the discharge summary shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the discharge summary. ○ The discharge summary must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.
Treatment Services	Level 3.7 residential programs provide a planned and structured regimen of 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in a facility with a defined set of policies, procedures and clinical protocols and delivers high-intensity services. • Provide SUD services, in accordance with the individual's treatment plan, for a minimum of thirty (30) hours per week including appropriate medical and nursing services, individual, group and family counseling and activity services.	Level 3.7 residential enhanced programs provide a planned and structured regimen of 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in a facility with a defined set of policies, procedures and clinical protocols and delivers high-intensity services. • Provide SUD services, in accordance with the individual's treatment plan, for a minimum of thirty (30) hours per week including appropriate medical and nursing services, individual, group and family counseling and activity services. • Daily programming to manage acute symptoms of the individual's biomedical, substance use, or

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	• Daily programming to manage acute symptoms of the individual's biomedical, substance use, or mental health disorder and enhance the individual's understanding of their substance use and/or mental health disorder. • At least 15 of the 30 hours (including at least 1 hour of individual/family therapy) includes clinical program activities delivered by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern to stabilize the acute addictive and/or psychiatric symptoms. • The program offers a range of evidence-based cognitive, behavioral, and other therapies administered on an individual and group basis, medication education and management, medication for addiction treatment, educational skill building groups, and occupational or recreational activities, adapted to the individual's developmental stage and level of comprehension, understanding, and physical abilities. • Staff provide a planned regimen of 24-hour professionally directed evaluation, care, and treatment services (including self-administration of prescribed medications). The program has the ability to deliver emergency psychiatric and emergency medical services or maintains written agreements enabling immediate access for individuals, when needed, to facilities that offer such care. • Clinical staff are knowledgeable about evidence-based practices (e.g., motivational interviewing) appropriate to the individual's stage of readiness to change, designed to facilitate the individual's understanding of the relationship between their SUD and attendant life issues. • Counseling and clinical monitoring to promote successful initial involvement or re-involvement in, and skill building for, regular, productive daily activity, such as work or school and, as indicated successful reintegration into family living. • Monitoring of the individual's adherence in self-administering any prescribed medications, including medication for addiction treatment (MAT), and/or any	mental health disorder and enhance the individual's understanding of their substance use and/or mental health disorder. - ***Programs also offer planned clinical activities designed to promote stabilization of the individual's behavioral health needs and psychiatric symptoms, and to promote such stabilization. The goals of therapy apply to both the SUD and any co-occurring mental health disorder.*** • At least 20 of the 30 hours (including at least 1 hour of individual/family therapy) includes clinical program activities delivered by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern to stabilize the acute addictive and/or psychiatric symptoms. • The program offers a range of evidence-based cognitive, behavioral, and other therapies administered on an individual and group basis, medication education and management, medication for addiction treatment, educational skill building groups, and occupational or recreational activities, adapted to the individual's developmental stage and level of comprehension, understanding, and physical abilities. • Staff provide a planned regimen of 24-hour professionally directed evaluation, care, and treatment services (including self-administration of prescribed medications). The program has the ability to deliver emergency psychiatric and emergency medical services or maintains written agreements enabling immediate access for individuals, when needed, to facilities that offer such care • Clinical staff are knowledgeable about evidence-based practices (e.g., motivational interviewing) appropriate to the individual's stage of readiness to change, designed to facilitate the individual's understanding of the relationship between their SUD and attendant life issues. • ***Specific attention is given to medication education and management, to motivational and engagement strategies and other evidenced-based practices, which are used in preference to confrontational approaches. Note: The therapies described encompass services for individuals who are able to tolerate and benefit from a planned program of therapies. Other individuals — especially***

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	permitted over-the-counter (OTC) medications or supplements. • Opportunities for the individual to be introduced to the potential benefits of medication for addiction treatment as a tool to manage their substance use disorder(s). • Access to medication for addiction treatment. The program does not preclude admission of individuals based on MAT profile and active medication prescriptions. If agency cannot support a medication need internally, they have policies in place to ensure communication with prescribing physician is ongoing. • Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g., HIV, hepatitis C, sexually transmitted diseases). • Services, as appropriate and whenever possible with the individual's consent, for the individual's family and significant others to promote positive contribution to the individual's treatment and recovery. • Provide onsite peer support, including at a minimum, alumni groups and recovery groups or linkage to 12-step groups that ideally are welcoming to people with co-occurring disorders. **Note**: these meetings do not count toward the thirty hours of weekly programming each individual receives. • Facilitate connections to recovery resources and community supports.	***those with severe and chronic mental illness — may not be able to benefit from such a program until further stabilized. Once stabilized, the individual and staff will plan for appropriate services to maintain stabilization, such as intensive case management, medication management, psychotherapy, and ongoing addiction treatment.*** • Counseling and clinical monitoring to promote successful initial involvement or re-involvement in, and skill building for, regular, productive daily activity, such as work or school and, as indicated successful reintegration into family living. • Monitoring of the individual's adherence in self-administering any prescribed medications, including medication for addiction treatment (MAT), and/or any permitted over-the-counter (OTC) medications or supplements. - ***Specific attention is given to medication education and management.*** • Opportunities for the individual to be introduced to the potential benefits of medication for addiction treatment as a tool to manage their substance use disorder(s). • Access to medication for addiction treatment. The program does not preclude admission of individuals based on MAT profile and active medication prescriptions. If agency cannot support a medication need internally, they have policies in place to ensure communication with prescribing physician is ongoing. • Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g., HIV, hepatitis C, sexually transmitted diseases). • Services, as appropriate and whenever possible with the individual's consent, for the individual's family and significant others to promote positive contribution to the individual's treatment and recovery. • Provide onsite peer support, including at a minimum, alumni groups and recovery groups or linkage to 12-step groups that ideally are welcoming to people with co-occurring disorders. Note: these meetings do not count toward the thirty hours of weekly programming each individual receives. • Facilitate connections to recovery resources and community supports.

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Provider Qualifications/ Staffing	Level 3.7 residential settings are staffed by an interdisciplinary staff (including physicians, nurses, addiction counselors and behavioral health specialists, licensed practitioners, unlicensed counselors, as well as certified peers and technicians) operating within their scope of practice to provide services appropriate to the biopsychosocial needs of individuals being admitted to the program. The staff are able to assess and treat the individual and to obtain and interpret information regarding the individual's psychiatric and substance use disorders. Facility's staffing pattern is gender responsive and trauma informed.
	
	• Minimum on-site staffing requirements (not counting on-call hours) shall be maintained 24 hours per day, 7 days per week as outlined below:
	  ○ 0-24 beds: 2 staff minimum at all times
	  ○ 25-64 beds: 3 staff minimum at all times
	  ○ 65-99 beds: 4 staff minimum at all times
	  ○ 100+ beds: 5 staff minimum at all times
	  – For facilities with multiple levels of care at the same physical address and within the same building and floor, minimum staff ratios can be shared between programs.
	  – If programs share the same address and are separated on different floors or different buildings, the minimum staff requirement shall apply to each floor and building. An exception to this is a 0-24 bed program located in one building in which there are resident rooms on multiple levels of the building (e.g. a house-like setting); only the minimum staffing of two persons would be required.
	  – Any requests to waive the above criteria must be submitted to The Departments for review and approval.
	• Level 3.7 programs must be able to provide 24-hour staff support. Ensure staff who have client contact receive training on cooccurring mental health and substance use disorders, including prevalence, signs/symptoms, assessment, treatment and the impact of one's own attitudes/beliefs on the delivery of services
		Level 3.7 residential enhanced settings are staffed by an interdisciplinary staff (including physicians, nurses, addiction counselors and behavioral health specialists, licensed practitioners, unlicensed counselors, as well as certified peers and technicians) operating within their scope of practice to provide services appropriate to the biopsychosocial needs of individuals being admitted to the program. The staff are able to assess and treat the individual and to obtain and interpret information regarding the individual's psychiatric and substance use disorders. Facility's staffing pattern is gender responsive and trauma informed.
		
		• Minimum on-site staffing requirements (not counting on-call hours) shall be maintained 24 hours per day, 7 days per week as outlined below:
		  ○ 0-24 beds: 2 staff minimum at all times
		  ○ 25-64 beds: 3 staff minimum at all times
		  ○ 65-99 beds: 4 staff minimum at all times
		  ○ 100+ beds: 5 staff minimum at all times
		  – For facilities with multiple levels of care at the same physical address and within the same building and floor, minimum staff ratios can be shared between programs.
		  – If programs share the same address and are separated on different floors or different buildings, the minimum staff requirement shall apply to each floor and building. An exception to this is a 0-24 bed program located in one building in which there are resident rooms on multiple levels of the building (e.g. a house-like setting); only the minimum staffing of two persons would be required.
		  – Any requests to waive the above criteria must be submitted to The Departments for review and approval.
		• Level 3.7RE programs must be able to provide 24-hour staff support. Ensure staff who have client contact receive training on co-occurring mental health and substance use disorders, including prevalence, signs/symptoms, assessment, treatment and the impact of one's own attitudes/beliefs on the delivery of services and the use of naloxone in response to an opioid overdose.
		• Some (if not all) of the addiction treatment professionals should have sufficient cross training to understand the signs and symptoms of psychiatric disorders and to understand and

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	and the use of naloxone in response to an opioid overdose. • Where on-call coverage is indicated for any of the below positions, such coverage can be combined across programs within the same agency. • Executive Director: Each facility shall have an executive director who is accountable to the governing authority. The executive director shall be responsible for the management of the facility • Psychiatric services are available on-site, via telemedicine per the state's telemedicine policy or through consultation. Such services are available within 8 hours by telephone or within 24 hours in person. ○ Psychiatric services may be made available through consultation or referral when a presenting issue could be attended to at a later time. • A physician (or NP/PA) is available to assess the individual in person within 24 hours of admission and thereafter as medically necessary. This provider also oversees the medical treatment process and assures the quality of care. The provider of such services should be knowledgeable about addiction treatment, especially pharmacotherapies. ○ A licensed physician to oversee the treatment process and assure the quality of care. Many individuals in this level of care receive medication for addiction treatment, integrated with psychosocial therapies. The provider of such care can be a physician assistant or other licensed independent practitioner with prescribing authority, but should be knowledgeable about addiction treatment, especially pharmacotherapies. ○ The physician (or NP/PA) provides oversight to the nursing staff who carry out the medical orders. Orders should not exceed the nurse or ordering practitioner's scope of practice. • Nursing staff (RN or LPN) onsite 40 hours per week per 16 residents and available 24 hours per day, 7 days per week. Facilities	explain to the individual the purposes of psychotropic medications and their interactions with substance use. • Where on-call coverage is indicated for any of the below positions, such coverage can be combined across programs within the same agency. • Executive Director: Each facility shall have an executive director who is accountable to the governing authority. The executive director shall be responsible for the management of the facility • A psychiatrist is available on-site as needed to meet the outlined standards and ensure in-person psychiatric care unless extenuating circumstances necessitate use of telemedicine consistent with the state's telemedicine policy; such exceptions to in-person care should be documented in the individual's record. ○ The psychiatrist shall assess the individual within 4 hours of admission by telephone and within 24 hours in person. ○ Psychiatric services may be made available through consultation or referral when a presenting issue could be attended to at a later time. ○ Program is ideally staffed by a certified addiction specialist physician along with a general psychiatrist, or by a physician certified as an addiction psychiatrist. • A physician (or NP/PA) is available to assess the individual in person within 24 hours of admission and thereafter as medically necessary. This provider also oversees the medical treatment process and assures the quality of care. The provider of such services should be knowledgeable about addiction treatment, especially pharmacotherapies. ○ A licensed physician to oversee the treatment process and assure the quality of care. Many individuals in this level of care receive medication for addiction treatment, integrated with psychosocial therapies. The provider of such care can be a physician assistant or other licensed independent practitioner with prescribing authority, but should be knowledgeable about addiction treatment, especially pharmacotherapies. ○ The physician (or NP/PA) provides oversight to the nursing staff who carry out the medical orders. Orders should not exceed the nurse or ordering practitioner's scope of practice.

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	greater than 64 residents will not be required to have more than 4 total nurses. ○ At least one nurse is an RN ○ An appropriately credentialed and licensed nurse is responsible for monitoring the individual's progress and for medication administration. Except that the self-administration of medication by clients may be permitted on a specific written order by the prescriber working within their scope of practice. Self-administered medications shall be dispensed, stored, monitored and recorded in accordance with an established procedure. ○ A registered nurse is available to conduct an alcohol or other drug focused nursing assessment ○ The RN works under the direction and orders of a licensed physician (or NP/PA). Orders should not exceed the nurse or ordering practitioner's scope of practice. • Employs a clinical supervisor with authority over all behavioral health treatment services, who shall have a minimum of a master's degree in a behavioral health treatment services field, at least three years of full-time work experience in SUD services and be independently licensed by the State in their respective discipline. ○ The Clinical Supervisor must be on-site at least 40 hours per week with at least one evening shift per week. Larger programs may require additional clinical supervisor hours to ensure all supervision requirements are met as detailed in the "Supervision Requirements" section below. ○ The Clinical Supervisor conducts and documents face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month. ○ There shall be 24-hour on-call coverage by telephone during those hours when the clinical supervisor is not physically present.	• Nursing staff (RN or LPN) onsite 40 hours per week per 16 residents and available 24 hours per day, 7 days per week; this is inclusive of at least one RN onsite every shift. Facilities greater than 64 residents will not be required to have more than four (4) total nurses present at any given time. ○ For third shift, only one nursing staff is required. ○ The RN is responsible for monitoring the individual's progress and administering or monitoring the individual's self-administration of psychotropic medications. ○ A registered nurse is available to conduct an alcohol or other drug focused nursing assessment ○ The RN works under the direction and orders of a licensed physician (or NP/PA). Orders should not exceed the nurse or ordering practitioner's scope of practice. • Employs a clinical supervisor with authority over all behavioral health treatment services, who shall have a minimum of a master's degree in a behavioral health treatment services field, at least three years of full-time work experience in SUD services and be independently licensed by the State in their respective discipline. ○ The Clinical Supervisor must be on-site at least 40 hours per week with at least one evening shift per week. Larger programs may require additional clinical supervisor hours to ensure all supervision requirements are met as detailed in the "Supervision Requirements" section below. ○ The Clinical Supervisor conducts and documents face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month. ○ There shall be 24-hour on-call coverage by telephone during those hours when the clinical supervisor is not physically present. • An independently licensed or associate licensed behavioral health practitioner is available to provide a minimum of twenty (20) hours (out of the total 30 hours of weekly programming) of clinical treatment per week. At least one (1) of these hours includes individual/family therapy. ○ Up to 25 percent of clinical treatment hours may be provided by a graduate-level intern

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	• An independently licensed or associate licensed behavioral health practitioner is available to provide a minimum of fifteen (15) hours (out of the total 30 hours of weekly programming) of clinical treatment per week. At least one (1) of these hours includes individual/family therapy. ○ Up to 25 percent of clinical treatment hours may be provided by a graduate-level intern whose accredited graduate degree program requires their students to participate in intern placements for clinical training in the provision of behavioral health services. ○ At least one behavioral health practitioner per 16 residents is on-site 40 hours per week. ○ Any behavioral health practitioner who is not independently licensed must be working under an independently licensed behavioral health practitioner who must sign off on clinical documentation and provide supervision. ○ Clinical staff should be knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment. Clinical staff should be able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation. ○ Clinical groups should be limited to no more than 12 group members regardless of payer. Psychoeducational and non-clinical groups should be limited to no more than 25 group members. ○ At least one behavioral health practitioner with competence in the treatment of substance use and mental health disorders is available by telephone 24 hours a day, seven days a week when not on-site. • Certified Peers may provide the additional remaining hours of weekly programming and may meet with residents individually and/or in group formats to support their ongoing engagement, retention and progress in treatment.	whose accredited graduate degree program requires their students to participate in intern placements for clinical training in the provision of behavioral health services. ○ At least one behavioral health practitioner per 16 residents is on-site 40 hours per week ○ Conducts a behavioral health focused assessment at the time of admission. ○ Any behavioral health practitioner who is not independently licensed must be working under an independently licensed behavioral health practitioner who must sign off on clinical documentation and provide supervision. ○ Clinical staff should be knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment. Clinical staff should be able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation. ○ Clinical groups should be limited to no more than 12 group members regardless of payer. Psychoeducational and non-clinical groups should be limited to no more than 25 group members. ○ At least one behavioral health practitioner with competence in the treatment of substance use and mental health disorders is available by telephone 24 hours a day, seven days a week when not on-site. • Certified Peers may provide the additional remaining hours of weekly programming and may meet with residents individually and/or in group formats to support their ongoing engagement, retention and progress in treatment. ○ Certification must be obtained by one of the state-approved certification boards. ○ Certified Peers should be onsite while residents are awake, including presence on evenings and weekends. Number of Certified Peers required depends on the size of the program: ▪ 0-32 beds: 1 peer onsite at least 40 hours per week ▪ 33-64 beds: 2 peers onsite at least 40 hours per week each ▪ 65+ beds: 3 peers onsite at least 40 hours per week each

	Medically-Monitored Intensive Inpatient (ASAM 3.7 (R))	Medically-Monitored Intensive Inpatient (ASAM 3.7 Enhanced (RE))
	○ Certification must be obtained by one of the state-approved certification boards. ○ Certified Peers should be onsite while residents are awake, including presence on evenings and weekends. Number of Certified Peers required depends on the size of the program: ▪ 0-32 beds: 1 peer onsite at least 40 hours per week ▪ 33-64 beds: 2 peers onsite at least 40 hours per week each ▪ 65+ beds: 3 peers onsite at least 40 hours per week each ○ Certified peers receive one hour of clinical supervision weekly, of which group supervision may be utilized once a month. This supervision can be provided by: ▪ The Clinical Supervisor (as defined above); ▪ An independently licensed or associate licensed behavioral health practitioner with at least 2 years of full-time work experience in SUD services; or ▪ A Certified Peer with at least 2 years of full-time experience in providing peer support services. • Technicians are available onsite, as needed, to ensure minimum staffing requirements are met and are awake and monitoring individuals' needs at all times. ○ Technicians may provide the additional remaining hours of weekly programming ○ Technicians report to a Tech Supervisor (or other leadership position) with at least 6 months experience in residential SUD programs. • A dedicated Service Coordinator that manages incoming referrals and discharge plans is required for each facility. The purpose of the Service Coordinator is to promote engagement and retention in treatment and facilitate an effective discharge plan whereby the individual successfully connects to the next level of care. The service coordinator facilitates referral arrangements and coordination with aftercare. ○ The Service Coordinator can also assist in networking individuals into	○ Certified peers receive one hour of clinical supervision weekly, of which group supervision may be utilized once a month. This supervision can be provided by: ▪ The Clinical Supervisor (as defined above); ▪ An independently licensed or associate licensed behavioral health practitioner with at least 2 years of full-time work experience in SUD services; or ▪ A Certified Peer with at least 2 years of full-time experience in providing peer support services. • Technicians are available onsite, as needed, to ensure minimum staffing requirements are met and are awake and monitoring individuals' needs at all times. ○ Technicians may provide the additional remaining hours of weekly programming ○ Technicians report to a Tech Supervisor (or other leadership position) with at least 6 months experience in residential SUD programs. • A dedicated Service Coordinator that manages incoming referrals and discharge plans is required for each facility. The purpose of the Service Coordinator is to promote engagement and retention in treatment and facilitate an effective discharge plan whereby the individual successfully connects to the next level of care. The service coordinator facilitates referral arrangements and coordination with aftercare. ○ The Service Coordinator can also assist in networking individuals into community-based ancillary or "wrap-around" services to build/maintain recovery capital. ○ The service coordinator shall be on-site weekdays during 1st shift for at least 80% of the time. The other 20% may be done second, third or weekend shifts. ○ The Service Coordinator may be a licensed practitioner, unlicensed counselor, or certified peer. • Each facility shall have at least one staff person in each building, when a resident is known to be present and who shall have immediate access to back up staff, for urgent or emergency situations. This is inclusive of the positions described above.

	Medically-Monitored Intensive Inpatient (ASAM 3.7 (R))	Medically-Monitored Intensive Inpatient (ASAM 3.7 Enhanced (RE))
	community-based ancillary or "wrap-around" services to build/maintain recovery capital. ○ The service coordinator shall be on-site weekdays during 1st shift for at least 80% of the time. The other 20% may be done second, third or weekend shifts. ○ The Service Coordinator may be a licensed practitioner, unlicensed counselor, or certified peer. • Each facility shall have at least one staff person in each building, when a resident is known to be present and who shall have immediate access to back up staff, for urgent or emergency situations. This is inclusive of the positions described above.	
Supervision Requirements	Supervisors conduct and document face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month. Certified peers with lived experience receive clinical supervision 1 hour weekly, of which group supervision may be utilized once a month – this can be from: the Clinical Supervisor; an independently licensed or associate licensed behavioral health practitioner with at least 2 years of full-time work experience in SUD services; or a Certified Peer with at least 2 years of full-time experience in providing peer support services. Technicians receive supervision from the Tech Supervisor or other leadership position for 30 minutes for every 40 hours worked. Tech administrative supervision can be in a group setting for all but one time a month. Techs must receive monthly group clinical supervision with a potential shift overlap (All staff meeting at least once a month). There should be a shift report or hand off for every shift or staggered starts.	
Target Length of Stay	As medically necessary, or dependent on time needed to sustain and further therapeutic gains and master the application of coping and recovery skills.	As medically necessary, or dependent on time needed to sustain and further therapeutic gains and master the application of coping and recovery skills.

Withdrawal Management

	Clinically Managed Residential Withdrawal Management (ASAM 3.2 - WM)	Medically Monitored Inpatient Withdrawal Management (ASAM 3.7-WM)
Ages Served	Age 18 and older	
Brief Service Description	Level 3.2-WM programs are an organized service that may be delivered by appropriately trained staff, who provide 24-hour supervision, observation, and support for individuals who are intoxicated or experiencing withdrawal. The process of withdrawal management includes not only attenuation of the physiological and psychological features of withdrawal, but also interrupting the momentum of habitual compulsive use in individuals with addiction. Thus, an individual admitted for withdrawal management is also receiving professional services that can serve to interrupt the cycle of use, enable the individual to establish the first day(s) of abstinence and be evaluated for the need for further care. This level of care provides the opportunity to engage an individual in what will hopefully be sustained recovery. Because withdrawal management protocols can relieve withdrawal symptoms quickly and effectively, counseling and therapy focused on initiation or resumption of recovery can be instituted at the same time as withdrawal management, rather than being delayed. This level is characterized by its emphasis on peer and social support rather than medical and nursing care. This level provides care for individuals whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support; however, the full resources of a Level 3.7-WM are not necessary. SUD residential programs utilizing buprenorphine-based medications for withdrawal management must have a “qualified practitioner” including physicians, PAs and nursing disciplines who must work within their scope of practice and adhere to state and federal prescribing laws.	Level 3.7-WM programs are an organized service delivered by medical and nursing professionals, which provides for 24-hour evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. The process of withdrawal management includes not only attenuation of the physiological and psychological features of withdrawal, but also interrupting the momentum of habitual compulsive use in individuals with addiction. Thus, an individual admitted for withdrawal management is also receiving professional services that can serve to interrupt the cycle of use, enable the individual to establish the first day(s) of abstinence and be evaluated for the need for further care. This level of care provides the opportunity to engage an individual in what will hopefully be sustained recovery. Because withdrawal management protocols can relieve withdrawal symptoms quickly and effectively, counseling and therapy focused on initiation or resumption of recovery can be instituted at the same time as withdrawal management, rather than being delayed. This level provides care to individuals whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. 24-hour observation, monitoring, and treatment are available. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary. An interdisciplinary team of appropriately trained clinicians (such as physicians, nurses, counselors, social workers, and psychologists) is available to assess and treat the individual and to obtain and interpret information regarding the individual's needs. SUD residential programs utilizing buprenorphine-based medications for withdrawal management must have a “qualified practitioner” including physicians,

	Clinically Managed Residential Withdrawal Management (ASAM 3.2 - WM)	Medically Monitored Inpatient Withdrawal Management (ASAM 3.7-WM)
	Residential programs offer at least three (3) hours per week of a combination of low-intensity clinical and recovery-focused services. These programs provide at least three (3) hours a week of individual, group, family therapy, medication management, and psychoeducation. At least one (1) hour of the total three (3) hours of weekly programming must include individual/family therapy provided by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern.	PAs and nursing disciplines who must work within their scope of practice and adhere to state and federal prescribing laws. Residential programs offer at least five (5) hours per week of a combination of low-intensity clinical and recovery-focused services. These programs provide at least five (5) hours a week of individual, group, family therapy, medication management, and psychoeducation. At least two (2) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern, at least one (1) hour of which must include individual/family therapy.
Admission criteria	Level 3.2-WM programs are expected to accept admissions 24 hours per day, 7 days per week. Individuals meeting the below criteria shall be admitted regardless of the environment they are coming from (e.g., the community, other levels of care). The individual is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive conditions) that withdrawal is imminent. The individual is assessed as not being at risk of severe withdrawal syndrome, and moderate withdrawal is safely manageable at this level of service. *Alcohol*: The individual is intoxicated or is withdrawing from alcohol and the CIWA-AR score is less than 8 at admission, and monitoring is available to assure that it remains less than 8 or the equivalent for a comparable standardized scoring system. *Opioids*: Withdrawal signs and symptoms are distressing but do not require medication for reasonable withdrawal discomfort, and the individual is impulsive and lacks skills needed to prevent immediate continued drug use.	Level 3.7-WM programs are expected to accept admissions 24 hours per day, 7 days per week. Individuals meeting the below criteria shall be admitted regardless of the environment they are coming from (e.g., the community, other levels of care). The individual is experiencing signs and symptoms of severe withdrawal, or there is evidence (based on history of substance intake; age; gender; previous withdrawal history; present symptoms; physical condition; and/or emotional, behavioral, or cognitive conditions) that severe withdrawal is imminent. The severe withdrawal syndrome is assessed as manageable at this level of service. Provides care to individuals whose withdrawal signs and symptoms are sufficiently severe to require 24-hour residential care. It sometimes is provided as a "step-down" service from a specialty unit of an acute care general or psychiatric hospital. 24-hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary. American Society of Addiction Medicine (ASAM) placement criteria are used to determine LOC. Continued Service Criteria — the individual is improving, but continues to experience withdrawal anxiety, tremors, and increased pulse rate and blood

	Clinically Managed Residential Withdrawal Management (ASAM 3.2 - WM)	Medically Monitored Inpatient Withdrawal Management (ASAM 3.7-WM)
	Stimulants: The individual has marked lethargy, hypersomnolence, paranoia, or mild psychotic symptoms due to stimulant withdrawal, and these are still present beyond a period of outpatient monitoring available in Level 2-WM services. In addition to the previous specifications, the individual is assessed as not requiring medication, but requires this level of service to complete withdrawal management and enter into continued treatment or self-help recovery because of inadequate home supervision or support structure, as evidenced by meeting [1], [2] or [3]: 1. The individual's recovery environment is not supportive of withdrawal management and entry into treatment, and the individual does not have sufficient coping skills to safely deal with the problems in the recovery environment. 2. The individual has a recent history of withdrawal management at less intensive levels of service that is marked by inability to complete withdrawal management or to enter into continuing addiction treatment, and the individual continues to have insufficient skills to complete withdrawal management. 3. The individual recently has demonstrated an inability to complete withdrawal management at a less intensive level of service, as by continued use of other than prescribed drugs or other mind-altering substances. **Note:** Individuals in Level 3.2WM programs may have co-occurring mental health disorders; or difficulties with mood, behavior, or cognition related to a substance use, other addictive, or mental health disorder; or emotional, behavioral, or cognitive symptoms that are troublesome but do not meet the DSM criteria for a mental health disorder. Therefore, all Level 3.2WM programs are expected to be co-occurring capable. **Transfer to another LOC** • When assessment indicates that an individual no longer meets the placement criteria noted above, they can be transferred to the next appropriate level of care based on a	pressure related to withdrawal. The individual continues to require withdrawal management medications and nurse monitoring every eight hours. Therefore, continued treatment can be provided effectively only in a Level 3.7-WM service • The individual continues in a Level 3.7-WM withdrawal management program until withdrawal signs and symptoms are sufficiently resolved that they can be safely managed at a less intensive level of care; or, alternatively, the individual's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a Level 4-WM intensive level of withdrawal management service is indicated. • An individual in a Level 3.7-WM program exhibits significant and stable improvement in their withdrawal anxiety, tremors, pulse rate, and blood pressure that nurse monitoring no longer is necessary. The individual's treatment can continue in a Level 2-WM program. *Alcohol*: The individual is withdrawing from alcohol, the CIWA-Ar score is 19 or greater (or the equivalent for a standardized scoring system) by the end of the period of outpatient monitoring available in Level 2-WM. *Alcohol and sedative hypnotics*: The individual has marked lethargy or hyper-somnolence due to intoxication with alcohol or other drugs, and a history of severe withdrawal syndrome, or the individual's altered level of consciousness has not stabilized at the end of the period of outpatient monitoring available at Level 2-WM. *Sedative hypnotics*: • The individual has ingested sedative/hypnotics at more than therapeutic levels daily for more than four weeks and is not responsive to appropriate recent efforts to maintain the dose at therapeutic levels. • The individual has ingested sedative/hypnotics at more than therapeutic levels daily for more than four weeks, in combination with daily alcohol use or regular use of another mind-altering drug

	Clinically Managed Residential Withdrawal Management (ASAM 3.2 - WM)	Medically Monitored Inpatient Withdrawal Management (ASAM 3.7-WM)
	reassessment of their severity of illness and rehabilitative needs.	known to pose a severe risk of withdrawal. Signs and symptoms of withdrawal are of moderate severity, and the individual cannot be stabilized by the end of the period of outpatient monitoring available at Level 2-WM. *Opioids*: For withdrawal management not using opioid agonist medication: The individual has used opioids daily for more than two weeks and has a history of inability to complete withdrawal as an outpatient or without medication in a Level 3.2-WM service. Antagonist medication is to be used in withdrawal in a brief but intensive withdrawal management (as in multiday pharmacological induction onto naltrexone). *Stimulants*: The individual has marked lethargy, hypersomnolence, agitation, paranoia, depression, or mild psychotic symptoms due to stimulant withdrawal, and has poor impulse control and/or coping skills to prevent immediate continued drug use. ALTERNATIVELY to the specifications above: There is a strong likelihood that the individual (who requires medication) will not complete withdrawal management at another level of care and enter into continuing treatment or self-help recovery, as evidenced (for example), by any of [1], [2] or [3]: 1. The individual requires medication and has a recent history of withdrawal management at a less intensive level of care, marked by past and current inability to complete withdrawal management and enter into continuing addiction treatment. The individual continues to have insufficient skills or supports to complete withdrawal management. 2. The individual has a recent history of withdrawal management at less intensive levels of service that is marked by inability to complete withdrawal management or to enter into continuing addiction treatment, and the individual continues to have insufficient skills to complete withdrawal management. 3. The individual has a comorbid physical, emotional, behavioral, or cognitive condition (such as chronic pain with active exacerbation or posttraumatic stress disorder with brief dissociative episodes) that is manageable in a

	Clinically Managed Residential Withdrawal Management (ASAM 3.2 - WM)	Medically Monitored Inpatient Withdrawal Management (ASAM 3.7-WM)
		Level 3.7WM setting but which increases the clinical severity of the withdrawal and complicates withdrawal management 1. **Note:** Individuals in Level 3.7WM programs may have co-occurring mental health disorders; or difficulties with mood, behavior, or cognition related to a substance use, other addictive, or mental health disorder; or emotional, behavioral, or cognitive symptoms that are troublesome but do not meet the DSM criteria for a mental health disorder. Therefore, all Level 3.7WM programs are expected to be co-occurring capable. **Transfer to another LOC** • When assessment indicates that an individual no longer meets the placement criteria noted above, they can be transferred to the next appropriate level of care based on a reassessment of their severity of illness and rehabilitative needs.
Interventions	While ASAM views addiction as a unitary condition, withdrawal syndromes are separate from each other depending on the pharmacological class of the substance the individual may be withdrawing from, and interventions differ accordingly. • Each individual whose substance of choice is other than alcohol shall be required to have an initial drug-screening urinalysis upon admission. ○ The facility shall have a provision for regular monitoring of chemical levels in urine specimens. ○ Note: DSS will establish upper limit on number of lab tests that can be sent out. Refer to associated lab policy for additional guidance. • Availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems. • Since Level 3.2-WM is managed by clinicians, not medical or nursing staff, protocols are in place should an individual's condition deteriorate and appear to need medical or nursing interventions. These protocols are used to determine the nature of the medical or nursing interventions that may be required. Protocols include under what conditions	While ASAM views addiction as a unitary condition, withdrawal syndromes are separate from each other depending on the pharmacological class of the substance the individual may be withdrawing from, and interventions differ accordingly. • Each individual whose substance of choice is other than alcohol shall be required to have an initial drug-screening urinalysis upon admission. ○ The facility shall have a provision for regular monitoring of chemical levels in urine specimens. ○ Note: DSS will establish upper limit on number of lab tests that can be sent out. Refer to associated lab policy for additional guidance. • A comprehensive nursing assessment at admission is conducted by a registered nurse or other licensed and credentialed nurse. This assessment should include an addiction-focused history and provide a clear understanding of the individual's present status. ○ Assessment to be reviewed with a physician during the admission process. • If self-administered withdrawal management medications are to be used, a physical examination by a physician (or NP/PA) should be made at time of admission.

	Clinically Managed Residential Withdrawal Management (ASAM 3.2 - WM)	Medically Monitored Inpatient Withdrawal Management (ASAM 3.7-WM)
	nursing and physician care is warranted and/or when transfer to a medically monitored facility or an acute care hospital is necessary. The protocols are developed and supported by a physician knowledgeable in addiction medicine. • A physical examination by a physician (or NP/PA) as part of the initial assessment, if self-administered withdrawal management medications are to be used. • Sufficient biopsychosocial assessment of the individual is completed or updated within 48 hours of admission to determine the level of care in which the individual should be placed and for the individualized treatment plan to address treatment priorities identified in Dimensions 2 through 6. ○ Staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders. ○ Credentials of the completing practitioner must be documented on the assessment. ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • An individualized treatment plan, which includes problem identification in Dimensions 2 through 6, needs, strengths, skills and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals. ○ The plan is initiated at the time of admission, is developed in collaboration with the individual and is completed within 48 hours of admission. The plan reflects the individual's personal goals while considering the individual's strengths, capabilities and existing recovery resources available to achieve the individual's personal goals. ○ The treatment plan also reflects case management conducted by onsite staff;	• A physical examination by a physician (or NP/PA) within 24 hours of admission and appropriate laboratory and toxicology tests. ○ Physician orders are required for medical and psychiatric management. ○ If Level 3.7-WM withdrawal management services are step-down services from Level 4-WM, records of a physical examination within the preceding seven days are evaluated by a physician within 24 hours of admission. • Sufficient biopsychosocial assessment of the individual is completed or updated within 48 hours of admission to determine the level of care in which the individual should be placed and for the individualized treatment plan to address treatment priorities identified in Dimensions 2 through 6. ○ Staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders. ○ Credentials of the completing practitioner must be documented on the assessment. ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • A multidisciplinary individualized assessment and treatment plan, which includes problem identification in Dimensions 2 through 6, needs, strengths, skills and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals. ○ The plan is initiated at the time of admission, is developed in collaboration with the individual and is completed within 48 hours of admission. The plan reflects the individual's personal goals while considering the individual's strengths, capabilities and existing recovery resources available to achieve the individual's personal goals. ○ The treatment plan also reflects case management conducted by onsite staff; coordination of related addiction treatment, health care, mental health, recovery support

	Clinically Managed Residential Withdrawal Management (ASAM 3.2 - WM)	Medically Monitored Inpatient Withdrawal Management (ASAM 3.7-WM)
	coordination of related addiction treatment, health care, mental health, recovery support services, social, vocational, or housing services (provided concurrently); and the integration of services at this and other levels of care. ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the treatment plan. ○ The treatment plan must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • Discharge/transfer planning begins at admission and is documented in the individual's record. ○ The duration of treatment always depends on individual progress and outcome. Because treatment plans should be individualized, lengths of stay should be flexible and individualized to meet the needs of each individual, not based on predetermined lengths of stay. ○ Transfer or Discharge Plan required except in an emergency, or when a client leaves of their own accord or against program advice. Discharge plans include obtaining necessary release(s) of information to refer to appropriate aftercare services, including clinical recovery supports. Plans are written in conjunction with the individual and their primary counselor and service coordinator. ○ There are concrete plans for community reintegration and transition to next appropriate level of care and treatment support and services documented including the aftercare the client is being discharged to. • Direct affiliations with other levels of care (such as IOP for purposes of discharge planning) and other services (such as supported	services, social, vocational, or housing services (provided concurrently); and the integration of services at this and other levels of care. ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the treatment plan. ○ The treatment plan must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • Daily assessment of individual progress through withdrawal management and any treatment changes. Withdrawal rating scale tables and flow sheets (which may include tabulation of vital signs) are used as needed. • Discharge/transfer planning begins at admission and is documented in the individual's record. ○ The duration of treatment always depends on individual progress and outcome. Because treatment plans should be individualized, lengths of stay should be flexible and individualized to meet the needs of each individual, not based on predetermined lengths of stay. ○ Transfer or Discharge Plan required except in an emergency, or when a client leaves of their own accord or against program advice. Discharge plans include obtaining necessary release(s) of information to refer to appropriate aftercare services, including clinical recovery supports. Plans are written in conjunction with the individual and their primary counselor and service coordinator. ○ There are concrete plans for community reintegration and transition to next appropriate level of care and treatment support and services documented including the aftercare the client is being discharged to. • Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services. ○ Provide an orientation to and facilitate connections to recovery resources

	Clinically Managed Residential Withdrawal Management (ASAM 3.2 - WM)	Medically Monitored Inpatient Withdrawal Management (ASAM 3.7-WM)
	employment, literacy training, and adult education). • Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services. ○ Provide an orientation to and facilitate connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment.	and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment.

Documentation	Level 3.2-WM programs will maintain individualized records which shall include:
	• The individual's Medicaid eligibility status
	• An addiction-focused history obtained as part of the initial assessment and reviewed with a physician during the admission process.
	• A physical examination by a physician (or NP/PA) as part of the initial assessment, if self-administered withdrawal management medications are to be used. Credentials of medical professional completing documented on assessment.
	• Sufficient biopsychosocial screening which includes assessment in each of the ASAM six dimensions; this assessment must be compliant with the most recent edition of ASAM.
	  ○ Documentation of any mental health and SUD diagnoses as well as any cognitive limitations
	  ○ Completion within 48 hours of admission
	  ○ Minimum credentials for the staff conducting or updating the screening shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders.
	  ○ Credentials of the completing practitioner must be documented on the screening.
	  ○ The screening shall be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.
		Level 3.7-WM programs will maintain individualized records which shall include:
		• The individual's Medicaid eligibility status
		• An addiction-focused history obtained as part of the initial assessment and reviewed by a physician during the admission process.
		• A physical examination by a physician (or NP/PA) within 24 hours of admission and appropriate laboratory and toxicology tests. If Level 3.7-WM withdrawal management services are step-down services from Level 4-WM, records of a physical examination within the preceding 7 days are evaluated by a physician within 24 hours of admission. Credentials of medical professional completing documented on assessment or review.
		• Sufficient biopsychosocial screening which includes assessment in each of the ASAM six dimensions; this assessment must be compliant with the most recent edition of ASAM.
		  ○ Documentation of any mental health and SUD diagnoses as well as any cognitive limitations
		  ○ Completion within 48 hours of admission
		  ○ Minimum credentials for the staff conducting or updating the screening shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders.
		  ○ Credentials of the completing practitioner must be documented on the screening.
		  ○ The screening shall be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.

	Clinically Managed Residential Withdrawal Management (ASAM 3.2 - WM)	Medically Monitored Inpatient Withdrawal Management (ASAM 3.7-WM)

	• Individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals.
	  ○ Discharge planning is integrated into the treatment plan.
	  ○ Initiated at the time of admission and completed within 48 hours of admission
	  ○ The treatment plan shall be modified as needed until the individual is discharged.
	  ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern.
	  ○ Credentials of the completing practitioner must be documented on the treatment plan.
	  ○ The treatment plan must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.
	• Individualized progress notes that clearly reflect implementation of the treatment plan and the individual's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. Notes shall include:
	  ○ Daily assessment of individual progress through withdrawal management and any treatment changes. Withdrawal rating scale tables and flow sheets (which may include tabulation of vital signs) are used as needed.
	  ○ The individual's physical condition, including vital signs.
	  ○ The individual's mood and behavior.
	  ○ Statements about the individual's condition and needs.
	  ○ Information about the individual's progress or lack of progress in relation to withdrawal management/treatment goals.
	  ○ Credentials of the practitioner completing
	  ○ Notes for clinical services provided by an associate licensed practitioner or graduate-level intern shall have the review and
		• Individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals.
		  ○ Discharge planning is integrated into the treatment plan.
		  ○ Initiated at the time of admission and completed within 48 hours of admission
		  ○ The treatment plan shall be modified as needed until the individual is discharged.
		  ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern.
		  ○ Credentials of the completing practitioner must be documented on the treatment plan.
		  ○ The treatment plan must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.
		• Individualized progress notes that clearly reflect implementation of the treatment plan and the individual's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. Notes shall include:
		  ○ Daily assessment of individual progress through withdrawal management and any treatment changes. Withdrawal rating scale tables and flow sheets (which may include tabulation of vital signs) are used as needed.
		  ○ The individual's physical condition, including vital signs.
		  ○ The individual's mood and behavior.
		  ○ Statements about the individual's condition and needs.
		  ○ Information about the individual's progress or lack of progress in relation to withdrawal management/treatment goals.
		  ○ Credentials of the practitioner completing
		  ○ Notes for clinical services provided by an associate licensed practitioner or graduate-level intern shall have the review and signature of an independently licensed behavioral health practitioner/clinical supervisor.

	Clinically Managed Residential Withdrawal Management (ASAM 3.2 - WM)	Medically Monitored Inpatient Withdrawal Management (ASAM 3.7-WM)
	signature of an independently licensed behavioral health practitioner/clinical supervisor. • Administration of toxicology screens and the test results. ○ Documentation of a written agreement maintained with a licensed CLIA-certified laboratory for the purpose of performing the required urine screenings when a waivered test is not appropriate. • Discharge summary which has been written within 15 working days of the individual leaving the program. This summary shall: ○ Address original reason for referral. ○ Indicate the individual's progress towards the established plan. ○ Describe the type, frequency and duration of treatment or services. ○ Specify reason(s) for discharge ○ Indicate the individual's participation in discharge planning. ○ Includes information regarding release(s) of information obtained and aftercare services referred to. ○ Staff completing the discharge summary shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the discharge summary. ○ The discharge summary must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.	• Administration of toxicology screens and the test results. ○ Documentation of a written agreement maintained with a licensed CLIA-certified laboratory for the purpose of performing the required urine screenings when a waivered test is not appropriate. • Discharge summary which has been written within 15 working days of the individual leaving the program. This summary shall: ○ Address original reason for referral. ○ Indicate the individual's progress towards the established plan. ○ Describe the type, frequency and duration of treatment or services. ○ Specify reason(s) for discharge ○ Indicate the individual's participation in discharge planning. ○ Includes information regarding release(s) of information obtained and aftercare services referred to. ○ Staff completing the discharge summary shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the discharge summary. ○ The discharge summary must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.
Treatment	Level 3.2-WM withdrawal management programs deliver low-intensity clinical and recovery-focused services to assess and address the needs of each individual. Such services may include appropriate medical services, individual and group therapies, and withdrawal support. • Provide SUD services, in accordance with the individual's treatment plan, for a minimum of three (3) hours per week. At least one (1) hour of individual/family therapy must be provided by an independently licensed or associate	Level 3.7-WM withdrawal management programs provide an organized service delivered by medical and nursing professionals, which provides for 24-hour evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. 24-hour observation, monitoring, and treatment are available. • Provide SUD services, in accordance with the individual's treatment plan, for a minimum of five

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	licensed behavioral health practitioner or a graduate-level intern. ○ Up to 25 percent of clinical hours may be provided by a graduate-level intern whose accredited graduate degree program requires their students to participate in intern placements for clinical training in the provision of behavioral health services • A range of evidence-based cognitive, behavioral, medical, mental health, and other therapies are administered to the individual as clinically necessary, depending on the individual's progress through withdrawal management and their assessed needs in Dimensions 2 through 6. These services are designed to enhance the individual's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment. • Facilitate connections to recovery resources and community supports. • Monitoring of the individual's adherence in self-administering any prescribed medications, including medication for addiction treatment (MAT), and/or any permitted over-the-counter (OTC) medications or supplements. • Opportunities for the individual to be introduced to the potential benefits of medication for addiction treatment as a tool to manage their substance use disorder(s). • Access to medication for addiction treatment. The program does not preclude admission of individuals based on MAT profile and active medication prescriptions. If agency cannot support a medication need internally, they have policies in place to ensure communication with prescribing physician is ongoing. • Ability to arrange for appropriate laboratory and toxicology tests. • Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g., HIV, hepatitis C, sexually transmitted diseases) • Services, as appropriate and whenever possible with the individual's consent, for the individual's family and significant others to	(5) hours per week. At least two (2) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern, at least one (1) hour of which must include individual/family therapy. ○ Up to 25 percent of clinical hours may be provided by a graduate-level intern whose accredited graduate degree program requires their students to participate in intern placements for clinical training in the provision of behavioral health services • A range of evidence-based cognitive, behavioral, medical, mental health, and other therapies are administered to the individual as clinically necessary, depending on the individual's progress through withdrawal management and their assessed needs in Dimensions 2 through 6. These services are designed to enhance the individual's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment. • Hourly nurse monitoring of the individual's progress and medication administration are available, if needed. • The program has the ability to deliver emergency psychiatric and emergency medical services or maintains written agreements enabling immediate access for individuals, when needed, to facilities that offer such care. • There shall be written policies and procedures, approved by the medical staff, for the safe prescribing and administration of drugs, and the recording of medication administration. • Medication shall be administered only upon written and signed orders of a practitioner acting within the scope of a license. • An individual medication record shall be maintained for all individuals. • Opportunities for the individual to be introduced to the potential benefits of medication for addiction treatment as a tool to manage their substance use disorder(s). • Access to medication for addiction treatment. The program does not preclude admission of individuals based on MAT profile and active medication prescriptions. If agency cannot support

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	promote positive contribution to the individual's treatment and recovery.	a medication need internally, they have policies in place to ensure communication with prescribing physician is ongoing. • Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g., HIV, hepatitis C, sexually transmitted diseases). • Services, as appropriate and whenever possible with the individual's consent, for the individual's family and significant others to promote positive contribution to the individual's treatment and recovery.
Provider Qualifications/ Staffing	NOTE: Staffing for this LOC may require partnership with DPH to develop new regulations. Currently, the regulations for "Residential Detoxification and Evaluation" programs would apply which exceeds the necessary staffing per ASAM. These areas of discrepancy are highlighted below. Level 3.2-WM programs include an interdisciplinary team of appropriately trained clinicians, licensed and unlicensed practitioners, certified peers and technicians operating within their scope of practice to assess and treat the individual and to obtain and interpret information regarding the individual's needs. Level 3.2-WM programs have support systems that include the availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems. Staff are trained and competent to implement physician-approved protocols for observation and supervision of the individual, determine appropriate level of care and facilitate the individual's transition to continuing care. Facility's staffing pattern is gender responsive and trauma informed. • Minimum on-site staffing requirements (not counting on-call hours) shall be maintained 24 hours per day, 7 days per week as outlined below: ○ 0-24 beds: 2 staff minimum at all times ○ 25-64 beds: 3 staff minimum at all times ○ 65-99 beds: 4 staff minimum at all times ○ 100+ beds: 5 staff minimum at all times - For facilities with multiple levels of care at the same physical address and within the	Level 3.7-WM programs include an interdisciplinary team of appropriately trained clinicians, licensed and unlicensed practitioners, certified peers and technicians operating within their scope of practice to assess and treat individuals and to obtain and interpret information regarding their needs. Facility's staffing pattern is gender responsive and trauma informed. • Minimum on-site staffing requirements (not counting on-call hours) shall be maintained 24 hours per day, 7 days per week as outlined below: ○ 0-24 beds: 2 staff minimum at all times ○ 25-64 beds: 3 staff minimum at all times ○ 65-99 beds: 4 staff minimum at all times ○ 100+ beds: 5 staff minimum at all times – For facilities with multiple levels of care at the same physical address and within the same building and floor, minimum staff ratios can be shared between programs. – If programs share the same address and are separated on different floors or different buildings, the minimum staff requirement shall apply to each floor and building. An exception to this is a 0-24 bed program located in one building in which there are resident rooms on multiple levels of the building (e.g. a house-like setting); only the minimum staffing of two persons would be required. – Any requests to waive the above criteria must be submitted to The Departments for review and approval. • Level 3.7-WM programs must be able to provide 24-hour staff support. Ensure staff who have client

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	same building and floor, minimum staff ratios can be shared between programs. - If programs share the same address and are separated on different floors or different buildings, the minimum staff requirement shall apply to each floor and building. An exception to this is a 0-24 bed program located in one building in which there are resident rooms on multiple levels of the building (e.g. a house-like setting); only the minimum staffing of two persons would be required. - Any requests to waive the above criteria must be submitted to The Departments for review and approval. • Level 3.2-WM programs must be able to provide 24-hour staff support. Ensure staff who have client contact receive training on co-occurring mental health and substance use disorders, including prevalence, signs/symptoms, assessment, treatment and the impact of one's own attitudes/beliefs on the delivery of services and the use of naloxone in response to an opioid overdose. • Where on-call coverage is indicated for any of the below positions, such coverage can be combined across programs within the same agency. • Medical Director: There shall be a physician, licensed in the State who is eligible to be certified by the American Board of Psychiatry and Neurology who is ideally a certified addiction medicine physician or addiction psychiatrist who is available on call during those hours when a physician is not physically present. • Executive Director: Each facility shall have an executive director who is accountable to the governing authority. The executive director shall be responsible for the management of the facility • Medical evaluation and consultation is available 24 hours a day, in accordance with treatment/transfer practice protocols and guidelines. • There shall be a pharmacist, currently licensed in the State of Connecticut, who shall be	contact receive training on cooccurring mental health and substance use disorders, including prevalence, signs/symptoms, assessment, treatment and the impact of one's own attitudes/beliefs on the delivery of services and the use of naloxone in response to an opioid overdose. • Medical Director: There shall be a physician, licensed in the State who is eligible to be certified by the American Board of Psychiatry and Neurology who is ideally a certified addiction medicine physician or addiction psychiatrist who is available on call during those hours when a physician is not physically present. • Where on-call coverage is indicated for any of the below positions, such coverage can be combined across programs within the same agency. • Executive Director: Each facility shall have an executive director who is accountable to the governing authority. The executive director shall be responsible for the management of the facility • There shall be a pharmacist, currently licensed in the State of Connecticut, who shall be responsible for the supervision of the pharmaceutical services. • A physician currently licensed in the State and who is eligible to be certified by the American Board of Psychiatry and Neurology (or a PA or registered nurse practitioner) is available for on-site psychiatric consultation as needed and as appropriate to the severity and urgency of the individual's condition. • A physician (or NP/PA) is available to assess the individual in person within 24 hours of admission and thereafter as medically necessary. This provider also oversees the medical treatment process and assures the quality of care. The provider of such services should be knowledgeable about addiction treatment, especially pharmacotherapies. ○ Any physical examination that is performed by a PA or NP shall be dated and countersigned by a physician within 72 hours signifying their review of and concurrence with the findings. ○ The physician (or NP/PA) provides oversight to the nursing staff who carry out the medical orders. Orders should not exceed the nurse or ordering practitioner's scope of practice.

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	responsible for the supervision of the pharmaceutical services.
	• A physician (or NP/PA) is available to review and countersign the admission assessment within 72 hours
	  ○ A physical examination by a physician (or NP/PA) as part of the initial assessment shall occur within 24 hours of admission (or earlier, if medically necessary).
	  ○ The physician (or NP/PA) provides oversight to the nursing staff who carry out the medical orders. Orders should not exceed the nurse or ordering practitioner's scope of practice.
	  ○ The physician shall be on call 24 hours per day by telephone during those hours when a physician is not physically present.
	• A registered nurse, who is currently licensed in the State, is available to conduct an alcohol or other drug focused nursing assessment at the time of admission.
	  ○ There shall be on each shift at least one registered nurse. In each separate residential withdrawal management unit there shall be at all times a licensed nurse and other technicians on duty to meet the needs of the clients.
	  ○ The RN works under the direction and orders of a licensed physician (or NP/PA). Orders should not exceed the nurse or ordering practitioner's scope of practice.
	  ○ Appropriately licensed and credentialed staff is available to administer medications or monitor an individual's self-administration in accordance with physician orders.
	• Employs a clinical supervisor with authority over all behavioral health treatment services, who shall have a minimum of a master's degree in a behavioral health treatment services field, at least three (3) years of full-time work experience in SUD services and be independently licensed by the state of Connecticut in their respective discipline.
	  ○ The Clinical Supervisor must be on-site at least 40 hours per week with at least one evening shift per week. Larger programs may require additional clinical supervisor
		○ The physician shall be on call 24 hours per day by telephone during those hours when a physician is not physically present.
		• A nurse is responsible for overseeing the monitoring of the individual's progress and medication administration or self-administration on an hourly basis, if needed.
		  ○ A registered nurse, who is currently licensed in the State, is available to conduct an alcohol or other drug focused nursing assessment at the time of admission.
		  ○ There shall be on each shift at least one registered nurse. In each separate residential withdrawal management unit there shall be at all times a licensed nurse and other technicians on duty to meet the needs of the clients.
		  ○ Appropriately licensed and credentialed staff is available to administer medications or monitor an individual's self-administration in accordance with physician orders.
		  ○ The RN works under the direction and orders of a licensed physician (or NP/PA). Orders should not exceed the nurse or ordering practitioner's scope of practice.
		• Employs a clinical supervisor with authority over all behavioral health treatment services, who shall have a minimum of a master's degree in a behavioral health treatment services field, at least three years of full-time work experience in SUD services and be independently licensed by the State in their respective discipline.
		  ○ The Clinical Supervisor must be on-site at least 40 hours per week with at least one evening shift per week. Larger programs may require additional clinical supervisor hours to ensure all supervision requirements are met as detailed in the "Supervision Requirements" section below.
		  ○ The Clinical Supervisor conducts and documents face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month.
		  ○ There shall be 24-hour on-call coverage by telephone during those hours when the clinical supervisor is not physically present.

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	hours to ensure all supervision requirements are met as detailed in the "Supervision Requirements" section below. ○ The Clinical Supervisor conducts and documents face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month. ○ There shall be 24-hour on-call coverage by telephone during those hours when the clinical supervisor is not physically present. • An independently licensed or associate licensed behavioral health practitioner is available to provide a minimum of 1 hour (of the total 3 hours of weekly programming) of individual/family therapy per week. ○ Up to 25 percent of clinical hours may be provided by a graduate-level intern whose accredited graduate degree program requires their students to participate in intern placements for clinical training in the provision of behavioral health services ○ At least one behavioral health practitioner per 16 residents is onsite 40 hours per week ○ Any behavioral health practitioner who is not independently licensed must be working under an independently licensed behavioral health practitioner who must sign off on clinical documentation and provide supervision. ○ Clinical staff should be knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment. Clinical staff should be able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation. ○ Clinical groups should be limited to no more than 12 group members regardless of payer. Psychoeducational and non-clinical groups should be limited to no more than 25 group members. ○ All behavioral health practitioners who assess and treat individuals are able to obtain and interpret information regarding	• An independently licensed or associate licensed behavioral health practitioner is available to provide a minimum of 2 hours (out of the 5 total hours of weekly programming) of clinical treatment per week. At least 1 of these hours includes individual/family therapy. ○ Up to 25 percent of clinical hours may be provided by a graduate-level intern whose accredited graduate degree program requires their students to participate in intern placements for clinical training in the provision of behavioral health services. ○ At least one behavioral health practitioner per 16 residents is on-site 40 hours per week. ○ Any behavioral health practitioner who is not independently licensed must be working under an independently licensed behavioral health practitioner who must sign off on clinical documentation and provide supervision. ○ Clinical staff should be knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment. Clinical staff should be able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation. ○ Clinical groups should be limited to no more than 12 group members regardless of payer. Psychoeducational and non-clinical groups should be limited to no more than 25 group members. ○ At least one behavioral health practitioner with competence in the treatment of substance use and mental health disorders is available by telephone 24 hours a day, seven days a week when not on-site. • Technicians are available onsite, as needed, to ensure minimum staffing requirements are met and are awake and monitoring individuals' needs at all times. ○ Technicians may provide the additional remaining hours of weekly programming ○ Technicians report to a Tech Supervisor (or other leadership position) with at least 6 months experience in residential SUD programs.

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	the needs of these individuals. Such knowledge includes the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the appropriate treatment and monitoring of those conditions and how to facilitate entry into ongoing care. ○ At least one behavioral health practitioner with competence in the treatment of substance use and mental health disorders is available by telephone 24 hours a day, seven days a week when not on-site. • Technicians are available onsite, as needed, to ensure minimum staffing requirements are met and are awake and monitoring individuals' needs at all times. ○ Technicians may provide the additional remaining hours of weekly programming ○ Technicians report to a Tech Supervisor (or other leadership position) with at least 6 months experience in residential SUD programs. • Certified Peers may provide the additional remaining hours of weekly programming and may meet with residents individually and/or in group formats to support their ongoing engagement, retention and progress in treatment. ○ Certification must be obtained by one of the state-approved certification boards. ○ Certified Peers should be onsite while residents are awake, including presence on evenings and weekends. Number of Certified Peers required depends on the size of the program: ▪ 0-32 beds: 1 peer onsite at least 40 hours per week ▪ 33-64 beds: 2 peers onsite at least 40 hours per week each ▪ 65+ beds: 3 peers onsite at least 40 hours per week each ○ Certified peers receive one hour of clinical supervision weekly, of which group supervision may be utilized once a month. This supervision can be provided by: ▪ The Clinical Supervisor (as defined above);	• Certified Peers may provide the additional remaining hours of weekly programming and may meet with residents individually and/or in group formats to support their ongoing engagement, retention and progress in treatment. ○ Certification must be obtained by one of the state-approved certification boards. ○ Certified Peers should be onsite while residents are awake, including presence on evenings and weekends. Number of Certified Peers required depends on the size of the program: ▪ 0-32 beds: 1 peer onsite at least 40 hours per week ▪ 33-64 beds: 2 peers onsite at least 40 hours per week each ▪ 65+ beds: 3 peers onsite at least 40 hours per week each ○ Certified peers receive one hour of clinical supervision weekly, of which group supervision may be utilized once a month. This supervision can be provided by: ▪ The Clinical Supervisor (as defined above); ▪ An independently licensed or associate licensed behavioral health practitioner with at least 2 years of full-time work experience in SUD services; or ▪ A Certified Peer with at least 2 years of full-time experience in providing peer support services. • A dedicated Service Coordinator that manages incoming referrals and discharge plans is required for each facility. The purpose of the Service Coordinator is to promote engagement and retention in treatment and facilitate an effective discharge plan whereby the resident successfully connects to the next level of care. The service coordinator facilitates referral arrangements and coordination with aftercare. ○ The Service Coordinator can also assist in networking individuals into community-based ancillary or "wrap-around" services to build/maintain recovery capital. ○ The service coordinator shall be on-site weekdays during 1st shift for at least 80% of the time. The other 20% may be done second, third or weekend shifts.

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	▪ An independently licensed or associate licensed behavioral health practitioner with at least 2 years of full-time work experience in SUD services; or ▪ A Certified Peer with at least 2 years of full-time experience in providing peer support services. • A dedicated Service Coordinator that manages incoming referrals and discharge plans is required for each facility. The purpose of the Service Coordinator is to promote engagement and retention in treatment and facilitate an effective discharge plan whereby the individual successfully connects to the next level of care. The service coordinator facilitates referral arrangements and coordination with aftercare. ○ The Service Coordinator can also assist in networking individuals into community-based ancillary or "wrap-around" services to build/maintain recovery capital. ○ The service coordinator shall be on-site weekdays during 1st shift for at least 80% of the time. The other 20% may be done second, third or weekend shifts. ○ The Service Coordinator may be a licensed practitioner, unlicensed counselor, or certified peer. • Each facility shall have at least one staff person in each building, when a resident is known to be present and who shall have immediate access to back up staff, for urgent or emergency situations. This is inclusive of the positions described above.	○ The Service Coordinator may be a licensed practitioner, unlicensed counselor, or certified peer. • Each facility shall have at least one staff person in each building, when a resident is known to be present and who shall have immediate access to back up staff, for urgent or emergency situations. This is inclusive of the positions described above.
Supervision Requirements	Supervisors conduct and document face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month. Certified peers with lived experience receive clinical supervision 1 hour weekly, of which group supervision may be utilized once a month – this can be from: the Clinical Supervisor; an independently licensed or associate licensed behavioral health practitioner with at least 2 years of full-time work experience in SUD services; or a Certified Peer with at least 2 years of full-time experience in providing peer support services. Technicians receive supervision from the Tech Supervisor or other leadership position for 30 minutes for every 40 hours worked. Tech administrative supervision can be in a group setting for all but one time a month. Techs must receive monthly group clinical supervision with a potential shift overlap (All staff meeting at least once a month). There should be a shift report or hand off for every shift or staggered starts.	

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Target Length of Stay	The individual continues in a Level 3.2-WM withdrawal management program until withdrawal signs and symptoms are sufficiently resolved that they can be safely managed at a less intensive level of care; or alternatively, the individual's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a more intensive level of withdrawal management service is indicated.	The individual continues in a Level 3.7-WM withdrawal management program until withdrawal signs and symptoms are sufficiently resolved that they can be safely managed at a less intensive level of care; or alternatively, the individual's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a Level 4-WM intensive level of withdrawal management service is indicated.

JBCSSD Contractor Requirements

Conduct statewide JBCSSD client screenings **within two weeks of the date of referral.** Screenings may occur at probation offices, courts or DOC facilities.

Immediately following the screening period the referral source must be notified in writing of program acceptance or denial. If the client is denied, state the reasons why and discharge client in CDCS as “ineligible for program”. If accepted, supply an acceptance letter to the referral source and, when possible, indicate to the referral source when a bed will be available.

Provide transportation to and from court appearance, probation offices, offsite evaluations etc.

Provide court reports to Bail staff **2 days prior to the scheduled court appearance.**

When planning aftercare for all JBCSSD clients leaving treatment, please coordinate with local JBCSSD staff and whenever possible, utilize the **JBCSSD contracted network of programs**.

UPDATE CDCS

- Scheduled screening and admission dates should be updated in CDCS **no later than 24 hours** from the time the date is scheduled
- Actual screening and admission dates should be updated in CDCS **no later than 24 hours** from the time the action took place
- Discharge dates should be updated in CDCS **no later than 24 hours from the time the client left your program**
- Acknowledge JBCSSD referrals in CDCS **within 24 hours**

REPORTING

- Immediate notification by phone to the referral source and by phone or email to JBCSSD central office for **all incidents** including when a JBCSSD client leaves the program AMA or absconds; followed by a written incident report within 24 hours.
- Provide Monthly reports to probation officers by the 10th day of the month.
- Provide notification/communication with referral source around non-compliance at the time of occurrence. When possible, include the referral source in sanctioning.

SECURITY

- Conduct searches of clients, visitors and packages. Search all JBCSSD clients when returning to the building. All visits should be supervised.
- Room searches shall be conducted randomly, weekly at minimum and documented in a log. Perimeter checks shall be conducted minimally once per shift.
- Random urinalysis (weekly), immediate notification by phone to referral source if positive, follow up with written **notification within 24 hours**. Additional urinalysis shall be conducted upon client return from pass or if substance use is suspected.

PRE-TRIAL CLIENTS

Pre-trial clients will not be discharged unsuccessfully for non-compliance of programs rules without court approval.

If wishing to be relieved of supervision of a JBCSSD pre-trial client, place a redocket request in writing to the appropriate bail commissioner. The request must include the reasons for the request for relief of supervision and must be clearly stated. It is recommended that the agency is represented at court on the date of the appearance to answer any questions regarding the request.

A redocket/request for removal from the program is NOT a guarantee that the client will not be returned to your program. The decision rests with the court.