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Service Transformation Toolkit and Guide

PROVIDER AMBASSADOR PROGRAM

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Service Transformation Toolkit and Guide:
ASAM LOC 3.2-WM (3rd Ed.) to 3.1 (4th Ed.)

Contents

Introduction

The release of the ASAM Criteria, Fourth Edition includes significant updates regarding how levels of care are defined and delivered- notably, Level 3.2-WM (Clinically Managed Residential Withdrawal Management) has been removed as a distinct service category. In alignment with this national shift, the State of Colorado is actively updating its behavioral health service delivery system to reflect these evidence-based standards. This transition is part of a broader commitment to improving quality of care, individual outcomes, and system alignment with best practice models.

Colorado is not losing a level of care. Rather, the state is advancing toward a more integrated, person-centered model where withdrawal management is no longer isolated but instead embedded across the continuum of behavioral health services. The ASAM Fourth Edition emphasizes that withdrawal management and access to medications for addiction treatment (MAT) should be flexibly delivered in settings that are clinically appropriate for the individual- whether in outpatient, residential, or medically managed environments- based on the individual's full clinical picture and multidimensional needs.

This shift creates an opportunity for agencies currently operating under the 3.2-WM model to transition toward services that are more comprehensive and aligned with best practices, such as ASAM Level 3.1 (Clinically Managed Low-Intensity Residential Treatment). ASAM 3.1 is designed to support individuals with substance use disorders and co-occurring mental health and functional impairments who require structure and support to build and practice recovery and coping skills. This is accomplished through the provision of between 9-19 weekly hours of structured clinical programming within a clinically managed and structured therapeutic milieu.

This document is intended to support providers navigating this transition. It outlines what a shift from 3.2-WM to ASAM Level 3.1 entails, highlights key updates in the Fourth Edition, and provides tools and guidance to help agencies align with Colorado's evolving system of care- while continuing to meet the needs of the communities they serve.

To effectively use this tool, start with the Service Type Comparison tool and the Implementation Workflow to identify the areas with the most urgent gaps in compliance. From here, based on your agency's identified needs, prioritize the use of the other tools outlined in this guide to ensure your agency is working toward meeting compliance for this level of care.

1. Use the Service Type Comparison Tool to evaluate whether this level of care is right for your agency

When mapping how best to begin planning for a transition to the ASAM 3.1 level of care, agencies can benefit significantly from using a structured resource that compares the agency's current programming, personnel, and operations in 3.2-WM to the expectations outlined in the ASAM Fourth Edition for the 3.1 level of care.

To use the Comparison Tool effectively, agency leaders and multidisciplinary teams should carefully read through each section, to identify areas where the agency is fully aligned, partially aligned, or not aligned at all with ASAM 3.1 expectations. This process provides a clear understanding of current strengths as well as gaps that would need to be addressed to meet the standard.

Agencies must consider the initial feasibility of addressing any gaps identified. For each misalignment, it's important to ask: Do we have the personnel, funding, and infrastructure to meet this expectation? Would this shift be sustainable with our current resources? Are we prepared to make operational or philosophical changes to support this level of care?

Equally important is evaluating the community's needs. ASAM 3.1 is a structured and moderately resource-intensive level of care. Agencies must examine whether there is a need for this service in the communities they serve in comparison to other service types offered in this transition. This includes understanding referral volume, community needs, and existing provider capacity.

Review of this Comparison Tool is the first step in an agency's strategic planning process. It provides the foundation for identifying gaps and related needs. In some cases, the crosswalk may reveal that transitioning to ASAM 3.1 is the right next step. In others, it may point toward strengthening existing services or pursuing a different level or type of care that better fits the agency's mission and capacity.

In all cases, starting with a comprehensive understanding of the ASAM Criteria and a structured review process through the crosswalk ensures that agencies are starting with a comprehensive understanding of what a transition to ASAM 3.1 level of care would entail.

Agency Service Type Comparison tool: 3.2-WM to 3.1

2. Ensure a Comprehensive Understanding of All Aspects of ASAM LOC 3.1

Starting an agency transformation with a full understanding of the ASAM Criteria, Fourth Edition is essential. The ASAM Criteria serves as a national standard for the assessment, placement, treatment planning, and service delivery for individuals with

substance use and co-occurring disorders. The Fourth Edition builds on decades of clinical research and real-world application, offering updated, clearer guidance that better aligns with person-centered care, health equity, and the integration of services across systems.

It's important to note that the 3.1 level of care is not simply "3.2-WM with more therapy." This is a clinically focused, 24-hour, integrated treatment model designed for individuals with significant substance use disorders, and co-occurring biopsychosocial needs, where individuals can apply recovery and coping skills in a safe setting. Clarity on the population and guidelines is critical to ensuring compliance with the model.

Individuals being admitted to a 3.1 level of care have multiple limitations, often across Dimensions 4 and 5. The individuals suitable for 3.1 have a *moderate likelihood* of engaging in substance use or substance use disorder (SUD)- related behaviors with significant risk of serious harm or destabilizing loss AND require residential structure and 24-hour clinically managed support to prevent these risks.[1]

Individuals in this level of care are able to safely leave the facility without supervision to participate in community activities, work, and school. However, appropriate accountability measures should be in place, and some individuals may initially need the support of supervision and/or group outings to practice recovery skills prior to leaving the agency alone. Because individuals at this level of care are preparing to re-enter the community, agencies should establish formal care coordination partnerships to provide community living skills, education/vocational skills, family reunification and other recovery skills while the person is in the 3.1 setting and for planning their transition to the community. Care coordination agreements should be formal with specific requirements for communication, data sharing, and referral timelines.

Goals for the individual served at this level of care include:

- Promoting remission of SUD
- Arresting other addictive and maladaptive behaviors
- Promoting changes in the individual's ways of thinking to support long-term recovery
- Community reintegration

[1]Waller RC, Boyle MP, Daviss SR, et al, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions, Volume 1: Adults*. 4th ed. Hazelden Publishing: 2023

It is recommended that, to begin this process, agency leadership and key agency personnel start with completing trainings in the ASAM Fourth Edition through ASAM directly and/or through state-approved trainers. Key areas to consider include:

- Understanding developments in the Fourth Edition
- Reviewing the evolution of the six dimensions of ASAM assessment
- Fully understanding the requirements in the ASAM levels of care, particularly 3.1

Here are some tools that your agency can use to get started:

- ASAM Fourth Edition Level 3.1 Compliance Workflow
- ASAM 3.1 Trainings
- ASAM Fourth Edition E-Learning

3. Conduct a Thorough Agency Assessment and Gap Analysis and Implementation Plan with Reasonable Timelines

Before an agency can effectively transition from ASAM 3.2-WM to 3.1, your organization must have a clear and realistic understanding of its current capabilities, infrastructure, and service delivery model. An agency assessment and gap analysis is more than a checklist- it's a strategic opportunity to uncover strengths, identify limitations, and prioritize areas for investment and improvement.

Key Areas for Evaluation Include:

Personnel Structure

Each agency will need to complete a comprehensive assessment of its current personnel structure in comparison to ASAM 3.1 to identify any gaps that will need to be met prior to implementation. The tool below can help agencies begin this process:

- Personnel Crosswalk

Why it matters: ASAM 3.1 expects a team of qualified professionals available 24/7 to address the clinical needs of residents, not just basic support or observation.

Use of ASAM Dimensions In Assessment and Documentation

Understanding the ASAM Fourth Edition's dimensions, subdimensions and risk ratings is essential for any program planning to operate at the ASAM 3.1 Level of Care. The six dimensions outlined by ASAM serve as the core framework for individualized, person-centered care. They not only guide how treatment decisions are made, but also how services are tailored, delivered, and documented throughout an individual's treatment journey.

For Level 3.1, which supports individuals with moderate needs and functional impairments, these dimensions help ensure that care is responsive, not rigid. Each dimension (intoxication, withdrawal, and addiction medications; biomedical conditions; psychiatric and cognitive conditions; substance use and related risks; recovery environment interactions; and person-centered considerations) provides insight into an individual's unique situation and what support is needed at this level of care. This lens is critical for ensuring that treatment is tailored to the unique needs of the individual and that services are aligned to best practices.

Additionally, agencies should ensure that the six dimensions are incorporated into documentation and treatment planning. This helps justify the necessity of 3.1 services and guides clinicians in shaping individualized treatment plans. Documentation that reflects the dynamic nature of each dimension over time also demonstrates clinical decision-making and progress, which is crucial for audits, payer reviews, and internal quality improvement.

Moreover, embedding the ASAM dimensions into everyday documentation- including intake, treatment planning, service delivery, and transition planning - promotes a shared language among multidisciplinary teams. It ensures that the individual's needs are being communicated clearly and consistently across team members, supervisors, and external reviewers.

To ensure your agency meets these requirements, please refer to the ASAM Fourth Edition Manual. Additionally, to guide this exploration, consider the items below:

- Are personnel currently trained and fluent in using ASAM's six dimensions and subdimensions?
- Are personnel trained and able to use the Fourth Edition risk ratings?
- Is the ASAM assessment completed at intake, and are all six dimensions incorporated into treatment planning?
- Are re-assessments conducted weekly to guide continued stay and discharge planning?
- Are clinical personnel able to justify the level of care for prior authorization and reauthorization?

Why it matters: The Fourth Edition emphasizes using the six dimensions continuously to guide clinical decisions- not just at admission. Documentation should demonstrate alignment with the individual's progress and evolving needs and movement through the levels of care based on the multi-dimensional assessment.

Physical Environment

Attending to the physical plant- the design, layout, and condition of the treatment environment- is a critical but often underappreciated aspect of the successful implementation of ASAM Level 3.1. The ASAM Fourth Edition emphasizes that the

physical environment is not merely a backdrop for care- it is an important part of the therapeutic journey of the individual.

ASAM 3.1 is intended for individuals with moderate functional impairment who require a structured, supportive, and recovery-focused living environment. These are often individuals with co-occurring disorders, histories of trauma, or unstable social supports. Therefore, the physical environment must create a safe, respectful, and trauma-informed environment that supports stabilization, dignity, and engagement in treatment.

A well-maintained and thoughtfully designed physical plant promotes psychological and physical safety, both of which are foundational to effective treatment. Safety also includes environmental predictability. A physical plant that is consistently maintained, well-lit, and organized reduces stress and confusion- especially for individuals navigating early recovery, cognitive challenges, physical discomfort, and/or mental health symptoms.

In residential treatment, the environment is the framework for the therapeutic milieu. The physical space should reflect the values of recovery: empowerment, inclusion, respect, structure, and hope. Key features that promote recovery include:

- **Welcoming and normalized spaces** that reflect comfort and autonomy, not punishment or control.
- **Designated areas for skill-building and recreation**, which are essential to recovery capital development and recurrence prevention.
- **Spaces that accommodate cultural, linguistic, and physical accessibility**, ensuring every individual feels respected and valued.
- **Community areas** that promote pro-social engagement, relationship-building, and peer support.

Additionally, a high-quality physical environment signals to individuals served and personnel that their well-being is a priority. It reflects a trauma-informed, person-centered ethos and helps reduce resistance to treatment by making individuals feel safer and more at ease.

To evaluate your agency's compliance with ASAM's requirements for 3.1 level of care, please refer to the tool below:

- ASAM 3.1 Physical Plant Tracking Tool

Why it matters: A 3.1-level facility must go beyond basic shelter. The setting should reflect a structured, therapeutic, and professional care environment, including adequate space for clinical services and supervision.

Policies and Procedures

Clear alignment of policies and procedures with the ASAM Fourth Edition standards for Level 3.1 Clinically Managed Low-Intensity Residential Treatment is a cornerstone of successful implementation. While clinical skills, strong leadership, and a well-designed environment are essential, they must be underpinned by clear, intentional documentation that reflects both the spirit and structure of the ASAM Criteria. Without this alignment, agencies risk inconsistencies in care delivery, confusion among personnel, and non-compliance with licensing, accreditation, and payer requirements.

Why Policy Alignment Matters

1. Alignment Operationalizes the Standard

ASAM 3.1 is a detailed clinical model with expectations around personnel, treatment type and amount, milieu structure, co-occurring capability, and recovery supports. Policies and procedures are how these expectations are translated into *everyday operations*. They clarify what is expected, how tasks are executed, who is responsible, and what fidelity looks like in practice.

2. Alignment Supports Personnel Consistency and Accountability

Clear policies reduce variation in how care is delivered, especially in 24/7 residential settings with large interdisciplinary teams. When expectations for assessment, treatment planning, crisis response, and use of evidence-based practices are documented, personnel are better able to deliver these services. This clarity also supports performance management, supervision, and onboarding of new employees.

3. Alignment Protects the Rights of Individuals Serves and Ensures Equity

ASAM Fourth Edition emphasizes individualized, person-centered, and equitable care. Policies aligned with ASAM should include mechanisms for incorporating the voice of the individual served, protecting rights, offering culturally responsive services, and reducing stigma- especially around co-occurring conditions and the use of MAT. These values must be codified to become standard practice, not left to chance or individual interpretation.

4. Alignment Demonstrates Regulatory and Reimbursement Readiness

Having clear, ASAM-aligned policies in place makes it easier for agencies to respond to audits, justify levels of care, and demonstrate compliance. Strong policies and procedures support agencies in sustaining funding or achieving licensure and certification.

5. Alignment Guides Change Management

Transitioning to ASAM 3.1 requires significant change- for personnel, systems, and culture. Clear policies serve as anchor points during this transition, helping teams navigate change with clarity and purpose.

To evaluate where your agency is regarding policies and procedures, please utilize the tool below:

- ASAM 3.1 Policy Alignment Tool

4. Ensure Programming is Co-occurring Capable

Being co-occurring capable is a critical component of delivering high-quality care under the ASAM Fourth Edition, especially at the Level 3.1 level of care. The Fourth Edition reflects a significant evolution in how substance use and mental health disorders are understood- as conditions that frequently coexist and interact in ways that impact treatment needs, outcomes, and recovery.

Many individuals in this level of care have co-occurring mental health disorders that may not rise to the level of requiring psychiatric hospitalization but are serious enough to interfere with daily functioning, engagement in treatment, and recovery progress. The ASAM Fourth Edition explicitly requires agencies at this level to be co-occurring capable, meaning they must be equipped to recognize, assess, and provide appropriate services for both substance use and mental health conditions in an integrated and coordinated manner.

Failing to address co-occurring disorders can lead to misdiagnosis, disengagement, recurrence, and readmission. Agencies that are not co-occurring capable are not able to deliver high-quality care because they are unable to provide the stabilization and skill-building necessary for long-term recovery.

In contrast, co-occurring capable agencies can offer a more person-centered, trauma-informed, and effective care experience, increasing the likelihood of improved retention, reduced symptom severity, and successful transitions to lower levels of care. This aligns directly with ASAM's multidimensional assessment approach, which emphasizes the interconnectedness of the whole person in driving treatment decisions.

At a minimum, ASAM requires the following:

- Agencies should complete integrated treatment plans that address substance use, mental health, and physical health conditions in a coordinated manner.
- Agencies should accept and actively welcome individuals with co-occurring mental health and substance use disorders.

- Agencies should screen for, identify, and document the presence of any co-occurring mental health or medical concerns- regardless of whether formal diagnoses have been made.
- Agencies should collaborate with existing mental health providers, including obtaining prior assessments and treatment information and maintaining coordinated care throughout the course of treatment.
- Agencies should arrange additional mental health, psychiatric, or medical assessments (including diagnostic evaluations) as clinically indicated.
- Agencies should engage individuals through integrated treatment teams that coordinate care across SUD, mental health, and medical domains.
- Agencies should assess each individual's stage of change for both mental health and medical concerns and provide stage-matched interventions.
- Agencies should educate individuals about their mental health conditions and the range of interventions available to help manage them effectively.
- Agencies should support individuals in developing skills to work with prescribers, initiate or adjust medications as needed, and adhere to prescribed regimens.
- Agencies should routinely incorporate discussion of co-occurring conditions into therapeutic groups, individual sessions, and overall programming.
- Agencies should foster a culture that supports co-occurring recovery.
- Agencies should ensure that transition and discharge planning addresses ongoing mental health and medical needs, including follow-up care and coordination.[2]

To take a deeper dive into whether your agency is co-occurring capable, consider using the following tools:

- Dual Diagnosis Capability in Addiction Treatment Toolkit [https://case.edu/socialwork/centerforebp/sites/default/files/2021-03/ddcattoolkit.pdf]
- Dual Diagnosis Capability in Mental Health Treatment Toolkit [https://med.stanford.edu/content/dam/sm/cdi/documents/ddcmhttoolkit4.0.pdf]

Why it matters: It is well-established that the presence of co-occurring conditions is an expectation, not the exception in individuals with SUD. For individuals seeking SUD treatment, addressing mental health and SUD needs in the same place at the same time, by the same team is more effective.[3] Thus, the Fourth Edition has the expectation that all programs are co-occurring capable.

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[2] Waller RC, Boyle MP, Daviss SR, et al, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions, Volume 1: Adults*. 4th ed. Hazelden Publishing: 2023

[3] Id.

5. Embed Trauma-Sensitive Practices

Being trauma-informed is a foundational expectation under the ASAM Fourth Edition because individuals often present with complex, layered histories of trauma, including abuse, neglect, incarceration, homelessness, and systemic oppression. Trauma is a universal factor in the lives of many individuals with substance use, including those with co-occurring mental health disorders. Failing to address trauma and maintain a trauma-informed environment can significantly undermine treatment effectiveness.

ASAM Fourth Edition emphasizes that trauma-informed care must be embedded into the culture, personnel, clinical practices, and physical environment of a program. This approach goes beyond simply identifying trauma histories; it involves understanding how trauma affects the brain, behavior, and capacity to engage in treatment. Trauma can manifest in hypervigilance, avoidance, emotional dysregulation, or mistrust of authority- behaviors that, if misunderstood, may be mislabeled as nonadherence or resistance.

All individual-facing personnel must have comprehensive training and working knowledge of trauma-informed care tenants and have structured supervision that maintains these standards.

Agencies that are not trauma-informed risk re-traumatizing individuals through triggering settings, rigid rules, punitive responses, or clinical models that overlook the role of past experiences in shaping current behavior. In contrast, trauma-informed agencies recognize that safety, trust, and empowerment are essential to engagement, retention, and recovery.

Primary Tenets of Trauma-Informed Care (per ASAM Fourth Ed. and SAMHSA principles):

1. **Safety** – Individuals and personnel should always feel physically and emotionally safe. This includes creating an environment that is predictable, respectful, and free from harm or humiliation.
2. **Trustworthiness and Transparency** – Agencies must operate with transparency in policies, procedures, and decision-making to build trust with individuals who may have experienced betrayal or coercion in past care settings.
3. **Peer Support** – Lived experience is a key part of trauma recovery. Peer roles are intentionally integrated to model hope, connection, and empowerment.
4. **Collaboration and Mutuality** – Personnel and individuals served share power and decision-making where possible. The goal is to shift from a hierarchical "expert" model to a collaborative relationship.

5. **Empowerment, Voice, and Choice** – Individuals are supported in regaining a sense of control over their treatment and recovery. Their preferences, strengths, and goals are respected.
6. **Cultural, Historical, and Gender Responsiveness** – Trauma cannot be separated from systemic and historical oppression. Agencies must recognize and respond to the impact of racism, homophobia, sexism, and other forms of discrimination.

To evaluate your agency's current alignment with trauma-informed care standards, please refer to the tool below. This tool includes key information regarding screening tools, services, and program evaluation:

- SAMHSA TIP 57: Trauma-Informed Care [https://library.samhsa.gov/product/tip-57-trauma-informed-care-behavioral-health-services/sma14-4816]

Why it matters: Studies show that individuals living with SUDs experience higher levels of physical, emotional, and sexual trauma. Trauma-focused therapy delivered alongside addiction treatment can reduce the severity of PTSD post-treatment. The expectation is that agencies are prepared to provide integrated care that considers the needs of these individuals.[4]

6. Promote Cultural Humility

Cultural humility is identified in the ASAM Fourth Edition as an essential principle of person-centered, recovery-oriented care. Unlike cultural competence- which implies mastery over a body of knowledge- cultural humility is an ongoing process of self-reflection, learning, and respectful engagement with individuals whose identities, histories, and lived experiences may differ significantly from those of the provider or the majority culture.

ASAM emphasizes that delivering effective care requires more than clinical knowledge. It requires the ability to recognize and respond to the cultural, historical, racial, gender, spiritual, and linguistic factors that influence an individual's understanding of substance use, mental health, recovery, and healing. This is particularly important in residential settings, where individuals bring their full selves into care, often including experiences of trauma related to racism, sexism, homophobia, transphobia, religious discrimination, immigration stress, and systemic oppression. An agency cannot profess to be trauma-informed without having a strong foundation of cultural humility and responsiveness.

[4] Waller RC, Boyle MP, Daviss SR, et al, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions, Volume 1: Adults*. 4th ed. Hazelden Publishing: 2023

The Fourth Edition also ties cultural humility directly to health equity, asserting that treatment systems must actively work to eliminate disparities in access, quality, and outcomes for historically marginalized populations. This means not only modifying the content of services, but also transforming the attitudes, structures, and systems that have historically excluded or harmed certain communities.

ASAM highlights that evidence-based interventions are often tested and evaluated in relation to majority populations, which calls into question their efficacy for other groups. Similarly, treatment structures are often designed in ways that are familiar to majority populations and may not feel inclusive to others. To be culturally humble and responsive, the following is recommended:

- Agencies must regularly conduct community needs assessments to understand the demographics, cultures, and unique needs of the populations they serve.
- Agencies must train and supervise *all* personnel to develop awareness of how individuals' identities and cultural backgrounds influence health beliefs, behaviors, and engagement in care.
- Agencies must train and supervise *all* personnel to explore how their own identities, biases, and cultural experiences shape their perceptions, clinical judgments, and interactions with individuals served.
- Agencies must utilize culturally focused and responsive assessment and screening tools to identify cultural nuance that may impact treatment planning and recovery
- Agencies must engage individuals served in collaborative, culturally informed decision-making throughout the treatment process.[5]

The link below contains information from SAMHSA regarding culturally responsive care. This resource includes agency and clinician self-assessments, tools that are culturally responsive or culturally neutral, and more:

- SAMHSA TIP 59: Improving Cultural Competence [https://library.samhsa.gov/product/tip-59-improving-cultural-competence/sma15-4849]
- National Association of Addiction Treatment Providers' Stage of Change Assessment: https://online.fliphtml5.com/xqpok/dyrr/#p=1
- National Association of Addiction Treatment Providers' Organizational Assessment Tool: https://online.fliphtml5.com/xqpok/cdum/

Why it matters: Studies show pervasive racial and ethnic disparities in care leading to poor outcomes and culture influences how individuals/families perceive and

[5] Waller RC, Boyle MP, Daviss SR, et al, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions, Volume 1: Adults*. 4th ed. Hazelden Publishing: 2023

understand SUD and the need for treatment.[6] Thus all levels of care are expected to practice cultural humility.

Social Determinants of Health

In the ASAM Fourth Edition, the consideration and screening for Social Determinants of Health (SDOH) is recognized as a vital component of delivering effective, high-quality, person-centered care. The 3.1 level of care is designed for individuals with functional impairments across multiple life areas, many of which are related to social determinants such as housing instability, poverty, food insecurity, lack of access to healthcare, and systemic discrimination.

For care at Level 3.1 to be effective, providers must identify and respond to the barriers that may hinder an individual's ability to engage in treatment or sustain recovery. This aligns with ASAM's multidimensional assessment framework, particularly Dimension 6: Person-Centered Considerations, which calls for evaluating an individual's preferences, barriers to accessing and remaining in care, and need for motivational enhancement interventions.

At the 3.1 level, there is a critical opportunity and responsibility to conduct routine screening for SDOH needs as part of the intake and transition planning process. This may include assessing for:

- Safe and stable housing
- Transportation access
- Financial insecurity
- Access to nutritious food
- Legal concerns
- Employment or education barriers
- Childcare and/or caregiving needs
- Access to culturally responsive care and community resources

Identifying these needs early allows providers to integrate wraparound supports into the treatment plan, make referrals to community-based services, and ensure that transition planning includes closed-loop referrals for SDOH-related services. When SDOH are overlooked, individuals are more likely to experience treatment dropout, return to use, or repeated readmissions due to unmet basic needs that directly impact recovery stability.

[6] Id.

Routine screening should occur through the use of validated and standardized tools[7].

Why it matters: Focusing solely on addiction as an individualized problem detracts from true systemic barriers to recovery and ignores community strengths that can be called upon to enhance long-term recovery. Individuals with behavioral health needs face multiple disparities and wraparound services are necessary to address SDOH to achieve long-term recovery. Thus, the expectation of all levels of care is to address SDOH.

7. Prioritize Personnel and Training

Transitioning to ASAM 3.1 requires an increase in clinical expertise and personnel availability compared to ASAM 3.2-WM. Agencies must understand that they cannot effectively "retrofit" a 3.2-WM model into the 3.1 level of care due to the significant differences between the two.

The 3.1 Level of Care requires a licensed, multidisciplinary team that can deliver structured, individualized treatment in a 24/7 residential setting. Ensuring that there is an adequate primary personnel plan, with strategies for vacancies, is paramount to ensuring this level of care is delivered safely and in accordance with regulations and guidelines.

Clinical coverage must be available 24/7, including nights, weekends and holidays. It is recommended that each agency create a personnel and recruitment plan that allows for ongoing recruitment so that vacancies can be filled quickly. Additionally, some agencies may opt to maintain a PRN or as-needed pool of personnel to help with coverage for unplanned absences.

Some tips for evaluating and addressing personnel needs include:

- Complete a personnel crosswalk, including position types, credentialing, and shifts to identify gaps
- Focus on critical gaps first while simultaneously working toward addressing longer-term needs
- Determine pathways to incentivize personnel to obtain needed credentials through agency investments
- Consider developing creative personnel partnerships including:
    - Telehealth providers
    - Personnel agencies

[7] PRAPARE is one option: https://prapare.org/

- College/university partnerships
- Internship programs

Similarly, training will need to be a priority for transitioning to the 3.1 level of care since there are significant differences between 3.2-WM and 3.1. Trainings that are recommended for all personnel include:

- Understanding the 3.1 Level of Care
- Evidence-Based Approaches
- De-Escalation
- Medications for Addiction Treatment
- Agency Policies and Procedures
- Safety and Security
- Medication Oversight
- Integrating Physical Health and Mental Health
- Multidisciplinary Team Collaboration
- Clinical Supervision Structure

To help plan for personnel, consider using the tool below:

- Personnel Crosswalk- 3.2-WM to 3.1

8. Develop An Intentional Clinical Program

ASAM 3.1 promotes structured and individualized clinical treatment within a 24-hour residential setting. It is designed to deliver active treatment for individuals with significant substance use disorders and co-occurring conditions. This means that an agency's clinical programming must be robust, trauma-informed, culturally responsive, and designed to address the needs of a high-acuity population.

To provide effective care, the service model must be developed with a clear purpose, clinical alignment, and quality assurance. This cannot be achieved by simply adding more groups or therapy hours to meet a quota. It requires connecting every element of programming to the ASAM dimensions, individual needs, and evidence-based practices.

ASAM requires 3.1 programs to offer:

- Treatment plans based on ASAM's six dimensions that are clinically driven according to the needs of the individual
- A milieu that is therapeutic and promotes recovery both during and outside of formal treatment sessions
- Between 9-19 clinical treatment hours per week, with structured services selected by master's level clinical personnel offered 7 days per week

- This means, these hours should be connected to an evidence-based intervention and be focused on promoting cognitive change. These are more robust than psychoeducation or skills-building.

When considering a transition to ASAM 3.1 level of care under the Fourth Edition, agencies must conduct a thorough evaluation of their current, point-in-time clinical schedule and capacity and how closely existing programming aligns with the updated expectations in the Fourth Edition of ASAM. This will help to inform where adjustments must be made to ensure clinical integrity, individualized care, and regulatory fidelity.

This evaluation helps to ensure that services are tailored not just to the *individual*, but also to the *milieu*. A residential setting requires an intentional balance of individual therapy, group services, psychoeducation, peer support, skills development, and therapeutic recreation. The structure of each day must feel purposeful and supportive, not overly rigid or repetitive. When done right, the environment itself becomes part of the treatment. To accomplish this, agencies must engage in deliberate planning.

The Fourth Edition of the ASAM Criteria not only outlines the level of hours required in clinical treatment, it emphasizes the *individualization* of care and the intentional use of a therapeutic milieu as part of the treatment experience. It's not enough to offer a full schedule of groups- those groups must be purposeful, relevant to the population, and delivered in a way that meets each individual's evolving needs. They must also be partnered with meaningful individual, couples, and/or family sessions as appropriate for the individual.

By comparing the current clinical schedule to ASAM 3.1 expectations, agencies can begin to identify:

- **Gaps in required services** (e.g., insufficient dosage of clinical hours, lack of evidence-based or co-occurring capable content)
- **Duplicative content** (e.g., individuals rotating through the same curriculum more than once during their stay)
- **Misalignment in personnel** (e.g., not enough credentialed facilitators available to meet frequency and intensity expectations)
- **Clinical Content Quality Issues** (e.g., sessions intended to be Clinical in nature and are not rooted in evidence-based practices and documented as such)

Reviewing current programming through this lens allows for proactive planning around curriculum rotation. Repetition of core topics can be valuable for reinforcement, but duplication without variation decreases the quality of care and is not aligned with

best practices. A structured review helps identify where curricula overlap, which modules can be modified or enhanced, and where new content is needed.

Agencies can use the tool below to map out their weekly service plan to ensure they thoroughly understand the requirements for ASAM 3.1 and have a plan in place for their programming:

- ASAM 3.1 Clinical Planning Tool

Why it matters: In contrast to the supportive, low-intensity environment of 3.2-WM, Level 3.1 requires a therapeutic milieu with clearly defined and documented clinical services.

9. Create Formal Pathways for Enhancing Medical and Psychiatric Support

Medical and psychiatric integration is a critical component of delivering high-quality care at the ASAM 3.1 Level of Care. This level of care is designed for individuals with moderate functional impairments and complex clinical presentations, including co-occurring mental health, physical health, and substance use disorder needs. Agencies must be equipped to address behavioral health, medical, and psychiatric concerns in a coordinated and expedient manner in effort to increase retention and decrease return to use and mortality.

ASAM 3.1 programs are not medical treatment programs, however they must be equipped to recognize, respond to, and collaborate around these needs as part of integrated treatment.

Many individuals entering Level 3.1 care have untreated or under-treated psychiatric conditions- such as depression, anxiety, PTSD, or bipolar disorder- that interact with their substance use patterns. Similarly, physical health conditions (e.g., chronic pain, diabetes, infectious diseases) may affect motivation, energy, cognition, and treatment engagement. Failing to address these issues concurrently can lead to disengagement, poor outcomes, or unnecessary readmission to higher levels of care.

A fully integrated model ensures that individuals receive timely medical and psychiatric assessments, care coordination, and access to evidence-based medications, including medications for addiction treatment (MAT) such as buprenorphine, methadone, or naltrexone. ASAM 3.1 programs must ensure that these medications are available for same-day administration through formal linkage with prescribing providers and that personnel are trained to support individuals in using them effectively and without perpetuating stigma.

Integration requires real-time communication between medical, psychiatric, and behavioral health providers; shared documentation; and treatment planning that reflects the interplay between these areas. For example, an individual's depression may affect their motivation to engage in group treatment, or their blood pressure

medication may interact with other prescribed drugs. An integrated team can identify and address these complexities, reducing risk and enhancing care outcomes.

Additionally, integrated care supports continuity. As individuals transition from Level 3.1 to lower levels of care, having medical and psychiatric services already in place helps to prevent disruption in treatment and medication access.

To take a deeper dive into your agency's readiness in this area, please use the following tool:

- ASAM 3.1 Medical and Psychiatric Integration Tool

Why it matters: ASAM 3.1 calls for integration of medical and behavioral health care. Programs must demonstrate the ability to respond to physical health and psychiatric needs in a timely and coordinated manner.

10. Develop a Strategic Implementation Plan that Includes Quality Assurance

Successfully transitioning to ASAM Level 3.1 will require a coordinated, agency-wide strategic plan. This strategic approach is critical because implementing this level of care will impact every aspect of the agency including physical space, workflows, personnel, clinical pathways, and culture. Without a clearly defined strategy, agencies risk failed launches and regulatory concerns.

A well-designed implementation plan not only prepares your agency to meet ASAM and State requirements, but also helps ensure clinical excellence, satisfaction, financial sustainability, and regulatory compliance. Key activities include:

- Determine a go-live date
    - Agencies should choose a date in which they want their program to be fully operational. From here, the implementation team can work backwards to define timelines and milestones. To make the transition more manageable, some agencies may choose to:
        - Start with a pilot unit or cohort to test workflows
        - Transition one workflow at a time
            - Example: Ramp up personnel first, and then launch the updated clinical programming schedule

- Build a detailed workplan with timelines and milestones. Items to consider include:
    - Key infrastructure upgrades (e.g., physical space, IT systems)
    - Policy and documentation changes
    - Workforce hiring and training plans
    - Licensing and payer engagement timelines

    - Internal communication and rollout
    - Quality assurance plan

- Create a comprehensive quality assurance (QA) plan to detect issues early and quickly be able to launch interventions
    - Ensure the QA process is aligned with ASAM and State regulations
    - Conduct regular internal audits, happening more frequently in the weeks after launch. Include:
        - Clinical documentation (e.g., alignment with ASAM's six dimensions, treatment plan quality)
        - Personnel patterns (e.g., are licensed clinicians meeting service hour requirements?)
        - Charts for completeness, medical necessity, and accuracy.
        - Facility standards and safety protocols.
    - Define policies and procedures for addressing issues detected through the QA process
    - Ensure that satisfaction of individuals served and outcomes are included in the QA process
    - Use data to drive continuous improvement

11. Navigate Payer Enrollment Requirements and Related Activities Early in the Change Process

When a provider decides to implement ASAM Level 3.1, one of the most important steps is navigating the payer landscape. Clinical readiness is essential, but administrative readiness is what ensures the service can be delivered and reimbursed. Without thoughtful planning around payer enrollment, authorizations, and documentation, even the most clinically sound agency can face financial instability or access barriers for individuals.

A key starting point is early enrollment. Providers should begin the credentialing and contracting process with all payers, including Medicaid, Medicaid managed care entities, and Behavioral Health Administrative Services Organizations (BHASOs) well in advance of opening or transitioning to ASAM 3.1. This is not a one-size-fits-all process. Each payer may have its own requirements, timelines, and systems, and some may need confirmation of state licensure or ASAM alignment before proceeding. Beginning early allows time to gather necessary credentials, complete site inspections, align with benefit designs, and ensure your program is recognized as a qualified 3.1 provider. Delays in enrollment can mean delays in care or expensive unreimbursed services.

Once a provider is enrolled with a payer, the provider must understand claim submission and authorization timelines. Most payers require prior authorization before a residential admission is approved, and many require ongoing concurrent reviews at regular intervals. These timelines vary and failing to adhere to them can result in denial of payment. A well-organized billing team and clear workflows between clinical and administrative personnel are essential.

Beyond timelines, the quality and alignment of documentation play a central role in getting authorizations approved and claims reimbursed. Clinical documentation must consistently reflect ASAM 3.1 criteria- especially regarding the individual's needs across the six ASAM dimensions. Treatment plans must be individualized, show functional impairments, and clearly outline therapeutic interventions tied to the individual's goals. Progress notes should demonstrate structured daily services, clinical engagement, and interdisciplinary care, including the integration of co-occurring and medical needs. Discharge and transition planning must be detailed and proactive, with referrals that are confirmed and documented as part of a closed-loop process.

Many payers now use utilization reviewers who are trained in ASAM or similar criteria and who expect the language and structure of documentation to mirror medical necessity requirements. Providers that do not align clinical language with authorization expectations risk delays or denials, even when care is appropriate.