To compassionately serve Hoosiers of all ages and connect them with social services, health care and their communities.

WWW.FSSA.IN.GOV
Indiana Levels of Care: for substance use disorder treatment

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Indiana Levels of Care: Brief overview

- Recap
- Your Voice
- Trainings
- Resources
Indiana Levels of Care for Addiction Services

The 30 day public comment period will run from January 24, 2020, through February 28, 2020. Comments may be sent to SUD.Services@fssa.IN.gov

Mail address below:
FSSA, Division of Mental Health and Addiction Addiction & Forensic Treatment Team
402 W. Washington St., W353
Indianapolis, IN 46204

Website: https://www.in.gov/fssa/dmha/3073.htm
<table>
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<tr>
<th>ASAM Level of Care</th>
<th>ASAM Brief Description</th>
<th>Indiana Levels of Care (In addition to ASAM)</th>
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</table>
| 0.5 - Early Intervention | Services for individuals who are at risk of developing substance-related disorders  
No withdrawal risk  
No substance use disorder  
Form of prevention and intervention | At risk means: meeting no more than two criteria in the DSM for a SUD and does not meet criteria for higher level of care.  
Binge drinking or similar type using of other substances.  
Underage drinking, tobacco or other drug use.  
Best Practice Group Size max 1:20 clinician to consumer ratio not to exceed 20. | 1. Employee Certification: Licensed Addiction Counselor (LAC), prevention certified person having completed the International Certification & Reciprocity Consortium (IC&RC) exam.  
2. Highly encouraged: Part Time Employee (PTE), Clinical supervisor  
3. Best Practice: Additional Non-clinical, peer recovery services throughout treatment for non-clinical services |
### ASAM Level of Care

#### 1.0 - Outpatient Services

- **ASAM Brief Description**
  - Outpatient treatment (usually less than 9 hours a week for adults and less than six for adolescents), including counseling, evaluations, and interventions.
  - Minimal risk of severe withdrawal.
  - WM services 1
  - Ability to arrange for pharmacotherapy for psychiatric or addiction medications

- **Indiana Levels of Care (In addition to ASAM)**
  - Less than 9 hours of clinical addiction services per week but must be at least one hour monthly
  - Processing Group Size max: 24
  - Best Practice for processing group clinician to consumer ratio 1:12
  - Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based on 40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and Biweekly after.

- **Staff Minimums**
  1. Employee Credentials: Licensed Clinical Addiction Counselor (LCAC).
  2. PTE: clinical supervisor, medical director if necessary
  3. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services
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| 1.0 - Outpatient Services (CONTINUED) | - Outpatient treatment (usually less than 9 hours a week for adults and less than six for adolescents), including counseling, evaluations, and interventions.  
- Minimal risk of severe withdrawal.  
- WM services 1  
- Ability to arrange for pharmacotherapy for psychiatric or addiction medications | - Each consumer must be staffed and overseen by a medical director at least once a month.  
- Required to provide protocols for the continuation of MAT, including direct operational linkage or access to methadone, buprenorphine, oral/injectable naltrexone providers  
- 75% of services are clinical in addition medical | 1. Employee Credentials: Licensed Clinical Addiction Counselor (LCAC).  
2. PTE: clinical supervisor, medical director if necessary  
3. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services |
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| 2.1 - Intensive Outpatient Services | ➢ 9-19 hours of structured programming per week
➢ (Counseling and education about addiction-related and mental health programs).
➢ Minimal risk of severe withdrawal
➢ WM services 2 and lower
➢ Ability to arrange for pharmacotherapy for psychiatric | ➢ 9-19 hours of clinical addiction services per week
➢ Processing Group Size max: 16
➢ Best Practice for processing group clinician to consumer ratio 1:8
➢ Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based of 40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and Biweekly after. | 1. Employee Credentials: clinical supervisor, LCAC
2. PTE: Medical director
3. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services |
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| 2.1 - Intensive Outpatient Services (CONTINUED) | ➢ 9-19 hours of structured programming per week  
➢ (Counseling and education about addiction-related and mental health programs).  
➢ Minimal risk of severe withdrawal  
➢ WM services 2 and lower  
➢ Ability to arrange for pharmacotherapy for psychiatric | ➢ Required to provide protocols for the continuation of MAT, including direct operational linkage or access to methadone, buprenorphine, oral/injectable naltrexone providers  
➢ Able to offer level 2 and 1 withdrawal management  
➢ 75% of services are clinical in addition medical  
➢ Must provide addiction medication upon intake as medically indicated.  
➢ Telehealth, contracted with dr. | 1. Employee Credentials: clinical supervisor, LCAC  
2. PTE: Medical director  
3. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services |
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| 2.5 - Partial Hospitalization | - 20 or more hours of clinically intensive programming per week  
- Moderate risk of severe withdrawal  
- Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications  
- WM services 2 and lower | - Processing Group Size max: 16  
- Best Practice for processing group clinician to consumer ratio 1:8  
- Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based on 40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and biweekly after.  
- Each consumer must be staffed and overseen by a medical director at least once a month. | 1. FTE: clinical supervisor, HSPP psychologist, Nurse  
2. PTE: Medical director  
3. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services |
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| 2.5 - Partial Hospitalization (CONTINUED) | ➢ 20 or more hours of clinically intensive programming per week  
➢ Moderate risk of severe withdrawal  
➢ Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications  
➢ WM services 2 and lower | ➢ Each consumer must meet with one of the medical staff (physician, physician assistant, or advanced practice registered nurse every 7 day. Required to provide protocols for the continuation of MAT, including direct operational linkage or access to methadone, buprenorphine, oral/injectable naltrexone providers  
➢ Able to offer levels 1 and 2 withdrawal management.  
➢ 75% of services are clinical in addition medical | 1. FTE: clinical supervisor, HSPP psychologist, Nurse  
2. PTE: Medical director  
3. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services |
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| 3.1 - Clinically Managed Low-Intensity Residential | ➢ 24-hour supportive living environment; at least 5 hours of low-intensity treatment per week  
➢ Minimal stable risk of withdrawal  
➢ WM services 2 and lower  
➢ Ability to arrange for and monitor pharmacotherapy for psychiatric medications  
➢ Must offer addiction medications when clinically indicated | ➢ Processing Group Size max: 16  
➢ Best Practice for processing group clinician to consumer ratio 1:8  
➢ Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based of 40hr week. Supervision should occur1 hour weekly for first year of licensure/credential and Biweekly after. | 1. FTE: clinical supervisor, LCAC  
2. PTE and on call: Medical director, Nurse  
3. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services |
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<td>3.1 - Clinically Managed Low-Intensity Residential (CONTINUED)’</td>
<td>➢ 24-hour supportive living environment; at least 5 hours of low-intensity treatment per week&lt;br&gt;➢ Minimal stable risk of withdrawal&lt;br&gt;➢ WM services 2 and lower&lt;br&gt;➢ Ability to arrange for and monitor pharmacotherapy for psychiatric medications&lt;br&gt;➢ Must offer addiction medications when clinically indicated</td>
<td>➢ Each consumer must be staffed and overseen by a medical director at least once a month.&lt;br&gt;➢ Required to provide protocols for the continuation of MAT, including access to buprenorphine, oral/injectable naltrexone providers and linkage to methadone.&lt;br&gt;➢ Able to offer levels 1 and 2 withdrawal management.&lt;br&gt;➢ 75% of services are clinical in addition medical</td>
<td>1. FTE: clinical supervisor, LCAC&lt;br&gt;2. PTE and on call: Medical director, Nurse&lt;br&gt;3. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services</td>
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<td>3.3 Clinically Managed Population – Specific High Intensity Residential services (Adult only)</td>
<td>24 hour living environment, treatment milieu depended on impairments.</td>
<td>➢ 10 - 20 hours of co-occurring enhanced clinical addiction services per week  ➢ Processing Group Size max: 16  ➢ Best Practice for processing group clinician to consumer ratio 1:8  ➢ Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based of 40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and Biweekly after.</td>
<td>1. FTE: clinical supervisor, Psychologist, LCAC, 2. PTE &amp; on call: Medical director, Nurse 3. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services</td>
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<tr>
<td>3.3 Clinically Managed Population – Specific High Intensity Residential services</td>
<td>- 24 hour living environment, treatment milieu depended on impairments.</td>
<td>- Each consumer must be staffed and overseen by a medical director at least twice a month.</td>
<td>1. FTE: clinical supervisor, Psychologist, LCAC,</td>
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<td>(Adult only)</td>
<td></td>
<td>- Required to provide protocols for the continuation of MAT, including access to buprenorphine, injectable naltrexone and linkage to methadone.</td>
<td>2. PTE &amp; on call: Medical director, Nurse</td>
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<td>(CONTINUED)</td>
<td></td>
<td>- Able to offer levels 1 and 2 withdrawal management.</td>
<td>3. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services</td>
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<td>3.5 - Clinically Managed High-Intensity Residential</td>
<td>➢ 24-hour living environment, more high-intensity treatment (level 3.7 without intensive medical and nursing component) ➢ Minimal risk of severe withdrawal ➢ WM services 3.2 and lower ➢ Ability to arrange for and monitor pharmacotherapy for psychiatric or anti-addiction medications</td>
<td>➢ 20 or more hours of clinical addiction services per week ➢ Group Size max: 1:8 not to exceed 16 ➢ Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based of 40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and Biweekly after. Each consumer must be staffed and overseen by a medical director at least twice a month.</td>
<td>1. FTE: clinical supervisor, LCAC, 2. PTE &amp; on call: Medical director, Nurse 3. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services</td>
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| 3.5 - Clinically Managed High-Intensity Residential | ➢ 24-hour living environment, more high-intensity treatment (level 3.7 without intensive medical and nursing component)  
➢ Minimal risk of severe withdrawal  
➢ WM services 3.2 and lower  
➢ Ability to arrange for and monitor pharmacotherapy for psychiatric or anti-addiction medications | ➢ Required to provide protocols for the continuation of addiction medication, including direct operational linkage or access to methadone, buprenorphine, injectable naltrexone providers  
➢ Able to offer levels 1, 2 and 3.2 withdrawal management.  
➢ 75% of services are clinical in addition to medical  
➢ Each consumer must meet with one of the medical staff (physician, physician assistant, or advanced practice registered nurse every 7 day.  
➢ Transpiration must be provided to the next level of care if other residential services are needed or if outside services are needed. | 1. FTE: clinical supervisor, LCAC,  
2. PTE & on call: Medical director, Nurse  
3. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services |
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| 3.7 - Medically Monitored Intensive Inpatient Services | ➢ 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in a hospital setting  
 ➢ High risk Inpatient of severe withdrawal  
 ➢ WM services 3.7 or lower  
 ➢ Ability to arrange for and administer pharmacotherapy for psychiatric or anti-addiction medications | ➢ 10 or more hours of clinical addiction services and medical educational services per week  
 ➢ Group Size max: 1:8 not to exceed 16  
 ➢ Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based of 40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and Biweekly after.  
 ➢ Each consumer must be staffed and overseen by a medical director at least twice a month. | 1. FTE: Medical Director, clinical supervisor, Psychologist, Nurse, LCAC  
 2. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services |
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<td>3.7 - Medically Monitored Intensive Inpatient Services</td>
<td>➢ 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in a hospital setting  &lt;br&gt;➢ High risk Inpatient of severe withdrawal  &lt;br&gt;➢ WM services 3.7 or lower  &lt;br&gt;➢ Ability to arrange for and administer pharmacotherapy for psychiatric or anti-addiction medications</td>
<td>➢ Required to provide protocols for the continuation of MAT, including access to buprenorphine, oral/injectable naltrexone providers  &lt;br&gt;Able to offer levels 1, 2, 3.2 and 3.7 withdrawal management.  &lt;br&gt;50% of services are medical in addition to clinical interventions  &lt;br&gt;Each consumer must meet with one of the medical staff (physician, physician assistant, or advanced practice registered nurse every day.  &lt;br&gt;Transpiration must be provided to the next level of care if other residential services are needed or if outside services are needed.</td>
<td>1. FTE: Medical Director, clinical supervisor, Psychologist, Nurse, LCAC  &lt;br&gt;2. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services</td>
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| 4.0 - Medically Managed Intensive Inpatient | ➢ 24-hour hospital setting treatment requiring the full resources of an acute care or psychiatric hospital  
➢ High risk of severe withdrawal  
➢ WM services 4 and lower  
➢ Ability to prescribe and administer pharmacotherapy for psychiatric or anti-addiction medications | ➢ 10 or more hours of clinical addiction services and medical educational services per week  
➢ Group Size max: 1:8 not to exceed 12  
➢ Best practice is to provide Clinical Supervision for licensed and or credentialed staff which is based on 40hr week. Supervision should occur 1 hour weekly for first year of licensure/credential and Biweekly after | 1. FTE, Medical Director, Psychiatrist, clinical supervisor, Nurse, LCAC  
2. Best Practice: Non-clinical, peer recovery services throughout treatment for non-clinical services |
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<td>4.0 - Medically</td>
<td>➢ 24-hour hospital setting treatment requiring the full resources of an acute care or</td>
<td>➢ Each consumer must be staffed and overseen by a medical director or MD/Psychiatrist that has the</td>
<td>1. FTE, Medical Director, Psychiatrist, clinical</td>
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<tr>
<td>Managed Intensive</td>
<td>psychiatric hospital</td>
<td>medical director’s approval to oversee at least three times a month.</td>
<td>supervisor, Nurse, LCAC</td>
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<tr>
<td>Inpatient (CONTINUED)</td>
<td>➢ High risk of severe withdrawal</td>
<td>➢ Able to offer levels 1, 2, 3.2, 3.7 and 4 withdrawal management.</td>
<td>2. Best Practice: Non-clinical, peer recovery</td>
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<td>➢ WM services 4 and lower</td>
<td>➢ 75% of services are medical in addition to clinical interventions</td>
<td>services throughout treatment for non-clinical</td>
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<tr>
<td></td>
<td>➢ Ability to prescribe and administer pharmacotherapy for psychiatric or anti-addiction</td>
<td>➢ Each consumer must meet with one of the medical staff (physician, physician assistant, or advanced</td>
<td>services</td>
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<td>medications</td>
<td>practice registered nurse every day.</td>
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<td>➢ Transpiration must be provided to the next level of care if other residential services are needed or if</td>
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<td>outside services are needed.</td>
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Participate in change and assisting those who you serve receive better care!

- This is your time to make your voice heard

- Will become rule July 1 2021
Next ASAM trainings

- **Vincennes, Indiana: Wednesday, February 5, 2020:**

- **Columbus, Indiana: Thursday, February 6, 2020:**

- **Lawrenceburg, Indiana: Friday, February 7, 2020:**

- **North training will be in April**

Contract [Kelly.Welker@fssa.in.gov](mailto:Kelly.Welker@fssa.in.gov) for any ASAM training questions
Save the date!!!
May 13th & 14th
Clinical Supervision Training
Indianapolis IGCS
Resources

Substance Abuse and Mental Health Services Administration (SAMHSA)
https://store.samhsa.gov/

Addiction Technology Transfer Center Network
https://attcnetwork.org/

Extension for Community Healthcare Outcomes (ECHO)
oudecho.iu.edu
kelleykr@iu.edu
Thank you!!!

The 30 day public comment period will run from January 24, 2020, through February 28, 2020. Comments may be sent to SUD.Services@fssa.IN.gov

Mail address below:
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402 W. Washington St., W353
Indianapolis, IN 46204

Website: https://www.in.gov/fssa/dmha/3073.htm