2.1 IOP = Intensive Outpatient
2.5 PHP = Partial Hospitalization

ADDENDUM:
PA – SPECIFIC EXPECTATIONS FOR CONTRACTUAL COMPLIANCE – 2.0 Levels of Care (IOP/PHP)

Note: While many of the items noted below are included in the Service Description and Self-Assessment Checklist Documents, the information below provides either specific expectations where the criteria offers only general parameters, or, emphasizes those elements that exist in the criteria that will likely require system change for effectively implementing the 1115 waiver and moving toward full alignment with the ASAM Criteria.

I. SETTING –

2.1 IOP are licensed as outpatient providers

2.5 PHP – all providers should be licensed specifically to deliver PHP and may deliver services through options which include, but are not limited to:

a) PHP specific staff and capacity to deliver the services and supports described;

b) a facility that provides multiple licensed services that can coordinate staffing/services, e.g., a provider delivering both 2.5 and 3.7 services with medical and psychiatric staff to serve both programs. In such an instance where residential staff serve individuals in both programs, the 2.5 services must be conducted on an ambulatory basis (this is to say, staff are shared, not the bed/facility space);

c) a dually licensed 2.5 D&A/MH program with the staffing and capacity to offer the supports and services needed at this level of care.

Because individuals meeting admission criteria for this service may require medical monitoring and/or medical management or have emotional, behavioral, or cognitive complications that significantly affect daily functioning, observable psychiatric decompensation, or are at mild to moderate risk of endangering self, others or property, PHPs are required to be co-occurring capable to ensure they can meet the clinical needs of the individuals served. Co-Occurring Capable is defined as follows:

> Treatment programs that address co-occurring mental and substance use disorders in their policies and procedures, assessment, treatment planning, program content, and discharge planning are described as "co-occurring capable". Such programs have arrangements in place for coordination and collaboration between addiction and mental health services. They also can provide medication monitoring and addiction and psychological assessment and consultation. Program staff are able to address the interaction between mental and substance use disorders and their effect on the patient's readiness to change-as well as relapse and recovery environment issues-through individual and group program content (Mee-Lee, et al, "The ASAM Criteria, 2013" 416)

II. SUPPORT SYSTEMS –

2.1 through formal affiliation, if not onsite

2.5 may be delivered through consultation/referral, but more likely onsite: medical, psychiatric, psychological, laboratory, and toxicology. Medical & psychiatric consultation within 8 hrs. by phone and 48 hrs. in person.

A. Pharmacotherapy – expected across the continuum of care by all contracted providers. This may be by affiliation or by direct provider prescribing and oversight.

ADDENDUM:
PA – SPECIFIC EXPECTATIONS FOR CONTRACTUAL COMPLIANCE – 2.0 Levels of Care (IOP/PHP)

B. CM – while treatment services cannot be denied if an individual does not participate in CM services, separate and distinct CM is an integral support service that must be available to any individuals requiring or requesting it and case management is a significant component of this Level of Care (LoC).

III. STAFFING

There must be medical (physician and/or nursing) and psychiatric services, either onsite, or referral through a formally executed arrangement such as a contract, MOU or LOA to meet the required need for 8-hour consultation by phone/48-hour consultation in person as needed.

A. *CLINICAL SUPERVISORS*

In addition to meeting the basic, standard minimum education and training requirements established via §704.6 of the PA Licensing Regulations, for alignment with *The ASAM Criteria, 2013*, it is required that all clinical supervisors be a licensed clinician by the Pennsylvania Department of State (DOS) or be credentialed through the Pennsylvania Certification Board (PCB) as a Certified Clinical Supervisor (CCS).

1. EXISTING STAFF, (hired prior to July 1, 2021)
   a. While it is recommended that all staff be credentialed by a license issued by the Department of State[1] or PCB certification, any staff hired before July 1, 2021 will not be required to become licensed/certified as long as they remain with the current employer. (To be hired as a clinical supervisor with another provider, the "new hire" protocols apply.)
2. NEW HIRES as of July 1, 2021
   a. In addition to meeting the minimum METs indicated by PA regulations §704.6, any newly hired clinical supervisor must have a clinical license through the Department of State or be certified as a CCS through PCB.
   b. Individuals who are not currently Certified Clinical Supervisors (CCS) through PCB, but who have previously been employed in the position at another provider(s) within the last 7 years should acquire certification as soon as they become eligible to do so by meeting the necessary requirements as per PCB.
   c. Individuals who have no prior clinical supervision experience, but who hold one of the following PCB credentials (CAAC, CADC, CAADC, CCDP, CCDPD or CCJP) have a total of 3 years to obtain their certification: 2 years from the date of hire in the position to be working on/acquire the necessary requirements established by PCB and 1 additional year to become fully certified.
   Note: it is to the employee's advantage to apply for certification as soon as possible upon meeting eligibility for certification in case it becomes necessary to re-take the certification exam.

[1] Department of State Licenses referenced in this document may include those issued by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, the State Board of Psychology, or those licenses deemed reciprocal by DOS from another state.

d. The "working toward" licensure or CCS must be evidenced by a log maintained in the employee file that includes hours worked/hours of supervision/ required training needed to qualify for full certification as per PCB. Said log will be monitored for compliance and evidence of active pursuit of credentialing will be monitored.

B. CLINICAL STAFF

COUNSELOR

1. EXISTING STAFF hired prior to July 1, 2021
    a. It is recommended that all staff be credentialed; however, any counseling staff hired before July 1, 2021 will not be required to become licensed/certified for as long as they remain with the current employer. (To be hired as a counselor with another provider, the "new hire" protocols apply.)
2. NEW HIRES as of July 1, 2021
    a. In addition to meeting the minimum METs indicated by §704.7 of the PA licensing regulations, all new staff must hold a professional license through DOS (see footnote (fn)) or be credentialed through PCB at the time of hire OR be actively working towards licensure or certification through the PCB.
    b. The "working toward" licensure or certification must be evidenced by a log maintained in the employee file that includes hours worked/hours of supervision/ required training needed to qualify for full licensure or certification as per the PA Department of State or PCB. Said log will be monitored for compliance and evidence of active pursuit of credentialing will be monitored.
    c. Licensure
        i. If the process of licensure for any given employee is anticipated to take longer than 1 year (e.g., current master's program will take longer than 1 year to complete); applicable certification should be obtained from PCB until which time eligibility for licensure is reached.
    d. Certification – Certified Associate Addiction Counselor (CAAC), Certified Alcohol and Drug Counselor (CADC), and Certified Advanced Alcohol and Drug Counselor (CAADC)
        i. The allowable time to acquire the necessary experience, training and supervision to qualify for certification varies from 1 - 3 years, depending on the specific certification. After meeting all applicable requirements outlined by PCB (years of experience, supervision and education), employees have an additional 1 year to become certified.

ii. Note: it is to the employee's advantage to apply for certification as soon as possible upon meeting eligibility for certification in case it becomes necessary to re-take the certification exam.

COUNSELOR ASSISTANT

1. EXISTING STAFF hired prior to July 1, 2021
   a. It is recommended that all staff be credentialed; however, any counseling staff hired before July 1, 2021 will not be required to become licensed/certified for as long as they remain with the current employer. (To be hired as a counselor with another provider, the "new hire" protocols apply.)
2. NEW HIRES as of July 1, 2021
   a. In addition to meeting the minimum METs indicated by §704.8 of the PA licensing regulations, all new staff must be credentialed through PCB at the time of hire OR be actively working towards licensure or certification through the PCB.
   b. The "working toward" licensure or certification must be evidenced by a log maintained in the employee file that includes hours worked/hours of supervision/ required training needed to qualify for full licensure or certification as per the PA Department of State or PCB. Said log will be monitored for compliance and evidence of active pursuit of credentialing will be monitored.

CASE MANAGERS

1. EXISTING STAFF hired prior to July 1, 2021
   a. It is recommended that all staff hold a certification; however, any case manager/case manager supervisor staff hired before July 1, 2021 will not be required to become licensed/certified for as long as they remain with the current employer. (To be hired as a Drug and Alcohol Case Manager/Supervisor with another provider/agency, or to be promoted to a different position within the same agency, the "new hire" protocols apply.)
2. NEW HIRES as of July 1, 2021
   a. In addition to meeting the minimum METs indicated by the State Civil Service Commission, all new staff must currently be licensed by DOS (see fn) or be a Certified Allied Addiction Practitioner (CAAP) or Certified Associate Addiction Counselor (CAAC), Certified Alcohol and Drug Counselor (CADC), and Certified Advanced Alcohol and Drug Counselor (CAADC) in good standing at the time of hire OR be actively working towards licensure or certification through the PCB, once hired.
   b. The "working toward" certification must be evidenced by a log maintained in the employee file that includes hours worked/hours of supervision/ required training needed to qualify for full certification as per the PA Department of State or PCB. Said log will be monitored for

compliance and evidence of active pursuit of credentialing will be monitored.

c. Required trainings by DDAP for case managers as indicated in the DDAP Manual must still be obtained within the required timeframes.

d. Certification- Certified Allied Addiction Practitioner (CAAP)

   i. Individuals have 2 years from the date of hire to meet all applicable requirements outlined by PCB for CAAP certification (years of experience, supervision and education), plus 1 additional year to become certified
   Note: it is to the employee's advantage to apply for certification as soon as possible upon meeting eligibility for certification in case it becomes necessary to re-take the certification exam.

   ii. All applicable prior experience, supervision, education that is valid for PCB certification (within the last 7 years) should be considered by a new employer for establishing allowable timeframes in which an employee must become certified.

Regarding certification for all positions noted above, applicable prior experience, supervision, education that is valid for PCB certification (within the last 7 years) should be considered by a new employer for establishing allowable timeframes in which an employee must become certified.

Programs address COD in their policies, procedures, assessment, treatment planning, program content, etc. Can provide medication monitoring and psychiatric assessment & consultation.

C. SPECIFIC TRAINING

1. Ongoing, adequate, and appropriate training directly related to the population and services delivered and interventions and counseling modalities utilized is imperative and should be reflected in individual staff training plans and training records.

   a. Training/education appropriate to populations served e.g., staff working in a Women's and Children Facility must have training on the unique clinical needs of women; those serving adolescents must have specific training and education regarding adolescents; those treating veterans should have training appropriate to the needs of veterans, etc. These areas of specialty should be noted on individualized training plans of the staff and a record of completed population-, or service-specific trainings should be maintained

2. Stages of Change and Motivational Interviewing: because understanding these concepts are foundational to appropriate application of the ASAM Criteria,

   a. As soon as possible and no later than 7/1/2021, all clinical staff should have a foundational knowledge of The Stages of Change Model and Motivational Interviewing. This can be obtained through any number of self-selected online trainings, independent reading, facility in-house guidance and instruction, etc. A record of how this foundational

awareness was obtained should be maintained in each employees training file.

b. Clinical Supervisors who have not had formal instruction on Stages of Change and Motivational Interviewing as evidenced by transcripts or training certificates prior to 7/1/2021 must take a DDAP-approved training by 7/1/2023.

c. Other clinical staff who have not had formal instruction on Stages of Change and Motivational Interviewing as evidenced by transcripts or training certificates prior to 7/1/2021 must take a DDAP-approved training by 7/1/2026.

d. Case managers should follow the training requirements outlined in DDAP's Case management and Clinical Services Manual.

3. Co-Occurring Conditions:

a. Clinical Supervisors must have education/training regarding co-occurring disorders and be able to identify signs and symptoms of acute psychiatric conditions including psychiatric decompensation in order to appropriately advise supervisees regarding such matters by 7/1/2022.

b. There must be a training plan in place for all other staff to incrementally come into full compliance with COD training by 2023.

c. COD core trainings will initially include the following *topics*:

- Signs and symptoms of co-occurring mental health disorders
- The relationship between psychoactive substance use and other mental and emotional disorders
- Crisis Intervention and Response
- The relationship between substance use and trauma
- Risk factors that relate to suicide, homicide, family violence, self-injury, and other harmful behaviors
- Psychopharmacology (including commonly used MH medications)

d. These topics align with basic COD competencies that must be demonstrated for PCB counseling certification. DDAP and DHS will continue to work on criteria and expectations regarding interventions and expectations for addressing COD and will advise the field as this becomes available.

IV. THERAPIES

A. Delivered hours of individualized service

IOP = 9 -19 hours per week

PHP = 20+ hours per week: the 20+ hours of service must be clinically intensive programming driven by the 6 dimensional assessment and individual treatment plan and can in no way mimic services that could otherwise be provided by 1.0 or 2.0 plus

engagement in recovery support services (i.e., more hours of OP/IOP) or that resemble "social rehabilitation programs" or recovery support centers with counseling.

1. Must show consistent evidence of a variable length of stay based upon client need:
   a. Clinical/psychotherapeutic services should include but not be limited to, the delivery of therapies such as Cognitive Behavioral Therapy, Rational Emotive Therapy, EMDT, etc. and can be delivered in the following milieus:
      Individual therapy
      Group therapy (maximum group size of 12)
      Family therapy
      Therapeutic recreational interventions related to the individual treatment plan & referenced in the progress notes
   b. Must be individualized & reflective of the treatment plan
   c. Clinical hours do not include 12 Step or other Self Help/Recovery Group Attendance

B. Evidence Based Practices
   1. Motivational Interviewing is required
   2. Every LoC must engage in the delivery of an array of evidenced based practices/interventions and psychotherapies as warranted to meet the needs of individuals
      a. This should be demonstrated through training as well proficiency to the utilized models and strategies employed

C. Family Services (beyond educational sessions required for visitation)
   1. Counseling with family members, when possible
   2. Counseling for family members by facility staff or through affiliation/referral, when necessary and appropriate

D. Counselor to client Ratio –
   2.1 IOP = 1:15
   2.5 PHP = 1:10

V. ASSESSMENT/TREATMENT PLAN REVIEW –

A. Must be an independent process of level of care assessment (LOCA)
   1. Usually conducted by the SCA or its contracted provider
   2. If conducted by treating provider, there must be evidence of neutrality as determined by DDAP (more information at later date)
      Examples to include:
      a. Evidence of client choice
      b. Data demonstrating referral to alternate programs

B. Admission decisions/LOCA reviewed, but not repeated
   1. With consent, LOCA should be shared by assessing entity to treating provider
   2. LOCA should be reviewed, confirmed, and amended as necessary with patient but not repeated

3. This process is a person-centered approach to helping facilitate timely intake (completion of biopsychosocial & treatment plan) and assist with patient engagement by not having to repeatedly provide the same information.

VI. DOCUMENTATION – refer to published documents