FAQ – Service Alignment for Level 1.0
9-1-2020

I. SETTING

I.Q.1: No questions submitted for this section

II.SUPPORT SYSTEMS

II.Q.1: Should Case Management services be SCA provided and not done by treatment providers?

II.A.1: Case Management Services may be provided by an SCA or a treatment provider as separate and distinct services. The provider may perform both case management and therapy sessions as long as the services are kept separate. A therapist should not be providing case management during a therapy session and a case manager should not be doing therapy. The services should be provided at different times. DDAP is working with SCAs to ensure that case management services are provided as distinct and separate services from clinical services, as has been outlined in the most recent Case Management and Clinical Services Manual issued by DDAP effective 7/1/2020. **Section 5.00 Case Management Overview** indicates

> "The SCAs and its contracted providers must offer case management as a separate and distinct service from treatment that addresses all relevant aspects of an individual's path to recovery. Case management includes screening, level of care assessment (LOCA), assessment of treatment-related needs, coordination of services, continued stay reviews, and ongoing management of an individual's needs throughout treatment and recovery. If the SCA contracts with a treatment provider to perform case management, the two services must be conducted either by two separate staff members or at two separate times. The treatment provider may not perform both treatment and case management services during a therapy session."

This change will help clinicians focus on the therapeutic process rather than spend large amounts of time addressing ancillary needs.

In those geographical areas where case management services have not yet been expanded as a formalized process, treatment programs/counselors should do their best to assist in meeting treatment related needs as possible. Where case management does exist, the case manager should be included as a member of the interdisciplinary treatment team.

II.Q.2: Are Case Management services allowed to continue with providers?

II.A.2: Yes, case management services can continue with a provider but must be separate and distinct from clinical services. See response above.

II.Q.3: Should SCAs provide Case Management services for all clients or only SCA funded?

II.A.3: Best practice standards suggest that Case Management services should be offered to all individuals engaging in SUD treatment; however, capacity to meet the demand may require that individuals are "triaged" for services based upon need and resources on a case by case basis.

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III. STAFF

III.Q.1: **Are the Case Managers hired within the SCA being held to the case manager staffing parameters found in the "*Addendum: PA-Specific Expectations for Contractual Compliance*"?**

III.A.1: YES

III.Q.2: On page 42 of The ASAM Criteria Text in the section titled "Who *can do an ASAM criteria assessment*?"; it clearly states who qualifies to complete an assessment using The ASAM Criteria formulary.

Since SCA Case Managers do not meet the qualifications outlined in this section nor do most SCA's have an internal system/staffing protocols in place to compensate, will DDAP be issuing an exception for the SCA Case Managers to conduct a level of care assessment as indicated in The ASAM Criteria text?

III.A.2: This issue was addressed very early on in the ASAM transition. The FAQ posted on DDAP's website dated 11-29-2017 indicates:

> **15. Who is credentialed to do an ASAM criteria assessment?**
> a. Those individuals who are identified as qualified by PA Drug and Alcohol Licensing Regulation and/or who are counselors or case managers credentialed by the Pennsylvania Certification Board (PCB) and/or those individuals meeting the staffing requirements outlined in the DDAP Treatment Manual are credentialed to do an ASAM criteria assessment.

While *The ASAM Criteria, 2013* text outlines qualifications of those it determines acceptable for completing assessments, the text also makes it very clear on page ix, that the criteria may not "…be wholly relevant to external judgement, such as those made by legal or regulatory entities (DDAP)….the criteria are designed to serve as a resource…"; on page x that "The Criteria are clinical guides; and on page 19 that "The ASAM Criteria are not intended to replace or supersede the relevant statutes, licensure, or certification requirements of any state or federal jurisdiction. In this context, it is appropriate for DDAP to applying state regulations, requirements, certifications, etc. when implementing the ASAM transition which we have done in permitting the existing minimum education and training requirements outlined by regulation, for those hired as case managers who are those most likely to complete LOCA in the PA system of care.

DDAP recognizes the importance of standardizing competencies for this importance role and position in our system, which is why we are requiring the need for certification after hire. This requirement will be waived for those individuals hired prior to July 1, 2021, as long as they remain employed with the same employer.

III.Q.4: In looking at the staffing according to the addendum for Pa Specific Expectations and keeping in line with wanting to support individuals in recovery will there be changes to the state specific expectations. As a provider that has to follow the state guidelines for job Code L0700 we can only hire a Drug and Alcohol Treatment Specialist if they have one of the degrees specified by DDAP. However, licensing requirements, and now according to the addendum, we can hire someone who has a Certification for example a CADC. According to staffing requirements from licensing and the PA Cert Board a specific Degree is not a requirement. The issue is potentially we have someone who can get certified as they have experience and a 4-year degree. But because we are a provider that has to meet both standards, we still could not hire them unless they had the degree specified in the attached document.

Is the state going to align with this addendum and licensing requirements or will providers have to meet both expectations have limited and not always experienced certified counselors because they have an unacceptable degree?

III.A.1: The regulations and addendum are currently in sync. The requirements established by the regulation must be met FOR HIRE. Once the individual has been hired, that person will have to work *toward* certification to further establish him or herself as qualified and credentialed by the PCB. This allows those with lived experience the opportunity for job entry and an avenue for professional growth as they pursue both on the job training as well as additional formal educational opportunities. In this way, an individual could pursue full certification which would, according to the regulation, allow an individual to be hired as a drug and alcohol counselor elsewhere should they move on from the current position/employer.

V. THERAPIES

IV.Q.1 Is psychotherapy a combination of Case Management, Outpatient Treatment, Recovery Support Services or is it just for Outpatient services?

IV.A.1: "Psychotherapy" is a general term for therapy or clinical services or modalities such as Rational Emotive Therapy, Cognitive Behavioral Therapy, Family and Couple Systemic Therapy, Dialectical Behavioral Therapy, etc. It does not include case management or recovery support services which address non-clinical needs. Psychotherapy needs to occur in all levels of care across the continuum of service.

IV.Q.2: The Addendum PA-specific Alignment Requirement for Outpatients under Therapies section lists various therapeutic milieus. Can you clarify the following: "Group therapy (minimum of 2 groups/day, 2 hrs./group)?" What exactly is the expectation for group therapy?

IV.A.2: The group stipulation for 2 hours, 2 times per day is an expectation for residential services and was included in the outpatient addendum *in error* and has since been removed. The expectation for group services related to outpatient is that services be delivered as deemed individually appropriate as per the six-dimensional assessment, the treatment plan and individual need/choice. The maximum group size is 12 individuals across the entire continuum of care.

IV.Q.3: Is there a curriculum approved for MI at this point and is there a process to get an established curriculum approved by DDAP? Will this training be a 6 hours requirement?

IV.A.3: To meet the *initial* requirement to obtain a "foundational understanding" of Motivational Interviewing and Stages of Changes, between now and July 1, 2021, clinical staff may obtain a base knowledge from any personally identified resource. Some possibilities include, but are not limited to:

https://ireta.org/resources/motivational-interviewing-toolkit/

https://www.youtube.com/watch?v=2qgdj2oBfOs

https://attcnetwork.org/centers/south-africa-hiv-attc/motivational-interviewing

https://www.naadac.org/finding-ambivalence-MI-webinar

DDAP's *Motivational Interviewing, Advancing the Practice* which is currently a required training for case managers hired on or after July 1, 2020 will be the "DDAP-approved" MI training. However, taking this course is not required until July 1, 2023 for Clinical Supervisors and July 1, 2016 for other clinicians. Currently, DDAP's priority is to engage case managers in this specific training. **After July 1, 2021**, there will be an increased capacity to provide this course through in person and online access with greater opportunity for those wanting to take the course to meet the requirement as a training for clinicians.

IV.Q.4: The group size has been limited at a total of 12 individuals. However, CCBH as per OMHSAS states groups are to be no more than 10 without a WAIVER. Please clarify.

IV.A.4: Group sizes should not exceed 12 individuals. For BH-MCO payment of 12 individuals in a group, the provider must submit the required waiver.

V. ASSESSMENT/TREATMENT PLAN REVIEW

V.Q.1: Can providers continue to complete assessments?

V.A.1: If providers are contracted by the SCA or MCO to conduct level of care assessments, then yes, they may continue to complete them. However, they must demonstrate evidence of neutrality in their process of completing the LOCA and referring to the most appropriate level of care. This includes offering client choice and ongoing data that indicates individuals have been referred to alternate programs other than the one conducting the level of care assessment.

V.Q.2: So, all SCAs will need to be doing all LOC assessments and referral to treatment?

V.A.2: No, this is determined by the structure of each Single County Authority or the contractual arrangements that SCAs have with their provider network(s). Some SCA's are administrative only and contract out all services and therefore will have an outside provider conducting level of care assessments. In other situations, SCAs may allow for after-hour or weekend assessments to be

completed by a provider. In any case, where a level of care assessment is completed by a treatment provider, evidence of neutrality will need to be provided.

VI. DOCUMENTATION

V.Q.1: No questions were submitted for this section

VII. MISCELLANEOUS

VII.Q.1: If a licensed SUD Treatment Program does *NOT* contract with an SCA, will that SUD Treatment Program be held to the same standards found in the "*Addendum: PA-Specific Expectations for Contractual Compliance* "document or are the *specific expectations* only applicable to those providers who contract with an SCA?

VII.A.1: The standards found within the "*Addendum: PA-Specific Expectations for Contractual Compliance*" applies to all programs required to align to the ASAM Criteria, 2013 for the receipt of state and federal funds, including programs that are contracted to receive medical assistance funds (MA or BH-MCO funds) but who may not be contracted with an SCA.

VII.Q.2: What about state minimums of 2.5 hours for new folks? *(DDAP is uncertain about the nature of this question and can only assume that it is referencing the therapy hours delivered at a narcotic treatment facility/methadone maintenance facility since this was the only reference made to "2.5 hours" of treatment time made during the presentation.)*

VII.A.2: The 2.5 hours of clinical service/treatment hours for individuals engaged in NTPs for the first and second year of engagement are minimum standards and, in fact, are to receive additional treatment as necessary. Despite the directive for additional therapy hours to be delivered, the minimum required number of hours has often become the "standard of care". Since NTPs are licensed as outpatient providers, they should at least be striving to provide up to 9 hours of therapy/counseling services to align with ASAM. DDAP will be working with NTPs to increase therapy hours and to align with the ASAM Criteria, 2013.

VII.Q.3: Will IOP and OP be considered one level of care?

VII.A.3: No. While DDAP licenses both levels of care under the same outpatient license, the ASAM Criteria delineates the services for Outpatient as Level 1.0, and Intensive Outpatient Services as Level 2.1. This distinction is made by the ASAM Criteria because the intensity of the services provided are vastly different.

VII.Q.4: Regulations recently changed to allow mental health providers to extend the due dates of Tx plans to 90 days…will this change move its way to substance use?

VII.A.4: It is DDAP's understanding that this MH regulation change was a temporary modification due to COVID-19. The current pandemic aside, there is no effort currently underway for a change to drug and alcohol regulation.
The current timeframes for treatment plan reviews noted in the 28 Pa. Code Ch. 709 are considered minimum standards for aligning with the ASAM Criteria, 2013 and if changes are needed more

frequently than noted in the regulation, they should be done. Clinicians should frequently reassess each individual and update the treatment plan as appropriate or when changes for the individual dictate such; documenting on the treatment plan as well as in the form of a progress note.

VII.Q.5: Is CM a reimbursable service?

VII.A.5: Yes, case management might be a reimbursable service depending on the service delivery model for each SCA and requirements for the BH-MCOs. Providers will need to work with these payers for additional information.

VII.Q.6: Does an ASAM self-assessment checklist have to be in client record?

VII.A.6: No. The self-assessment checklist discussed during the presentation is a tool to be used by the provider to self-determine its overall alignment to the ASAM Criteria, 2013 and is not designed to be stored in the client record. Contracted providers should be using PA-WITS for data entry when doing client admission and discharge and the ASAM Criteria is embedded in the data system as part of the "client chart".

VII.Q.7: In the Addendum on p. 6, Section V, B.2, it is suggested that LOCA should not be "repeated" on admission. During the presentation, it was stated that "review does not mean redo." So, the suggestion seems to be that OP providers should receive a LOCA from the referral source (assuming the referral source is an SCA or another provider). This has never happened in our area. We can write a policy saying that we review the LOCA that we receive, but we have no control over whether the referring organization sends a LOCA. Likewise, within our own agency, we refer back and forth between OP and IOP, and our SCA has stated clearly that there must be two, clearly separate LOCA when we do that, one for the discharge and one for the admission. I respectfully request some clarity on this procedure, and identification of exactly who should be doing what would be helpful.

VII.A.7: Best practice is for the SCA or contracted provider to complete the LOCA and refer the individual to the appropriate level of care. With the individual's consent, the LOCA, along with the ASAM summary sheet and Risk Rating, should be provided to the treatment facility the individual is referred to for treatment. The receiving treatment provider should then review the LOCA, ASAM Summary, and Risk Rating. If necessary, a new ASAM Summary and Risk Rating should be completed if the status of the individual's use has changed. The LOCA does not need to be repeated upon admission to the receiving facility and can be reviewed and updated based on the individual's responses at the time of admission. Refer to Licensing Alert # 1-2007. Providers and SCAs should be working together on meeting this requirement and if additional technical assistance is needed, it is suggested that contact be made through the ASAM email account (ra-daasam@pa.gov) to request such. For assurance, the LOCA can be the basis for the psychosocial histories.