FAQ-Service Alignment for 2.0 Level of Care
12-2020

I. SETTING

(no questions were submitted regarding Setting)

II. SUPPORT SYSTEMS

II.Q.1: Can you clarify the distinctions in support services between the IOP and PHP levels of care?

II.A.1: Level 2.0 services include both Intensive Outpatient (IOP) and Partial Hospitalization Program (PHP) Services, both are intended to meet the needs of individuals who have complex co-occurring mental and or substance-related conditions. Because the complexity of needs increases from what would be addressed in the 1.0 Outpatient level of care, 2.0 programs should have the capacity to arrange for, or provide, medical and psychiatric consultation, medication management [medication assisted treatment - MAT, as well as mental health(MH) and medications] and 24-hour crisis services.

The biggest difference between IOP and PHP is the intensity of need that is addressed, with PHP serving individuals who meet admission criteria based on higher levels of instability and decompensation. Therefore, support services delivered in PHP such as medical, psychiatric and lab/toxicology are likely to be onsite rather than off site or by affiliation. These support services are also likely to be needed on a more regular, routine basis. PHPs might also have onsite nursing staff, for medication monitoring or especially if there is ambulatory withdrawal management (WM) services offered in conjunction with the PHP clinical service.

III. STAFF

III.Q.1: How are staffing ratios calculated when the same counselor is responsible for clients in IOP and OP services?

III.A.1: Intensive Outpatient (2.1) serves individuals with a much higher level of need than those served in standard outpatient (1.0) services. Therefore, due to the severity of need and the intensity of the services delivered, the staff ratio has been set at 1:15 for alignment to the ASAM Criteria rather than the 1:35 established in Pennsylvania regulation for standard outpatient (OP). With the amount of hours increasing in range from 9 – 19 hours and services that include both individual and group sessions, the need for family therapy, the increased amount of re-assessment and adjustment to treatment planning that will be warranted, etc., it is necessary for a clinician to have a caseload that permits this increased level of management and clinical engagement.

The staffing ratio can be established in several ways. Either by straight designation for a counselor who sees only IOP clients, who would then have 15 clients; *OR,* by percentage of time served in the delivery of split services. If a counselor spends 60% of time providing IOP services and 40% in providing OP services then that counselor could have 9 IOP clients and 14 OP clients, for a total of 23 clients. See example below:

60% of 15 = 9
40% of 35 = 14
23 total clients

III.Q.2: Please provide clarification regarding licensing vs. credentialing at time of hire, does the type of license matter?

III.A.2: An applicant does not need to be licensed or credentialled at the time of hire; however, be aware that it will be a requirement to become certified or licensed after hire. If an employee does not hold either a professional counseling license OR a certification issued by the Pennsylvania Certification Board (PCB) applicable to his assigned duties, either type of credential must be obtained after hire within the indicated timeframes noted in the Addendum Document. (Treatment providers may want to consider adding this requirement as a conditional clause at the time of hire).

Any license, obtained through the Department of State, Board of Social Workers, Marriage and Family Therapists and Professional Counselors will meet this requirement, either at the time of hire or obtained after hire.

III.Q.3: Must a clinical supervisor hold a specific type of licensure, such as Licensed Clinical Social Worker or can they be a Licensed Social Worker?

III.A.3: Clinical Supervisors can be certified through PCB or be licensed. If they hold a license, it should be through the Department of State, Board of Social Workers, Marriage and Family Therapists and Professional Counselors. DDAP has not made a distinction between the licenses issued by this Board, at present. Any of the licenses coupled with the required Clinical Supervision training will suffice as meeting the required education and training for the Clinical Supervisor position.

Note that it is not a requirement that Clinical Supervisors specifically be licensed. They can be/obtain a Certified Clinical Supervisor (CCS) credential from PCB.

IV. THERAPIES

IV.Q.1: How was the maximum group capacity determined by DDAP?

IV.A.1: In examining a number of resources for group therapy, the optimum group therapy size was identified as being between 8-12 members. In determining the group size as 12 for ASAM Criteria alignment, DDAP was aware of the Medicaid billing regulation (1223) that caps group size at 10-members. However, OMHSAS allows for a group size of 12 through the submission of an annual waiver request. For specific information regarding the 1223 regulation or how to obtain an exception to conduct a 12-person group, please contact OMHSAS.

IV.Q.2: What is the difference between client ratio and group size?

IV.A.2: Group size and client ratio are not the same. Group size is the maximum number of individuals that may be served in any one therapy group. Client ratio is how many clients an individual counselor is permitted to have on his or her caseload and this is used as a determination that all individuals being served by the program can be adequately cared for as per regulation.

In most instances, caseload is determined by those individuals for whom a counselor is responsible for personally directing care and services; i.e., establishing the treatment plan, conducting re-assessments, providing individual therapy. That is to say, they are a person's "primary therapist or counselor". In the course of duty, this same counselor may conduct a group session in which there are clients for whom he is not the primary therapist. In such a case, this does not calculate into the staff:client ratio.

IV.Q.3: Even while utilizing motivational strategies, many individuals who are appropriate for IOP may be unwilling to participate in more than 9 hours of treatment per week. How can we be sure we will not be penalized for an individual's unwillingness to engage in treatment as recommended? Won't it look like we are just offering 9 hours of IOP?

IV.A.3: While there will be those who refuse the therapeutic hours recommended, others will accept them. For this reason, there will be evidence of varied hours of program delivery. Whenever an individual is unwilling to participate in the recommended numbers of hours, this should be documented in the chart. In the meantime, active engagement and use of motivating strategies should be applied to assist an individual in meeting the needs identified on the treatment plan. If the negotiated fewer hours are not meeting with success, for example, there is continued use or continued negative consequences or inability to achieve the desired goals within the designated programming, this should necessitate a change to the treatment plan including a change to interventions, strategies *and program hours*. The assessment will drive the treatment plan, the treatment plan will drive the interventions, *the response to the interventions* will drive the progress notes and need for modifications to the interventions and ongoing assessment. This will not allow for a stagnant course of treatment and such will be evidenced in the client record/chart.
Just as the number of service hours must be determined by individual need, so do the therapeutic interventions. As therapy and interventions are modified to meet an individual's stages of change and personal goals and needs, hours of service can be increased or decreased to appropriately fit the interventions needed. But, there should not be a "canned" or program-driven curriculum, hours of service, or protocol of care for any one person or group of individuals.

IV.Q.4: How will inflexible billing policies be reconciled with the need for individualized care?
IV.A.4: Some billing requirements are established in regulation while others are based in policy and established practice. In such cases where regulation (especially federal) dictates billing practice, there may not be an option for flexibility. In cases where there may be a possibility for change, open dialogue will be required between all parties moving forward. Remember that system transformation is a process that will take time and engagement.

V. ASSESSMENT/TREATMENT PLAN REVIEW

V.Q.1: How often should reassessments be done for IOP and PHP levels of care?

V.A.1: The ASAM Criteria recommendation, on page 110 of the text, indicates that an individual in IOP should be re-assessed about three times a week and once a week in PHP. More regular re-assessment may be warranted for several reasons: the frequency and intensity of service will permit significant work on the treatment plan and the accomplishment of goals; or, instability and life circumstances may warrant a change of focus, etc. Because of the intensity of these services, reassessment of needs should occur frequently in order to ascertain if the treatment plan is current and applicable or if the individual's present circumstances require any changes to the plan and interventions. Any reassessment data and updates to the treatment plan should also be charted in the progress notes.

The timing of re-assessment and treatment plan updates as indicated by the ASAM Criteria is much more frequent than what is required by regulation. More frequent reassessment and evaluation is needed with the move to individualized care as opposed to program-driven service.

VI. DOCUMENTATION

VI.Q.1: What aspects of the ASAM Criteria can be incorporated into other documentation, such as progress notes and assessments? Do ASAM assessments need to remain separate and distinct documents?

VI.A.1: [This question was posed by a provider desiring to make revisions to its electronic health record (EHR) and was wanting DDAP to advise on what could be incorporated into the record. It can be answered in this way…] Everything about an individual's treatment should be reflective of the 6-dimensional assessment. The assessment and risk factors should drive the treatment planning, the treatment planning should drive the interventions that are utilized in group, individual, and family treatment. The progress notes should reflect the interventions, the needs addressed, the needs yet to be addressed, etc. Therefore, the ASAM Criteria will become the backbone of the therapeutic process and, in theory, should be reflected throughout. With that said, it should also be noted that the ASAM Criteria is copyrighted material. A provider that is looking to incorporate portions of the ASAM Criteria 2013 text into an EHR should reference the Fair Use Guidelines issued by ASAM, which can be found on their webpage (https://www.asam.org/copyright-and-permissions) or seek the advice of its legal counsel.

VII. MISCELLANEOUS

(no questions were submitted for this section)