FAQ-Service Alignment for 4.0 Level of Care
10-2020

I. SETTING

(no questions were submitted regarding Setting)

II. SUPPORT SYSTEMS

II.Q.1: Are there work-arounds for the physician needing to complete a physical exam within 12 hours of admission to the 4.0 Level of Care?

II.A.1: The question as it was submitted asked if the physical exam conducted by the Emergency Care Center physician qualifies for the physical requirement OR would tele-psych be ok if the RN does the physical and the Physician charts it?

We basically translated that very specific question into one that is more applicable across the board to all 4.0 providers while still addressing the question at hand, to be… are there work arounds for the physician doing a physical exam within 12 hours of admission?

The answer really is "it depends". The physical exam should be an actual, hands-on medical assessment done by the physician or qualified medical staff such as a physician's assistant serving on the care team responsible for delivering SUD treatment services to the individual and establishing and providing oversight and input into the treatment plan. If the emergency staff serves as part of the SUD treating team, then the answer would be yes. If that physician is not part of the SUD treatment team, then the answer would be no. As is indicated on page 280 of the ASAM Criteria text, "By definition, Level 4, Medically Managed Intensive Inpatient services are managed by a physician –likely an addiction certified physician or one with significant experience in the field of substance use disorders - who is responsible for diagnosis, treatment and treatment plan decisions in collaboration with the patient." Therefore, this role and activity is of paramount importance.

In an inpatient setting, telehealth would not be an appropriate means of conducting a physical exam due to the acute needs that necessitated the inpatient admission in the first place. While RNs would be engaged in evaluation, it would be through the completion of a comprehensive *nursing* assessment and not a physical exam, which would be outside of the scope of a nurse's practice.

III. STAFF

III.Q.1: What are the Staffing Credentialing Requirements?

III.A.1: Certification is not required at the time of hire. There are different credentials for clinical staff, each related to a particular degree that an individual may have. The expectation is that a new hire would have as much time as designated by the Pennsylvania Certification Board to acquire the training, experience and supervision necessary to qualify for certification, PLUS 1 additional year to obtain the certification. You are encouraged to get full details from the PCB website, but the simplified chart provided as an illustration should help to clarify:

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Requirements for PCB Credentials at a Glance

For complete details see https://www.pacertboard.org/certifications

Certification	Education	Experience	Training/Education	Supervision
CAAC **Certified Associate Addiction Counselor**	**High School Diploma or Associates Degree**	**3 yrs. FT or 6,000 hrs. PT in last 7 years**	**300 hours SUD**	**300 hours**
CADC **Certified Alcohol & Drug Counselor**	**Bachelor's Degree**	**2 yrs. FT or 4000 hrs. PT in last 7 yrs.**	**300 hours SUD**	**200 hours**
CAADC **Certified Advanced Alcohol & Drug Counselor**	**Master's Degree**	**1 yr. FT or 2000 PT in last 7 yrs.**	**180 hours SUD**	**100 hours**
CCS **Certified Clinical Supervisor**	**Certification OR Master's Degree**	**5 yrs. FT/10,000 hrs. PT as counselor AND 2 yrs. FT/4,000 hrs. PT as clinical supervisor**	**30 hours clinical supervision trainings**	**200 hours**

Using the CADC certification above and considering the individual is a new FT hire with a bachelors' degree with no prior D & A experience, he or she would have 2 years in the current position to acquire the necessary 300 hours of SUD specific training (some of which may be counted from his or her college transcript as applicable) and supervision hours. Once the requirements of those 2 years were met, this individual would then have an additional year to apply for and successfully acquire the certification; totaling 3 years from the point of hire to actually obtain full PCB certification.

Using the same CADC certification example above and considering the individual is a new FT hire but has been employed for 1 year within the previous 7 year at another D&A provider… the employee could use the documented supervision hours and training acquired at the previous employer, plus 1 year of employment at the present employer to total the 2 required FT years to meet the combined requirements for employment, training and supervision. In this case, it would take 1 year of employment with the current facility plus one additional year to actually apply for and acquire the certification, for a total of 2 years from hire with the current employer before obtaining full PCB certification. **(Requirements for PCB Credentials at a Glance** *For complete details see https://www.pacertboard.org/certifications)*

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III.Q.3: Does the requirement of a Physician being available 24-hours a day include the option of utilizing a Physician's Assistant?

III.A.3: YES, both are credentialled to provide expertise medical care and are knowledgeable to assess and treat medical conditions. However, a physician must sign off on the work of a Physician Assistant.

III.Q.4: In order to meet the 16 hrs. of counseling services, could a nurse be utilized to do counseling to fill in any staffing gap?

III.A.4: That depends…While an individual with a nursing background/degree who has a clinical specialty in human services can apply for and be hired as a counselor, a nurse could not automatically fill in as counseling staff to meet a staffing void for that 16-hour requirement on an ongoing basis. Being qualified for a position means having both the degree and the experience. So, if a nurse is qualified for the position of counselor, he/she could serve as a counselor, "in a pinch", even if they were not initially hired for counselor. However, if the nurse is counseling on a somewhat regular basis or is officially filling a portion of the 16 hours of required therapeutic availability, DDAP would expect to see an updated job description reflecting both nursing and counseling duties and the nurse would also need to meet the annual training requirements for counselor.

Otherwise, the staffing regulations remaining intact and Alert 3–02 specifically addresses primary care staffing availability including dual roles. In quoting from that Alert, it states… "For the detoxification activity, this means that primary care hours are 24 hours a day, seven days a week. Staffing levels of primary care staff must be maintained for each shift, 24 hours each day. These designated staff may not have any duties other than in the detoxification unit." Therefore, in this case, a nurse would not be able to serve in a dual capacity.

III.Q.5: Regarding 16 hours of counseling, must these counseling services be available daily from 7:00 am – 11:00pm?

III.A.5: The intent of the requirement is that there is the availability of therapeutic services available for the 16 hours of awake time on a daily basis, so technically, this covers first and second shifts.

III.Q.6: Could the 16 hours of counseling be met by using "on call" or PRN staff?

III.A.6: As stated earlier, the intent of the 16 hours designated for clinical services is so a person can be accommodated during awake hours with their counseling needs as their medical and/or psychiatric conditions are being addressed and stabilized. Depending upon the medical diagnosis and interventions; the latter being the priority issues for the acute hospital setting. A significant portion of the day shift hours may be engaged addressing biomedical needs rather than in meeting the psychosocial/Counseling needs of the individual. While counseling staff

may have historically delivered services primarily during first shift working around or even taking a backseat to the biomedical interventions, in order to align with the ASAM Criteria, it will mean extending counseling availability into the second shift to better meet those needs. There is nothing to prohibit a facility from using on-call or PRN counseling staff; however, this would need to be done on a consistent, daily basis in order to achieve the overall expectation. So, one would wonder at what point would the PRN staff then become regular employees? Additionally, all PRN counseling staff must be fully qualified and meet the appropriate training requirements. Lastly and most importantly, if second shift were always to be staffed by on call or PRN therapists, one might wonder about the continuity of care from day to day with existing patients or even consistency of operations for the facility in general.

III.Q.7: Regarding 16 hours of counseling, are counseling services need to be delivered in the building for a 16-hour period on a daily basis? If I work 2 therapists' daylight, does that meet this requirement? Or does this have to be 16 hours a day 7am to 11pm example?

III.A.7: The intent of the requirement is that there is the availability of therapeutic services available for the 16 hours of wake time on a daily basis, so technically, this covers first and second shifts.

III.Q.8: Do social workers need to be licensed if they are operating as internal case managers?

III.A.8: All staff delivering professional services within a SUD treatment provider should be either licensed or certified. In the instance of case managers, there is an option for staff to either be licensed in the discipline for which they hold a degree – such as in the case of a social worker – or, to have or obtain the credential of Certified Allied Addiction Practitioner (CAAP) through the Pennsylvania Certification Board. In the situation of a social worker who serves the entire hospital and not just the SUD unit, contact should be made with the Single County Authority's case management services for collaboration and coordination of care, when available.

IV. THERAPIES

Questions submitted related to Therapies overlapped with staffing questions and were answered in section III.

V. ASSESSMENT/TREATMENT PLAN REVIEW

V.Q.1: What is "evidence of neutrality" when conducting a Level of Care Assessment (LOCA) and how will it be monitored?

V.A.1: Whether intended or implicit, bias toward the services delivered at the facility where the assessment is being conducted might occur. To prevent this, it is best that an independent process for LOCAs occur. In many cases, SCAs or their contracted providers are conducting an independent assessment and then making a referral. However, there are those situations where the LOCA is being done by a potential treating provider. In those cases, evidence of neutrality will include, but not be limited to evidence demonstrating appropriate application of the ASAM admission criteria, evidence of client choice, data demonstrating a sufficient number of referrals to alternate treatment providers, etc. All of the conditions of "evidence of neutrality" have not yet been determined. DDAP will be announcing this more fully in the coming months. This will be an item that will be included in the required monitoring tool issued by DDAP to the SCAs for monitoring the SCAs. DDAP's County Program Oversight Section will be putting additional information out about this in the weeks to come, including how evidence of neutrality will need to be documented.

V.Q.2: Monitoring of Evidence of Neutrality is to begin in the February 2021 monitoring cycle – is this the DDAP monitoring cycle or the SCA monitoring cycle?

V.A.2: SCAs monitor contracted providers, not DDAP. The SCA-Provider monitoring tool is usually issued to the Single County Authorities around late December-early January. The SCAs will have to monitor client files for these contracted providers to ensure 1 – that the individual was referred to the most appropriate level of care based on the application of ASAM criteria and 2 – that the individual was given choice of providers. When DDAP's County Program Oversight Section (otherwise known as CPO) monitors the SCAs, we will be looking at how the requirement was monitored/enforced by the SCA, through a review of the completed monitoring tools. As previously stated, CPO will be putting out additional information about evidence of neutrality in the coming weeks.

VI. DOCUMENTATION

VI.Q.1: How frequently should ASAM Continued Stays be completed for patients receiving opioid treatment services in a Methadone Maintenance Program?

VI.A.1: Because medication assisted treatment, including methadone maintenance offered through a Methadone Maintenance Program is now encouraged to be provided through the full continuum of care, continued stay must be considered in a multi-faceted way. For the clinical/counseling purpose, continued stay must be assessed based upon meeting the criteria for the particular level of care in which the individual is receiving psycho-social counseling, with consideration of continued stay, transfer or discharge based upon meeting the needs addressed on the treatment plan for that particular level of care. Treatment plan reviews must be done in light of continued, ongoing 6-dimensional assessment, be it through a formal or informal process, but one that is always reflected in the progress notes and treatment plan updates. A

guideline for the frequency of re-assessment can be found in the ASAM Criteria, 2013 text on page 110 and for the typical Methadone Maintenance Program which is licensed as an Outpatient Provider the guidance indicates that re-assessment should occur about every 6 sessions.
A person remains appropriate for a given level of care as long as they meet one of 3 conditions: the individual is making progress, but has not yet achieved the goals on the treatment plan; the individual is not yet making progress, but has the capacity to resolve the problems and can meet his or her needs at the assigned level of care or, new problems have been identified that can be appropriately treated at the present level of care. Continued stay is addressed on pages 299-303 of the ASAM Criteria Text, as well as in the PA Guidance Document, pp 18- 20.

VI.Q.2: Does an ASAM Summary sheet need to be completed for clients at the residential and detox level of care? What are the requirements regarding clinician and supervisory sign off/signature on the ASAM Summary sheet?

VI.A.2: DDAP has offered a great deal of historical information about the completion of Level of Care Assessments, Treatment Planning, Continued Stay Reviews in its Treatment Manual, now referred to as The Case Management and Clinical Services Manual and more recently in relation to the alignment with the ASAM Criteria in the "Pennsylvania Guidance for Applying The ASAM Criteria, 2013 revised August 2019/Edited September 2019". Both resources are located on DDAP's website.
Regarding Withdrawal Management, a Level of Care Assessment Summary Sheet has historically not been required because often individuals are referred to this service as emergent care and rather than taking the time to complete a full assessment, referral to withdrawal management has often occurred at the point of screening or before a full level of care assessment could be completed. However, once in withdrawal management, a level of care assessment must be completed in order to determine where the most appropriate level of care for ongoing treatment should occur and so that an appropriate referral can be made. Level of care assessments have always been necessary for residential services. Please reference Part 5 of the Case Management and Clinical Services Manual under the Case Management section.
https://www.ddap.pa.gov/Professionals/Documents/SCA%20Manuals%20and%20incorporated%20documents/2020-25%20Case_Mgt_and_Clinical_Srvcs_FINAL.pdf
Specifically, section 5.02 discusses when a LOCA must occur, section 5.06 discusses WITS requirements, and sections 5.7 references supervisory requirements.

VII. MISCELLANEOUS

VII.Q.1: How will the transition/alignment to the ASAM Criteria be monitored?

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VII.A.1: There will be an ASAM alignment monitoring process that is twofold: certifying that a program has aligned to the service descriptions as far as hours, staffing, etc. and secondly, that care is being delivered according to the criteria in an individualized, clinically appropriate manner. DDAP and DHS is currently engaged in developing this process since monitoring is specifically a requirement of the Centers for Medicare and Medicaid Services for the implementation of the 1115 Waiver. In addition to monitoring being a requirement, we also need a process in place to ensure that what we are currently working toward with alignment is actually being achieved and being done as intended.

Currently, there are various entities that monitor providers for a variety of reasons be it DDAP licensing, DHS, SCAs, or the BH-MCOs. We are currently in the process of working with DHS to sort out the elements of the ASAM alignment to determine what is actually *already* being monitored in the course of other duties be it through licensing reviews, SCA monitoring, BH-MCO audits and monitoring, etc. We prefer not to add any additional layers of review. But exactly who will do what, we are still working that out. So, to specifically answer the question about licensing, we know that they will have a role in ASAM monitoring, but we don't know the full details of what that will entail just yet. While the monitoring process is still in the planning phase, we anticipate monitoring occurring in cooperative, multi-phased way using the monitoring and auditing measures that are already in place wherever possible to assist in the process to keep the process as clean, orderly and with as little administrative burden as possible. We will release the monitoring plan as soon as we can.