pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

DDAP ASAM Technical Assistance Series

Questions and Answers

December 6th, 2021

1. We have had numerous questions regarding the need to complete a discharge ASAM when a client is moving from one level of care to another within the same organization. Some people do not believe a Discharge ASAM needs to be completed by the referring program, just an admit ASAM at the next LOC. Others believe that a discharge ASAM needs to be completed to close out the LOC and indicate the new LOC and then the new LOC would complete an admit ASAM. Could you please clarify when a discharge ASAM is to be completed?

   A discharge ASAM Summary sheet should be completed when a client has completed their entire treatment episode. If a patient is transferring to another level of care, an admission ASAM Summary Sheet should be completed by the receiving provider.

2. What are the ASAM alignment requirements for documentation of nonclinical groups?

   ASAM criteria 2013, edition states across the levels of care that “Documentation standards . . . include individualized progress notes in the patient’s record that clearly reflect the implementation of the treatment plan and the patient’s response to therapeutic interventions for all disorders treatment, as well as subsequent amendments to the plan.”
   programs should include individualized progress notes in the patient record that clearly reflect

   DDAP regulations require the presence of progress notes in the client record, however they do not detail the content of progress notes. DDAP Bureau of Program Licensure does review progress notes during inspections. DDAP Bureau of Program Licensure compares the record of service entry with the corresponding progress note (i.e. if a record of service documents an individual session was conducted on October 10, DDAP will verify there is an individual progress note for October 10.) DDAP Bureau of Program Licensure reviews the progress notes to confirm the therapy is being conducted according to the treatment plan. (i.e. if the treatment plan states type and frequency of treatment is 3 groups a week and 1 individual per week, DDAP verifies there are 3 group notes per week and one individual session per week.) 709.92(c) The project shall assure that counseling services are provided according to the individual treatment and rehabilitation plan, and 709.92(d) Counseling shall be provided to a client on a regular and scheduled basis. The provider is encouraged to discuss with their MCO and all payers whether they have a required format for clinical documentation (individual progress notes, group notes, etc.)

3. How would recreational interventions be documented? Would para-professional staff (tech staff) be able to document?

   There are no requirements in regulation or requirements or recommendations in ASAM about who does what documentation or what needs to be included in documentation. DDAP regulations require the presence of progress notes in the client record, however they do not detail or regulate the content of progress notes. Recreational interventions must be tied to a specific need identified in the assessment and addressed through a particular goal on the individualized treatment plan. The progress note, charted for a group or for each person, should be individualized to reflect the progress of the treatment plan and can be noted by the person overseeing the intervention. Providers should follow their policies and procedures regarding documentation standards and reach out to payors for requirements regarding staff qualifications and other standards for documentation.

4. For documentation of life skills and therapeutic recreation do these need to be done in DAP format?

   No, there are no requirements in regulation or requirements or recommendations in ASAM about progress note format. DDAP regulations require the presence of progress notes in the client record, however they do not detail the content of progress notes. While DDAP or ASAM does not specify the format the provider must use, it is the expectation that the life skills or recreational activity relates to an individual's need based on the treatment plan, and this should be clear in the clinical documentation of this service. Providers should follow their policies and procedures regarding documentation standards, and they should discuss with their MCO whether they have a required format for life skills and recreation notes.

5. Based on the information provided, would this Daily Summary of Service Form meet the criteria on your monitoring tool to suffice as documentation for group interventions?

   Daily Summary of Services (DSS) Form that documents the following:

   - Patient Name
   - Date and time of service
   - Primary Counselor
   - Whether the service is identified as a self-help service, a seminar (psycho-education/didactic lesson), or clinical group therapy service.
   - The form identifies the title of the group service, the name of the staff facilitating it the specific start and end time of the group intervention
   - Whether the client was in attendance,
   - Individualized assessment of his/her attitude towards the intervention and his/her level of participation in that group intervention.
   - The last part of the document is the Individual Assessment section where the primary counselor will confer with other treatment team members and document an individual assessment of his/her participation in the day's interventions.
   - Includes the stage of change the client appears to be in, and a plan where applicable to modify interventions as needed based on client individual demonstration or need.

   The above example appears to be in line with individualized progress notes which clearly document how the intervention ties back to the assessment and the treatment plan, the patient's response to the intervention, and a plan for next steps. **<u>Strengths</u>** of the above example include individualized assessment of how the patient responded to **<u>each intervention</u>** including participation level and any other clinical observations, identification of the stage of change, and clear documentation of the need for plan modifications, if any. **<u>Weaknesses</u>** or concerns about the above example include the fact that all patients are attending the same programming daily, leaving no room or very little room for individualized patient interventions.

   DDAP regulations require the presence of progress notes in the client record, however they do not detail the content of progress notes. Providers should follow their policies and procedures regarding documentation standards and reach out to payors for requirements regarding staff qualifications and other standards for documentation.

6. As a team, we have reviewed a variety of changes to documentation, one of which includes having patients complete a portion of the document to demonstrate their perception of and commitment to their treatment. Is this allowed?

No, there are no requirements in regulation or requirements or recommendations in ASAM about progress note format. DDAP regulations require the presence of progress notes in the client record, however they do not detail the content of progress notes. Providers should follow their policies and procedures regarding documentation standards and reach out to payors for requirements regarding staff qualifications and other standards for documentation.

7. Most of us do thorough assessments that identify multiple problems. We work with the client to identify what is most important for them to work on. Is it the expectation that we weave all identified areas of concern through treatment plans? This is not realistic for many.

There are no requirements in regulation or requirements or recommendations in ASAM indicating that all identified areas of concern must be addressed in treatment plan, however ASAM Criteria discusses the importance of completing a multidimensional assessment, to include risk ratings, and identifying the priority needs of each individual patient. ASAM Criteria states "Appropriate and well-informed level of care placement can only occur after a sufficient multidimensional assessment and matching of needed services has been performed . . . all six dimensions are evaluated. . . to determine what risks and needs are most pressing for the patient in his or her current situation" (p.59).

Across all levels of care, the ASAM Criteria includes a section titled "assessment/treatment plan review" which providers should be referencing for guidance on this topic. For example, in Level 2.1the following is stated regarding treatment planning: "An individualized treatment plan, which involves problems, needs, strengths, skills and priority formulation and articulation of short-term, measurable treatment goals and preferences and activities designed to achieve those goals. The plan is developed in collaboration with the patient and reflects the patient's personal goals . . . "(p.200) In addition, non-clinical needs can be addressed through case management services (CM). SCAs and contracted providers offering CM services to DDAP funded individuals should follow the requirements outlined in the Case Management and Clinical Services manual section 5.05.

8. Are there examples of an ASAM / DDAP approved treatment plan?

There are no examples of an ASAM/DDAP approved treatment plan. DDAP is not able to "approve" any specific treatment plan template since treatment plans should be driven by the individual patient needs. Providers should follow their policies and procedures regarding documentation standards and reach out to payors for requirements regarding treatment planning. In addition, DDAP recommends providers attend trainings relevant to this topic, including Treatment Planning with the ASAM Criteria DDAP Training - Treatment Planning with the ASAM Criteria (pa.gov).