COMMONWEALTH OF PENNSYLVANIA – DEPARTMENT OF HEALTH

CHAPTER 157. DRUG AND ALCOHOL SERVICES

GENERAL PROVISIONS


When a hospital provides inpatient drug and alcohol detoxification services or inpatient drug and alcohol detoxification and treatment and rehabilitation services, it shall provide the services in a manner sufficient to meet the medical and psychological needs of the patients.

§157.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Aftercare plan – A plan for patients to follow after they leave formal treatment. It is the patient’s individual plan for the future, including an identification of the patient’s personal goals and objectives.

Detoxification – The process whereby a drug or alcohol intoxicated or dependent patient is assisted through the period of time necessary to eliminate, by metabolic or other means, the presence of the intoxicating substance, while keeping the physiological or psychological risk to the patient at a minimum. This process should also include efforts to motivate and support the patient to seek formal treatment after the detoxification phase.

Follow-up – The procedure by which the staff determines the status of a patient who has been referred to an outside service provider for services or who has been discharged from the drug and alcohol service.

Treatment and rehabilitation – Following the physiological detoxification phase, activities carried out specifically to effect the reduction of the dysfunction of the patient. This includes the systematic application of social, psychological or medical service methods to assist individuals to deal with the causative effects or consequences of drug or alcohol abuse.
§157.3.   Organization.

(a) Inpatient drug and alcohol services shall comply with §§157.21 – 157.25 (relating to inpatient hospital activities – detoxification). These detoxification services should be provided in an identified drug and alcohol unit, but may be provided in beds dispersed throughout the hospital.

(b) Those drug and alcohol programs that intend to provide formal treatment beyond the detoxification phase of care shall also comply with §§157.41 – 157.44 (relating to inpatient hospital activities – treatment and rehabilitation). The services shall be provided in an identified drug and alcohol treatment and rehabilitation unit within the hospital.

§157.4.   Director of drug and alcohol services.

When a hospital provides inpatient drug and alcohol detoxification services or inpatient drug and alcohol detoxification and treatment and rehabilitation services, there shall be a director of the drug and alcohol services who is responsible for the planning, organization, implementation, and management of the services and is qualified to perform these functions by education and experience.

INPATIENT HOSPITAL ACTIVITIES DETOXIFICATION


(a) Admission procedures other than initial medical or psychiatric care shall be performed at a time when the patient is mentally and physically capable of comprehension and response.

(b) Admission procedures shall include documentation of the following:

(1) Histories, which include the following:

   Histories should be constructed to collect as much personal information about a patient as possible since they form the basis from which the psychosocial evaluation and subsequent treatment plans are formulated.

   (i) Medical history.

   A history documenting the patient’s personal medical history, family medical history, and history of illness and symptoms.

   (ii) Drug or alcohol history, or both.

   A history documenting the substances most frequently abused, the length and patterns of use, prior treatment episodes. Include the
patient’s perception of their effect on his/her social, physical and mental
state. It is recommended that any substance abuse history within the
family, or that of significant others be noted.

(iii) Personal history.

Historical and current personal data including: family, legal,
employment/vocational, educational, military, recreational, sexual, and
others where appropriate.

(2) Consent to treatment.

A consent to treatment form should be signed by the patient and staff person at
intake. This consent could be integrated with other forms/procedures, e.g.,
liability determination, support plan, intake and orientation verification.

(3) Physical examination.

The results of the physical examination should be documented according to the
following: evidence of injuries, serial neurological examination, an
investigation of the organ systems for possibilities of infectious disease,
pulmonary, liver, and cardiac abnormalities, dermatologic sequelae of
addiction, and concurrent problems. In addition, the physical examination
should include a determination of the patient’s vital signs (temperature, pulse,
and blood pressure and respiratory rate); an examination of the patient’s
general appearance, head, ears, eyes, nose, throat (thyroid), chest (including
heart, lungs and breasts), abdomen, extremities, skin assessment; and the
project physician’s overall impression of the patient.

The project should make every effort to utilize results of physcals in
determining related medical care needed and the appropriateness of patient
involvement in all project activities.

It is recommended that the following laboratory tests be completed for each
patient at admission to a project in addition to the required examination stated
in the above paragraph:

- STAT blood alcohol level;
- Complete blood count and differential;
- Blood or urine drug screen for the detection of multiple drug use;
- Serological test for syphilis;
- Routine and microscopic urinalysis;
• Liver function profile, e.g., SMA-12, etc.;

• Tuberculin skin test, and when positive, a chest X-ray;

• When clinically indicated; Australian Antigen HG Ag Testing (HAA testing), EKG; and

• When appropriate, pregnancy test and a pap smear.

When a patient is readmitted to a project within one year, the physical exam or lab tests should be at the discretion of the physician.

(4) Psychosocial evaluation.

The evaluation should provide a composite picture of the individual in relationship to the collected historical information in order to identify possible relationships, conditions and causes leading to the patient’s current situation.

§157.22. Patient management services.

(a) There shall be a written plan that delineates specific service planning and counseling approaches used to promote patient interest in participating in necessary treatment following the detoxification process.

(b) The service staff shall develop a written patient aftercare policy.

The policy should include the staff members responsible for the aftercare plan, when and how it is to be developed and the format to be used.

(c) The service staff shall develop a written patient follow-up policy.

The policy should include who is responsible, method and frequency of contact and the manner of documentation.


(a) In addition to the requirements contained in §115.32 (relating to contents), the patient’s medical record shall contain a drug and alcohol support plan, follow-up information, and an aftercare plan, if applicable.

Drug and alcohol support plan.

A plan that reflects the project’s efforts to support and motivate the patient to seek formal treatment after the detoxification process. This plan should delineate methods the project plans to use to cope with denial, to promote better understanding of chemical dependency and to encourage patient participation in formal treatment.
Follow-up information.

When a patient has been discharged and referred to an outside resource, the project should, with the written consent of the patient and within one week from the day the referral is to be completed, attempt to determine from the resource the disposition of the referral. Once the attempt has been made and documented, a project may consider its obligation to the individual fulfilled.

Where patients are not referred after discharge, some attempt should be made to follow-up the ex-patient’s progress and status in accordance with the agency’s written policy.

Aftercare plan, if applicable.

A plan for patients to follow after they leave formal treatment. It is the patient’s individual plan for the future, including an identification of the patient’s personal goals and objectives. It should focus on sustaining and building on the progress achieved during treatment and should have input from all significant persons, especially the patient. It is recommended that the plan should contain the following:

- The patient’s future goals with time frames.
- A description of the services that can be provided by the project after discharge, if necessary.
- The method and frequency of continuing contact to provide patient support.
- Criteria for re-entry into the project.
- Provision for the periodic re-evaluation and termination of the plan.

Aftercare plans are not required where patients have left treatment against project advice or refuse to participate in an aftercare plan. Plans are also not required if a patient is being referred to another facility for further treatment. In this case, follow-up would suffice. This action should be documented in the patient record.

(b) Patient records shall be kept confidential in accordance with applicable Federal drug and alcohol regulations and the confidentiality requirements in 4 Pa. Code §255.4 and §255.5 (relating to UDCS: confidentiality and access to information and projects and coordinating bodies: disclosure of client-oriented information).


The drug and alcohol service shall comply with the Department’s Uniform Data Collection System if the service utilizes Department funds.
§157.25. Notification and termination.

(a) The director shall notify the patient, in writing, of a decision to involuntarily terminate the patient’s treatment in the service. The notice shall include the reason for termination.

*A copy of this notice should be maintained in the patient’s record.*

(b) The patient shall have an opportunity to request reconsideration of a decision terminating treatment.

*The patient should be informed of this right in the termination notice itself and/or in a patient’s rights statement disclosed to the patient during intake/orientation.*

*The request should be in writing and a copy maintained in the patient’s record.*

INPATIENT HOSPITAL ACTIVITIES TREATMENT AND REHABILITATION


(a) The service director shall develop a written plan providing for admission which shall include, but not be limited to, the following:

(1) Criteria for admission.

*Criteria should include age, sex, physical and/or mental conditions, geographic requirements and nature of the D/A problem. Any special project limitations should also be noted, e.g., serving the handicapped, psychotic, non-English speaking populations.*

(2) Treatment models utilized by the service.

*Examples – individual, group, family counseling, bio-feedback, antabuse, or other medication, etc.*

(3) Requirements for completion of treatment.

*Requirements for completion of treatment should be viewed from both the project and the patient perspectives, including the length of treatment, employment, financial independence, substance usage, interpersonal relationships, etc.*

(4) Involuntary discharge/termination criteria.

*Examples – involuntary discharges (acts of violence, use/misuse of chemicals, etc.) and administrative discharges (absenteeism, failure to actively follow the treatment plan, etc.).*
(b) Admission procedures shall include documentation of the following:

(1) Disclosure to the patient of criteria for admission, treatment, completion, and discharge.

*Disclosure may be documented in initial progress notes, the consent to treatment, or orientation packet.*

(2) Patient orientation to the service which shall include, but not be limited to a familiarization with the following:

*See (b)(1) above for acceptable documentation of patient orientation.*

(i) Service policies.

*Project rules and requirements related to treatment.*

(ii) Services provided.

(3) Initial treatment and rehabilitation plan.

*An Initial Treatment Plan should be developed based upon information derived from the initial interview, psychosocial and other evaluations. This plan should also identify critical patient problems and strategies for their resolution.*

§157.42. Treatment and rehabilitation services.

(a) The director shall be responsible for a written plan for the coordination of patient treatment and rehabilitation services which shall include, but not be limited to:

(1) Defined target population.

*That portion of the general population toward whom facility services are directed.*

(2) Treatment models utilized by the service.

*Examples – Behavior Modification, Reality Therapy, Conjoint Family Therapy, Ego Psychology, Transactional Analysis, Gestalt, etc. Documentation of patient services should be consistent with the conceptual treatment model.*

(3) Written procedures for the development, approval and ongoing management of treatment/rehabilitation services for patients.
This procedure should indicate who is responsible for the development, approval, monitoring and evaluation of patient services (intake through discharge).

(4) Written procedures for referral outlining cooperation with other service providers.

Referral procedures should state who makes and accepts referrals and how they are to be documented. Procedures should address incoming as well as outgoing referrals.

(b) An individual treatment and rehabilitation plan shall be developed with each patient. This plan shall include, but not be limited to written documentation of the following:

(1) Short and long-term goals for treatment as formulated by both staff and patient.

Goals should be realistic and stated in terms of measurable criteria.

(2) Type and frequency of treatment and rehabilitation services.

Example – group counseling twice a week, family therapy every three weeks, bio-feedback bi-weekly.

(3) Proposed type of support service.

These services may include medical, psychiatric or psychological services, economic, legal, AA, NA, etc.

(c) Treatment and rehabilitation plans shall be reviewed and updated at least every 15 days.

Treatment plan update should include an assessment of the patient’s progress in relationship to the stated goals of the comprehensive treatment plan. The following issues should be considered.

• Have problems or issues that have been identified in the comprehensive treatment plan been impacted upon through treatment?

• Do the goals need to be revised or restated?

• Do the treatment strategies or action steps need to be modified?

• Is closure reflected when goals have been achieved?

Treatment plan update should be signed and dated by the primary counselor and it is recommended that it be countersigned and dated by the supervisory counselor.
(d) Treatment services shall be provided on a regular and scheduled basis in accordance with the individual treatment and rehabilitation plan.

Counseling services may be documented within the progress notes and the record of services.

§157.43. Patient support services.

The service staff shall assist the patient in obtaining the following supportive services, when necessary:

Examples of documentation may include letters of agreement/understanding, referral log, progress notes, etc.

(1) Educational.

Examples – GED services, reading development, special tutoring, on grounds school.

(2) Vocational.

Examples – vocational assessment, skill development, preparation for job applications/interviews.

(3) Job development and placement.

(4) Economic.

Examples – housing, income, food supplements, general/medical assistance, transportation.

(5) Legal.

Examples – court representation, bail services, legal assistance.

(6) Recreational/social.

Examples – athletics, arts and crafts, games, cultural field trips, dances, picnics.

(7) Medical/dental.

§157.44. Therapeutic environment.

There shall be adequate space, facilities and equipment to meet the needs of the patients for privacy and for group interaction.