



**pennsylvania**

DEPARTMENT OF DRUG AND  
ALCOHOL PROGRAMS

*Department of Drug and Alcohol Programs*

**TREATMENT MANUAL**

July 1, 2015 – June 30, 2020

Effective 7-1-2015  
*Revised January 2016*

# TREATMENT MANUAL

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## **Section 1.00 Purpose and Use of the Treatment Manual**

DDAP has developed this manual to provide SCAs and service providers with information to assist in implementing the necessary requirements for the provision of treatment, treatment-related and case management services. The intention of the Treatment Manual is not to be all inclusive as it relates to the provision of treatment and treatment related services; therefore, other documents may need to be referenced (e.g. PCPC, ASAM, licensing regulations, etc.). Additionally, there are other requirements outlined in the Grant Agreement specifically pertaining to special initiatives that may be applicable to the SCA and its contracted providers.

If there are conflicts with other documents, the SCA Grant Agreement takes precedence over the Prevention, Treatment, Fiscal, Operations, and SCA Gambling Manuals issued by DDAP, unless otherwise specified by DDAP or the Commonwealth, such as in Policy Bulletins or Management Directives. In addition, it may be necessary to issue temporary instructions, which will take precedence over material in this Manual. When this is done, the temporary instructions will clearly state the exception and include an expiration date.

## Section 2.00 History and Context for the Treatment Manual

Historically, drug and alcohol treatment was rooted in a peer based model of care, with recovering individuals working collaboratively in all aspects of the drug and alcohol system. Over time there have been changes which have diminished this practice, as well as new approaches that have developed.

Recovery from alcohol and other drug dependency is a highly individualized journey that includes the pursuit of spiritual, emotional, mental and physical well-being which may be supported through the use of medication that is appropriately prescribed and taken.

In general, there are several significant movements occurring whose principles are interwoven throughout the Treatment Manual and are encouraged within the context of diverse local procedures:

1. **Recovery Oriented System of Care:** There is a movement in the drug and alcohol field from an acute care model of treatment to a recovery management model, also known as a chronic care approach to recovery. Understanding Substance Use Disorder as a disease, it can be understood from a management perspective like other similar diseases such as diabetes, heart disease and asthma. This model has changed over time but currently the concept is often referred to as Recovery-Oriented Systems of Care (ROSC). The foundation of this approach includes but is not limited to: accessible services; holistic health focus; a continuum of services rather than crisis-oriented care; person-centered emphasis; utilization of support from individuals with lived-experience; and culturally competent care that is age and gender appropriate. Principles of ROSC are detailed in the interagency white paper “*Recovery Oriented System of Care: A Recovery Community Perspective*” (Pennsylvania Drug and Alcohol Coalition, 2010)
2. **Trauma Informed Care:** There is a growing awareness of the impacts of trauma among those with Substance Use Disorder. This can improve identification and response to these needs. Systems and interventions can benefit from awareness of effective treatment tools for these issues, as well as sensitivity to how these experiences impact engagement, retention and recovery.
3. **Motivational Enhancement:** Motivation plays an important role in client engagement and retention. Often individuals have low motivation or external motivation when they first contact the treatment systems. It is the responsibility of any professionals or peers in contact with these individuals to actively utilize practices to engage and motivate individuals to the types of services that are most appropriate, even if those services are offered at a different provider or service system. This is especially important if the needs of the individual exceed the expertise and scope of practice of the professional or peer attempting to increase engagement. Motivational Interviewing and Motivational Enhancement Therapy are examples of theory and practices to target specific interventions to increase motivation at all stages of individual engagement.
4. **Evidence-Based Practices:** In this time when only one individual receives treatment for every eight individuals in need, it is important that interventions be selected which

emphasize *research tested* principles, and that we avoid funding of practices which have proven ineffective or harmful. While innovative practices are encouraged and may be used with caution, there are a range of evidence-based programs and practices that have been replicated for positive outcomes for over 40 years, which should be a driving force in treatment approaches. Nationally recognized programs can be found in several registries such as the federal Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices (NREPP) located at <http://www.nrepp.samhsa.gov/> as well as the Blueprints Program's listed at <http://www.blueprintsprograms.com/>. Appropriate intensity, duration and continuum of services are prime examples of principles that have been validated as critical for effective outcomes. In contrast, *undertreatment* in these three areas (e.g. detox only, or outpatient when long-term residential treatment is indicated by the PCPC) leads to poorer outcomes and contributes to the rates of fatal overdoses. Other examples of elements that have been found to be ineffective are fear-based tactics in prevention services, and simple drug education/information for those in need of treatment.

## Section 3.00 Training for Contracted Drug and Alcohol Treatment Providers

### Training Requirements

The SCA is required to ensure adherence to the following training requirements.

1. All persons providing adult treatment services and their supervisors must complete the following courses:
  - a. DDAP approved Pennsylvania Client Placement Criteria (PCPC)
  - b. DDAP approved Practical Applications of PCPC criteria
  - c. DDAP approved or Pennsylvania Certification Board (PCB) approved Confidentiality
  - d. DDAP approved Practical Applications of Confidentiality Laws and Regulations
  - e. Screening and Assessment
  - f. Addictions 101
  
2. All persons providing adolescent treatment services and their supervisors must complete the following courses:
  - a. Most recent edition of the ASAM Patient Placement Criteria
  - b. DDAP approved, or PCB approved Confidentiality
  - c. DDAP approved Practical Applications of Confidentiality Laws and Regulations
  - d. Screening and Assessment
  - e. Addictions 101

Required courses must be completed within 365 days of hire. All training certificates for required courses must be available for review.

Individuals who completed Confidentiality and PCPC training courses prior to November 2003 are not required to take the related practical application courses.

**Note:** Staff may not administer the PCPC independently until they have completed all training and competency requirements. Upon completion of these requirements, the supervisor must complete the PCPC Attestation Form (DDAP-EFM-1010), which is published on DDAP's website ([www.ddap.pa.gov](http://www.ddap.pa.gov)) under the DDAP Document Library, Forms page. The supervisor must maintain the signed attestation within the staff personnel folder.

Exceptions to the Addictions 101 and Screening & Assessment trainings may be made based on education and experience at the discretion of the SCA.

## **Section 4.00 SCA Treatment Needs Assessment**

The Department of Drug and Alcohol Programs' (DDAP) mission is to engage, coordinate and lead the Commonwealth of Pennsylvania's effort to prevent and reduce substance use disorders and to promote recovery, thereby reducing the human and economic impact of the disease. This work is carried out in conjunction with Single County Authorities (SCAs), their contracted providers and the community at large. As a result, the SCAs have flexibility to develop their service delivery system in response to community needs.

It is well documented that the prevalence of substance use disorders and the demand for treatment do not commonly match the available resources. An estimate of a community's substance use prevalence, incidence and treatment demand can be used to match available treatment resources with projected demand and to plan for the development of new resources based upon unmet needs. Drug use trends and vulnerable populations can change over time across communities. These changes will impact prevalence, incidence and treatment demand estimates and should be used to develop new treatment approaches and systems, if necessary.

It is anticipated that the information provided by the SCAs will significantly contribute to the Commonwealth's ability to detect patterns of unmet need, and to provide a strategic view to funding agencies about what must be done to improve the treatment service system.

It is understood that SCAs are different in their geography, economics, population demographics and density. Consequently, there would be no basis for DDAP to make judgments about the differences between SCAs. When developing a local treatment needs assessment response, SCA Administrators should not be concerned about providing "right or wrong" answers. What is important is to start working with the data to understand it, improve it, and apply it to a needs assessment. Staff from DDAP's Division of Treatment will review SCA responses.

Local information will be helpful when brought to the attention of the Department, since the Commonwealth has an important role to play in facilitating cooperative relationships among the service systems encountered in the daily work of the SCA.

### **Submission of SCA Treatment Needs Assessment**

The Needs Assessment must be completed per the DDAP Report Schedule and in accordance with the directions and any accompanying documents provided by DDAP.

## **Section 5.00 SCA Treatment Plan**

The Treatment Plan provides the opportunity for Single County Authorities (SCAs) to present information on how they are providing the best care and treatment, in the most efficient and effective manner and at the most appropriate level of care to those persons who are in need. It is anticipated that the information provided by the SCAs will significantly contribute to the Commonwealth's ability to detect patterns of unmet need, and to provide a strategic view to funding agencies about what must be done to improve the treatment service system.

The treatment planning process should provide local accountability and reporting regarding the goals and activities of the SCA; identify and address trends and needs based on the population being served; identify the funding required to address those needs; and identify changes in the system that would improve the quality of treatment program services and support services.

These plan guidelines are designed to assist SCAs in using available data as part of the county planning process, in addition to defining needs and developing the resources necessary to meet those needs.

The SCA treatment plan submission allows for DDAP to review the deficiencies identified by SCAs regarding programs, services, and support needs, as well as corresponding plans of action, to correct such deficiencies.

### **Submission of SCA Treatment Plan**

The SCA Treatment Plan must be completed per the DDAP Report Schedule and in accordance with the directions and any accompanying documents provided by DDAP.

## **Section 6.00 Special Populations**

### **Priority Populations**

The SCA and providers which serve an injection drug use population shall give preference to treatment as follows:

1. Pregnant injection drug users;
2. Pregnant substance users;
3. Injection drug users;
4. Overdose survivors; and
5. Veterans

All individuals identified in the above Priority Populations must be offered admission into recommended level of care immediately. If the SCA chooses to restrict access to assessment and/or admission to treatment, such restrictions shall not apply to these Priority Populations.

## **Section 6.01 Pregnant Women**

The SCA must address the needs of each pregnant woman as follows:

1. Screen for emergent care needs.
  - a. If emergent care needs are identified, a referral must be made to the appropriate service.
  - b. If no emergent care needs are identified and an assessment is necessary then;
2. The SCA must conduct a level of care assessment to determine the need for treatment. If treatment is indicated then;
3. Refer the woman to a treatment provider that has the capacity to provide treatment services to the woman immediately.\* If no treatment facility has the capacity to admit the woman, then;
4. Make available interim services to the woman within 48 hours after the assessment.

\* DDAP has special provisions for narcotic treatment programs (NTP) that are at capacity but need to admit a pregnant woman. DDAP's Division of Drug and Alcohol Program Licensing will consider approving an exception request for any NTP, on a case-by-case basis.

Interim Services are defined as services to reduce adverse health effects of substance abuse, to promote the health of the individual, and to reduce the risk of transmission of a disease until the individual is admitted to a treatment program. At a minimum, interim services include:

1. Counseling and education about HIV and TB;
2. Counseling and education about the risks of needle sharing;
3. Counseling and education about the risks of transmission to sexual partners and infants;
4. Counseling and education about the steps that can be taken to ensure that HIV and TB transmission do not occur;
5. A referral for HIV and TB treatment services, if necessary;
6. Counseling on the effects of alcohol and drug use on the fetus; and
7. A referral for prenatal care.

The SCA must have a resource list that clearly identifies, by address and phone number, who will provide each interim service. The title of each type of interim service must be on the resource list exactly as written in the above list. The SCA must also have written procedures that include a description of the mechanism to maintain contact with the pregnant woman until admission into treatment occurs. Tracking of the pregnant woman must occur regardless of

whether the woman is receiving interim services. Any reference to interim services in procedures or a resource list must be stated exactly as written above.

The SCA shall ensure that the availability of preferential treatment services to pregnant women is publicized. This may be done by means of ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community-based organizations, health care providers and social service agencies. The listing of priority populations cannot serve as publication of preferential treatment for pregnant woman.

## Section 6.02 Injection Drug Users (IDU)

The SCA shall require notification within seven days from those programs that treat individuals for injection drug use upon reaching 90 percent of its capacity to admit individuals to the program.

*Note: The following only pertains to non-pregnant IDU.* The SCA shall ensure that each individual who has been identified as needing treatment services for injection drug use is offered admission to a program for such treatment immediately following the assessment. If the individual cannot be admitted immediately, interim services must be made available to the individual within 48 hours of assessment and admission must occur no later than 120 days after assessment. During this waiting period for admission, a mechanism for maintaining contact with the individual must be in place.

Interim Services are defined as services to reduce adverse health effects of substance abuse; to promote the health of the individual; and to reduce the risk of transmission of a disease until the individual is admitted to a treatment program. At a minimum, interim services include:

1. Counseling and education about HIV and TB;
2. Counseling and education about the risks of needle sharing;
3. Counseling and education about the risks of transmission to sexual partners and infants;
4. Counseling and education about the steps that can be taken to ensure that HIV and TB transmission do not occur; and
5. Referral for HIV and TB treatment service, if necessary.

The SCA must have a resource list that clearly identifies, by address and phone number, who will provide each interim service. The title of each type of interim service must be on the resource list exactly as written in the above list. The SCA must also have written procedures that include a description of the mechanism to maintain contact with the individual until admission into treatment occurs. Tracking of the individual must occur regardless of whether he or she is receiving interim services. Any reference to interim services in procedures or a resource list must be stated exactly as written above.

6. The SCA shall ensure outreach activities are carried out for injection drug users who have not yet entered treatment. For the purpose of contracting and expenditure reporting, these outreach activities are to be identified as Activity 7200 – Intervention, per DDAP’s Fiscal Manual. The SCA must have written outreach procedures that include the following:
  - a. Who at the SCA ensures that outreach activities are carried out as planned and how oversight is accomplished;
  - b. Who, specifically, is selected to perform outreach;
  - c. What types of training the outreach workers receive;

- d. What those specific outreach activities are;
- e. How outreach workers contact and follow up with the IDU population;
- f. How the IDU population is made aware of the relationship between injection drug use and communicable diseases, like HIV;
- g. How the IDU population is made aware of the steps that can be taken to prevent the transmission of such diseases; and
- h. How outreach workers encourage entry into treatment.

### **Section 6.03 Women with Children**

The SCA shall ensure that, at a minimum, treatment programs providing treatment services to pregnant women and women with dependent children treat the family as a unit, when appropriate, and also provide or arrange for the provision of the following services to these women, including women who are attempting to regain custody of their children:

1. Primary medical care for women, including a referral for prenatal care as well as child care while the women are receiving such services;
2. Primary pediatric care, including immunization, for their children;
3. Gender-specific substance abuse treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, family therapy, nutrition education and education to GED level;
4. Therapeutic interventions for the children in the custody of the women receiving treatment services which may address, among other things, the children's developmental needs, issues of sexual and physical abuse, and neglect; and
5. Sufficient case management and transportation to ensure those women and their children have access to the services provided in the four items listed above.

The SCA shall maintain a current resource list that clearly identifies, by address and phone number, a provider for each service listed above.

## Section 6.04 Overdose Survivors

### Overview

DDAP defines an overdose as a situation in which an individual is in a state requiring emergency medical intervention as a result of the use of drugs or alcohol. Specific examples may be seen in the International Classification of Disease (ICD-10) diagnosis codes for substance overdose or poisoning.

### Requirements

In order to ensure expedient, appropriate and seamless care for an individual who has overdosed, SCAs must develop, implement, and maintain a plan for screening, assessment, treatment and tracking of individuals who have survived a recent overdose. The policy and procedure must include:

1. The details or process by which an overdose survivor will be offered a 24/7 direct referral from the ED to treatment by one or any combination of models noted below;
2. The parties responsible (including having on file any MOU or LOA that may apply);
3. The timelines for the processes involved; and
4. The mechanism for tracking such referrals or refusals for treatment.

This may be accomplished through a timely exchange of referral information from the referring party to the SCA. Such a tracking mechanism may be between the hospital and SCA and/or between the treatment provider network and the SCA. This should include those individuals who are publicly funded, and wherever possible, those individuals who are otherwise funded, even if by basic, unidentified referral statistics.

Regardless of the models chosen by the SCA, all of the elements noted in the preceding paragraph must be present to receive approval of the policy.

As indicated, the policy and procedure established must include one or a combination of the following identified models:

1. **SCA Agency Model:** The SCA, through case management staff or, in the case of a functional unit, through treatment staff, provide assessment services to local healthcare facilities/EDs. In such instances, the SCA would need to assure that procedures for referral to treatment during after hours, weekends and holidays are established for their county, rather than the provision of a number to call during non-business hours.
2. **Contracted Provider Model:** The SCA contracts with a provider(s) i.e., case management units, treatment providers, crisis intervention, etcetera to conduct screening, assessment, and referral services to area hospital EDs. Such an arrangement would be noted in the SCA's contractual agreement with the applicable provider agencies, and would include a work statement and cost of completing such assessments. The SCA facilitates discussions with the agencies and hospital to develop a process to conduct assessments in the hospital setting.

An MOU between *that* agency and the healthcare facilities/EDs (rather than the SCA) may be developed to include protocols for completion of assessments.

3. **Certified Recovery Specialist Model:** Where Certified Recovery Specialist (CRS) services are available to or through an SCA, such staff would be utilized to provide either assessments/referral from healthcare facilities/EDs to treatment OR to provide screening, and/or referral to a professional/provider qualified to clinically assess and refer to treatment. Appropriate training commensurate with the service would need to be completed.
4. **Treatment Provider Model:** The SCAs can assure that *through* the business practices of a local treatment/service provider(s), provider staff is serving the area's Hospital EDs. This may already be occurring as a courtesy/referral source by treatment providers to local healthcare facilities/EDs. (In some instances, the treatment provider may actually be hospital owned/affiliated.)
5. **Direct Referral to Treatment by Hospital Staff:** The hospital Social Worker, detox personnel, or other hospital staff assists a patient with referral directly to SUD treatment. This may occur through a special arrangement that the SCA has with the hospital or by the hospital staff, independent of the SCA; however, it is the expectation that the SCA would be engaged in some level of relationship/arrangement with the hospital or receiving treatment provider as it relates to authorization for funding when necessary and statistically reporting.
6. **Recovery Community Model:** Where the SCA has a strong relationship with the recovery community, be it through a recovery organization or a strong presence of a 12-Step Fellowship, the SCA can arrange for identified/designated individuals who are willing to volunteer with assisting an overdose survivor getting to a treatment facility. This would more likely include client engagement, information and referral to clinical assessment and potential transportation to treatment, rather than assessment and referral. The SCA would be responsible for entering into the necessary agreements with the organization/individuals and for providing basic information on how to access the treatment system within that county.
7. **DDAP Approved Model:** The SCA can present another viable alternative not otherwise mentioned in this policy for DDAP approval or a combination of any of the above. Possible examples might be where an SCA has a strong relationship with the ED hospital staff whose social work department, nursing staff or other identified staff utilize resources made available by the SCA to make a referral directly from the ED; or the SCA might serve as a single point-of-contact with the ED to facilitate referral to treatment with a plan in place for after-hours, weekend and holiday access to treatment.

It should be noted that in those instances in which an entity other than the SCA is responsible for the actual post overdose referral to treatment activity, the SCA should be engaged inasmuch as to have an awareness of the protocol(s) that are occurring within the county and be a partner in the process, especially as it relates to establishing a mechanism for post overdose referrals to treatment of publicly-funded individuals.

SCAs are required to identify which models they will be utilizing and the particular details of the policy and procedure to CPO staff upon DDAP's request.

DDAP is identifying individuals who have overdosed as an additional priority in an effort to better facilitate access to care directly following an overdose event. Admission to treatment for individuals who have overdosed must be considered in conjunction with the requirements delineated in the DDAP Treatment Manual. Further, if the SCA chooses to restrict access to assessment/admission to treatment, such restrictions shall not apply to overdose survivors.

In those instances in which an SCA is unable to actively engage in any of the identified strategies noted within this policy, a waiver request must be submitted to DDAP identifying those specific barriers which prevent implementation as well as action steps and timelines for mitigating the barriers.

## **Section 6.05 Veterans**

### **Requirements**

The SCA or contracted provider is required to address the needs of veterans as follows:

1. Provide the full continuum of treatment services to veterans;
2. Conduct screening and assessment services;
3. Utilize the PCPC to determine the appropriate level of care;
4. Make a referral to treatment; and
5. Provide additional case management services as appropriate.

The SCA cannot deny funding to a veteran regardless of the veteran's eligibility status for Veterans Affairs (VA) benefits.

### **Referrals to VA Facility**

If it is determined that a VA facility is the most appropriate facility to provide treatment for the veteran, the SCA or contracted provider must facilitate a direct connection with the individual and admitting provider, and the referring provider must follow up to determine that the individual actually got to the new provider as planned. It is unacceptable to only provide contact information to the veteran. Case Management Services may continue to be provided while the veteran is in the VA facility, at the discretion of the SCA. If a VA facility cannot facilitate an admission to the appropriate level of care, the veteran must be funded by the SCA.

## **Section 7.00 Placement**

In order to ensure placement in the proper level of care, the SCA and its contracted providers must use the most recent edition of the PCPC for adults and the most recent edition of the ASAM for adolescents.

### **Continuum of Care**

1. The SCA must enter into a fee-for-service contract with at least one provider for each service activity in the full continuum of care. Two exceptions to using a fee-for-service contract may apply: 1) start-up programming costs; and 2) treatment services that occur in a jail setting. For specific contract information, refer to the DDAP Operations Manual.

The development of this provider network shall occur either within or beyond the SCA's geographical area. The full continuum of care shall include the following services:

- a. Outpatient to include Intensive Outpatient (adult and adolescent);
  - b. Partial Hospitalization (adult);
  - c. Halfway House (adult);
  - d. Medically Monitored Inpatient Detoxification (adult);
  - e. Medically Monitored Short-Term Residential (adult, adolescent, women with children)
  - f. Medically Monitored Long-Term Residential (adult)
2. Early Intervention may be delivered by the SCA directly or via contract with a service provider. Contracts may be fee-for-service or cost reimbursed.
  3. The SCA shall contract with a licensed and approved methadone maintenance provider and refer adults for its service as indicated by the PCPC.
  4. SCAs are not required to contract with providers of Medically Monitored Long-Term Residential for adolescents, Medically Managed Inpatient Detoxification, Medically Managed Inpatient Residential, Adolescent Halfway House, and Early Intervention. However, before the SCA expends DDAP funds for these services, a contract with the provider must be fully executed.
  5. Contract language must specify all of the populations served (i.e., adult, adolescent, pregnant women, IDU).

## **Section 7.01 Halfway House Services**

### **Overview**

A halfway house provides a home-like atmosphere within the local community, is accessible to public transportation, and provides opportunities for independent growth and responsible community living. Mutual self-help, assistance in economic and social adjustment, integration of activities of daily living and development of a sound recovery program are components of halfway houses.

### **Requirements**

Prior to the expenditure of DDAP funds, the SCA must:

1. Only contract with DDAP approved halfway house providers.
2. Ensure that a halfway house:
  - a. Is an independent physical structure containing no more than 25 beds;
  - b. Provides no other licensed treatment activity within the same physical structure; and
  - c. First obtains an inpatient non-hospital residential treatment license for the specific facility where the halfway house activity is provided.
3. Ensure that all requests for the establishment and approval of halfway house activities be submitted in writing to DDAP. The SCA responsible for drug and alcohol services in the county in which the facility is located must submit the request. If the location of a halfway house changes, the SCA must submit a new request for approval of the halfway house. The request must be submitted at least 90 days in advance of the projected admissions.
4. The request must include:
  - a. A cover letter from the SCA indicating that the SCA has conducted a review of the facility and material presented, and that the facility meets the requirements contained in the DDAP Treatment Manual.
  - b. Facility full name, facility number, address, telephone number, and director;
  - c. Halfway house capacity including total beds, ratio breakdown of male/female, and focus, if servicing special populations;
  - d. Length of program;
  - e. A copy of the DDAP License for inpatient non-hospital residential treatment and effective date;
  - f. A description of frequency and length of the following:
    - i. Individual Therapy
    - ii. Group Therapy
    - iii. Peer Groups
    - iv. Community Meetings
    - v. Educational Groups

- g. A description of the following Support Services and how services will be accessed by individuals at the facility or in the community:
  - i. Accessibility to public transportation within the community
  - ii. Transportation provided by the facility to employment and appointments
  - iii. Educational services
  - iv. Employment opportunities
  - v. Job training
  - vi. Vocational services
  - vii. Healthcare
  - viii. Recreational activities
  - ix. Life skills
  - x. Social services
  - xi. Mental health services (if an identified need of individual);
- h. A copy of the floor plan and description of the physical structure to include the following:
  - i. Independent physical structure
  - ii. Independent food preparation and dining area
- i. A description of how the facility promotes self-sufficiency and independent living; and
- j. Job descriptions and proposed staff composition and qualifications.

Address all applications for approval of halfway house activities as follows:

Pennsylvania Department of Drug and Alcohol Programs  
 Attention: Director of Treatment  
 Division of Treatment  
 02 Kline Village  
 Harrisburg, PA 17104-1503  
 (717) 783-8200

Upon receipt of the request, staff from the Division of Treatment will review all submitted materials. The SCA administrator will be contacted for additional information or clarification, if necessary. Staff from the Division of Treatment may conduct a site visit in order to determine if the facility meets all definitional, programmatic, and funding criteria.

DDAP will send a letter of notification, approving or denying the request to the SCA and treatment facility. In the event the request is denied, the SCA may submit a written appeal to the Director of the Division of Treatment within ten days of the denial.

The SCA may not establish a rate for new halfway house services or enter into a contract prior to receiving written approval by DDAP.

## **Section 7.02 Emergency Housing Services**

The SCA may provide emergency shelter and housing assistance to homeless or near homeless individuals who agree to participate in drug and alcohol treatment, self-help groups, or other recovery support services. The SCA shall ensure that DDAP funds are used only when housing assistance from other agencies is not available. SCAs may authorize housing services retroactively; however, actual payment cannot be made until the individual is assessed by the SCA or one of its subcontractors. Payment shall be limited to 30 days per individual per state fiscal year. If it is determined that the individual is in need of drug and alcohol treatment, self-help groups, or other recovery supports, the individual must agree to participate in such services and follow all recommendations, in order for the SCA to continue to pay for housing services. Individuals who receive emergency housing assistance must be made aware of the requirement to participate in treatment, self-help groups, or other recovery support services as well as the time constraints related to emergency housing. Notification of these limitations must be in writing and individuals receiving emergency housing assistance must sign off on the notification.

### **Section 7.03 Recovery Housing**

A recovery house is a safe and supportive environment where residents in recovery live together as a community. The SCA may contract with an agency or an individual who provides recovery housing. The SCA must develop a standardized approval process that addresses the requirements listed below. Prior to final approval, the SCA must conduct a site visit. Results of the site visit must be documented and be available for DDAP review. Any individual receiving recovery house funding from the SCA must be screened and, if appropriate, receive a level of care assessment. The individual's referral to recovery housing must come from the SCA or one of its assessment providers.

#### **Requirements**

The SCA must ensure that recovery houses funded with DDAP dollars:

1. Have protocols in place regarding appropriate use and security of medication;
2. Verify that residents are informed in writing of all house rules, residency requirements, and any lease agreements upon admission;
3. Have a policy in place which promotes recovery by requiring resident participation in treatment, self-help groups, or other recovery supports;
4. Have a policy requiring abstinence from alcohol and other drugs;
5. Have procedures, including referral agreements, to handle relapse;
6. Have safeguards in place to ensure the safety and protection of each resident, as well as the community; and
7. Be in compliance with all state and local municipal ordinances.

The aforementioned requirements must apply to all residents of the recovery house, regardless of funding source. Payment shall be limited to 90 days per individual per state fiscal year. The SCA must ensure that all individuals receiving this service are notified of limitations on funding for recovery housing. Notification must be in writing and individuals must sign off on the notification.

## **Section 7.04 Medication Assisted Treatment (MAT)**

When an SCA pays for MAT (such as Buprenorphine, Naltrexone, etc.) excluding methadone, individuals must either:

1. Have gone through a level of care assessment and be in the process of being placed into drug and alcohol treatment;
2. Be concurrently enrolled in substance abuse counseling; or
3. Have successfully completed licensed drug and alcohol treatment.

SCAs are not permitted to require drug-free treatment programs to admit individuals who are receiving medication-assisted treatment. Conversely, individuals receiving medication-assisted treatment must have access to all levels of care. SCAs must establish contracts with programs that are entirely drug-free and programs that accept individuals receiving medication-assisted treatment.

The SCA is not permitted to continue to pay for MAT services for individuals who are non-compliant with treatment recommendations. Individuals receiving MAT must be notified of this and any other limitation on funding for MAT. Notification to individuals must be in writing and individuals must sign off on the notification.

SCAs are permitted to reimburse for physician and pharmacy services. SCAs that are paying for MAT services (such as Buprenorphine, Naltrexone, etc.) excluding methadone, are required to have written procedures describing how the coordination and payment of such services will occur within the SCA. These procedures must also include the population being served (i.e., women with children, young adults age 18-24, criminal justice, etc.) and funding being utilized for MAT. These MAT procedures cannot conflict with any of the requirements delineated in the grant agreement. Written procedures must be submitted to DDAP prior to payment for MAT services. The SCA will be notified in writing that their procedures have been reviewed, contain all required information, and do not conflict with grant agreement requirements in order to permit payment for the services by the SCA.

Send procedures to:

Pennsylvania Department of Drug and Alcohol Programs  
Attention: Director of Treatment  
Division of Treatment  
02 Kline Village  
Harrisburg, PA 17104-1503  
(717) 783-8200

Please reference the Substance Abuse and Mental Health Services Administration's (SAMHSA) website (<http://www.dpt.samhsa.gov/medications/medsindex.aspx>) for a listing of FDA-approved medications, to be used in conjunction with substance abuse treatment, for which SCAs are permitted to pay.

## **Section 8.00 Performance Measures**

### **Performance Measure Requirements**

The SCA must adhere to the following performance measures related to timely access to assessment and admission to treatment. Individuals are expected to be assessed or admitted to treatment within established timeframe requirements unless the person is incarcerated, hospitalized or otherwise incapacitated. SCAs must meet DDAP established benchmarks, as follows:

1. No more than 5% of individuals shall wait longer than 7 days for a level of care assessment.
2. No more than 7% of individuals shall wait longer than 14 days to be admitted into the recommended level of care\*.

\*Individuals requiring detoxification must be admitted within 24 hours of identifying the need for this level of care.

## **Section 9.00 Adult Case Management**

### **The Functions of Adult Case Management**

DDAP requires the SCA to provide screening, assessment, and coordination of services. These functions encompass various activities. Screening includes evaluating the individual's need for a referral to emergent care including detoxification, prenatal, perinatal, and psychiatric services. Assessment includes Level of Care (LOC) assessment and placement determination. Through Coordination of Services, the SCA ensures that the individual's treatment and non-treatment needs are addressed as well as ensuring the individual is enrolled in the appropriate health care coverage.

The SCA is responsible for ensuring the individual has access to available drug and alcohol treatment and treatment-related services, which is facilitated through the case management system. All individuals who present for drug and alcohol treatment services must be screened and, if appropriate, referred for a LOC assessment. The provision of services will vary from county to county in terms of how these functions are organized and delivered. In some instances, the SCA may choose to contract for certain case management functions and activities while retaining others.

## Section 9.01 Screening

### Overview

DDAP defines screening as the determination of the need for emergent care services. Another purpose of screening is setting the stage for subsequent interventions. This is the first activity that is provided to an individual that is attempting to access services.

### Requirements

Screening must be provided 24 hours a day, seven days a week. Screening can be conducted by telephone or in person. Initial referrals may come from a number of different entities including intake units, emergency rooms, the criminal justice system, juvenile justice system, primary health care providers, individual practitioners, mental health agencies, child welfare system, family, employers, self-referrals, schools, treatment facilities, clergy, and other social service agencies. However, screening must be done by speaking with the individual who may be in need of services.

Purposes of screening include:

1. To obtain information to ascertain if emergent care is needed in the following areas:
  - a. Detoxification
  - b. Prenatal Care
  - c. Perinatal Care
  - d. Psychiatric Care
2. To motivate and refer, if necessary, for a LOC assessment or other services. After-hours screening does not require the ability to schedule a LOC assessment.
3. To identify individuals being referred by an emergency room or urgent care facility following an overdose.

Due to differences in service delivery systems, DDAP allows emergent care screening to be conducted in the following three ways.

**Option 1:** Ideally individuals conducting screening should be skilled medical or human service professionals (e.g. emergency room triage nurse, crisis intervention caseworker, SCA case manager, counselor) proficient in identifying the need for a referral for emergent care services through a combination of education, training, and experience; or

**Option 2:** Support staff may conduct screening in conjunction with skilled medical or human service professionals. The DDAP screening tool contains trigger questions, which prompt the support staff to transfer the individual to a skilled professional who is able to determine the need for a referral for emergent care services. The Screening Tool – Part 1 Client Profile form (DDAP-EFM-1000) and the Screening Tool – Part 2 Client Screen form (DDAP-EFM-1001) are published on DDAP’s website ([www.ddap.pa.gov](http://www.ddap.pa.gov)) under the DDAP Document Library, Forms page.

**Option 3:** Support staff may conduct screening if the SCA is able to demonstrate, through documentation to be provided during the Quality Assurance Assessment or upon DDAP request, that the individual determining the need for a referral for emergent care services has a combination of education, training, and experience in the following areas:

1. Psychiatric (identification of suicide and homicide risk factors);
2. Perinatal and prenatal (identification of alcohol and other drug use effects on the fetus); and
3. Detoxification (pharmacology, basic addiction, identification of drug interactions).

The SCA must have written referral procedures to address emergent care services available during business hours and after-hours. If procedures are updated at any time by the SCA, the most current dated version of the policy must be signed off by all staff.

If the individual is in need of emergent care, those needs must be addressed at the time they are identified. If an individual is in need of detox at the time of screening, the individual must be admitted to this level of care within 24 hours. If this timeframe cannot be met, the reason must be documented in the individual's file.

There may be times when an individual is assessed but not screened. In these situations, the SCA must document the reason that a screening was not conducted.

### **SCREENING TOOL**

A screening tool at a minimum, must contain:

1. Date of initial contact;
2. Demographic information;
3. Appointment date for LOC assessment (if appropriate);
4. Questions to determine the need for emergent care in the above identified areas; and
5. Identification of individuals who have been referred by an emergency room or urgent care facility following an overdose.

DDAP's screening tool contains two parts and is as follows:

1. Screening Tool – Part 1 Client Profile (DDAP-EFM-1000)
2. Screening Tool – Part 2 Client Screen (DDAP-EFM-1001)

Forms are published on DDAP's website ([www.ddap.pa.gov](http://www.ddap.pa.gov)) under the DDAP Document Library, Forms page.

In cases where the SCA chooses to use support staff in conjunction with skilled professionals, the screening tool must include trigger questions, as per the DDAP tool that would prompt a support staff person to transfer the individual to a skilled medical or human services professional when there is a potential need for emergent care services or a LOC assessment. Any screening tool utilized must be completed in its entirety.

## **Section 9.02 Assessment**

### **Overview**

DDAP defines assessment as the gathering of clinical and non-clinical information which is used to determine the most appropriate level of care (LOC) and any additional non-treatment needs that may impact placement and the recovery process.

### **Requirements**

LOC assessment that may be done by the SCA or by the SCA's contracted assessment providers. The SCA has discretion in determining whether SCA staff and/or contracted staff provide the following assessment activities:

1. LOC assessment and placement determination utilizing the most recent version of the Pennsylvania Client Placement Criteria (PCPC); and
2. Tuberculosis (TB) Screening and Referral Services.

### **LOC Assessment and Placement Determination:**

LOC assessment is defined as a face-to-face interview with the individual to ascertain treatment needs based on the degree and severity of alcohol and other drug use/abuse through the development of a comprehensive confidential personal history, including significant medical, emotional, social, occupational, educational, and family information. A LOC assessment must be completed within seven calendar days from the date of initial contact with the individual. The assessment must be completed in its entirety in one session prior to referring the individual to the appropriate LOC, except when the individual is in need of detox. If either of those timeframes are not met, the reason must be documented. A client cannot be admitted into any other LOC until the LOC assessment is completed.

Once a LOC assessment is completed, it will be valid for a period of six months. The six-month timeframe does not pertain to active clients. This applies to individuals who have never engaged in treatment after being assessed or who have been discharged and are seeking to reinstate services. An exception to this timeline may be made for individuals who were incarcerated during this six-month time period. Specifically, time prior to being in the controlled environment may be considered. If an individual requests to reinstate services prior to the end of the six-month period, the case manager may update the most recent assessment in lieu of completing a new assessment; however, a new PCPC Summary Sheet (DDAP-EFM-1003) must be completed.

If the SCA limits the number of LOC assessments or admissions to treatment, the limitations must be expressed in writing and all individuals must sign off to indicate that they have been notified of the limitations in writing. Such limitations cannot apply to Priority Populations identified in Section 6.00.

In order to determine the appropriate LOC, the individual conducting the LOC assessment must apply PCPC criteria. The PCPC Summary Sheet (DDAP-EFM-1003) must be used to record and exchange client information necessary in making or validating placement determinations. The contents of the PCPC Summary Sheet must comply with state and federal confidentiality regulations. Alterations, modifications, or additions to the PCPC Summary Sheet cannot be made.

The PCPC Summary Sheet (DDAP-EFM-1003) is published on DDAP’s website ([www.ddap.pa.gov](http://www.ddap.pa.gov)) under the DDAP Document Library, Forms page. This form must be completed accurately to reflect the recommendation of the assessor based on PCPC criteria. The PCPC must be based on what LOC the client actually needs and not what funding is or is not available for a specific LOC, or what LOC the client or the referral source is requesting. If, by client choice, the LOC received is lower than the LOC recommended, case notes should document attempts to engage the individual into clinically appropriate services.

<p><b><u>Level 5</u></b> Early Intervention</p> <p><b><u>Level 1</u></b> A Outpatient B Intensive Outpatient</p> <p><b><u>Level 2</u></b> A Partial Hospitalization B Halfway House</p>	<p><b><u>Level 3</u></b> A Medically Monitored Detox B Medically Monitored Short-Term Residential C Medically Monitored Long-Term Residential</p> <p><b><u>Level 4</u></b> A Medically Managed Detox B Medically Managed Inpatient Residential</p>
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**\*Medication-Assisted Treatment may be provided in concert with any LOC**

In addition, the PCPC requires that the following areas be considered prior to placement in order to determine, and maximize retention in, a particular type of service:

Co-Occurring Disorders	Women with Dependent Children
Cultural/Ethnic/Language Considerations	Women’s Issues
Sexual Orientation and Gender Identity	Impairment (e.g. hearing, learning)
Medication-Assisted Treatment (e.g. methadone, buprenorphine)	Criminal Justice Involvement

**Referral and Admission to Treatment**

All individuals must be referred to and admitted to the most appropriate LOC available within 14 days of the assessment excluding previously mentioned Priority Populations identified in Section 6.00 for whom admission must be immediate. Individuals in need of detox must be admitted to treatment within 24 hours. If these time frames cannot be met, the reason must be documented in the individual’s file.

DDAP considers admission to treatment as the first attended appointment with a provider after the LOC assessment has been completed. A treatment episode begins with the admission to treatment.

### **TB Screening and Referral Services**

DDAP collaborated with the Department of Health, Bureau of Communicable Diseases to develop questions in reference to assessing the need for referrals to appropriate TB services. These questions must be included as part of the LOC assessment process.

The SCA must ensure that any entity providing LOC assessment services assess the individual to determine whether or not the individual would be considered high risk for TB as follows:

1. Have you traveled extensively (more than 4 weeks) outside the U.S. in the last five years to high TB-incidence areas (Asia, Africa, South America, Central America)?
2. Are you a recent immigrant (within the past 5 years) from a high TB-risk foreign country (includes countries in Asia, Africa, South America, and Central America)?
3. Have you resided in any of these facilities in the past year: jails, prisons, shelters, nursing homes and other long-term care facilities such as rehabilitation centers? \*If residents of any of these facilities were tested within the past three months, they don't need to have their risk for TB reassessed.
4. Have you had any close contact with someone diagnosed with TB?
5. Have you been homeless within the past year?
6. Have you ever been an injection drug user?
7. Do you or anyone in your household, currently have the following symptoms, such as a sustained cough for two or more weeks, coughing up blood, fever/chills, loss of appetite, unexplained weight loss, fatigue, night sweats?

Any individual that responds with a “yes” to any of the above questions is considered high risk for TB. Written procedures must be in place to address how individuals identified as high risk will be referred to the County’s Public Health TB Clinic.

## Assessment Components

The SCA must ensure that all assessment tools for determining LOC include the following components:

1. **Date of initial contact and date of assessment;**
2. **Demographics:** name, address, birth date, social security number, phone, marital status, sex, race, birth/maiden name;
3. **Education:** literacy, degree to which the alcohol/drug problem has interfered with education
4. **Employment:** degree to which the drug/alcohol problem interferes with employment, are you currently working, what is your job;
5. **Military:** eligibility for VA benefits, combat experience/potential trauma issues;
6. **Physical health:** chronic and current acute medical conditions, past and present medications, are medications taken as prescribed, pregnancy, TB assessment questions (per 9.03.3);
7. **Drug and alcohol:** type and frequency, date of last use, amount and route of administration, length, patterns and progression of use, impact on behavior and relationships with others;
8. **Abstinence and recovery periods:** treatment history, support systems, clean time – when and how;
9. **Behavioral and emotional:** mental health symptoms, involvement in mental health treatment/hospitalizations, suicidal/homicidal ideations or attempts, psychotropic medications;
10. **Family/social/sexual:** child custody/visitation, childcare arrangements, sexual orientation;
11. **Spiritual:** spiritual/religious preference;
12. **Living arrangements:** current living arrangements, recovery environment;
13. **Abuse:** history of any abuse (yes/no), issues that might impact placement
14. **Legal:** probation/parole status, conviction record to include disposition, current charges;
15. **Gambling:** lack of control in frequency of betting, lack of control over amount bet, lying about how much is bet;
16. **Potential barriers to treatment:** other areas that may impact treatment (i.e. transportation, cultural/language, childcare needs); and
17. **Assessment summary:** clinical impressions, level of care determination/PCPC and other special needs considerations, referral to LOC and provider, and interim services (if applicable).

## **Section 9.03 Coordination of Services**

### **Overview**

DDAP defines Coordination of Services as a function of case management through which the SCA establishes an organized approach to coordinating service delivery in order to ensure the most comprehensive process for meeting an individual's treatment and non-treatment needs throughout the recovery process. Through Coordination of Services, the SCA ensures that individuals with complex, multiple problems receive the individualized services they need in a timely and appropriate fashion. The process of Coordination of Services is intended to promote self-sufficiency and empower the individual to assume responsibility for his or her recovery.

Coordination of Services is a collaborative process that includes the following activities: engagement, evaluation of needs, establishing linkages, arranging access to services ensuring enrollment in the appropriate healthcare coverage, advocacy, monitoring, and other activities to address client needs throughout the course of treatment. Coordination of Services includes communication, information sharing, and collaboration, and occurs regularly with case management and/or provider staff serving the client within and between agencies in the community.

### **Requirements**

The SCA shall be responsible for the planning and implementation of case coordination. The SCA shall have the following responsibilities:

1. The SCA must ensure that Coordination of Services occurs for each individual receiving services paid for by the SCA.
2. The SCA must develop a policy which delineates the procedures used for the Coordination of Services.
3. When the SCA contracts with a service provider(s) to perform Coordination of Services on behalf of the SCA, it is required that the SCA provide the service provider with their policy and procedures relating to Coordination of Services.
4. The SCA's Coordination of Services policy and procedures must include the following:
  - a. A mechanism to track and document the delivery of services paid for by the SCA;
  - b. How the SCA or providers will assist with arranging access to services ensuring enrollment in the appropriate healthcare coverage. (i.e. the Medical Assistance application process)
  - c. How and when continued stay review PCPCs are reviewed and approved or disapproved in accordance with timeframes outlined in the PCPC manual.
  - d. A mechanism in place to attempt to re-engage individuals who do not show for treatment or leave treatment prior to being discharged;

- e. A mechanism to ensure a direct contact is made from one level of care to another. Procedures must also include that a follow up contact is made to ascertain whether the client was admitted as planned.
  - f. At a minimum, the need to document that the individual is no longer receiving services from the SCA and reason why services ended.
5. Case Management Service Plan must be completed upon admission to each level of care and every sixty days thereafter, using the Case Management Service Plan form (DDAP-EFM-1008) which is published on DDAP's website ([www.ddap.pa.gov](http://www.ddap.pa.gov)) under the DDAP Document Library, Forms page.

## **Section 9.04 Case Management File Content**

Case Management files must, when applicable, include:

1. Screening tool (DDAP-EFM-1000 and DDAP-EFM-1001)\*;
2. Assessment tool;
3. Documentation of interim services, if applicable;
4. PCPC Summary Sheets (DDAP-EFM-1003)\*;
5. Case Management Service Plan (DDAP-EFM-1008)\*;
6. Consent to release information forms;
7. Acknowledgement of receipt of the Grievance and Appeal policy;
8. Acknowledgement of any limitations;
9. Case notes, which must adequately describe the nature and extent of each contact to include the following:
  - a. Information gathered about the individual,
  - b. Analysis of the information to identify the individual's treatment and non-treatment needs,
  - c. Action to be taken to meet the individual's treatment and non-treatment needs, and
  - d. Case manager's signature or initials and date.
10. Discharge information, once the individual is no longer receiving services from the SCA (i.e., discharge form, case note, etc.).

DDAP strongly encourages all documentation to be typewritten, when possible. Files that are maintained electronically must contain all required components, and a hard copy must be available upon request.

\*These forms/tools referenced above can be found on DDAP's website ([www.ddap.pa.gov](http://www.ddap.pa.gov)) under the DDAP Document Library, Forms page.

## **Section 9.05 Supervision**

### **Requirements of Case Management Supervision**

Supervision of staff providing case management services should be designed to ensure the adequate provision of those services. Procedures regarding supervision will be at the discretion of the SCA. However, the supervision of new staff performing case management functions without having received required core trainings must include a combination of job shadowing and direct observation of LOC assessments. In addition, close supervision and supervisory review of written documentation, to include, at a minimum, the LOC assessment and PCPC Summary Sheets (DDAP-EFM-1003) must be documented in case notes until the case manager has received or been exempted from all required training.

**Note:** This exemption does not pertain to the PCPC or adolescent ASAM trainings.

## **Section 9.06 Staffing Qualifications**

### **Required Qualifications of Staff Providing Case Management Services are as follows:**

Staff delivering case management services must meet the minimum education and training (MET) requirements established by the State Civil Service Commission for one of the following classifications:

1. D&A Case Management Specialist,
2. D&A Case Management Specialist Trainee,
3. D&A Treatment Specialist, or
4. D&A Treatment Specialist Trainee.

Those persons responsible for supervision of staff delivering case management services must meet the MET requirements established by the State Civil Service Commission for the Case Management Supervisor or Treatment Specialist Supervisor. If case management services are being performed by a contracted licensed drug and alcohol treatment provider, individuals delivering the services must meet either the MET requirements for the classifications referenced in this paragraph or the DDAP licensing staffing regulations for either a Counselor or Counselor Assistant. Supervisors of these staff must meet either the MET requirements for the supervisory classifications referenced in this paragraph or the DDAP licensing staffing requirements for Clinical Supervisor or Lead Counselor.

## **Section 9.07 Core Training**

The SCA is required to ensure that those persons providing case management functions and their supervisors complete all required and applicable DDAP-approved case management core trainings within 365 days of hire. All SCA/provider staff certificates from required trainings must be maintained by the SCA/provider.

Exemptions may be made at the discretion of the SCA Administrator for both SCA staff and provider staff for the Case Management Overview, Addictions 101, and Screening and Assessment courses, provided that comparable training and educational requirements have been met. If the SCA Administrator chooses to exempt any staff from the above trainings, the SCA/provider must be able to provide written documentation to justify the exemption. If the SCA Administrator serves in the capacity of case management supervisor and wishes to be exempted from the above training requirements, a written request for the exemption and supporting documentation must be submitted to the SCA's Project Officer in DDAP's CPO Section. Exemptions will then be made at the discretion of DDAP.

SCA Administrators are not permitted to exempt themselves from training requirements. Any staff that previously conducted screening and assessment and had the DDAP-required core trainings prior to November 2003 is not required to take the Case Management Overview course, Addictions 101, and Screening and Assessment. In addition, staff that completed Confidentiality training course prior to November 2003 are not required to take the related practical application courses. All case management staff at the SCA or their subcontracted provider must meet the training requirements of the current edition of PCPC.

Course selection and completion requirements depend upon which functions the case manager has been assigned to perform. The course requirements for each function are outlined below:

### **Assessment - 36 total training hours**

1. Addictions 101 – 6 hours
2. Confidentiality – 6 hours
3. Practical Application of Confidentiality Laws and Regulations – 3 hours
4. Case Management Overview – 6 hours
5. Screening & Assessment – 6 hours
6. PCPC – 6 hours
7. Practical Application of PCPC Criteria – 3 hours

## **Coordination of Services – 21 (30\*) total training hours**

1. Addictions 101 – 6 hours
2. Confidentiality – 6 hours
3. Practical Application of Confidentiality Laws and Regulations – 3 hours
4. Case Management Overview – 6 hours
5. \*PCPC – 6 hours
6. \*Practical Application of PCPC Criteria – 3 hours

\*If conducting continued stay reviews

### **Course Prerequisites:**

Certificates for Practical Application courses are not considered valid if the dates on the certificates are prior to the dates on the PCPC and Confidentiality certificates.

Practical Application of PCPC:

- PCPC

Practical Application of Confidentiality Laws and Regulations:

- Confidentiality

### **Required trainings include:**

1. Addictions 101 – 6 hours (requires DDAP certificate)

This course will cover: Disease concept, stages of dependence, characteristics of common drugs of abuse, mini pharmacology lesson, relapse, withdrawal and detoxification, twelve step recovery, treatment philosophy, intervention, overview of assessment, general concepts about levels of care, motivation for treatment and what makes treatment successful.

2. Confidentiality – 6 hours (requires DDAP certificate or PCB approved)

This course provides participants with the information that they need in order to comply with the applicable federal and state laws and regulations for the confidentiality of drug and alcohol treatment services in the Commonwealth of Pennsylvania. This training is a foundation course for anyone working in the field of substance abuse treatment.

3. Practical Application of Confidentiality Laws and Regulations – 3 hours (requires DDAP certificate)

Case examples allow participants to apply federal and state laws and regulations to field-relevant situations.

4. Case Management Overview – 6 hours (requires DDAP certificate)

This course includes the history and functions of case management in Pennsylvania. The course will also address listening skills, boundary setting, motivational interviewing, engaging the client, stages of change, and an overview of ethics.

5. Screening & Assessment – 6 hours (requires DDAP certificate)

This course will provide an understanding on how to determine emergent care needs as well as how to conduct an effective assessment. The required components of each tool, emergent care issues, screening options, interviewing techniques and review of the DSM-5 Criteria for Substance Use Disorders as well as Gambling Disorder will be covered.

6. Pennsylvania Client Placement Criteria – 6 hours (requires DDAP certificate)

This course is designed to provide participants with the skills and information required to use the Pennsylvania Client Placement Criteria for adults. Participants will be able to apply PCPC to assessment data in order to identify the LOC and treatment type most relevant to meet the individual's needs.

7. Practical Application of Pennsylvania Client Placement Criteria – 3 hours (requires DDAP certificate)

Case examples allow participants to apply placement criteria to field-relevant situations.

**Note:** Staff may not administer the PCPC independently until they have completed all training and competency requirements. Upon completion of these requirements, the supervisor must complete the PCPC Attestation Form (DDAP-EFM-1010) which is published on DDAP's website ([www.ddap.pa.gov](http://www.ddap.pa.gov)) under the DDAP Document Library, Forms page. The supervisor must maintain the signed attestation within the staff personnel folder.

## Section 9.08 Grievance and Appeal Process

The primary objective of the grievance and appeal process is to promote a step-by-step effort at reconciliation between an aggrieved individual and the SCA. Contracted treatment providers and other agencies may have separate grievance and appeal protocols arising from the individual's direct involvement with those programs; however, the SCA's policy must be followed in cases where the grievance concerns an administrative or financial decision made by, or on behalf of, the SCA. The SCA must have an expeditious, accessible, fair, and uniform appeal process in place for resolving grievances.

A grievance is defined as a written complaint by an individual of the decision made by the SCA. An appeal is the *process* utilized to resolve a grievance. At a *minimum*, individuals must be able to file a grievance in the four areas listed below.

1. Denial or termination of services;
2. LOC determination;
3. Length of stay in treatment; and
4. Violation of the individual's human or civil rights.

If the SCA chooses to include additional categories (e.g., "other") that an individual can grieve, it must be made clear what those areas specifically include.

SCAs are required to have an appeal process that includes the following:

1. A policy that describes, at a minimum, a two-stage appeal process where:
  - a. The first level of appeal must be made to a panel made up of SCA staff or a supervisory level staff person, none of whom are directly involved in the dispute. A decision by the SCA must be rendered within seven days upon receipt of the grievance at each level of appeal. In addition, the SCA must inform both the individual and DDAP of the outcome within seven days via the DDAP-approved Grievance and Appeal Reporting form (DDAP-EFM-1009) which is published on DDAP's website ([www.ddap.pa.gov](http://www.ddap.pa.gov)) under the DDAP Document Library, Forms page. It is imperative that client identifying information is not included or attached to this form.
  - b. The final level of appeal must be made to an independent review board or hearing panel that is comprised of an odd number (no less than three) of members who have no financial, occupational, or contractual agreements with the SCA. A decision by the panel chairperson must be rendered within seven days upon receipt of the grievance at each level of appeal. Access to confidential records must be in accordance with state and federal confidentiality regulations. The Department of Drug and Alcohol Programs, the Department of Human Services, or the members of the SCA's governing body (County Executive, County Commissioners, or governing Board of Directors) may not serve as the independent review board or hearing panel. The SCA is required to identify the composition and number of members designated as the independent

review board or hearing panel. In addition, the SCA must inform both the individual and DDAP of the outcome within seven days via the DDAP-approved Grievance and Appeal Reporting form (DDAP-EFM-1009). It is imperative that client identifying information is not included or attached to this form.

2. Notification: The individual must sign-off that they have been notified about the following areas:
  - a. The grievance and appeal policy that outlines the four areas that an individual can grieve with the SCA;
  - b. The need for a signed consent form from the individual so confidential client information relating to the appeal can be provided to an independent review board for the purpose of rendering a decision on the appeal;
  - c. The right to have access to all documentation pertaining to the resolution of the grievance within the confines of state and federal confidentiality regulations; and
  - d. The right to be involved in the process and have representation by means of a client advocate, case manager, or any other individual chosen by the individual at each level of appeal.

## **Section 9.09 Reporting**

### **Service Limitations**

The SCA must notify its Project Officer at DDAP, in writing, within five days, if the SCA discontinues or limits authorization for admission to any LOC or type of service, for any reason, including lack of funding. When limitations are removed, the SCA must notify its Project Officer at DDAP, in writing, within five days. Any limitations cannot apply to Priority Populations identified in Section 6.00.

### **Report Schedule**

All reporting will be due as per the DDAP Reports Schedule which is provided at the beginning of each fiscal year.

## Section 9.10 Confidentiality of Information

The SCA and its contracted providers agree that all persons currently or formerly screened, assessed, diagnosed, counseled, treated and rehabilitated for drug and alcohol abuse and dependence, shall be protected from disclosure of their names, identities, patient records and the information contained therein except as disclosure is permitted by state and federal statute and regulations. To assure confidentiality of client information, the SCA shall make adequate provision for system security and protection of individual privacy. The SCA, treatment providers, and others are subject to the confidentiality requirements of the Pennsylvania Drug and Alcohol Abuse Control Act (71 P.S. §§ 1690.101, et seq.), the Public Health Service Act (42 U.S.C §§ 290ee-3, 290dd-2), Federal Confidentiality Regulations (42 CFR Part 2). Drug and alcohol information is protected in a number of ways that include the following:

71 P.S. § 1690.101, et seq. - established the Pennsylvania Advisory Council on Drug and Alcohol Abuse in 1972 whose authority was ultimately transferred to the Department of Drug and Alcohol Programs by Act 50 of 2010 (71 P.S. § 613.1(9)) and addresses confidentiality requirements at 71 P.S. §§ 1690.108.

28 Pa. Code § 709.28 - standards for licensing freestanding treatment facilities to include adherence to confidentiality requirements

42 CFR Part 2, Subparts A-E - federal regulation governing patient records and information

45 CFR Part 96 - federal regulation governing the privacy of health care information that went into effect on April 14, 2003

4 Pa. Code § 255.5 and § 257.4 - state regulations governing patient records

42 Pa. C.S.A. § 6352.1 - state law clarifying what information may be released by SCAs and treatment providers to children and youth agencies and the juvenile justice system.

Client confidentiality is one of the cornerstones guiding the treatment of substance use disorders. The critical concepts to understand include:

1. Those working with addicted individuals must always be conscious of where and how client identifying information is discussed;
2. Valid consent forms must be formatted to capture all of the required elements to include:
  - a. Name of the individual;
  - b. Name of the program disclosing the information;
  - c. Name of person, agency or organization to whom disclosure is made;
  - d. Specific information to be disclosed;
  - e. Purpose of disclosure;
  - f. Statement of the individual's right to revoke consent (must allow verbal and written revocation);
  - g. Expiration date of the consent;
  - h. Dated signature of individual;

- i. Dated signature of witness; and
  - j. Copy offered to the individual.
3. The information to be released must relate to the purpose of the consent.

DDAP often reviews the SCA and/or their provider consent forms; however, they are only acceptable to DDAP if the forms meet the state and federal drug and alcohol confidentiality requirements.

The SCA and its contracted treatment providers are required to have written procedures associated with the adherence to all federal and state confidentiality regulations. The procedures must include the components below and be signed off by all staff performing or supervising treatment and treatment-related services. Staff not directly performing or supervising services must sign a statement indicating that all information acquired through their employment duties will be kept confidential. The statement must delineate that disciplinary action will be taken if confidentiality is breached.

1. Release of client-identifying information;
2. Storage and security of client records, to include computer security;
3. Completion of required confidentiality training;
4. Staff access to records;
5. Disciplinary protocols for staff violating confidentiality regulations;
6. Revocation of consent, to include how this is documented on the consent form; and,
7. Notification that re-disclosure is prohibited without proper consent.

## **Section 10.00 Adolescent Case Management**

### **The Functions of Adolescent Case Management**

DDAP requires the SCA to provide screening, assessment, and coordination of services. These functions encompass various activities. Screening includes evaluating the individual's need for a referral to emergent care including detoxification, prenatal, perinatal, and psychiatric services. Assessment includes Level of Care (LOC) assessment and placement determination. Through Coordination of Services, the SCA ensures that the individual's treatment and non-treatment needs are addressed as well as ensuring the individual is enrolled in the appropriate health care coverage.

The SCA is responsible for ensuring the individual has access to available drug and alcohol treatment and treatment-related services, which is facilitated through the case management system. All individuals who present for drug and alcohol treatment services must be screened, and if appropriate, referred for a LOC assessment. The provision of services will vary from county to county in terms of how these functions are organized and delivered. In some instances, the SCA may choose to contract for certain case management functions and activities while retaining others.

## Section 10.01 Screening

### **OVERVIEW**

DDAP defines screening as the determination of the need for emergent care services. Another purpose of screening is setting the stage for subsequent interventions. This is the first activity that is provided to an individual that is attempting to access services.

### **REQUIREMENTS**

Screening must be provided 24 hours a day, seven days a week. Screening can be conducted by telephone or in person. Initial referrals may come from a number of different entities including: intake units, emergency rooms, the criminal justice system, juvenile justice system, primary health care providers, individual practitioners, mental health agencies, child welfare system, family, employers, self-referrals, schools, treatment facilities, clergy, and other social service agencies. However, screening must be done by speaking with the individual who may be in need of services.

Purposes of screening include:

1. To obtain information to ascertain if emergent care is needed in the following areas:
  - a. Detoxification
  - b. Prenatal Care
  - c. Perinatal Care
  - d. Psychiatric Care
2. To motivate and refer, if necessary, for a LOC assessment or other services. After-hours screening does not require the ability to schedule a LOC assessment.
3. To identify individuals being referred by an emergency room or urgent care facility following an overdose.

Due to differences in service delivery systems, DDAP allows emergent care screening to be conducted in the following three ways.

**Option 1:** Ideally individuals conducting screening should be skilled medical or human service professionals (e.g. emergency room triage nurse, crisis intervention caseworker, SCA case manager, counselor) proficient in identifying the need for a referral for emergent care services through a combination of education, training, and experience; or

**Option 2:** Support staff may conduct screening in conjunction with skilled medical or human service professionals. The DDAP screening tool contains trigger questions, which prompt the support staff to transfer the individual to a skilled professional who is able to determine the need for a referral for emergent care services. The Screening Tool – Part 1 Client Profile form (DDAP-EFM-1000) and the Screening Tool – Part 2 Client Screen form (DDAP-EFM-1001) are published on DDAP's website ([www.ddap.pa.gov](http://www.ddap.pa.gov)) under the DDAP Document Library, Forms page.

**Option 3:** Support staff may conduct screening if the SCA is able to demonstrate, through documentation to be provided during the Quality Assurance Assessment or upon DDAP request, that the individual determining the need for a referral for emergent care services has a combination of education, training, and experience in the following areas:

1. Psychiatric (identification of suicide and homicide risk factors);
2. Perinatal and prenatal (identification of alcohol and other drug use effects on the fetus); and
3. Detoxification (pharmacology, basic addiction, identification of drug interactions).

The SCA must have written referral procedures to address emergent care services available during business hours and after-hours. If procedures are updated at any time by the SCA, the most current dated version of the policy must be signed off by all staff.

If the individual is in need of emergent care, those needs must be addressed at the time they are identified. If an individual is in need of detox at the time of screening, the individual must be admitted to this level of care within 24 hours. If this time frame cannot be met, the reason must be documented in the individual's file.

There may be times when an individual is assessed but not screened. In these situations, the SCA must document the reason that a screening was not conducted.

### **SCREENING TOOL**

A screening tool at a minimum, must contain:

1. Date of initial contact;
2. Demographic information;
3. Appointment date for LOC assessment (if appropriate);
4. Questions to determine the need for emergent care in the above identified areas; and
5. Identification of individuals who have been referred by an emergency room or urgent care facility following an overdose.

DDAP's screening tool contains two parts and is as follows:

1. Screening Tool – Part 1 Client Profile (DDAP-EFM-1000)
2. Screening Tool – Part 2 Client Screen (DDAP-EFM-1001)

Forms are published on DDAP's website ([www.ddap.pa.gov](http://www.ddap.pa.gov)) under the DDAP Document Library, Forms page.

In cases where the SCA chooses to use support staff in conjunction with skilled professionals, the screening tool must include trigger questions, as per the DDAP tool that would prompt a support staff person to transfer the individual to a skilled medical or human services professional when there is a potential need for emergent care services or a LOC assessment. Any screening tool utilized must be completed in its entirety.

## **Section 10.02 Assessment**

### **Overview**

DDAP defines assessment as the gathering of clinical and non-clinical information which is used to determine the most appropriate LOC and any additional non-treatment needs that may impact placement and the recovery process.

### **Requirements**

LOC assessment that may be done by the SCA or by the SCA's contracted assessment providers. The SCA has discretion in determining whether SCA staff and/or contracted staff provide the following assessment activities:

1. LOC assessment and placement determination utilizing the most recent version of the American Society of Addiction Medicine (Adolescent ASAM); and
2. Tuberculosis (TB) Screening and Referral Services.

### **LOC Assessment and Placement Determination:**

LOC assessment is defined as a face-to-face interview with the individual to ascertain treatment needs based on the degree and severity of alcohol and other drug use/abuse through the development of a comprehensive confidential personal history, including significant medical, emotional, social, occupational, educational, and family information. A LOC assessment must be completed within seven calendar days from the date of initial contact with the individual. The assessment must be completed in its entirety in one session prior to referring the individual to the appropriate level of care, except when the individual is in need of detox. If either of those timeframes are not met, the reason must be documented. A client cannot be admitted into any other LOC until the LOC assessment is completed.

Once a LOC assessment is completed, it will be valid for a period of six months. The six-month time frame does not pertain to active clients. This applies to individuals who have never engaged in treatment after being assessed or who have been discharged and are seeking to reinstate services. An exception to this timeline may be made for individuals who were incarcerated during this six-month time period. Specifically, time prior to being in the controlled environment may be considered. If an individual requests to reinstate services prior to the end of the six-month period, the case manager may update the most recent assessment in lieu of completing a new assessment; however, a new Adolescent Placement Summary Sheet (DDAP-EFM-1002) must be completed.

If the SCA limits the number of LOC assessments or admissions to treatment, the limitations must be expressed in written policy, and all individuals must sign off to indicate that they have been notified of the limitations in writing. Any limitations cannot apply to Priority Populations identified in Section 6.00.

In order to determine the appropriate LOC, the individual conducting the LOC assessment must apply ASAM criteria. The Adolescent Placement Summary Sheet (DDAP-EFM-1002) must be used to record and exchange client information necessary in making or validating placement determinations. The contents of the Adolescent Placement Summary Sheet (DDAP-EFM-1002) must comply with state and federal confidentiality regulations. Alterations, modifications, or additions to the Adolescent Placement Summary Sheet (DDAP-EFM-1002) cannot be made.

The Adolescent Placement Summary Sheet (DDAP-EFM-1002) is published on DDAP’s website ([www.ddap.pa.gov](http://www.ddap.pa.gov)) under the DDAP Document Library, Forms page. This form must be completed accurately to reflect the recommendation of the assessor based on ASAM criteria. The Adolescent Placement Summary Sheet (DDAP-EFM-1002) must be based on what LOC the client actually needs and not what funding is or is not available for a specific LOC or what LOC the client or the referral source is requesting.

<p><b><u>Level 0.5</u></b> Early Intervention</p> <p><b><u>Level 1</u></b> Outpatient Treatment</p> <p><b><u>Level 2</u></b> 2.1 Intensive Outpatient Treatment 2.5 Partial Hospitalization Treatment</p>	<p><b><u>Level 3</u></b> 3.1 Clinically Managed Low-Intensity Residential Treatment (e.g., Halfway House) 3.5 Clinically Managed Medium-Intensity Residential Treatment 3.7 Medically Monitored High-Intensity Inpatient Treatment</p>
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**Referral and Admission to Treatment**

All individuals must be referred to and admitted to the most appropriate LOC available within 14 days of the assessment excluding previously mentioned Priority Populations identified in Section 6.00 for whom admission must be immediate. Individuals in need of detox must be admitted to treatment within 24 hours. If these timeframes cannot be met, the reason must be documented in the individual’s file.

DDAP considers admission to treatment as the first attended appointment with a provider after the LOC assessment has been completed. A treatment episode begins with the admission to treatment.

**TB Screening and Referral Services**

DDAP collaborated with the Department of Health, Bureau of Communicable Diseases to develop questions in reference to assessing the need for referrals to appropriate TB services. These questions must be included as part of the LOC assessment process.

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The SCA must ensure that any entity providing LOC assessment services assess the individual to determine whether or not the individual would be considered high risk for TB as follows:

1. Have you traveled extensively (more than 4 weeks) outside the U.S. in the last five years to high TB incidence areas (Asia, Africa, South America, Central America)?
2. Are you a recent immigrant (within the past 5 years) from a high TB risk foreign country (includes countries in Asia, Africa, South America, and Central America)?
3. Have you resided in any of these facilities in the past year: jails, prisons, shelters, nursing homes and other long-term care facilities such as rehabilitation centers? \*If residents of any of these facilities were tested within the past three months they don't need to have their risk for TB reassessed.
4. Have you had any close contact with someone diagnosed with TB?
5. Have you been homeless within the past year?
6. Have you ever been an injection drug user?
7. Do you or anyone in your household, currently have the following symptoms, such as a sustained cough for two or more weeks, coughing up blood, fever/chills, loss of appetite, unexplained weight loss, fatigue, night sweats?

Any individual that responds with a “yes” to any of the above questions is considered high risk for TB. Written procedures must be in place to address how individuals identified as high risk will be referred to the County’s Public Health TB Clinic.

### **Assessment Components**

The SCA must ensure that all assessment tools for determining LOC include the following components:

1. **Date of initial contact and date of assessment;**
2. **Demographics:** name, address, birth date, social security number, phone, marital status, sex, race, birth/maiden name;
3. **Education:** degree or level of education, education history to include academic performance and behavior, learning-related problems, extracurricular activities, attendance problems, and degree to which the drug/alcohol problem interferes with school;
4. **Employment:** degree to which the drug/alcohol problem interferes with employment, are you currently working, what is your job;
5. **Physical health:** chronic and current acute medical conditions, past and present medications, are medications taken as prescribed, pregnancy, TB assessment questions;

6. **Drug and alcohol:** type and frequency, date of last use, amount and route of administration, length, patterns and progression of use, impact on behavior and relationships with others;
7. **Abstinence and recovery periods:** treatment history, support systems, clean time – when and how;
8. **Behavioral and emotional:** mental health symptoms, involvement in mental health treatment/hospitalizations, suicidal/homicidal ideations or attempts, psychotropic medications;
9. **Family/social/sexual:** family of origin, immediate family, family relationships, family history of substance abuse, childcare arrangements, interpersonal relations/skills, sexual orientation;
10. **Spiritual:** spiritual/religious preference;
11. **Living arrangements:** current living arrangements, recovery environment;
12. **Social service agency program involvement, child welfare involvement, and residential treatment;**
13. **Abuse:** history of any abuse yes/no, issues that might impact placement
14. **Legal:** juvenile justice involvement and delinquency including types and incidences of behavior, probation/parole status, conviction record to include disposition, current charges;
15. **Gambling:** lack of control in frequency of betting, lack of control over amount bet, lying about how much is bet;
16. **Potential barriers to treatment:** other areas that may impact treatment (i.e. transportation, cultural/language, childcare needs);
17. **Assessment summary:** clinical impressions, level of care determination/ASAM and other special needs considerations, referral to LOC and provider, and interim services (if applicable).

## **Section 10.03 Coordination of Services**

### **Overview**

DDAP defines Coordination of Services as a function of case management through which the SCA establishes an organized approach to coordinating service delivery in order to ensure the most comprehensive process for meeting an individual's treatment and non-treatment needs throughout the recovery process. Through Coordination of Services, the SCA ensures that individuals with complex, multiple problems receive the individualized services they need in a timely and appropriate fashion. The process of Coordination of Services is intended to promote self-sufficiency and empower the individual to assume responsibility for his or her recovery.

Coordination of Services is a collaborative process that includes the following activities: engagement, evaluation of needs, establishing linkages, arranging access to services ensuring enrollment in the appropriate healthcare coverage, advocacy, monitoring, and other activities to address client needs throughout the course of treatment. Coordination of Services includes communication, information sharing, and collaboration, and occurs regularly with case management and/or provider staff serving the client within and between agencies in the community.

### **Requirements**

The SCA shall be responsible for the planning and implementation of case coordination. The SCA shall have the following responsibilities:

1. The SCA must ensure that Coordination of Services occurs for each individual receiving services paid for by the SCA.
2. The SCA must develop a policy which delineates the procedures used for the Coordination of Services.
3. When the SCA contracts with a service provider(s) to perform Coordination of Services on behalf of the SCA, it is required that the SCA provide the service provider with their policy and procedures relating to Coordination of Services.
4. The SCA's Coordination of Services policy and procedures must include the following:
  - a. A mechanism to track and document the delivery of services paid for by the SCA;
  - b. How the SCA or providers will assist with arranging access to services ensuring enrollment in the appropriate healthcare coverage. (i.e. the Medical Assistance application process)
  - c. How and when continued stay review ASAMs are reviewed and approved or disapproved in accordance with timeframes outlined in the PCPC Manual.
  - d. A mechanism in place to attempt to re-engage individuals who do not show for treatment or leave treatment prior to being discharged;
  - e. A mechanism to ensure a direct contact is made from one level of care to another. Procedures must also include that a follow up contact is made to ascertain whether the client was admitted as planned.

- f. At minimum the need to document that the individual is no longer receiving services from the SCA and reason why services ended.
5. Case Management Service Plan must be completed upon admission to each level of care and every sixty days thereafter, using the Case Management Service Plan form (DDAP-EFM-1008) which is published on DDAP's website ([www.ddap.pa.gov](http://www.ddap.pa.gov)) under the DDAP Document Library, Forms page.

## **Section 10.04 Case Management File Content**

Case Management files must, when applicable, include:

1. Screening tool (DDAP-EFM-1000 and DDAP-EFM-1001)\*;
2. Assessment tool;
3. Documentation of interim services, if applicable;
4. PCPC Summary Sheets (DDAP-EFM-1003)\*;
5. Case Management Service Plan (DDAP-EFM-1003)\*;
6. Consent to release information forms;
7. Acknowledgement of receipt of the Grievance and Appeal policy;
8. Acknowledgement of any limitations;
9. Case notes, which must adequately describe the nature and extent of each contact to include the following:
  - a. Information gathered about the individual;
  - b. Analysis of the information to identify the individual's treatment and non-treatment needs;
  - c. Action to be taken to meet the individual's treatment and non-treatment needs; and
  - d. Case manager's signature or initials and date
10. Discharge information, once the individual is no longer receiving services from the SCA (i.e., discharge form, case note, etc.).

DDAP strongly encourages all documentation to be typewritten, when possible. Files that are maintained electronically must contain all required components, and a hard copy must be available upon request.

\*These forms/tools referenced above can be found on DDAP's website ([www.ddap.pa.gov](http://www.ddap.pa.gov)) under the DDAP Document Library, Forms page.

## **Section 10.05 Case Management Supervision**

### **Requirements of Case Management Supervision**

Supervision of staff providing case management services should be designed to ensure the adequate provision of those services. Procedures regarding supervision will be at the discretion of the SCA. However, the supervision of new staff performing case management functions without having received required core trainings must include a combination of job shadowing and direct observation of LOC assessments. In addition, close supervision and supervisory review of written documentation, to include, at a minimum, the LOC assessment and Adolescent Placement Summary Sheets (DDAP-EFM-1002) must be documented in case notes until the case manager has received or been exempted from all required training.

**Note:** This exemption does not pertain to the PCPC or ASAM criteria trainings.

## **Section 10.06 Staffing Qualifications**

### **Required Qualifications of Staff Providing Case Management Services are as follows:**

Staff delivering case management services must meet the minimum education and training (MET) requirements established by the State Civil Service Commission for one of the following classifications:

1. D&A Case Management Specialist,
2. D&A Case Management Specialist Trainee,
3. D&A Treatment Specialist, or
4. D&A Treatment Specialist Trainee.

Those persons responsible for supervision of staff delivering case management services must meet the MET requirements established by the State Civil Service Commission for the Case Management Supervisor or Treatment Specialist Supervisor. If case management services are being performed by a contracted licensed drug and alcohol treatment provider, individuals delivering the services must meet either the MET requirements for the classifications referenced in this paragraph or the DDAP licensing staffing regulations for either a Counselor or Counselor Assistant. Supervisors of these staff must meet either the MET requirements for the supervisory classifications referenced in this paragraph or the DDAP licensing staffing requirements for Clinical Supervisor or Lead Counselor.

## **Section 10.07 Core Training**

The SCA is required to ensure that those persons providing case management functions and their supervisors complete all required and applicable DDAP-approved case management core trainings within 365 days of hire. All SCA/provider staff certificates from required trainings must be maintained by the SCA/provider.

Exemptions may be made at the discretion of the SCA Administrator for both SCA staff and provider staff for the Case Management Overview, Addictions 101, and Screening and Assessment courses, provided that comparable training and educational requirements have been met. If the SCA Administrator chooses to exempt any staff from the above trainings, the SCA/provider must be able to provide written documentation to justify the exemption. If the SCA Administrator serves in the capacity of case management supervisor and wishes to be exempted from the above training requirements, a written request for the exemption and supporting documentation must be submitted to the SCA's Project Officer in DDAP's CPO Section. Exemptions will then be made at the discretion of DDAP.

SCA Administrators are not permitted to exempt themselves from training requirements. Any staff that previously conducted screening and assessment and had the DDAP-required Core Trainings prior to November 2003 is not required to take the Case Management Overview course, Addictions 101, and Screening and Assessment. In addition, staff that completed Confidentiality training course prior to November 2003 are not required to take the related practical application course. All case management staff at the SCA or their subcontracted provider must meet the training requirements of the current edition of Adolescent ASAM.

Course selection and completion requirements depend upon which functions the case manager has been assigned to perform. The course requirements for each function are outlined below:

### **Assessment - 36 total training hours**

1. Addictions 101 – 6 hours
2. Confidentiality – 6 hours
3. Practical Application of Confidentiality Laws and Regulations – 3 hours
4. Case Management Overview – 6 hours
5. Screening & Assessment – 6 hours
6. ASAM Criteria – 6 hours

## **Coordination of Services – 21 (30\*) total training hours**

1. Addictions 101 – 6 hours
2. Confidentiality – 6 hours
3. Practical Application of Confidentiality Laws and Regulations – 3 hours
4. Case Management Overview – 6 hours
5. \*ASAM Criteria – 6 hours

\*If conducting continued stay reviews

### **Course Prerequisites:**

Certificates for Practical Application of Confidentiality Laws and Regulations courses are not considered valid if the dates on the certificates are prior to the dates on the Confidentiality certificates.

### **Required trainings include:**

1. Addictions 101 – 6 hours (requires DDAP certificate)

This course will cover: Disease concept, stages of dependence, characteristics of common drugs of abuse, mini pharmacology lesson, relapse, withdrawal and detoxification, twelve step recovery, treatment philosophy, intervention, overview of assessment, general concepts about levels of care, motivation for treatment and what makes treatment successful.

2. Confidentiality – 6 hours (requires DDAP certificate or PCB approved)

This course provides participants with the information that they need in order to comply with the applicable federal and state laws and regulations for the confidentiality of drug and alcohol treatment services in the Commonwealth of Pennsylvania. This training is a foundation course for anyone working in the field of substance abuse treatment.

3. Practical Application of Confidentiality Laws and Regulations – 3 hours (requires DDAP certificate)

Case examples allow participants to apply federal and state laws and regulations to field-relevant situations.

4. Case Management Overview – 6 hours (requires DDAP certificate)

This course includes the history and functions of case management in Pennsylvania. The course will also address listening skills, boundary setting, motivational interviewing, engaging the client, stages of change, and an overview of ethics.

5. Screening & Assessment – 6 hours (requires DDAP certificate)

This course will provide an understanding on how to determine emergent care needs as well as how to conduct an effective assessment. The required components of each tool, emergent care issues, screening options, interviewing techniques and review of the DSM-5 Criteria for Substance Use Disorders, as well as Gambling Disorder will be covered.

6. ASAM Criteria– 6 hours (requires DDAP certificate)

This course is designed to provide participants with the skills and information required to use the ASAM Criteria for adolescents. Participants will be able to apply ASAM Criteria to assessment data in order to identify the LOC and treatment type most relevant to meet the individual's needs.

## Section 10.08 Grievance and Appeal Process

The primary objective of the grievance and appeal process is to promote a step-by-step effort at reconciliation between an aggrieved individual and the SCA. Contracted treatment providers and other agencies may have separate grievance and appeal protocols arising from the individual's direct involvement with those programs; however, the SCA's policy must be followed in cases where the grievance concerns an administrative or financial decision made by, or on behalf of, the SCA. The SCA must have an expeditious, accessible, fair, and uniform appeal process in place for resolving grievances.

A grievance is defined as a written complaint by an individual of the decision made by the SCA. An appeal is the *process* utilized to resolve a grievance. At a *minimum*, individuals must be able to file a grievance in the four areas listed below.

1. Denial or termination of services;
2. LOC determination;
3. Length of stay in treatment; and
4. Violation of the individual's human or civil rights.

If the SCA chooses to include additional categories (e.g., "other") that an individual can grieve, it must be made clear what those areas specifically include.

SCAs are required to have an appeal process that includes the following:

1. A policy that describes, at a minimum, a two-stage appeal process where:
  - a. The first level of appeal must be made to a panel made up of SCA staff or a supervisory level staff person, none of whom are directly involved in the dispute. A decision by the SCA must be rendered within seven days upon receipt of the grievance at each level of appeal. In addition, the SCA must inform both the individual and DDAP of the outcome within seven days via the DDAP-approved Grievance and Appeal Reporting form (DDAP-EFM-1009) which is published on DDAP's website ([www.ddap.pa.gov](http://www.ddap.pa.gov)) under the DDAP Document Library, Forms page. It is imperative that client identifying information is not included or attached to this form.
  - b. The final level of appeal must be made to an independent review board or hearing panel that is comprised of an odd number (no less than three) of members who have no financial, occupational, or contractual agreements with the SCA. A decision by the panel chairperson must be rendered within seven days upon receipt of the grievance at each level of appeal. Access to confidential records must be in accordance with state and federal confidentiality regulations. The Department of Drug and Alcohol Programs, the Department of Human Services, or the members of the SCA's governing body (County Executive, County Commissioners, or governing Board of Directors) may not serve as the independent review board or hearing panel. The SCA is required to identify the composition and number of members designated as the independent

review board or hearing panel. In addition, the SCA must inform both the individual and DDAP of the outcome within seven days via the DDAP-approved Grievance and Appeal Reporting form (DDAP-EFM-1009). It is imperative that client identifying information is not included or attached to this form.

2. Notification: The individual must sign-off that they have been notified about the following areas:
  - a. The grievance and appeal policy that outlines the four areas that an individual can grieve with the SCA;
  - b. The need for a signed consent form from the individual so confidential client information relating to the appeal can be provided to an independent review board for the purpose of rendering a decision on the appeal;
  - c. The right to have access to all documentation pertaining to the resolution of the grievance within the confines of state and federal confidentiality regulations; and
  - d. The right to be involved in the process and have representation by means of a client advocate, case manager, or any other individual chosen by the individual at each level of appeal.

## **Section 10.09 Reporting**

### **Service Limitations**

The SCA must notify its Project Officer at DDAP, in writing, within five days, if the SCA discontinues or limits authorization for admission to any Level of Care or type of service, for any reason, including lack of funding. When limitations are removed, the SCA must notify its Project Officer at DDAP, in writing, within five days. Any limitations cannot apply to Priority Populations identified in Section 6.00.

### **Report Schedule**

All reporting will be due as per the DDAP Reports Schedule which is provided at the beginning of each fiscal year.

## Section 10.10 Confidentiality of Information

The SCA and its contracted providers agree that all persons currently or formerly screened, assessed, diagnosed, counseled, treated and rehabilitated for drug and alcohol abuse and dependence, shall be protected from disclosure of their names, identities, patient records and the information contained therein except as disclosure is permitted by state and federal statute and regulations. To assure confidentiality of client information, the SCA shall make adequate provision for system security and protection of individual privacy. The SCA, treatment providers, and others are subject to the confidentiality requirements of the Pennsylvania Drug and Alcohol Abuse Control Act (71 P.S. §§ 1690.101, et seq.), the Public Health Service Act (42 U.S.C §§ 290ee-3, 290dd-2), Federal Confidentiality Regulations (42 CFR Part 2). Drug and alcohol information is protected in a number of ways that include the following:

71 P.S. § 1690.101, et seq. - established the Pennsylvania Advisory Council on Drug and Alcohol Abuse in 1972 whose authority was ultimately transferred to the Department of Drug and Alcohol Programs by Act 50 of 2010 (71 P.S. § 613.1(9)) and addresses confidentiality requirements at 71 P.S. §§ 1690.108.

28 Pa. Code § 709.28 - standards for licensing freestanding treatment facilities to include adherence to confidentiality requirements

42 CFR Part 2, Subparts A-E - federal regulation governing patient records and information

45 CFR Part 96 - federal regulation governing the privacy of health care information that went into effect on April 14, 2003

4 Pa. Code § 255.5 and § 257.4 - state regulations governing patient records

42 Pa. C.S.A. § 6352.1 - state law clarifying what information may be released by SCAs and treatment providers to children and youth agencies and the juvenile justice system.

Client confidentiality is one of the cornerstones guiding the treatment of substance use disorders. The critical concepts to understand include:

1. Those working with addicted individuals must always be conscious of where and how client identifying information is discussed;
2. Valid consent forms must be formatted to capture all of the required elements to include:
  - a. Name of the individual;
  - b. Name of the program disclosing the information;
  - c. Name of person, agency or organization to whom disclosure is made;
  - d. Specific information to be disclosed;
  - e. Purpose of disclosure;
  - f. Statement of the individual's right to revoke consent (must allow verbal and written revocation);
  - g. Expiration date of the consent;
  - h. Dated signature of individual;

- i. Dated signature of witness; and
  - j. Copy offered to the individual.
3. The information to be released must relate to the purpose of the consent.

DDAP often reviews the SCA and/or their provider consent forms; however, they are only acceptable to DDAP if the forms meet the state and federal drug and alcohol confidentiality requirements.

The SCA and its contracted treatment providers are required to have written procedures associated with the adherence to all federal and state confidentiality regulations. The procedures must include the components below and be signed off by all staff performing or supervising treatment and treatment-related services. Staff not directly performing or supervising services must sign a statement indicating that all information acquired through their employment duties will be kept confidential. The statement must delineate that disciplinary action will be taken if confidentiality is breached.

1. Release of client-identifying information;
2. Storage and security of client records, to include computer security;
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4. Staff access to records;
5. Disciplinary protocols for staff violating confidentiality regulations;
6. Revocation of consent, to include how this is documented on the consent form; and
7. Notification that re-disclosure is prohibited without proper consent.

## **Section 11.00 Recovery Support Services**

Recovery Support Services (RSS) are non-clinical services that assist individuals and families to recover from substance use disorders. These services complement the focus of treatment, outreach, engagement and other strategies and interventions to assist people in recovery in gaining the skills and resources needed to initiate, maintain, and sustain long-term recovery. RSS are not a substitute for necessary clinical services.

While DDAP understands that the list of RSS is extensive, the SCA may utilize DDAP dollars for the following:

1. Mentoring Programs in which individuals newer to recovery are paired with more experienced people in recovery to obtain support and advice on an individual basis and to assist with issues potentially impacting recovery (these mentors are not the same as 12-step sponsors);
2. Training and Education utilizing a structured curriculum relating to addiction and recovery, life skills, job skills, health and wellness that is conducted in a group setting;
3. Family Programs utilizing a structured curriculum that provides resources and information needed to help families and significant others who are impacted by an individual's addiction;
4. Telephonic Recovery Support (recovery check-ups) designed for individuals who can benefit from a weekly call to keep them engaged in the recovery process and to help them maintain their commitment to their recovery;
5. Recovery Planning to assist an individual in managing their recovery;
6. Support Groups for recovering individuals that are population focused (i.e. HIV/AIDS, veterans, youth, bereavement, etc.);
7. Recovery Housing (for parameters in funding this RSS, please see Section 6.04); and
8. Recovery Centers where recovery support services are designed, tailored and delivered by individuals from local recovery communities.

## **Section 12.00 Miscellaneous**

### **Additional Case Management Activities**

If the SCA chooses to provide additional activities or services, such as Intensive Case Management (ICM) or Resource Coordination (RC), individuals cannot be required to participate in these or any other ancillary services in order to be eligible to receive a specific level of care or type of service (e.g., Methadone, Buprenorphine). Additionally, the SCA cannot require that a specific population (e.g., pregnant women, criminal justice, adolescents) participate in ICM or RC or other ancillary services in order to receive a specific level of care or type of service.

### **Policy and Procedure Updates**

If procedures are updated at any time by the SCA, the most current dated version of the policy must be signed off by all staff.

### **County MA Jail Process**

All SCAs will be required to participate in the County MA Jail Process whereby LOC assessments will be conducted at the county correctional institution. Either the county correctional institution, the SCA, or the contracted provider will submit the Medical Assistance application prior to the inmate's release using the estimated release date as the requested start date for services. It is imperative that a note is placed in the comment section stating: "For expedited determination of MA eligibility for inmate being released to a Residential Drug and Alcohol Treatment Facility". The SCA or the contracted provider will work with the County Assistance Office (CAO) to keep them notified of any changes to the release date.

## Section 13.00 Appendix A

### ACRONYM LIST

**AIDS:** Acquired Immune Deficiency Syndrome  
**APSS:** Adolescent Placement Summary Sheet  
**ASAM:** American Society of Addiction Medicine  
**C.F.R.:** Code of Federal Regulations  
**CPO:** County Program Oversight  
**CRS:** Certified Recovery Specialist  
**CSR:** Continued Stay Review  
**D&A:** Drug and Alcohol  
**DDAP:** Department of Drug and Alcohol Programs  
**ED:** Emergency Department  
**E.I.:** Early Intervention  
**ESL:** English as a Second Language  
**HIPAA:** Health Insurance Portability and Accountability Act  
**HIV:** Human Immunodeficiency Virus  
**ICD:** International Classification of Disease  
**ICM:** Intensive Case Management  
**IDU:** Injection Drug User  
**LOA:** Letter of Agreement  
**LOC:** Level of Care  
**MA:** Medical Assistance  
**MAT:** Medication Assisted Treatment  
**MET:** Minimum Education and Training  
**MOU:** Memorandum of Understanding  
**NTP:** Narcotic Treatment Programs  
**OVR:** Office of Vocational Rehabilitation  
**PCPC:** Pennsylvania Client Placement Criteria  
**RC:** Resource Coordination  
**RSS:** Recovery Support Services  
**SCA:** Single County Authority  
**TB:** Tuberculosis  
**VA:** Veterans Affairs

## Section 13.01 APPENDIX B

### GLOSSARY

**Advocacy:** The process of being a proponent for the client in helping to remove any obstacles that may prevent the client from obtaining necessary services.

**American Society of Addiction Medicine Criteria (ASAM):** A tool used to determine the appropriate level of care and type of service for adolescents.

**Appeal:** A request for reconsideration of an SCA's decision at progressive stages until a grievance is resolved.

**Assessment:** A face-to-face interview with an individual to ascertain treatment needs based on the degree and severity of drug and alcohol use through the development of a comprehensive confidential personal history.

**Barrier:** An impediment to accessing treatment and/or support services.

**Case Management:** A collaborative process between the client and the case manager that facilitates the access to available resources and retention in treatment and support services, while simultaneously educating the client in the skills necessary to achieve and maintain self-sufficiency and recovery from substance abuse disorders.

**Case Manager:** Individuals performing screening, assessments, and/or Case Coordination, to include clinical staff at the provider level performing these functions.

**Continued Stay Review (CSR):** The process for reviewing the appropriateness of continued stay at a level of care and/or referral to a more appropriate level of care.

**Drug free approach:** The provision of guidance, advice, and psychological treatment as a means to deal with the client's emotional structure and concurrent problems without the use of a maintenance substance. Temporary medication for treatment of physiological conditions or as an adjunct to psychosocial treatment may be utilized in this approach.

**Early Intervention:** An organized screening and Psycho-educational service designed to help individuals identify and reduce risky substance use behaviors.

**Emergent Care:** Those conditions related to detoxification, psychiatric, and perinatal/prenatal that require an immediate referral for services.

**Engagement:** The process through which the case manager establishes rapport with a client or potential client.

**Grievance:** A written complaint by an individual regarding a decision made by an SCA related to denial or termination of services, level of care determination, length of stay in treatment,

length of stay in ICM, determination of financial liability, or violation of the individual's human or civil rights.

**Halfway House:** A community based residential treatment and rehabilitation facility that provides services for chemically dependent persons in a supportive, chemical-free environment.

**Health Insurance Portability and Accountability Act (HIPAA):** Federal regulation addressing healthcare issues related to the standardization of electronic data, the development of unique health identifiers, and security standards protecting confidentiality and the integrity of health information.

**Intensive Outpatient:** An organized non-residential SUD treatment service provided according to a planned regime consisting of regularly scheduled treatment sessions at least 3 days per week with a minimum greater than 5 hours and a maximum of 10 hours per week. (Note: IOP is licensed as an outpatient activity).

**Level of Care:** Intensity and types of treatment services ranging from outpatient to medically-managed residential.

**Linking:** This is the process by which case managers should refer individuals to available resources that best meet individual needs and support the completion of goals specified in the service plan. It is important to maintain a balance between linking the individual to services and doing too much for the client.

**Maintenance Substance:** Methadone or other DDAP approved substance used in sufficient doses to achieve stabilization or prevent withdrawal symptoms.

**Medically Managed Inpatient Detox:** An inpatient health care facility that provides 24-hour medically directed evaluation and detoxification in an acute care setting.

**Medically Managed Inpatient Residential:** An inpatient health care facility that provides 24-hour medically directed evaluation, care and treatment for individuals with coexisting biomedical and/or psychiatric conditions and/or behavioral conditions which require frequent medical management. Such service requires immediate on-site access to nursing, specialized medical care, intensive medical care and physician care.

**Medically Monitored Inpatient Detox:** A residential facility that provides 24-hour professionally directed evaluation and detoxification of addicted individuals.

**Medically Monitored Long-Term Residential:** A residential facility that provides 24-hour professionally directed evaluation, care and treatment for individuals in chronic distress, whose addiction symptomatology is demonstrated by severe impairment of social, occupational or school functioning, with habilitation as a treatment goal.

**Medically Monitored Short-Term Residential:** A residential facility that provides 24-hour professionally directed evaluation, care and treatment for individuals in acute distress, whose

addiction symptomatology is demonstrated by moderate impairment of social, occupational or school functioning, with rehabilitation as a treatment goal.

**Medication Assisted Treatment (MAT):** FDA-approved medications, to be used in conjunction with substance abuse treatment, designed to assist in recovery.

**Minimum Education and Training Requirements (METs):** Employment standards established by the State Civil Service Commission.

**Non-Treatment Needs:** Needs that the individual may have in the following areas: education/vocation, employment, physical health, emotional/mental health, family/social, living arrangements/housing, legal status, basic needs (food, clothing, utilities), life skills, child care, and transportation.

**Outpatient:** An organized, non-residential AOD treatment service provided in regularly scheduled treatment sessions for a maximum of 5 contact hours per week.

**Overdose:** A situation in which an individual is in a state requiring emergency medical intervention as a result of the use of drugs or alcohol.

**Partial Hospitalization:** The provision of psychiatric, psychological, and other therapies on a planned and regularly scheduled basis. Partial hospitalization is designed for those individuals who would benefit from more intensive services than are offered in outpatient treatment programs, but who do not require 24-hour inpatient care. This environment provides multi-modal and multi-disciplinary programming. Services consist of regularly scheduled treatment sessions a minimum of 3 days per week with a minimum of 10 or more hours per week.

**Pennsylvania Client Placement Criteria (PCPC):** The tool used in Pennsylvania to determine the appropriate level of care and type of service for adults.

**Perinatal:** The time frame ranging from the twenty-eighth week of pregnancy to twenty-eight days after birth.

**Placement:** The process of matching the assessed service and treatment needs of an individual with the appropriate level of care and type of service.

**Prenatal:** The time frame ranging from conception to the twenty-eighth week of pregnancy.

**Recovery Support Services (RSS):** Recovery support services are non-clinical services that assist individuals and families to recover from alcohol and other drug problems. These services complement the focus of treatment, outreach, engagement and other strategies and interventions to assist people in recovery in gaining the skills and resources needed to initiate, maintain, and sustain long-term recovery.

**Screening:** The first step in identifying the presence or absence of alcohol or other drug use whereby data is collected on an individual in order to determine if a referral for emergency services is warranted.

**Self-sufficiency:** The point at which the client is able to maintain recovery efforts and service needs without the help of the case manager or significant support from other social service agencies.

**Single County Authority (SCA):** Local entities responsible for program planning and the administration of federal and state-funded grants agreements and contracts.

**Treatment-Related:** Services that assist the treatment client in meeting other deficiencies inherent in their life, and ultimately aid them in securing recovery and a self-sufficient life style.