



**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

# TREATMENT MANUAL

## TABLE OF CONTENTS

<b>Part One</b>	<b>Purpose and Use of the Treatment Manual</b>
<b>Part Two</b>	<b>History and Context for the Treatment Manual</b>
<b>Part Three</b>	<b>SCA Treatment Needs Assessment</b>
<b>Part Four</b>	<b>SCA Treatment Plan</b>
<b>Part Five</b>	<b>Special Population Requirements</b>
Priority Populations	5.01
Pregnant Women	5.02
Injection Drug Users	5.03
Women With Children	5.04
Overdose Survivors	5.05
Veterans	5.06
<b>Part Six</b>	<b>Placement</b>
Continuum of Care	6.01
Halfway House Services	6.02
Emergency Housing Services	6.03
Recovery Housing	6.04
Medication Assisted Treatment	6.05
<b>Part Seven</b>	<b>Performance Measure Requirements</b>
<b>Part Eight</b>	<b>Training for Contracted Drug and Alcohol Treatment Providers</b>
<b>Part Nine</b>	<b>Adult Case Management</b>
The Functions of Case Management	9.01
Screening	9.02
Assessment	9.03
Case Coordination	9.04
Case Management File Content	9.05
Supervision	9.06
Staffing Qualifications	9.07
Core Trainings	9.08
Grievance and Appeal Process	9.09
Reporting	9.10
Confidentiality of Information	9.11

<b>Part Ten</b>	<b>Adolescent Case Management</b>
The Functions of Case Management	10.01
Screening	10.02
Assessment	10.03
Case Coordination	10.04
Case Management File Content	10.05
Supervision	10.06
Staffing Qualifications	10.07
Case Management Core Trainings	10.08
Grievance and Appeal Process	10.09
Reporting	10.10
Confidentiality of Information	10.11

---

<b>Part Eleven</b>	<b>Recovery Support Services</b>
--------------------	----------------------------------

---

<b>Part Twelve</b>	<b>Quality of Care (Placeholder)</b>
--------------------	--------------------------------------

---

<b>Part Thirteen</b>	<b>Appendices</b>
Appendix A: DDAP Screening Tool	13.01
Appendix B: Non-Treatment Needs Checklist	13.02
Appendix C: Grievance and Appeal Reporting Form	13.03
Appendix D: PCPC Summary Sheet	13.04
Appendix E: Adolescent Placement Summary Sheet	13.05
Appendix F: Glossary	13.06
Appendix G: Acronyms	13.07
Appendix H: PCPC Attestation	13.08

## **PART I. 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.

## **PART II. 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 requires abstinence from all mood altering substances. This journey is a voluntarily maintained lifestyle 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:

- **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)
- **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.
- **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.
- **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.

### **PART III. 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 SCA Treatment Needs Assessment will be due in accordance with the DDAP Report Schedule.

## **TREATMENT NEEDS ASSESSMENT OBJECTIVES**

### **Objective 1: Obtain an estimate of the prevalence of substance use disorder in the total population of an SCA.**

#### Definitions:

**Estimate:** A numerical description of the current or past situation, based on data from known sources relating to the same time period using a known method which can be replicated.

**Prevalence:** The number of individuals with a diagnosable condition at a given time.

**Substance use disorder:** A problematic pattern of substance use leading to clinically significant impairment or distress.

**Total Population:** All people who are located in the geographic region of the SCA.

**Data Sources:** DDAP will provide data for each SCA (Table 1) based on surveys which yield valid estimates of the prevalence of substance use disorders. Only 7% to 10% of the estimated number of people presented in this table would admit to having a substance use problem, but the larger number may be thought of as those whose behavior is creating personal consequences and affecting their family and friends. They are also the pool of people, who eventually, under the right circumstances, may present for treatment services.

**Use of the data:** These numbers may be used by SCAs to describe need (as distinguished from demand) and the extent of the problem. They show the potential for demand for services.

### **Prevalence of substance use disorder in special populations**

Each SCA is responsible for developing prevalence estimates of substance use disorder (for its service area) for the special population groups listed in Table 2. These numbers may be used by the SCA to describe the possible need and the extent of the problem. The special population groups listed in Table 2 (column 1) are the minimum requirements for the SCA needs assessment. SCAs may include other special population groups, as desired.

DDAP provides appropriate web links for county level population data for the criminal justice and family court categories in Table 2, column 2 (items 1-3, 6, and 7). The SCA is then responsible for adding the statistical information relevant for each category. Based on Department of Corrections (DOC) and national estimates, approximately 70% of all inmates have a substance use disorder and require some form of treatment. This information will be used to provide the estimates needed for Table 2, columns 4 & 5, where appropriate (items 3-5). Based on The National Center on Substance Abuse & Child Welfare, approximately 50% of substantiated child abuse cases have an underlying substance use issue and require some level of treatment. This information will be used to provide the estimates needed for Table 2, columns 4 & 5, where appropriate (item 6). Based on SAMHSA Substance Abuse Treatment & Domestic Violence TIP 25, approximately 25% of Protection From Abuse (PFA) orders issued by the court

have an underlying substance use issue and require some level of treatment. This information will be used to provide the estimates needed for Table 2, columns 4 & 5, where appropriate (item 7).

### **Directions for the SCA**

- Complete Table 2 and include in the treatment needs assessment, so that the information is part of the document submitted to DDAP.
- List the local sources of information used, in a narrative response. Examples may include Criminal Justice Advisory Board, Student Assistance Programs, Coroner's report, United Way, hospital coalitions, Advisory Boards, Task Forces, physicians who prescribe Buprenorphine, Consumer/Family Satisfaction Teams, etc.

### **Objective 2: Identify emerging substance use problems by type of chemical, route of administration, population, availability and cost, etc.**

#### Definitions:

**Emerging substance use problems:** This implies that there is a situation which is qualitatively different from what came before, and which could not have been fully anticipated and planned for. The difference may be the population of users, the type of substance, the nature of the substance or the rate of increase. The implication is that a new problem confronts the community and it may need to be addressed. The new problem may be an isolated event that requires immediate action or it may take the form of a gradual pattern change that was initially anecdotal information, tracked over time, and now requires a response impacting service delivery.

### **Directions for the SCA**

- Provide a concise narrative that identifies emerging treatment needs in the SCA.  
(For example: increase in heroin use and/or deaths, increase in prescription drug use, identification of new drugs of abuse)
- Include a succinct description of the information relied upon to identify the emerging need, and include supporting data.  
(For example: Review STAR and SCA data; anecdotal information obtained from treatment providers, police, probation/parole officers, human service staff, MH case managers, or children & youth case workers; other data source information such as emergency room deaths, increase in HIV/AIDS cases, D&A-related arrests, Student Assistance Program data, Hepatitis C data, etc.)

### **Objective 3: Identify local, state, and national trends that may impact the SCA.**

#### Definitions:

**Local, state, and national trends:** A prevailing tendency or information relating to the economy, government, legal issues, technological and medical advances, or socio-culture patterns that may influence business practices of the SCA.

Examples of local, state, or national trends may include a move to integrated health/behavioral health care, implementation of the Affordable Care Act, local unemployment rates, aging of “baby boomers”, electronic medical records, implementation of evidence-based/promising practices, focus on special initiatives (i.e., Underage Drinking, offender re-entry, co-occurring), medication management, political priorities, etc.

### **Directions for the SCA**

- Complete Table 3, checking off all items that apply. Additional items may be added to the chart, if not already listed. Provide a concise narrative response to expand on the information provided in Table 3 and include any data to support these trends. Include Table 3 in the treatment needs assessment, so that the information is part of the document submitted to DDAP.

### **Objective 4: Identify the demand for substance use disorder treatment.**

#### Definitions:

**Demand:** Demand for treatment is the number of people who will seek treatment for a substance use disorder.

**Data Sources:** STAR data, SCA data, and other data resources can be used to identify demand for both assessment and treatment services. It will show where the gaps are in the availability of specific levels of care.

DDAP will prepare and provide the following STAR data (Tables 4-7) for each SCA to review and respond to.

- **Table 4: SCA Pattern of Referrals into Treatment** - Table 4 presents the number and percentage of all first admissions for SCA-paid adult clients for the previous year, broken down by each referral source. The percentages for each individual SCA and the state as a whole will be displayed side by side, for comparison.
- **Table 5: Non-Voluntary referrals/SCA clients paid for** – Table 5 provides an example based on STAR criminal justice referrals (not referred by a provider) to show the

differences among SCAs in strategies for identifying and engaging criminal justice clients in need of treatment.

- **Table 6: Service Strategy for each SCA** – Table 6 is slightly different from the referral source tables. It is limited to SCA clients as defined by the “*Submit to SCA*” item in STAR. It counts treatment admissions that began during the year, rather than individual clients. This report identifies differences in the pattern of services provided by each SCA, compared to the statewide pattern.
- **Table 7: Demand for Service by primary Substance of Abuse** – Table 7 is also limited to SCA admissions as defined by the “*Submit to SCA*” item in STAR. It counts treatment admissions that began during the year, rather than individual clients, based on the primary drug of choice at admission. The percentage of admissions attributed to each substance is compared with the percentage of statewide admissions for that substance for age categories: under age 18 and age 18+.

## **Directions for the SCA**

Review data and discuss any issues identified in a narrative response that addresses the items listed below. Include Tables 4-7 in the treatment needs assessment, so that the information is part of the document submitted to DDAP.

- The number of individuals waiting longer than 7 days for an assessment.
- The number of individuals recommended for treatment that did not receive the recommended type of service.
- The reasons why individuals recommended for treatment did not receive the recommended type of service.
- The number of individuals recommended for treatment that had to wait longer than two weeks to access the recommended type of service. Discuss the reasons why individuals had to wait longer than 2 weeks to access treatment.
- Prepare a concise narrative discussing the SCA Pattern of Referral into Treatment data and the SCA Service Strategy, and Demand for Services by Primary Substance, as reflected in the data in Tables 4-7 (use the categories in tables). The explanation should reference the following:
  - Nature of the need and demand for the most prominent and least prominent categories of referral sources, and the levels of service utilized by the SCA, as reflected by the data.

- Activities of other service systems in the SCA, such as private pay providers and criminal justice providers not connected with the SCA, and juvenile services.
- Issues for the management of your program which may be associated with demand for services from users of specific substances.
- The most critical areas of need into which new resources are needed, or would be applied. Examples may be: need for Methadone or Buprenorphine services associated with Heroin use; inappropriate court-stipulated treatment for persons arrested for DUI; a specific problem with youth; or, specific enforcement/interdiction issues.

**Objective 5: Identify issues and systems barriers that impede the ability to meet the assessment and treatment demand in the SCA.**

Definitions:

**Systems barriers:** All aspects of the institutions and the communications involved in identifying and serving treatment demand, which do not fully contribute to providing effective services to everyone as promptly as necessary. System barriers should be barriers other than the resources discussed in Objective 5.

Examples of system barriers include lack of access, quality and appropriateness of care, insurance denials, childcare, transportation, language, zoning restrictions, parental resistance to permitting SAP assessments, interface with county systems, length of time from application to acceptance for HealthChoices, restrictions of available funds, ineffectual tracking of individuals between payers, varied perceptions of medical necessity criteria, SCA protocols/policies & procedures, etc.

**Directions for the SCA**

Complete Table 8, checking off all items that apply. Additional items may be added to the chart, if not already listed. Provide a concise narrative response to expand on the information provided in Table 8 and include any data to support these trends. Include Table 8 in the treatment needs assessment, so that the information is part of the document submitted to DDAP.

**Objective 6: Identify assets or resources available in the county or region to help respond to treatment demand.**

Definitions:

**Resources:** money, staff, assessment and treatment capacity, capacity to serve acute and chronic need, task forces, and the capability to provide various types, levels, and intensities of care, etc.

Examples of assets or resources include: Level-1 trauma centers that are now required to implement Screening, Brief Intervention and Referrals to Treatment (SBIRT), funds and/or services available through other systems (i.e., Children, Youth & Families, Office of Vocational Rehabilitation, HealthChoices, PA Commission on Crime & Delinquency, Liquor Control Board, federal grants, Centers for Disease Control, Department of Education, private industry, health care), regional or local partnerships, etc.

**Directions for the SCA**

Complete Table 9, checking off all items that apply. Additional items may be added to the chart, if not already listed. Provide a concise narrative response to expand on the information provided in Table 9 and include any data to support these trends. Include Table 9 in the treatment needs assessment, so that the information is part of the document submitted to DDAP.

**Objective 7: Identify evidence-based programs and practices in the county or region to help respond to emerging trends and treatment demand.**

Definitions:

Evidence-Based Program (EBP): There is no universal definition for the term “evidence-based program.” Evidence-based is often used synonymously with research based and science-based programming. Other terms commonly used are promising programs, effective programs, and model programs. Evidence-Based Programs are comprised of a set of coordinated services/activities that demonstrate effectiveness based on research. EBPs may incorporate a number of evidence-based practices in the delivery of services.

Evidence-Based Practice: While many use the terms “programs” and “practices” interchangeably, more and more researchers and practitioners are beginning to differentiate between these terms. A “practice” is defined as a habitual or customary performance that a professional does in order to achieve a positive outcome. Evidence-based practices are skills, techniques, and strategies that can be used when a practitioner is interacting with a consumer of services.

## **Directions for the SCA**

Implementing evidence-based programs is important to ensure that resources are spent on programs that have a high probability of achieving desired, long-term outcomes and that incorporate principles of effective programming that bring about positive results.

The SCA must identify providers who utilize evidence-based programs or evidence-based practices, and provide a comprehensive listing of such programs or practices. To avoid duplication, the SCA is only required to report this information for contracted providers within its geographical boundaries.

Complete Table 10, checking off all items that apply. Additional items may be added to the chart, if not already listed. Provide a concise narrative response to expand on the information provided in Table 10 and include any data to support these trends. Include Table 10 in the treatment needs assessment, so that the information is part of the document submitted to DDAP.

**Objective 8: Identify and quantify the resources necessary to meet the estimated treatment demand (identified in Objective 4) and any emerging trends that impact current demand.**

### Definitions:

**Resources:** money, staff, providers, Drug Courts, Buprenorphine eligible physicians, inter-systems collaboration, Health Choices implementation, SCA policies & procedures, assessment and treatment capacity, capacity to serve acute need and chronic need, the capability to provide various types, levels, and intensities of care, etc.

## **Directions for the SCA**

Complete Table 11, checking off all items that apply. Additional items may be added to the chart, if not already listed. Provide a concise narrative response to expand on the information provided in Table 11 and include any data to support these trends. Include Table 11 in the treatment needs assessment, so that the information is part of the document submitted to DDAP.

**TABLE 1: ESTIMATES OF THE PREVALENCE OF SUBSTANCE USE DISORDERS<sup>1</sup>**  
**Pennsylvania, Single County Authorities and State**  
**Based on 2006-2007 National Survey on Drug Use and Health (NSDUH)<sup>2</sup>**

SCA	Total 2007 Population	Age 12+		Age 12-17		Age 18-25		Age 26+	
		Population	Prevalence (Rate = 7.70%)	Population	Prevalence (Rate = 7.06%)	Population	Prevalence (Rate = 20.35%)	Population	Prevalence (Rate = 5.70%)
Allegheny	1,219,210	1,055,941	81,307	97,296	6,869	134,498	27,370	824,147	46,976
Armstrong / Indiana	156,749	136,000	10,472	12,413	876	22,507	4,580	101,080	5,762
Beaver	173,074	150,428	11,583	13,599	960	16,235	3,304	120,594	6,874
Bedford	49,650	42,514	3,274	3,974	281	4,084	831	34,456	1,964
Berks	401,955	335,630	25,844	34,334	2,424	44,048	8,964	257,248	14,663
Blair	125,527	107,955	8,313	9,821	693	13,098	2,665	85,036	4,847
Bradford / Sullivan	67,671	58,021	4,468	5,993	423	6,251	1,272	45,777	2,609
Bucks	621,144	526,835	40,566	52,095	3,678	55,200	11,233	419,540	23,914
Butler	181,934	154,437	11,892	15,455	1,091	19,285	3,924	119,697	6,823
Cambria	144,995	126,818	9,765	10,858	767	15,368	3,127	100,592	5,734
Cameron / Elk / McKean	81,592	70,745	5,447	6,981	493	7,381	1,502	56,383	3,214
Carbon / Monroe / Pike	286,597	246,375	18,971	25,891	1,828	31,851	6,482	188,633	10,752
Centre	144,658	129,656	9,984	9,710	686	45,675	9,295	74,271	4,233
Chester	486,345	405,651	31,235	43,251	3,054	50,851	10,348	311,549	17,758
Clarion	40,028	34,839	2,683	3,035	214	6,761	1,376	25,043	1,427
Clearfield / Jefferson	126,587	110,300	8,493	9,455	668	12,499	2,543	88,346	5,036
Columbia / Montour / Snyder / Union	164,380	143,742	11,068	12,948	914	26,544	5,402	104,250	5,942
Crawford	88,663	75,664	5,826	7,711	544	9,906	2,016	58,047	3,309
Cumberland / Perry	273,182	236,098	18,180	22,337	1,577	36,776	7,484	176,985	10,088
Dauphin	255,710	215,893	16,624	20,939	1,478	23,785	4,840	171,169	9,757
Delaware	554,399	470,368	36,218	47,983	3,388	65,403	13,310	356,982	20,348
Erie	279,092	238,078	18,332	24,073	1,700	36,093	7,345	177,912	10,141
Fayette	144,556	125,089	9,632	11,346	801	12,675	2,579	101,068	5,761
Forest / Warren	47,941	41,886	3,225	3,873	273	4,608	938	33,405	1,904
Franklin / Fulton	156,604	132,093	10,171	12,295	868	16,236	3,304	103,562	5,903
Greene	39,503	34,656	2,669	2,921	206	4,511	918	27,224	1,552
Huntingdon / Mifflin / Juniata	115,665	98,890	7,615	9,363	661	11,542	2,349	77,985	4,445
Lackawanna	209,330	181,643	13,987	16,299	1,151	23,453	4,773	141,891	8,088
Lancaster	498,465	416,651	32,082	44,953	3,174	57,494	11,700	314,204	17,910
Lawrence	90,991	78,422	6,038	7,522	531	9,574	1,948	61,326	3,496
Lebanon	127,889	109,286	8,415	10,024	708	14,404	2,931	84,858	4,837

**TABLE 1: ESTIMATES OF THE PREVALENCE OF SUBSTANCE USE DISORDERS<sup>1</sup>**  
**Pennsylvania, Single County Authorities and State**  
**Based on 2006-2007 National Survey on Drug Use and Health (NSDUH)<sup>2</sup>**

SCA	Total 2007 Population	Age 12+		Age 12-17		Age 18-25		Age 26+	
		Population	Prevalence ( Rate = 7.70% )	Population	Prevalence ( Rate = 7.06% )	Population	Prevalence ( Rate = 20.35% )	Population	Prevalence ( Rate = 5.70% )
Lehigh	337,343	287,324	22,124	29,279	2,067	37,878	7,708	220,167	12,550
Luzerne / Wyoming	340,100	296,267	22,813	25,850	1,825	36,627	7,454	233,790	13,326
Lycoming / Clinton	154,024	133,144	10,252	12,459	880	19,579	3,984	101,106	5,763
Mercer	116,809	100,408	7,731	10,015	707	12,927	2,631	77,466	4,416
Montgomery	776,172	656,374	50,541	61,925	4,372	71,770	14,605	522,679	29,793
Northampton	293,522	250,186	19,264	25,453	1,797	35,389	7,202	189,344	10,793
Northumberland	91,003	78,884	6,074	7,196	508	7,366	1,499	64,322	3,666
Philadelphia	1,449,634	1,217,846	93,774	127,706	9,016	204,338	41,583	885,802	50,491
Potter	16,987	14,363	1,106	1,433	101	1,613	328	11,317	645
Schuylkill	147,269	128,957	9,930	10,851	766	13,288	2,704	104,818	5,975
Somerset	77,861	68,156	5,248	5,834	412	6,939	1,412	55,383	3,157
Susquehanna	41,123	35,713	2,750	3,662	259	3,847	783	28,204	1,608
Tioga	40,681	34,793	2,679	3,838	271	5,064	1,030	25,891	1,476
Venango	54,763	46,960	3,616	4,625	327	4,656	948	37,679	2,148
Washington	205,553	177,176	13,643	15,687	1,108	21,575	4,391	139,914	7,975
Wayne	51,708	45,322	3,490	3,707	262	4,705	957	36,910	2,104
Westmoreland	362,326	315,441	24,289	27,946	1,973	32,579	6,630	254,916	14,530
York / Adams	521,828	442,718	34,089	43,843	3,095	52,662	10,717	346,213	19,734
Pennsylvania	12,432,792	10,620,636	817,789	1,030,057	72,722	1,411,395	287,219	8,179,184	466,213

1. Substance use disorder is based on definitions found in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

2. The National Survey on Drug Use and Health (NSDUH), formerly known as the National Household Survey on Drug Abuse (NHSDA), is an annual survey conducted by SAMHSA's Office of Applied Studies. NSDUH is the primary source of statistical information on the use of illicit drugs by the U.S. civilian population aged 12 or older, based on face-to-face interviews at their place of residence. The survey covers residents of households, non-institutional group quarters (e.g., shelters, rooming houses, dormitories), and civilians living on military bases. Persons excluded from the survey include homeless people who do not use shelters, active military personnel, and residents of institutional group quarters, such as prisons and long-term hospitals.

State level estimates are based on a survey-weighted hierarchical Bayes estimation approach.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007, Table 78.

Population Data Source: Penn State Data Center 2007 Population Estimates.

County-level estimates prepared by the Division of Statistical Support, Pennsylvania Department of Health. Estimates may not sum to totals due to rounding.

Use of the data: These estimates may be used to describe the need for treatment services (as distinguished from demand) and the extent of the problem. They show potential for demand for services.

**TABLE 2: LOCAL SPECIAL POPULATION NEED DATA**  
As reported by (SCA name)

<b>Special Population Category (Column 1)</b>	<b>Source of Data and web link (Column 2)</b>	<b>How to Locate Data (Column 3)</b>	<b>(Column 4) Enter Total Number from Column 1</b>	<b>(Column 5) Percent of these persons who have substance use problems.</b>	<b>(Column 6) Estimated number who have substance use problems = Col 4 x Col 5 for each category</b>
1. Drug Possession Arrests: 18E-Drug Possession - Opium – Cocaine;18F-Drug Possession – Marijuana;18G-Drug Possession – Synthetic;18H-Drug Possession - Other (Total Arrests Adult & Juvenile)	Pennsylvania Uniform Crime Reporting Program  <a href="http://ucr.psp.state.pa.us/UCR/Reporting/Monthly/Summary/MonthlySumArrestUI.asp">http://ucr.psp.state.pa.us/UCR/Reporting/Monthly/Summary/MonthlySumArrestUI.asp</a>	1) Select Arrests by Age & Sex 2) Select Year 3) Select Month (December) 4) Select YTD 5) Select County 6) Select Appropriate UCR Codes 7) Click Submit 8) Record Total		100%	
2. Arrests for 210-Driving Under the Influence; 220-Liquor Law; 230-Drunkenness (Total Adult & Juvenile Arrests)	Pennsylvania Uniform Crime Reporting Program  <a href="http://ucr.psp.state.pa.us/UCR/Reporting/Monthly/Summary/MonthlySumArrestUI.asp">http://ucr.psp.state.pa.us/UCR/Reporting/Monthly/Summary/MonthlySumArrestUI.asp</a>	1) Select Arrests by Age & Sex 2) Select Year 3) Select Month (December) 4) Select YTD 5) Select County 6) Select Appropriate UCR Codes 7) Click Submit 8) Record Total Arrests		100%	
3. Adult County Probation and Parole	Pennsylvania Board of Probation and Parole  <a href="http://www.pbpp.state.pa.us/pbppinfo/cwp/browse.asp?a=468&amp;bc=0&amp;c=69783">http://www.pbpp.state.pa.us/pbppinfo/cwp/browse.asp?a=468&amp;bc=0&amp;c=69783</a>	1) Locate Table with Caseload information 2) Locate the County or Counties 3) Record the Total caseload.		70% (DOC estimate)	
4. County jail population	SCA to provide from local contacts	Contact Local Source		70% (DOC estimate)	
5. Persons on state probation or parole in county	SCA to provide from local contacts	Contact Local Source		70% (DOC estimate)	

**TABLE 2: LOCAL SPECIAL POPULATION NEED DATA**  
As reported by (SCA name)

<b>Special Population Category (Column 1)</b>	<b>Source of Data and web link (Column 2)</b>	<b>How to Locate Data (Column 3)</b>	<b>(Column 4) Enter Total Number from Column 1</b>	<b>(Column 5) Percent of these persons who have substance use problems.</b>	<b>(Column 6) Estimated number who have substance use problems = Col 4 x Col 5 for each category</b>
6. Reported Substantiated Child Abuse & Neglect Cases (Total)	Pennsylvania Department of Human Services  <a href="http://www.dhs.state.pa.us/publications/childabuserports/index.htm">http://www.dhs.state.pa.us/publications/childabuserports/index.htm</a>	1) Select Annual Report Year 2) Click on Table and Charts 3) Locate status of evaluation, rates of reporting and substantiation by county Table 4) Locate your County 5) Record Total Substantiated Cases		50 % (National Center on Substance Abuse and Child Welfare—April 2005)	
7. Domestic Violence (PFA)	Administrative Office of Pennsylvania Courts  <a href="http://www.pacourts.us/T/AOPC/ResearchandStatistics.htm">http://www.pacourts.us/T/AOPC/ResearchandStatistics.htm</a>  Then click on 2007 AOPC Caseload Statistics	1) Select the Caseload Statistics Year 2) Click on Common Pleas 3) Click on Family Court 4) Click on Filings & Dispositions 5) Click on Protection From Abuse 6) Locate County or Counties 7) Record Total Number of Final Order by Stipulation or Agreement		25% (SAMHSA Substance Abuse Treatment & Domestic Violence TIP 25)	
8. Other Categories *					

\* SCAs may include other special population categories as desired

TABLE 3: TRENDS IMPACTING THE SCA					
Aging Population		Increase in Overdose Deaths		Other (please explain)	
Drug Court Implementation		Prescription Drug Abuse/Addiction			
DUIs		Synthetic Drug Use (bath salts, K2, etc.)			
Growth of Latino Population		Workforce Issues			
Heroin Use		Underage Alcohol Use			
High Unemployment Rate		Underage Drug Use			

TABLE 4: STAR PATTERN OF REFERRALS FOR: (SCA NAME)			
SCA Paid Unique Clients <i>DDAP will provide this data</i>			
Referral Source for New Clients	Number of Clients	Percentage of SCA clients	Percentage of Statewide
Clergy/Religious			35%
Community Service Agency			15%
Court/Criminal Justice			15%
Drug & Alcohol Abuse Providers			5%
Employer/EAP			5%
Family/Friend			20%
Hospital/Physicians			5%
SCA			
Self			
Other Voluntary			
Other Non-Voluntary			
<b>Total:</b>			100%
<b>Below is the percentage for juveniles only</b>			
Juveniles			15%

**TABLE 5: CLIENTS PAID FOR BY SCAS (based on STAR)  
And Not Referred by a Provider (Non-Voluntary Proportion)**

*DDAP will provide this data*

<b>Referring SCA</b>	<b>Criminal Justice/ Non-Voluntary Clients</b>	<b>Total Clients</b>	<b>Percent Non-Voluntary</b>
Westmoreland		1421	85%
Somerset		139	76%
Venango		270	73%
Lycoming/Clinton		464	73%
Crawford		329	71%
....		...	...
Bradford/Sullivan		675	2%
Venango		519	1%
Armstrong/Indiana		902	1%
Tioga		164	1%
Susquehanna		157	0%
Clarion		35	0%

**TABLE 6: SERVICE STRATEGY (based on STAR) for: (SCA name)**

*DDAP will provide this data*

<b>Level of Care Usage for Treatment Admissions</b>	<b>Number of Admissions</b>	<b>Percentage of SCA</b>	<b>Percentage of Statewide</b>
Intervention			
Outpatient			
Intensive Outpatient			
Partial Hospitalization			
Halfway house			
Detoxification			
Short-term Inpatient Rehabilitation			
Long-Term Inpatient Rehabilitation			
Dual Diagnosis Inpatient Rehabilitation			
Women & Children's Inpatient Rehabilitation			
Medication Assisted Treatment			
Methadone Maintenance			
<b>Total Admissions paid by SCA</b>			

**SFY 2005-2006**  
**TABLE 7A: DEMAND FOR SERVICE BY PRIMARY SUBSTANCE OF ABUSE (under age 18)**  
*DDAP will provide this data*

<b>SCA Paid Admissions (Under Age 18) for: (SCA name)</b>			
<b>Primary Substance of Abuse</b>	<b>Number of Admissions (Under Age 18)</b>	<b>Percentage of SCA Admissions (Under Age 18)</b>	<b>Percentage of Statewide Admissions (Under Age 18)</b>
Marijuana / Hashish	500	74.52%	63.38%
Alcohol	79	11.77%	21.22%
Heroin	47	7.00%	3.93%
Cocaine / Crack	19	2.83%	4.93%
Other Opiates / Synthetics	17	2.53%	2.06%
Barbiturates	3	0.45%	0.11%
Other	3	0.45%	1.66%
Benzodiazepine	2	0.30%	0.62%
Non-Prescription Methadone	1	0.15%	0.09%
Other Sedatives / Hypnotic	0	0.00%	0.49%
Inhalants	0	0.00%	0.48%
Methamphetamine	0	0.00%	0.28%
Over-the-Counter	0	0.00%	0.26%
Other Hallucinogens	0	0.00%	0.16%
Other Amphetamines	0	0.00%	0.11%
Other Stimulants	0	0.00%	0.09%
PCP	0	0.00%	0.07%
Other Tranquilizers	0	0.00%	0.07%
Buprenorphine			
<b>Total paid by SCA</b>	<b>671</b>	<b>100.00%</b>	<b>100.00%</b>

**SFY 2005-2006**  
**TABLE 7B: DEMAND FOR SERVICE BY PRIMARY SUBSTANCE OF ABUSE (age 18+)**  
*DDAP will provide this data*

<b>SCA Paid Admissions (Age 18+) for: (SCA name)</b>			
<b>Primary Substance of Abuse</b>	<b>Number of Admissions (Age 18+)</b>	<b>Percentage of SCA Admissions (Age 18+)</b>	<b>Percentage of Statewide Admissions (Age 18+)</b>
Alcohol	4127	32.32%	38.90%
Heroin	4110	32.18%	24.40%
Cocaine / Crack	2914	22.82%	18.83%
Marijuana / Hashish	880	6.89%	9.54%
Other Opiates / Synthetics	502	3.93%	5.76%
Other	67	0.52%	0.58%
Benzodiazepine	55	0.43%	0.62%
Non-Prescription Methadone	30	0.23%	0.16%
Methamphetamine	19	0.15%	0.46%
Other Sedatives / Hypnotic	15	0.12%	0.16%
Other Tranquilizers	12	0.09%	0.04%
Barbiturates	10	0.08%	0.08%
Other Hallucinogens	9	0.07%	0.08%
PCP	6	0.05%	0.17%
Other Amphetamines	5	0.04%	0.10%
Over-the-Counter	3	0.02%	0.05%
Other Stimulants	3	0.02%	0.03%
Inhalants	3	0.02%	0.03%
Buprenorphine			
<b>Total paid by SCA</b>	<b>12770</b>	<b>100.00%</b>	<b>100.00%</b>

TABLE 8: SYSTEM BARRIERS					
Funding Issues		Lack of Safe/Affordable Housing		Other (please explain)	
Health Insurance		MA Eligibility			
Lack of Childcare		Poor Stakeholder Collaboration			
Lack of MAT availability		Stigma			
Lack of Recovery Supports		Transportation			
Lack of Treatment Providers		Workforce Issues			

TABLE 9: ASSETS/RESOURCES AVAILABLE IN COUNTY OR REGION					
ACA Implementation		Other Grants (please explain)		Other (please explain)	
CAO Collaboration					
Experienced Staff					
HealthChoices MCO					
MAT Providers					
Mental Health Providers					
Non-DDAP Funding					
Non-Hospital Rehab Availability					
PCCD Grant					
Recovery Houses					
Recovery Supports					
SBIRT Utilization					
Stakeholder Involvement					
Systems of Care County					
VA Facility					

**TABLE 10: EVIDENCE-BASED PROGRAM UTILIZATION**

Anger Management		Medication Assisted Therapy		Other (please list)	
Assertive Adolescent & Family Treatment		Motivational Enhancement Therapy (Motivational Incentives)			
Behavioral Couples Therapy		Motivational Interviewing			
Brief Intervention/SBIRT		Multidimensional Family Therapy			
Cognitive Behavioral Therapy		Multisystemic Therapy			
Community Reinforcement Therapy		Relapse Prevention			
Contingency Management		Therapeutic Community			
Dialectical Behavior Therapy		12-Step Facilitation			
Matrix Model					

**TABLE 11: RESOURCES NEEDED TO MEET TREATMENT DEMAND**

Bi-lingual Staff		Increase Treatment Capacity		Other (please explain)	
Co-Occurring Capable Providers/Staff		Increase Use of Buprenorphine			
Detox Unit(s)		More MAT Providers			
Drug Court		Peer Navigator/Outreach			
Funding Increase		Permanent Supportive Housing			
Healthcare Navigators		Staffing Increase			
Improved Stakeholder Collaboration		Training			
Increase of Recovery Housing Availability		Transportation			
Increase of Recovery Supports in Community		Trauma Informed Care Facilities			

## **PART IV. 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 will be due in accordance with the DDAP Report Schedule.

## **I. Background**

This section should describe the process designed and implemented for completing the plan, including the process for stakeholder input. The description should include the methods and approaches used to engage and involve stakeholders in assessing and analyzing the needs assessment data and developing the plan.

## **II. Executive Summary**

The Executive Summary should be a stand-alone overview of the plan and status report that the SCA could use as a handout to summarize the plan contents. To complete this section, the SCA may include any narrative information or data it deems necessary.

## **III. Needs Assessment Results and Corresponding Plans of Action**

This section should include a narrative of the SCA's analysis of the Needs Assessment results. The SCA is expected to address both positive and negative aspects of their needs assessment results. A corresponding plan of action describing how each item will be addressed must also be included. Results of the Needs Assessment must be addressed individually by Objective. If there are items the SCA is not able to address, an explanation for this must be included in the narrative. This section should also include identification of any barriers encountered due to the availability of data or to missing data, as well as any problems in analyzing data. A brief summary of the limits and the plans to address any data issues should also be included.

**Objective 1:** Obtain an estimate of the prevalence of substance use disorder in the total population of an SCA.

**Objective 2:** Identify emerging substance use problems by type of chemical, route of administration, population, availability and cost, etc.

**Objective 3:** Identify local, state, and national trends that may impact the SCA.

**Objective 4:** Identify the demand for substance use disorder treatment.

**Objective 5:** Identify issues and systems barriers that impede the ability to meet the assessment and treatment demand in the SCA.

**Objective 6:** Identify assets or resources available in the county or region to help respond to treatment demand.

**Objective 7:** Identify evidence-based programs and practices in the county or region to help respond to emerging trends and treatment demand.

**Objective 8:** Identify and quantify the resources necessary to meet the estimated treatment demand (identified in Objective 4) and any emerging trends that impact current demand.

#### **IV. Fiscal Impact**

This section of the plan requires the SCA to describe their internal process to allocate funding to the various levels of care, case management activities, recovery support services, and other related support services.

#### **V. Quality Assurance and Outcome/Performance Measures**

A quality management process should provide a framework to operationalize a data driven, outcome-focused approach to the SCA planning process. This section should summarize the SCA's quality management initiatives. Describe how the SCA evaluates the quality of services provided. Describe how the SCA is utilizing outcome and performance measures (i.e. policy formation, performance based contracting, client satisfaction surveys, etc). Also, identify what type of strategies the SCA is using to ensure that its providers are able to meet state and national outcome measures.

#### **VI. Eligibility and Access**

This section of the Treatment Plan looks at how the SCA determines eligibility for the individuals it serves and how services are accessed. At a minimum, the following information must be included in this section:

- A description of how individuals access screening and assessment services during regular business hours, after hours, weekends and holidays. Also, describe any protocols the SCA has in place to ensure the system is working.
- A description of SCA residency requirements and how these affect active clients transferring from another SCA.
- A description of any additional eligibility criteria and treatment restrictions (i.e. number of treatment episodes per year/lifetime, level of care limitations, etc.).

## **PART V. Special Populations**

### **5.01 Priority Populations**

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

- Pregnant injection drug users;
- Pregnant substance users;
- Injection drug users; and
- Overdose survivors.

If the SCA chooses to restrict access to assessment and/or admission to treatment such restrictions shall not apply to pregnant women. 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.

## 5.02 Pregnant Women

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

- Screen for emergent care needs. If emergent care needs are identified, a referral must be made to the appropriate service. If no emergent care needs are identified and an assessment is necessary then;
- The SCA must conduct a level of care assessment to determine the need for treatment. If treatment is indicated then;
- Refer the woman to a treatment provider that has the capacity to provide treatment services to the woman within 14 days of the assessment. If no treatment facility has the capacity to admit the woman, then;
  - DDAP has special provisions for narcotic treatment programs (NTP) that are at capacity but need to admit a pregnant woman. The Department will consider approving an exception request for any NTP, on a case by case basis.
- Make available interim services to the woman within 48 hours after the assessment.

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:

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

### 5.03 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 within 14 days of assessment. If the individual cannot be admitted within 14 days, 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:

- Counseling and education about HIV and TB;
- Counseling and education about the risks of needle sharing;
- Counseling and education about the risks of transmission to sexual partners and infants;
- Counseling and education about the steps that can be taken to ensure that HIV and TB transmission do not occur; and
- 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.

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:

- Who at the SCA ensures that outreach activities are carried out as planned and how oversight is accomplished;

- Who, specifically, is selected to perform outreach;
- What types of training the outreach workers receive;
- What those specific outreach activities are;
- How outreach workers contact and follow up with the IDU population;
- How the IDU population is made aware of the relationship between injection drug use and communicable diseases, like HIV;
- How the IDU population is made aware of the steps that can be taken to prevent the transmission of such diseases; and
- How outreach workers encourage entry into treatment.

#### **5.04 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:

- Primary medical care for women, including a referral for prenatal care as well as child care while the women are receiving such services;
- Primary pediatric care, including immunization, for their children;
- 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;
- 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
- Sufficient case management and transportation to ensure those women and their children have access to the services provided in the four bullets 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.

## 5.05 Overdose Survivor

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 ICD-10 diagnosis codes for substance overdose or poisoning.

In order to ensure expedient and appropriate care for an individual who has overdosed, SCAs must:

- Develop and maintain a current listing of contact information for all local contracted facilities providing drug and alcohol screening, assessment, and treatment.
  - Contact information must include types of services provided, phone numbers, and addresses of these facilities.
- Distribute the referral listing to all emergency rooms, urgent care facilities, and other primary referral sources within the SCA's geographic area.
- Document annually that the contact listing has been reviewed and revised as needed.
- Redistribute the listing to the aforementioned referral sources as any revisions are made.

In addition, the SCA must develop procedures to:

- Ensure up to date contact information is provided to urgent/emergent care facilities and other primary referral sources;
- Describe the process to access care in their locale during business hours, and if different, during evenings and holidays;
- Allow priority access to substance abuse treatment for those being referred by an emergency room following an overdose; and
- Describe the process of access to care for insured and uninsured individuals to be included with the list of contracted providers given to urgent/emergent care facilities and other primary referral sources.

## **5.06 Veterans**

### **REQUIREMENTS**

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

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

### **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.

## **PART VI. 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.

### **6.01 Continuum of Care**

- 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:

- Outpatient to include intensive outpatient (adult and adolescent);
  - Partial hospitalization (adult);
  - Halfway house (adult);
  - Medically monitored detoxification (adult);
  - Medically monitored residential (adult, adolescent, and women with children)
- Early Intervention services may be delivered by the SCA directly or via contract with a service provider. Contracts may be fee for service or cost reimbursed.
  - The SCA shall contract with a licensed and approved methadone maintenance provider and refer adults for its service as indicated by the PCPC.
  - SCAs are not required to contract with providers of Medically Managed Inpatient Detox, Medically Managed Inpatient Residential services, Adolescent Halfway House, and Early Intervention services. However, before the SCA expends Department of Drugs and Alcohol funds for these services, a contract with the provider must be fully executed.
  - Contract language must specify all of the populations served (i.e., adult, adolescent, pregnant women, IDU).

## **6.02 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:

- Only contract with DDAP approved halfway house providers.
- Ensure that a halfway house:
  - Is an independent physical structure containing no more than 25 beds;
  - Provides no other licensed treatment activity within the same physical structure; and
  - First obtains an inpatient non-hospital residential treatment license for the specific facility where the halfway house activity is provided.
- 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 60 days in advance of the projected admissions.
- The request must include:
  - 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 Treatment Manual.
  - Facility Full Name, Facility Number, Address, Telephone Number, and Director;
  - Halfway House capacity including total beds, ratio breakdown of male/female, and focus, if servicing special populations;
  - Length of Program;
  - A copy of the DDAP License for inpatient non-hospital residential treatment and effective date;

- A description of frequency and length of the following:
  - Individual Therapy
  - Group Therapy
  - Peer Groups
  - Community Meetings
  - Educational Groups;
  
- A description of the following Support Services and how services will be accessed by individuals at the facility or in the community:
  - accessibility to public transportation within the community
  - transportation provided by the facility to employment and appointments
  - educational services
  - employment opportunities
  - job training
  - vocational services
  - healthcare
  - recreational activities
  - life skills
  - social services
  - mental health services (if an identified need of individual);
  
- A copy of the floor plan and description of the physical structure to include the following:
  - Independent Physical Structure
  - Independent Food Preparation and Dining Area;
  
- A description of how the facility promotes self-sufficiency and independent living; and
  
- 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  
 Division of Treatment  
 2 Kline Village  
 Harrisburg, PA 17104  
 (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. 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.

### **6.03 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.

## **6.04 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:

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

## **6.05 Medication Assisted Treatment (MAT)**

When an SCA pays for MAT, 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. The SCA must ensure that all individuals receiving this service are 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 are required to have written procedures (Methadone excluded) 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  
(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.

## **PART VII. 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:

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

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

## **PART VIII. Training For Contracted Drug And Alcohol Treatment Providers**

### **Training Requirements**

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

All persons providing adult treatment services and their supervisors must complete the following courses:

- DDAP approved Pennsylvania Client Placement Criteria (PCPC)
- DDAP approved Practical Applications of PCPC criteria
- DDAP approved or Pennsylvania Certification Board (PCB) approved Confidentiality
- DDAP approved Practical Applications of Confidentiality Laws and Regulations
- Screening and Assessment
- Addictions 101

All persons providing adolescent treatment services and their supervisors must complete the following courses:

- Most recent edition of the ASAM Patient Placement Criteria
- DDAP approved, or PCB approved Confidentiality
- DDAP approved Practical Applications of Confidentiality Laws and Regulations
- Adolescent Drug Abuse
- Screening and Assessment
- 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, located in Appendix H of the DDAP Treatment Manual. The supervisor must maintain the signed attestation within the staff personnel folder.

## **PART IX. Adult Case Management**

### **9.01 The Functions Of Adult Case Management**

The requirements of Case Management outlined in this manual are based on 4 Pa. Code §257.4. DDAP requires the SCA to provide screening, assessment, and case coordination. 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. In addition, screening includes evaluating the need for Early Intervention services. Assessment includes Level of Care (LOC) assessment and placement determination. Through Case Coordination, the SCA ensures that the individual's treatment and non-treatment needs are addressed.

The SCA is responsible for ensuring that individuals have 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.

## 9.02 Screening

### OVERVIEW

Screening is the first function in the Case Management process. The main purpose of screening is to determine the need for emergent care services. A companion purpose of screening is setting the stage for subsequent interventions.

### REQUIREMENTS

Screening must be provided 24 hours a day, seven days a week. Screening can be conducted by telephone or in person. After-hours screening does not require the ability to schedule a level of care assessment. 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:

- To obtain information to ascertain if emergent care is needed in the following areas:
  - Detoxification
  - Prenatal Care
  - Perinatal Care
  - Psychiatric Care
- To motivate and refer, if necessary, for a LOC assessment or other services.
- To identify individuals being referred by an emergency room or urgent care facility following an overdose.
- To identify individuals who are appropriate for Early Intervention services.

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. This tool is found in Appendix A; or

- 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:
  - psychiatric (identification of suicide and homicide risk factors);
  - perinatal and prenatal (identification of alcohol and other drug use effects on the fetus); and
  - 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, 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 and the date of initial contact in the individual's file.

### **SCREENING TOOL**

A screening tool must include the following, at a minimum:

- date of initial contact;
- demographic information;
- appointment date for LOC assessment (if appropriate);
- questions to determine the need for emergent care in the above identified areas; and
- Identification of individuals who have been referred by an emergency room or urgent care facility following an overdose.

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.

## 9.03 Assessment

### OVERVIEW

The activities encompassed in the function of assessment serve to coordinate all aspects of the individual's involvement in the drug and alcohol service delivery system. This function, which is primarily focused on the determination of needed resources, includes a LOC assessment that identifies the need for drug and alcohol treatment and any other needs an individual may have that affect placement decisions.

### REQUIREMENTS

The function of assessment includes a number of activities 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:

- LOC assessment and placement determination utilizing the most recent version of the Pennsylvania Client Placement Criteria (PCPC); and
- 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. An LOC assessment must be completed within seven calendar days from the date of initial contact with the individual. If this time frame is not met, the reason must be documented. An LOC 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 an individual is referred from detox directly to residential treatment, the biopsychosocial completed by the provider may be used in place of the LOC assessment.

Once an 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 PCPC Summary Sheet must be completed.

If the Single County Authority (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.

In order to determine the appropriate LOC, the individual conducting the LOC assessment must apply PCPC criteria. The PCPC Summary Sheet 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, with the exception of the addition of the SCA name, provider name, or client identification number.

The PCPC Summary Sheet 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.

The PCPC Summary Sheet can be found in Appendix D. The PCPC Summary Sheet in the STAR Treatment Data System may be used in lieu of the PCPC Summary Sheet, located in Appendix D, of the Department of Drug and Alcohol Programs (DDAP) Treatment Manual.

<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>
---	--

***\*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

### **Admission to Treatment**

All individuals must be admitted to the most appropriate level of care available within 14 days of the assessment. 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:
  - 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)?
  - 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)?
  - 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.
  - Have you had any close contact with someone diagnosed with TB?
  - Have you been homeless within the past year?
  - Have you ever been an injection drug user?
  - 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:

- **date of initial contact and date of assessment;**
- **demographics:** name, address, birth date, social security number, phone, marital status, sex, race, birth/maiden name;
- **education:** literacy, degree to which the alcohol/drug problem has interfered with education
- **employment:** degree to which the drug/alcohol problem interferes with employment; are you currently working, what is your job;
- **military:** eligibility for VA benefits, combat experience/potential trauma issues
- **physical health:** chronic and current acute medical conditions; past and present medications, are medications taken as prescribed, pregnancy, TB assessment questions;
- **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;
- **abstinence and recovery periods:** treatment history, support systems, clean time – when and how;
- **behavioral and emotional:** mental health symptoms, involvement in mental health treatment/hospitalizations, suicidal/homicidal ideations or attempts, psychotropic medications;
- **family/social/sexual:** child custody/visitation, childcare arrangements, sexual orientation;
- **spiritual:** spiritual/religious preference;
- **living arrangements:** current living arrangements, recovery environment;
- **abuse:** history of any abuse yes/no, issues that might impact placement
- **legal:** probation/parole status, conviction record to include disposition, current charges;
- **gambling:** lack of control in frequency of betting, lack of control over amount bet, lying about how much is bet;
- **potential barriers to treatment:** other areas that may impact treatment (i.e. transportation, cultural/language, childcare needs); and
- **assessment summary:** clinical impressions, level of care determination/PCPC and other special needs considerations, referral to LOC and provider, and interim services (if applicable). If the level of care to which the individual is referred is different than the recommended level of care, documentation of the reason must be maintained.

## **9.04 Case Coordination**

### **OVERVIEW**

Per 4 Pa. Code §257.4, SCAs shall, in cooperation with services providers, develop a plan for the provision of a case management system for all individuals entering or currently a recipient of drug and alcohol treatment services funded by the SCA. Case coordination requirements are based on this regulation. DDAP defines case coordination as a function of case management through which the SCA or contracted provider 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. Case Coordination is a mechanism for ensuring that individuals with complex, multiple problems receive the individualized services they need in a timely and appropriate fashion. The process of Case Coordination is intended to promote self-sufficiency and empower the individual to assume responsibility for his or her recovery.

Case coordination 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. Case Coordination is a collaborative process that includes the following activities: engagement, evaluation of needs, establishing linkages, arranging access to services, advocacy, monitoring, and other activities to address client needs throughout the course of treatment.

Non-treatment needs are needs the individual may have that do not directly impact level of care and placement decisions; however, they are issues that need to be addressed as part of the individual's recovery process. Non-treatment needs are 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, transportation), and life skills. These categories may overlap with components of the level of care assessment, however, needs identified during case coordination do not directly impact the individual's ability to participate in treatment. Transportation is one example. In the assessment, transportation may be identified as a need that affects an individual's ability to attend treatment. In case coordination, transportation may be identified as a non-treatment need because the individual needs transportation to attain or maintain employment. The SCA may utilize Appendix B (Non-Treatment Needs Checklist) to assist in identifying non-treatment needs. If the SCA chooses not to use the form in Appendix B, the SCA's form must include all of the required categories listed above. In order to assist individuals in the management of their recovery, it is necessary to ensure that resources to address the individual's needs are in place, and that those resources are made available to all clients at the time the needs are identified. Case coordination will facilitate the identification of services offered to and utilized by the individual.

### **REQUIREMENTS**

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

1. Supervise, coordinate, monitor and ensure the performance of case coordination activities.
  - The SCA or contracted provider(s) are required to provide case coordination for each individual seeking services paid for by the SCA.
  - The SCA must develop a case coordination policy and procedures that meet DDAP's minimum requirements and all SCA staff involved in client care must follow the SCA's policy and procedures.
  - When the SCA contracts with a service provider(s) to perform any function of case coordination on behalf of the SCA, then it is required that the SCA provide the service provider with their policy and procedures relating to case coordination. The SCA shall ensure their policy and procedures are being met at least annually during provider monitoring visits.
  - The SCA shall design case coordination to meet their local needs. The SCA must develop a Case Coordination policy and procedures which delineate the following:
    - If it is determined that the individual presenting for services is in need of public funding (e.g., SCA, MA, etc.), the SCA will provide, or arrange for, assistance with the process to access public funds for SUD treatment services.
      - It is not acceptable to simply direct an individual to apply for MA or refer an individual to another entity to seek funds for services. The SCA or subcontracted provider shall provide appropriate assistance with the MA application process and/or any other avenues for funding until the individual has received financial assistance/benefits that enables access to the proper level of care as indicated by the assessment.
    - A mechanism to maintain engagement with individuals in need of detox who are not able to be admitted immediately.
      - It is not acceptable to send an individual to the emergency room and not follow up with him or her.
      - Follow-up contact must be attempted each business day until the individual is admitted to detox.
      - All follow-up attempts must be documented in the client record.
    - How and when non-treatment needs are identified initially and on an ongoing basis;
      - At a minimum, non-treatment needs must be re-evaluated at the time of continued stay review or treatment plan updates.
    - How identified non-treatment needs are documented;
    - How identified non-treatment needs are addressed (i.e. resource list);
    - The SCA must have a mechanism in place as to how the delivery of services paid for by the SCA is tracked and documented, including:
      - the SCA's process for ensuring the requirements of STAR, per Section 9.10 of this manual, are utilized to monitor the delivery of services paid for by the SCA;
      - how the SCA ensures that its contracted treatment providers are meeting the requirements of STAR per Section 9.10 of this manual;

- How continued stay review PCPCs are reviewed and approved or disapproved;
- A mechanism in place to attempt to re-engage individuals who do not show for treatment or leave treatment prior to being discharged; and
- A description of additional activities/services.
  - The SCA may choose to provide or refer for additional activities/services to increase an individual's level of self-sufficiency based on the individual's needs (e.g., early intervention, face-to face contact with the individual to assess progress in addressing identified needs, intensive case management, etc.) that go beyond oversight of services. These additional services are not mandated.

*(Note: If SCAs opt to provide structured Intensive Case Management that was previously required by DDAP, that information is available at <http://www.health.state.pa.us/bdapiem>).*

- 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 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 in order to receive a specific level of care or type of service.
  - The staff person providing Case Coordination must meet the staffing qualifications outlined in Part 9.07 of this manual.
- 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.

2. Periodically review client files for continuity of service, continued appropriateness of service, and utilization of available resources.

- Continued Stay Review
  - An individual's treatment needs are expected to be addressed at the time of the LOC assessment and at the individual's continued stay review utilizing PCPC criteria. If the individual no longer meets the criteria of his/her current LOC, a PCPC is completed by the clinician for determination of the appropriate LOC for which the individual meets admission criteria. A referral should be made to the subsequent provider and the admission PCPC is forwarded to the provider and the authorizing agency/payer.
  - The SCA must have established written procedures that facilitate an active referral from one level of care/provider to another and one level of care to the next. These procedures must ensure that there is a direct contact made with the new provider and that a follow up contact is made to ascertain whether the client

was admitted as planned. If the SCA allows contracted providers to refer individuals to other providers/levels of care, the procedures required in this paragraph must be included or referenced in the provider’s contract.

- Placement decisions and length of stay need to be reconsidered throughout the course of an individual’s treatment utilizing PCPC criteria for admission, continued stay and discharge (OP only). Continued stay criteria are used to review and determine the clinical necessity of an individual’s status in a particular LOC and TOS. Use of continued stay criteria ultimately determines the appropriate LOS (until admission criteria are met for another LOC or the individual is discharged from the continuum).The PCPC must be completed by the clinical staff person working directly with the individual.
- Continued stay criteria should also be used whenever deemed clinically appropriate by the treatment provider due to a sudden change in status. For example, if an individual relapses, this could trigger review prior to the recommended timeframe.
- Continued stay reviews must be conducted within the parameters of the following timeframes:

<b>Level of Care</b>	<b>Timeframes</b>	<b>Continued Stay Process</b>
Early Intervention	Not Applicable	Not Applicable
Outpatient	Every 60 days to 180 days	Following the LOC assessment and application of the PCPC, outpatient treatment may be approved for a maximum of 180 days. Treatment beyond the last day approved requires the treatment provider to document that the case was clinically staffed and that a continued stay PCPC Summary Sheet was completed and maintained in the individual’s file.
Intensive Outpatient	Every 30 days to 120 days	Following the LOC assessment and application of the PCPC, intensive outpatient treatment may be approved for a maximum of 120 days. Treatment beyond the last day approved requires the treatment provider to document that the case was clinically staffed and that a continued stay PCPC Summary Sheet was completed and maintained in the individual’s file.
Partial Hospitalization	Every 30 days to 60 days	Following the LOC assessment and application of the PCPC, partial hospitalization treatment may be approved for a maximum of 60 days. Treatment beyond the last day approved requires the

		treatment provider to document that the case was clinically staffed and that a continued stay PCPC Summary Sheet was completed and maintained in the individual's file.
Halfway House	Every 30 days to 60 days	Following the LOC assessment and application of the PCPC, halfway house treatment may be approved for a maximum of 60 days. Treatment beyond the last day approved requires that a continued stay PCPC Summary Sheet be completed and forwarded to the SCA for approval.
Medically Monitored Detox	Every 3 days to 7 days	Pre-approved Detoxification may occur for a maximum of 7 days. Treatment beyond the last day approved requires the completion of a PCPC Summary Sheet that must be forwarded to the SCA for approval. The summary sheets must also be maintained in the individual's file.
Medically Monitored Residential, Short-Term	Every 7 days to 14 days	Following the LOC assessment and application of the PCPC, short-term inpatient residential treatment may be approved for a maximum of 14 days. Treatment beyond the last day approved requires that a continued stay PCPC Summary Sheet be completed and forwarded to the SCA for approval.
Medically Monitored Residential, Long-Term	Every 30 days to 60 days	Following the LOC assessment and application of the PCPC, long-term inpatient residential treatment may be approved for a maximum of 60 days. Treatment beyond the last day approved requires that a continued stay PCPC Summary Sheet be completed and forwarded to the SCA for approval.
Medically Managed Inpatient Detox	Every 1 to 2 days	Following the LOC assessment and application of the PCPC, medically managed inpatient detox treatment may be approved for a maximum of 2 days. Treatment beyond the last day approved requires that a continued stay PCPC Summary Sheet be completed and forwarded to the SCA for approval.
Medically Managed Residential	Every 7 days	Following the LOC assessment and application of the PCPC, medically managed residential treatment may be approved for a

		maximum of 7 days. Treatment beyond the last day approved requires that a continued stay PCPC Summary Sheet be completed and forwarded to the SCA for approval.
--	--	---

## **9.05 Case Management File Content**

Case Management files must, when applicable, include:

- screening tool,
- assessment tool,
- documentation of interim services (if applicable),
- PCPC Summary Sheets (admission, continued stay, and discharge),
- consent to release information forms,
- acknowledgement of receipt of the Grievance and Appeal policy,
- acknowledgement of receipt of treatment limitations,
- acknowledgement of receipt of housing limitations,
- documentation of the evaluation and re-evaluation of non-treatment needs,
- documentation of how non-treatment needs are addressed,
- client-related meetings and phone contact information, and
- discharge information, once the individual is no longer receiving services from the SCA (i.e., discharge form, case note, etc.).

### **Case Notes**

All contacts related to an individual must be documented in the individual's file. Case notes must adequately describe the nature and extent of each contact to include the following:

- Information that is gathered about the individual;
- Analysis of the information to identify the individual's treatment and non-treatment needs; and
- Action to be taken to meet the individual's treatment and non-treatment needs

The case manager is required to sign or initial and date all case note entries.

All documentation in the file must be legible. 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.

## **9.06 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 must be documented in case notes until the case manager has received all required training.

## 9.07 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: D&A Case Management Specialist, D&A Case Management Specialist Trainee, D&A Treatment Specialist, or 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.

## 9.08 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 Director of Treatment. 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 and PCPC training courses prior to November 2003 are not required to take the related practical application courses.

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 function - 36 total training hours

- Addictions 101 – 6 hours
- Confidentiality – 6 hours
- Practical Application of Confidentiality Laws and Regulations – 3 hours
- Case Management Overview – 6 hours
- Screening & Assessment – 6 hours
- PCPC – 6 hours
- Practical Application of PCPC Criteria – 3 hours

### Case Coordination function – 21 (30\*) total training hours

- Addictions 101 – 6 hours
- Confidentiality – 6 hours
- Practical Application of Confidentiality Laws and Regulations – 3 hours
- Case Management Overview – 6 hours
- \*PCPC – 6 hours
- \*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:**

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

- 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, located in Appendix I of the DDAP Treatment Manual. The supervisor must maintain the signed attestation within the staff personnel folder.

## 9.09 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.

- denial or termination of services;
- LOC determination;
- length of stay in treatment; and
- 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:

- A policy that describes, at a minimum, a two-stage appeal process where:
  - 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 Form found in Appendix C. It is imperative that client identifying information is not included or attached to this form.
  - 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 Form found in Appendix C. It is imperative that client identifying information is not included or attached to this form.

- Notification: The individual must sign-off that they have been notified about the following areas:
  - the grievance and appeal policy that outlines the four areas that an individual can grieve with the SCA;
  - 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;
  - 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
  - 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.

## 9.10 Reporting

### Service Limitations

The SCA shall notify DDAP's Director of Treatment, 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 treatment limitations are removed, the SCA must notify DDAP's Director of Treatment, in writing, within five days.

### Strengthening Treatment and Recovery (STAR) Data System

#### OVERVIEW

STAR is a web-based application that manages client data on three levels: provider, SCA and state. STAR also establishes a mechanism to receive data from providers that already have existing technology solutions. Use of this standardized application allows federal and state reporting requirements to be fulfilled. STAR also allows the state, SCAs and providers to track individuals throughout Episodes of Care. An Episode of Care is defined as the entirety of services in which an individual engages from the date of initial contact through the final date of any service, including treatment and non-treatment services. In a complete Episode of Care, no more than one month can elapse between different levels of care or between encounters in a given level of care/type of service in which an individual was not discharged. Within an Episode of Care, an individual is admitted into a specific program. Each time he/she changes a level of care, a discharge must be entered from that program. At such time that the individual is no longer receiving *any* services funded from the SCA, he/she is discharged. That discharge marks the end of the Episode of Care.

#### REQUIREMENTS

With regard to all clients funded by the SCA, all federal and state-required data elements pertaining to individuals who are screened, assessed, admitted into treatment, or are receiving recovery support services must be entered or uploaded into STAR. All required data elements are contained within the forms listed below. Data must be entered into STAR Provider Client Management and processed in STAR Payer Client Management per the DDAP Report Schedule.

The following forms in STAR are required to be entered into Provider Client Management and submitted to the SCA, as the payer, in this order:

- Client profile
- Screen
- Pennsylvania Client Placement Criteria (PCPC)
  - Includes Admission, Continued Stay, and Discharge PCPC (as applicable)
- Insurance (needs to be completed but not submitted to the SCA)
- Admission
  - If the client is admitted into treatment, the Treatment Episode Data Set (TEDS) information must be submitted to the SCA.

- Discharge
  - If the client is discharged from treatment, the TEDS information must be submitted to the SCA.

The following forms in STAR are required to be processed and reviewed in Payer Client Management in this order:

- Screen
- PCPC
  - Includes Admission, Continued Stay, and Discharge PCPC (as applicable).
- Admission
- Discharge

## 9.11 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:

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

- 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.

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

## **PART X. Adolescent Case Management**

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

The requirements of Case Management outlined in this manual are based on 4 Pa. Code §257.4. DDAP requires the SCA to provide screening, assessment, and case coordination. These functions encompass various activities. Screening includes evaluating the adolescent's need for a referral to emergent care including, detoxification, prenatal, perinatal, and psychiatric services. In addition, screening includes evaluating the need for Early Intervention services. Assessment includes Level of Care (LOC) assessment and placement determination. Through Case Coordination, the SCA ensures that the adolescent's treatment and non-treatment needs are addressed.

The SCA is responsible for ensuring that adolescents have 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.

## 10.02 Screening

### Overview

Screening is the first function in the Case Management process. The main purpose of screening is to determine the need for emergent care services. A companion purpose of screening is setting the stage for subsequent interventions.

### Requirements

Screening must be provided 24 hours a day, seven days a week. Screening can be conducted by telephone or in person. After-hours screening does not require the ability to schedule a level of care assessment. 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:

- To obtain information to ascertain if emergent care is needed in the following areas:
  - Detoxification
  - Prenatal Care
  - Perinatal Care
  - Psychiatric Care
- To motivate and refer, if necessary, for a LOC assessment or other services.
- To identify adolescents being referred by an emergency room or urgent care facility following an overdose.
- To identify adolescents who are appropriate for Early Intervention services.

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 adolescent to a skilled professional who is able to determine the need for a referral for emergent care services. This tool is found in Appendix A; or

- 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:
  - psychiatric (identification of suicide and homicide risk factors);
  - perinatal and prenatal (identification of alcohol and other drug use effects on the fetus); and
  - 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 adolescent is in need of emergent care, those needs must be addressed at the time they are identified. If an adolescent is in need of detox, the adolescent 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 and the date of initial contact in the adolescent's file.

### **SCREENING TOOL**

A screening tool must include the following, at a minimum:

- date of initial contact;
- client demographic information;
- appointment date for LOC assessment (if appropriate);
- questions to determine the need for emergent care in the above identified areas; and
- Identification of adolescents who have been referred by an emergency room or urgent care facility following an overdose.

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, which would prompt a support staff person to transfer the client 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.

## **10.03 Assessment**

### **Overview**

The activities encompassed in the function of assessment serve to coordinate all aspects of the adolescent's involvement in the drug and alcohol service delivery system. This function, which is primarily focused on the determination of needed resources, includes a LOC assessment that identifies the need for drug and alcohol treatment and any other needs an adolescent may have that affect placement decisions.

### **Requirements**

The function of assessment includes a number of activities 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:

- LOC assessment and placement determination utilizing the most recent version of The ASAM Criteria for Adolescents; and
- TB Screening and Referral Services.

### **LOC assessment and placement determination**

LOC assessment is defined as a face-to-face interview with the adolescent 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. If this time frame is not met, the reason must be documented. A LOC 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. The assessor, not the adolescent, must complete the clinical portions of the assessment tool. Any demographic information and/or support data gathered prior to the face-to-face interview must be reviewed by the clinician or case manager with the client during the LOC assessment.

Once an 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 adolescents who have never engaged in treatment after being assessed or who have been discharged and are seeking to reinstate services. If an adolescent 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 (APSS) must be completed using The ASAM Criteria.

If the SCA limits the number of LOC assessments or admissions to treatment, the limitations must be expressed in written policy and all adolescents must sign off to indicate that they have been notified of the limitations, in writing.

After gathering the necessary information through the assessment process, the appropriate level of care, type of service, length of stay, and the most appropriate facility can be determined. For adolescents, the LOC determination must be made in accordance with the most recent edition of The ASAM Criteria.

The APSS must be completed accurately to reflect the recommendation of the assessor based on The ASAM Criteria. The APSS 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> <b>2.1</b> Intensive Outpatient Treatment <b>2.5</b> Partial Hospitalization Treatment</p>	<p><b><u>Level 3</u></b> <b>3.1</b> Clinically Managed Low-Intensity Residential Treatment (e.g., Halfway House) <b>3.5</b> Clinically Managed Medium-Intensity Residential Treatment <b>3.7</b> Medically Monitored High-Intensity Inpatient Treatment</p>
---	---

Currently, DDAP requires that the APSS in Appendix E or the ASAM Summary Sheet be used to record and exchange client information necessary in making placement determinations. The contents of the summary sheet must comply with state and federal confidentiality regulations. Alterations, modifications, or additions to the APSS cannot be made, with the exception of the addition of the SCA name. The APSS in the STAR Treatment Data System may be used in place of the APSS, located in Appendix E, of the DDAP Treatment Manual.

**Admission to Treatment**

All adolescents must be admitted to the most appropriate level of care available within 14 days of the assessment. If these time frames cannot be met, the reason must be documented in the adolescent’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 adolescent to determine whether or not the individual would be considered high risk for TB as follows:
  - 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)?
  - 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)?
  - 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.
  - Have you had any close contact with someone diagnosed with TB?
  - Have you been homeless within the past year?
  - Have you ever been an injection drug user?
  - 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:

- **date of initial contact and date of assessment;**
- **demographics:** name, address, birth date, social security number, phone, marital status, sex, race, birth/maiden name;
- **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;
- **employment:** degree to which the drug/alcohol problem interferes with employment, are you currently working, what is your job;
- **physical health: chronic and current acute medical conditions;** past and present medications, are medications taken as prescribed, pregnancy, TB assessment questions;
- **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;
- **abstinence and recovery periods:** treatment history, support systems, clean time – when and how;
- **behavioral and emotional:** mental health symptoms, involvement in mental health treatment/hospitalizations, suicidal/homicidal ideations or attempts, psychotropic medications;
- **family/social/sexual:** family of origin, immediate family, family relationships, family history of substance abuse, childcare arrangements, interpersonal relations/skills, sexual orientation;
- **spiritual:** spiritual/religious preference;
- **living arrangements:** current living arrangements, recovery environment;
- **social service agency program involvement, child welfare involvement, and residential treatment;**
- **abuse:** history of any abuse yes/no, issues that might impact placement
- **legal:** juvenile justice involvement and delinquency including types and incidences of behavior, probation/parole status, conviction record to include disposition, current charges;
- **gambling:** lack of control in frequency of betting, lack of control over amount bet, lying about how much is bet;
- **potential barriers to treatment:** other areas that may impact treatment (i.e. transportation, cultural/language, childcare needs);
- **assessment summary:** clinical impressions, level of care determination/ASAM and other special needs considerations, referral to LOC and provider, and interim services (if applicable). If the level of care to which the adolescent is referred is different than the recommended level of care, documentation of the reason must be maintained.

## **10.04 Case Coordination**

### **Overview**

Per 4 Pa. Code §257.4, SCA's shall, in cooperation with services providers, develop a plan for the provision of a case management system for all adolescents entering or currently a recipient of drug and alcohol treatment services funded by the SCA. Case coordination requirements are based on this regulation. DDAP defines case coordination as a function of case management through which the SCA or contracted provider establishes an organized approach to coordinating service delivery in order to ensure the most comprehensive process for meeting an adolescent's treatment and non-treatment needs throughout the recovery process. Case Coordination is a mechanism for ensuring that adolescents with complex, multiple problems receive the individualized services they need in a timely and appropriate fashion. The process of Case Coordination is intended to promote self-sufficiency and empower the adolescent to assume responsibility for his or her recovery.

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

Non-treatment needs are needs the adolescent may have that do not directly impact level of care and placement decisions; however, they are issues that need to be addressed as part of the adolescent's recovery process. Non-treatment needs are needs that the adolescent 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, transportation), and life skills. These categories may overlap with components of the level of care assessment, however, needs identified during case coordination do not directly impact the adolescent's ability to participate in treatment. Transportation is one example. In the assessment, transportation may be identified as a need that affects an adolescent's ability to attend treatment. In case coordination, transportation may be identified as a non-treatment need because the adolescent needs transportation to attain or maintain employment. The SCA may utilize Appendix B (Non-Treatment Needs Checklist) to assist in identifying non-treatment needs. If the SCA chooses not to use the form in Appendix B, the SCA's form must include all of the required categories listed above. In order to assist adolescents in the management of their recovery, it is necessary to ensure that resources to address the adolescent's needs are in place, and that those resources are made available to all clients at the time the needs are identified. Case coordination will facilitate the identification of services offered to and utilized by the adolescent.

## **Requirements**

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

1. Supervise, coordinate, monitor and ensure the performance of case coordination activities.
  - The SCA or contracted provider(s) are required to provide case coordination for each adolescent receiving services paid for by the SCA.
  - The SCA must develop a case coordination policy and procedures that meet DDAP's minimum requirements and all SCA staff involved in client care must follow the SCA's policy and procedures.
  - When the SCA contracts with a service provider(s) to perform any function of case coordination on behalf of the SCA, then it is required that the SCA provide the service provider with their policy and procedures relating to case coordination. The SCA shall ensure their policy and procedures are being met at least annually during provider monitoring visits.
  - The SCA shall design case coordination to meet their local needs. The SCA must develop a Case Coordination policy and procedures which delineate the following:
    - If it is determined that the individual presenting for services is in need of public funding (e.g., SCA, MA, etc.), the SCA will provide, or arrange for, assistance with the process to access public funds for SUD treatment services.
      - It is not acceptable to simply direct an individual to apply for MA or refer an individual to another entity to seek funds for services. The SCA or subcontracted provider shall provide appropriate assistance with the MA application process and/or any other avenues for funding until the individual has received financial assistance/benefits that enables access to the proper level of care as indicated by the assessment.
    - A mechanism to maintain engagement with adolescents in need of detox who are not able to be admitted immediately.
      - It is not acceptable to send an adolescent to the emergency room and not follow up with him or her.
      - Follow-up contact must be attempted each business day until the adolescent is admitted to detox.
      - All follow-up attempts must be documented in the client record.
    - How and when non-treatment needs are identified initially and on an ongoing basis;
      - At a minimum, non-treatment needs must be re-evaluated at the time of continued stay review or treatment plan updates.
    - How identified non-treatment needs are documented;
    - How identified non-treatment needs are addressed (i.e. resource list);
    - The SCA must have a mechanism in place as to how the delivery of services paid for by the SCA is tracked and documented, including:

- The SCA’s process for ensuring the requirements of STAR, per Section 10.10 of this manual, are utilized to monitor the delivery of services paid for by the SCA;
    - How the SCA ensures that its contracted treatment providers are meeting the requirements of STAR per Section 10.10 of this manual;
  - How continued stay review ASAMs are reviewed and approved or disapproved;
  - A mechanism in place to attempt to re-engage individuals who do not show for treatment or leave treatment prior to being discharged; and
  - A description of additional activities/services.
    - The SCA may choose to provide or refer for additional activities/services to increase an adolescent’s level of self-sufficiency based on the adolescent’s needs (e.g., early intervention, face-to face contact with the adolescent to assess progress in addressing identified needs, intensive case management, etc.) that go beyond oversight of services. These additional services are not mandated.

*(Note: If SCAs opt to provide structured Intensive Case Management that was previously required by DDAP, that information is available at <http://www.health.state.pa.us/bdapicm>).*

- If the SCA chooses to provide additional activities or services, such as Intensive Case Management (ICM) or Resource Coordination (RC), adolescents cannot be required to participate in these 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 in order to receive a specific level of care or type of service.
  - The staff person providing Case Coordination must meet the staffing qualifications outlined in Part 9.07 of this manual.
- 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.

2. Periodically review client files for continuity of service, continued appropriateness of service, and utilization of available resources.

- Continued Stay Review
  - An adolescent’s treatment needs are expected to be addressed at the time of the LOC assessment and at the adolescent’s continued stay review utilizing ASAM criteria. If the adolescent no longer meets the criteria of his/her current LOC, an ASAM is completed by the clinician for determination of the appropriate LOC for which the adolescent meets admission criteria. A referral should be made to the

subsequent provider and the admission ASAM is forwarded to the provider and the authorizing agency/payer.

- The SCA must have established written procedures that facilitate an active referral from one level of care/provider to another and one level of care to the next. These procedures must ensure that there is a direct contact made with the new provider and that a follow up contact is made to ascertain whether the client was admitted as planned. If the SCA allows contracted providers to refer individuals to other providers/levels of care, the procedures required in this paragraph must be included or referenced in the provider’s contract.
- Placement decisions and length of stay (LOS) need to be reconsidered throughout the course of an adolescent’s treatment utilizing ASAM criteria for admission, continued stay and discharge (OP only). Continued stay criteria are used to review and determine the clinical necessity of an adolescent’s status in a particular LOC and TOS. Use of continued stay criteria ultimately determines the appropriate LOS (until admission criteria are met for another LOC or the adolescent is discharged from the continuum).The ASAM must be completed by the clinical staff person working directly with the adolescent.
- Continued stay criteria should also be used whenever deemed clinically appropriate by the treatment provider due to a sudden change in status. For example, if an adolescent relapses, this could trigger review prior to the recommended timeframe.
- Continued stay reviews must be conducted within the parameters of the following timeframes:

<b>Level of Care</b>	<b>Timeframes</b>
Early Intervention	Not Applicable
Outpatient	Every 30 days to 120 days
Intensive Outpatient	Every 30 days to 120 days
Partial Hospitalization	Every 30 days to 120 days
Residential/Intensive Inpatient Treatment (includes Halfway House)	Every 30 days

## **10.05 Case Management File Content**

Case Management files must, when applicable, include:

- screening tool,
- assessment tool,
- documentation of interim services (if applicable),
- APSS or ASAM Summary Sheet (admission, continued stay, and discharge),
- consent to release information forms,
- signed Grievance and Appeal form,
- signed treatment limitations form (if applicable),
- signed housing limitations form (if applicable),
- documentation of the evaluation and re-evaluation of non-treatment needs,
- documentation of how non-treatment needs are addressed,
- client-related meetings and phone contact information, and
- discharge information, once the adolescent is no longer receiving services from the SCA (i.e., discharge form, case note, etc.).

### **Case Notes**

All contacts related to the adolescent must be documented in the individual's file. Case notes must adequately describe the nature and extent of each contact to include the following:

- Information that is gathered about the adolescent;
- Analysis of the information to identify the adolescent's needs; and
- Action to be taken to meet the adolescent's needs

The case manager is required to sign or initial and date all case note entries.

All documentation in the file must be legible. 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.

## **10.06 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 sign-off on written documentation, to include, at a minimum, the LOC assessment, and APSS or ASAM Summary Sheet forms must continue until the case manager has received all appropriate training.

## **10.07 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: D&A Case Management Specialist, D&A Case Management Specialist Trainee, D&A Treatment Specialist, or 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.

## 10.08 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, Adolescent Drug Abuse, 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 Director of Treatment. 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 are not required to take Case Management Overview, Addictions 101, and Screening and Assessment. In addition, staff that completed Confidentiality training prior to November 2003 are not required to take the related practical application course.

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 function - 39 total training hours

- Addictions 101 – 6 hours
- Confidentiality – 6 hours
- Practical Application of Confidentiality Laws and Regulations – 3 hours
- Case Management Overview – 6 hours
- Screening & Assessment – 6 hours
- The ASAM Criteria – 6 hours
- Adolescent Drug Abuse- 6 hours

### Case Coordination function – 27 (33\*) total training hours

- Addictions 101 – 6 hours
- Confidentiality – 6 hours
- Practical Application of Confidentiality Laws and Regulations – 3 hours
- Case Management Overview – 6 hours
- \*The ASAM Criteria – 6 hours
- Adolescent Drug Abuse- 6 hours

\*If conducting continued stay reviews

### **Course Prerequisites:**

Practical Application of Confidentiality Laws and Regulations:

- Confidentiality

### **Required trainings include:**

- 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.

- Confidentiality – 6 hours (requires DDAP 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.

- 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.

- 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.

- 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. An overview of the Clinical Institute Withdrawal Assessment for Alcohol, the Narcotics Withdrawal Scale, the Diagnostic and Statistical Manual IV-Revised for substance abuse disorders and cultural competency will be addressed.

- The 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. Participants will be able to apply The ASAM Criteria in order to identify the LOC and treatment type most relevant to meet the client's needs.

- Adolescent Drug Abuse

Discussion as to how and why adolescents abuse alcohol and other drugs of abuse, current trends, supported by survey data, drug described regarding various effects, signs, symptoms, populations, who uses, toxicity, withdrawal, treatment and prevention strategies.

## 10.09 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 adolescent and the SCA. Contracted treatment providers and other agencies may have separate grievance and appeal protocols arising from the adolescent'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 process in place for resolving grievances.

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

- denial or termination of services;
- LOC determination;
- length of stay in treatment; and
- violation of the adolescent's human or civil rights.

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

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

- A policy that describes, at a minimum, a two-stage appeal process where:
  - 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 adolescent and DDAP of the outcome within seven days via the DDAP-approved Grievance and Appeal Form found in Appendix C. It is imperative that client identifying information is not included or attached to this form.
  - 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 adolescent and DDAP of the outcome within seven days via the DDAP-approved Grievance and Appeal Form found in Appendix C. It is imperative that client identifying information is not included or attached to this form.

- Notification: The adolescent must sign-off that they have been notified about the following areas:
  - the grievance and appeal policy that outlines the five areas that an adolescent can grieve with the SCA;
  - the need for a signed consent form from the adolescent 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;
  - 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
  - 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 adolescent at each level of appeal.

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.

## 10.10 Reporting

### Service Limitations

The SCA shall notify DDAP's Director of Treatment, 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 treatment limitations are removed, the SCA must notify DDAP's Director of Treatment, in writing, within five days.

### Strengthening Treatment and Recovery (STAR) Data System

#### OVERVIEW

STAR is a web-based application that manages client data on three levels: provider, SCA and state. STAR also establishes a mechanism to receive data from providers that already have existing technology solutions. Use of this standardized application allows federal and state reporting requirements to be fulfilled. STAR also allows the state, SCAs and providers to track individuals throughout Episodes of Care. An Episode of Care is defined as the entirety of services in which an individual engages from the date of initial contact through the final date of any service, including treatment and non-treatment services. In a complete Episode of Care, no more than one month can elapse between different levels of care or between encounters in a given level of care/type of service in which an individual was not discharged. Within an Episode of Care, an individual is admitted into a specific program. Each time he/she changes a level of care, a discharge must be entered from that program. At such time that the individual is no longer receiving *any* services funded from the SCA, he/she is discharged. That discharge marks the end of the Episode of Care.

#### REQUIREMENTS

With regard to all clients funded by the SCA, all federal and state-required data elements pertaining to individuals who are screened, assessed, admitted into treatment, or are receiving recovery support services must be entered or uploaded into STAR. All required data elements are contained within the forms listed below. Data must be entered into STAR Provider Client Management and processed in STAR Payer Client Management per the DDAP Report Schedule.

The following forms in STAR are required to be entered into Provider Client Management and submitted to the SCA, as the payer, in this order:

- Client profile
- Screen
- American Society of Addiction Medicine (ASAM)
  - Includes Admission, Continued Stay, and Discharge ASAM (as applicable)
- Insurance (needs to be completed but not submitted to the SCA)
- Admission

- If the client is admitted into treatment, the Treatment Episode Data Set (TEDS) information must be submitted to the SCA.
- Discharge
  - If the client is discharged from treatment, the TEDS information must be submitted to the SCA.

The following forms in STAR are required to be processed and reviewed in Payer Client Management in this order:

- Screen
- ASAM
  - Includes Admission, Continued Stay, and Discharge ASAM (as applicable)
- Admission
- Discharge

## 10.11 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, 1690.112.
- 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:

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

- 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.

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

## **PART XI. Recovery Support Services**

Recovery Support Services (RSS) 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. 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:

- 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);
- 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;
- 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;
- 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;
- Recovery Planning to assist an individual in managing their recovery;
- Support Groups for recovering individuals that are population focused (i.e. HIV/AIDS, veterans, youth, bereavement, etc.);
- Recovery Housing (for parameters in funding this RSS, please see Section 6.04); and
- Recovery Centers where recovery support services are designed, tailored and delivered by individuals from local recovery communities.

## **PART XII. Quality of Care (Placeholder)**

The Department (DDAP) is actively working to establish Quality of Care requirements to ensure that all consumers receive quality care no matter what level of service they are accessing. Since quality of care may be difficult to measure or quantify, DDAP is going to define the minimum standards that will be required, that will provide the basic framework for delivering quality care. The minimum standards may also make direct reference to applicable chapters of 28 Pa. Code and will augment the specific levels of care delineated in the PCPC, Third Edition. Please be advised that the minimum standards are designed to provide a measurable and objective starting point for providers in their pursuit of delivering quality care. However, the establishment of minimum standards is not intended to prevent providers from implementing even more stringent standards as they see fit.

DDAP reserves the right to update Part 12 once it has established the Quality of Care requirements referenced above.

# 13.01 APPENDIX A

## DDAP SCREENING TOOL

Type of Screening:  Telephone  Face To Face

### DEMOGRAPHICS

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Birth/Maiden name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referral source: \_\_\_\_\_ Phone: \_\_\_\_\_

Marital Status:  Married  Never Married  Separated  Divorced  Widowed  
 Other: (specify) \_\_\_\_\_

Sex:  M  F

Race:  White  Black  Alaskan Native  American Indian  Asian or Pacific Islander  
 Puerto Rican  Mexican  Cuban  Other Hispanic  Other: (specify) \_\_\_\_\_

### DRUG & ALCOHOL

What are you currently using (alcohol/drug)? \_\_\_\_\_

Last use? \_\_\_\_\_

How much/how often are you drinking/using? \_\_\_\_\_

Have you ever injected drugs?  Y  N  
If yes, when? \_\_\_\_\_

Have you ever tried and failed to control your use or stop using? If so, explain \_\_\_\_\_

In the past 3 months, how often has your use led to health, social, legal, or financial problems? \_\_\_\_\_

Are you experiencing any of the following withdrawal symptoms? (If the individual answers "yes" to this question, he/she must be transferred to a clinical staff person.)  
 Uncontrollable shaking  Hallucinations  Seizures  Nausea/Vomiting  Severe cramps  
 Other: (specify) \_\_\_\_\_

Have you ever experienced any of the above symptoms? If so, explain: \_\_\_\_\_

Have you recently been treated by medical personnel for an overdose?  Y  N If so, when? \_\_\_\_\_

Have you ever received drug/alcohol treatment or services?  Y  N  
If yes, most recent? \_\_\_\_\_

Type:  Outpatient  Intensive Outpatient  Partial  Halfway House  Detox  Inpatient  Hospital-based  
 Long-term  MAT  Community Support Groups  Other (specify): \_\_\_\_\_

**PSYCHIATRIC**

Are you having any thoughts of harming yourself or others? \_\_\_Y \_\_\_N (If the individual answers "yes" to this question, he/she must be transferred to a clinical staff person.)

Suicide plan: \_\_\_\_\_

Ability to contract for safety: \_\_\_\_\_

Thoughts to harm others: \_\_\_\_\_

Plan to harm others: \_\_\_\_\_

Have you ever received mental health services? \_\_\_Y \_\_\_N

If yes, most recent? \_\_\_\_\_

Type: \_\_\_Inpatient \_\_\_Outpatient \_\_\_Other: (specify)\_\_\_\_\_

Was medication prescribed? \_\_\_Y \_\_\_N If yes, specify: \_\_\_\_\_

**PRENATAL/PERINATAL**

Are you pregnant? \_\_\_Y \_\_\_N If yes, how far along? \_\_\_\_\_

Are you receiving prenatal care? \_\_\_\_\_

Have you given birth within the last twenty-eight days? \_\_\_Y \_\_\_N

Are you experiencing any complications that you feel may require emergency care? \_\_\_Y \_\_\_N

(If the individual answers "yes" to this question, she must be transferred to a clinical staff person.)

If yes, explain: \_\_\_\_\_

**REFERRAL FOR EMERGENT CARE SERVICES**

**\*\*SCREENER\*\***

Is there a need for a referral for emergent care services? \_\_\_Y \_\_\_N

Reason: \_\_\_\_\_

If yes, where? \_\_\_\_\_

**EMPLOYMENT / FUNDING / LEGAL**

Are you employed? \_\_\_Y \_\_\_N Employer? \_\_\_\_\_

Do you have health insurance or Medical Assistance? \_\_\_Y \_\_\_N Specify: \_\_\_\_\_

Are you a veteran? \_\_\_Y \_\_\_N Other funding sources? (specify)\_\_\_\_\_

Are you involved with the criminal/juvenile justice system? \_\_\_Y \_\_\_N

If yes, what is your status? \_\_\_\_\_

Do you have any pending charges? \_\_\_Y \_\_\_N If yes, specify: \_\_\_\_\_

\_\_\_\_\_

**PRIORITY POPULATIONS / SPECIAL NEEDS**

Pregnant IDU       Pregnant substance abuser       IDU       Overdose survivor

Woman w/ children →  Number of children under 18       Number living with client

Other (specify) \_\_\_\_\_

Do you have any special needs?  Y  N      If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**ACCESS / ASSESSMENT**

Screener Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Date of Assessment: \_\_\_\_\_ Time: \_\_\_\_\_

Location: \_\_\_\_\_

Assessor: \_\_\_\_\_

If the assessment cannot be scheduled within the required timeframe, why:

Client choice

SCA/Provider schedule will not permit

Other (specify) \_\_\_\_\_

\_\_\_\_\_

## 13.02 APPENDIX B

### **NON-TREATMENT NEEDS CHECKLIST**

<b>DOMAINS</b>	<b>Is the individual in need of assistance in the following areas?</b>
<b>EDUCATION /VOCATION</b>	i.e., GED, job training, resumé writing, tutoring, etc.
<b>EMPLOYMENT</b>	i.e., job search assistance, etc.
<b>PHYSICAL HEALTH</b>	i.e., medication management, pressing medical issues needing attention, pregnancy testing, pre-natal care, TB assessment, HIV/AIDS, Hepatitis, etc.
<b>EMOTIONAL/MENTAL HEALTH</b>	i.e., mental health referral, psychotropic medication management; co-occurring referral, etc.
<b>FAMILY/SOCIAL</b>	i.e., assisting client with: child custody/visitation and/or childcare arrangements, develop healthy leisure activities, develop social skills, referral to social service agencies, etc.
<b>LIVING ARRANGEMENTS / HOUSING</b>	i.e., assistance with getting client into a healthy recovery environment, referral to housing agencies, etc.
<b>LEGAL STATUS</b>	i.e., referral for legal assistance, communication skills when dealing with probation/parole, etc.
<b>BASIC NEEDS</b>	i.e., assistance with meeting basic needs such as food, clothing, and transportation, etc.
<b>LIFE SKILLS</b>	i.e., assistance with cooking, cleaning, grocery shopping, paying bills in a timely manner, etc.

## 12.03 APPENDIX C

### GRIEVANCE AND APPEAL REPORTING FORM

SCA: \_\_\_\_\_

Level: \_\_\_\_\_

Issue: \_\_\_\_\_

Date: \_\_\_\_\_

Client ID #: \_\_\_\_\_

Briefly describe the individual's grievance with the SCA: (Include date grievance was filed with the SCA).

Briefly describe the outcome of the grievance and the basis for the decision: (Include date of review).

Grievance Resolved: Yes ( ) No ( )

Submit to:  
DDAP Director of Treatment  
02 Kline Village  
Harrisburg, PA 17104  
Or Fax to 717-787-6285

**13.04 APPENDIX D**

**PCPC Summary Sheet**

Name: \_\_\_\_\_  
Reviewer/Therapist: \_\_\_\_\_  
Facility: \_\_\_\_\_

SS#: \_\_\_\_\_  
Phone # & Ext. \_\_\_\_\_  
Date: \_\_\_\_\_

**Circle One:**      **ADMISSION**                      **CONTINUED STAY**                      **DISCHARGE (OP only)**

Show the level of care and criteria indicated for each dimension below (e.g., Dimension 1:  
LOC 3A; Criteria 3A1.B):

Indicate the level of care recommended: \_\_\_\_\_                      Indicate the level of care received: \_\_\_\_\_

If recommended level of care was different from received, why? \_\_\_\_\_  
\_\_\_\_\_

Indicate the program or facility referred to: \_\_\_\_\_

	<u>Level of Care</u>	<u>Criteria Indicated</u>	
1. Intoxication/Withdrawal	_____	_____	If referred from another provider, has the receiving provider validated this PCPC as the clinically appropriate Level of Care? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Biomedical Conditions	_____	_____	
3. Emotional/Behavioral	_____	_____	
4. Treatment Accept/Resistance	_____	_____	
5. Relapse Potential	_____	_____	
6. Recovery Environment	_____	_____	

A brief comment about the individual's progress or status is required in each dimension.

Dimension 1: \_\_\_\_\_  
\_\_\_\_\_

Dimension 2: \_\_\_\_\_  
\_\_\_\_\_

Dimension 3: \_\_\_\_\_  
\_\_\_\_\_

Dimension 4: \_\_\_\_\_  
\_\_\_\_\_

Dimension 5: \_\_\_\_\_  
\_\_\_\_\_

Dimension 6: \_\_\_\_\_  
\_\_\_\_\_

**Clinician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Supervisor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(Supervisor signature is required until the clinician has met the training and competency requirements)*

# 13.05 APPENDIX E

## Adolescent Placement Summary Sheet

1. Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Reviewer/Therapist: \_\_\_\_\_ Phone # & Ext. \_\_\_\_\_  
 Facility: \_\_\_\_\_ Date: \_\_\_\_\_

**Circle One:**    **ADMISSION**    **CONTINUED STAY**    **DISCHARGE/REFERRAL (OP only)**

2. Show the level of care and criteria indicated for each dimension below (e.g., Dimension 3: LOC 1; Criteria a, b, c):

Indicate the level of care recommended: \_\_\_\_\_ Indicate the level of care received: \_\_\_\_\_

If recommended level of care was different from received, why? \_\_\_\_\_

Indicate the program or facility referred to: \_\_\_\_\_

	<u>Level of Care</u>	<u>Criteria Indicated</u>	
1. Acute Intoxication and/or Withdrawal Potential	_____	_____	
2. Biomedical Conditions and Complications	_____	_____	If referred from another provider, has the receiving provider validated this APSS as the clinically appropriate Level of Care? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Emotional/Behavioral or Cognitive Conditions and Complications	_____	_____	
4. Readiness to Change	_____	_____	
5. Relapse, Continued Use or Continued Problem Potential	_____	_____	
6. Recovery/Living Environment	_____	_____	

3. A brief comment about the client's progress or status is required in each dimension.

Dimension 1: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Dimension 2: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Dimension 3: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Dimension 4: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Dimension 5: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Dimension 6: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Clinician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Supervisor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## 13.06 APPENDIX F

# 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 Coordination:** A function of case management through which the SCA ensures that the individual's treatment and non-treatment needs are addressed.

**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.

**Coaching:** The process of skill building through educating the individual on appropriate behaviors and interactions. Techniques used in coaching include modeling, rehearsing interviews, and role-playing difficult or problematic situations with clients.

**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.

## **13.07 Appendix G**

### **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

**CRS:** Certified Recovery Specialist

**CSR:** Continued Stay Review

**D&A:** Drug and Alcohol

**DDAP:** Department of Drug and Alcohol Programs

**HIPAA:** Health Insurance Portability and Accountability Act

**HIV:** Human Immunodeficiency Virus

**ICM:** Intensive Case Management

**IDU:** Injection Drug User

**ISS:** Inventory of Support Services

**LOC:** Level of Care

**LOCM:** Level of Case Management

**MAT:** Medication Assisted Treatment

**MET:** Minimum Education and Training

**PCPC:** Pennsylvania Client Placement Criteria

**RC:** Resource Coordination

**RSS:** Recovery Support Services

**SCA:** Single County Authority

**TB:** Tuberculosis

13.08 Appendix H

**Pennsylvania Client Placement Criteria Attestation**

I attest that \_\_\_\_\_ has completed all training and competency requirements for the Pennsylvania Client Placement Criteria (PCPC), 3<sup>rd</sup> Edition, and is now qualified to administer the PCPC.

**Employee's job title:** \_\_\_\_\_ **Date of hire in current position:** \_\_\_\_\_

<b>Course</b>	<b>Date of Training</b> <i>*If an exemption was approved for these trainings, indicate "exempt" and note the justification.</i>
For staff who are PCPC - II trained:	
6-hour PCPC course 2 <sup>nd</sup> Edition	
3-hour update - 3 <sup>rd</sup> Edition	

For staff who are PCPC - III Trained:	
6-hour PCPC course 3 <sup>rd</sup> Edition	
Addictions 101 *	
Screening and Assessment *	
Confidentiality (DDAP or PCB approved only)	
Practical Applications of PCPC	
Practical Applications of Confidentiality	
Case Management Overview (applies to SCA/provider case management staff only) *	

Name of Supervisor (please print): \_\_\_\_\_

Signature of Supervisor: \_\_\_\_\_

Provider/Agency Name: \_\_\_\_\_

Date: \_\_\_\_\_

Note: Place this form within the staff personnel folder. For information on course waivers, please refer to Part 9.08 of the DDAP Treatment Manual.