

## 10.01 The Functions of Case Management

BDAP requires the SCA to provide two primary functions of case management for adolescents which are screening, and assessment. These functions encompass various activities, including the nine activities delineated in 4 Pa. Code § 257.4. The function of screening involves the evaluation regarding the need for a referral to emergent care including, detoxification, prenatal, perinatal, and psychiatric services. Assessment includes the activities of LOC assessment and placement determination, identification of non-treatment needs, and referral.

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The SCA is responsible for ensuring that clients have access to available drug and alcohol treatment and treatment-related services, which is facilitated through the case management system. All clients 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 step in identifying the presence or absence of alcohol or other drug use/abuse. Information is collected from the adolescent in order to make initial decisions concerning his or her emergent care needs. BDAP recognizes that SCAs screen for emergent care needs and eligibility for services. Although screening may include gathering demographic and other information to determine eligibility, for the purpose of this manual, screening is specifically defined as the determination of the need for a referral to emergent care services.

### REQUIREMENTS

The primary requirement of screening is to determine if emergent care services are warranted. Screening for emergent care needs must be provided 24 hours a day, seven days a week. After hours screening does not require the ability to schedule a level of care assessment. Screening can be conducted by telephone or in person. Initial referrals may come from a number of different entities including: intake units, emergency rooms, the criminal justice system, juvenile justice system, primary health care providers, individual practitioners, mental health agencies, child welfare system, family, employers, self-referrals, schools, treatment facilities, clergy, and other social service agencies.

The purposes of screening are:

- 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.

Due to differences in service delivery systems, BDAP allows 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 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 if they utilize a tool that contains the components of BDAP's screening tool, including trigger questions, which prompt

the support staff to transfer the client to a skilled professional who is able to determine the need for an emergent care referral. This tool can be 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 BDAP request, that the individual determining the need for a referral for emergent care 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 needs. If the client is in need of emergent care, those needs must be addressed at the time they are identified.

If the client is not in need of emergent care, a LOC assessment must be completed within seven calendar days from the date of initial contact. If this time frame is not met, the reason must be documented in the client 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 client file.

### **SCREENING TOOL**

A screening tool developed to ascertain the need for emergent care is available in Appendix A of this manual. If the SCA or its contractors choose to develop their own screening tool, the tool must include areas to gather the following information:

- Date of initial contact;
- Client demographic information;
- Appointment date for LOC assessment; and
- Questions to determine the need for emergent care in the above identified areas

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 BDAP tool that 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 an emergent care referral. Any screening tool used must be completed in its entirety.

Other questions may be added as the SCA or its contractor deems appropriate to meet the needs of their populations.

## 10.03 ASSESSMENT

### OVERVIEW

The activities encompassed in the function of assessment serve to coordinate all aspects of the client'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 as well as the need for non-treatment services.

### REQUIREMENTS

The function of assessment includes a number of activities that may be provided 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 adolescent assessment activities:

- LOC assessment and placement determination;
- Identification of Non-treatment Needs;
- TB Screening and Referral Services; and
- Continued stay review

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

LOC assessment is defined as a face-to-face interview with the client 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, social, occupational, educational, and family information. A LOC assessment must be completed within seven calendar days from the date of initial contact. If this time frame is not met, the reason must be documented. A LOC assessment must be completed in its entirety prior to referring the client to the appropriate level of care. Once an assessment is completed, it will be valid for a period of six months. The 6-month time frame does not pertain to active clients. This applies to clients who have never engaged in treatment after being assessed or who have been discharged and are seeking to reinstate services. If a client 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 APSS must be completed using the ASAM Patient Placement Criteria.

If the SCA limits the number of LOC assessments or admissions to treatment, the limitations must be expressed in written policy and all clients must be 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

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<#>Identify the severity of the substance use disorder;¶  
<#>Identify factors that contribute to or are related to the substance use disorder;¶  
<#>Identify a corrective plan of action to address these problem areas;¶  
<#>Detail an interim plan to ensure that the treatment plan is implemented and monitored to its conclusion;¶  
<#>Make a recommendations for referral to appropriate agencies or services; and¶  
<#>Describe how resources and services of multiple agencies can best be coordinated and integrated. ¶

can be determined. For adolescent clients, the LOC determination must be made in accordance with the most recent edition of the ASAM Patient Placement Criteria.

___5 Early Intervention	___ I Outpatient Treatment
___ II Intensive Outpatient Treatment/Partial Hospitalization II.1 Intensive Outpatient Treatment II.5 Partial Hospitalization	___ III Residential/Intensive Inpatient Treatment III.1 Clinically Managed Low Intensity Residential Treatment III.5 Clinically Managed Medium Intensity Residential Treatment III.7 Medically Monitored High Intensity Residential/Inpatient Treatment

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Currently, BDAP **requires** that the APSS in Appendix K 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.

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### Admission to Treatment

All clients 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 client file.

BDAP 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.

### **Identification of Non-treatment Needs**

In addition to gathering the information necessary to determine the most appropriate LOC, the assessment is also utilized to identify other needs that the client may have, such as lack of transportation, housing, self-care, childcare, etc. Once needs have been identified, the SCA must provide documentation to demonstrate how such needs were appropriately addressed.

If a client is actively involved in treatment, non-treatment needs must continually be evaluated throughout the treatment experience. The SCA must have written procedures in place describing how and at what frequency the identification of non-treatment needs occurs throughout the course of treatment.

## TB Screening and Referral Services

BDAP collaborated with the Bureau of Communicable Diseases to develop questions in reference to assessing the need for referrals to appropriate TB services.

The SCA must ensure that any entity providing LOC assessment services:

- Assess the client to determine whether or not the client 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 have ~~or had~~ 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 client 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 the SCA will:
  - Refer all the clients identified as high risk to the County's Public Health TB Clinic;
  - Provide case management activities, to all clients referred to the County's Public Health TB Clinic; and,

- o Allow for disclosure of communicable disease reporting (e.g. client consent form or Qualified Service Organization Agreement with the County's Public Health TB Clinic)

**Continued Stay Review**

Placement decisions and length of stay need to be reconsidered throughout the course of a client's treatment utilizing ASAM criteria for admission, continued stay, discharge and referral. The ASAM must be completed by the clinical staff person working directly with the client. Continued stay reviews must be conducted within the parameters of the following process:

<b>LOC</b>	<b>CONTINUED STAY PROCESS</b>
Early Intervention	Not applicable
Outpatient	Following completion of the level of care assessment and the application of the ASAM, outpatient treatment may be approved for up to six months. Treatment beyond the six month period requires the treatment provider to document that the case was clinically staffed and that a continued stay APSS was completed and maintained in the client file.
Partial Hospitalization / Intensive Outpatient	Following completion of the level of care assessment and the application of the ASAM, partial hospitalization or intensive outpatient treatment may be approved for up to 10 weeks. Treatment beyond the ten week period requires the treatment provider to document that the case was clinically staffed and that a continued stay APSS was completed and maintained in the client file.
Residential/Intensive Inpatient Treatment	Following completion of the level of care assessment and the application of the ASAM, inpatient residential treatment may be approved for up to 30 days. Treatment beyond the 30-day period requires that a continued stay APSS be completed and forwarded to the SCA for approval. The summary sheets must be maintained in the client file.

## ASSESSMENT COMPONENTS

BDAP has been meeting with the Division of Drug and Alcohol Program Licensure, DOH Legal Counsel, and other stakeholders in an attempt to resolve multiple issues surrounding the assessment process. Until such time as these issues can be resolved, the SCA must ensure that all assessment tools for determining LOC and non-treatment needs 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:** job history;
- **physical health:** personal history of illnesses/impairments, 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;
- **physical/sexual/emotional abuse:** history of abuse or assault;
- **legal:** juvenile justice involvement and delinquency including types and incidences of behavior, probation/parole status, conviction record to include disposition, current or pending charges;
- **basic needs and other considerations:** ability to meet basic needs of self and dependents (i.e. food, clothing, shelter), other areas that may impact treatment (i.e. transportation, cultural/language, literacy);
- **assessment worksheets/results:** assessment summary, level of care determination/ASAM and other special needs considerations, identification of non-treatment needs, referral (if LOC referral differs from recommended LOC, explain why), and interim services (if applicable).

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## **10.04 CASE MANAGEMENT FILE CONTENT**

All documentation in the file must be legible. BDAP 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.

Case Management client files must, when applicable, include:

- Screening Tool
- Assessment Tool
- Valid Consent Forms
- APSS or ASAM Summary Sheet
- Grievance and Appeal Form
- Case Notes
- Documentation of interim and ancillary services

### **Case Notes**

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

- Information that is gathered about the client
- Analysis of the data to identify client's needs
- Action to be taken to meet a client's needs

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

## **10.05 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.

## 10.06 STAFFING QUALIFICATIONS

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

- Case managers employed in a Planning Council or Public Executive SCA model must meet all State Civil Service Commission classification requirements of the 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 case managers must meet, at a minimum, all State Civil Service Commission classification requirements of the D&A Case Management Supervisor or the D&A Treatment Supervisor.
- Staff employed in a Private Executive or Independent SCA model who provides the functions of case management must meet the MET requirements of the State Civil Service Commission classification for D&A Case Management Specialist, D&A Case Management Specialist Trainee, D&A Treatment Specialist, or D&A Treatment Specialist Trainee. Supervisors of these staff persons must meet, at a minimum, the MET requirements of the State Civil Service Commission classification for Case Management Supervisor or Treatment Specialist Supervisor.
- Staff employed by a contracted, non-treatment provider who provides the functions of case management must meet the MET requirements of the State Civil Service Commission classification for D&A Case Management Specialist, D&A Case Management Specialist Trainee, D&A Treatment Specialist, or D&A Treatment Specialist Trainee. Supervisors of these staff persons must meet, at a minimum, the MET requirements of the State Civil Service Commission classification for Case Management Supervisor or Treatment Specialist Supervisor.
- Staff employed by a contracted drug and alcohol treatment provider who provides the functions of case management must meet the DOH licensing requirements for either Counselor or Counselor Assistant. Supervisors of these staff persons must meet, at a minimum, the DOH licensing requirements for Clinical Supervisor or Lead Counselor.

## 10.07 CASE MANAGEMENT CORE TRAININGS

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

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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 BDAP. SCA Administrators are not permitted to exempt themselves from training requirements. Any staff that previously conducted screening, assessment, and/or ICM services and had the BDAP-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.

Required trainings include:

- Addictions 101 – 6 hours

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

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

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

- Case Management Overview – 6 hours

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

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.

- American Society of Addiction Medicine Patient Placement Criteria – 6 hours

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

## 10.08 GRIEVANCE AND APPEAL PROCESS

The primary objective of the grievance and appeal process is to promote a step-by-step effort at reconciliation between an aggrieved client and the SCA. As contracted treatment providers and other agencies may have separate grievance and appeal protocols arising from the client's direct involvement with those programs, this process is intended to resolve those issues where the SCA's administrative or financial decisions are in dispute. The SCA must have an expeditious, accessible, fair, and uniform process in place for resolving grievances and appeals.

A grievance is defined as a written complaint by a client of the decision made by the SCA relative to the five areas identified below:

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

An appeal is defined as a request for reconsideration of a SCA's decision at progressive stages until the grievance is resolved. SCAs are required to have a review 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 client and BDAP of the outcome within seven days via the BDAP-approved Grievance and Appeal Form found in Appendix I. 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 Health, BDAP, the Department of Public Welfare, 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 client and BDAP of the outcome within seven days via the BDAP-approved Grievance and Appeal Form found in Appendix I. It is imperative that client identifying information is not included or attached to this form.

- Client notification about the SCA's grievance and appeal policy upon accessing any services completed or contracted by the SCA. The client must sign-off with signature and date that they have been notified about the following areas:
  - the grievance and appeal policy that outlines the five areas that a client can grieve with the SCA;
  - the need for a signed consent form from the client 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 client at each level of appeal.

## **10.09 REPORTING**

The SCA shall notify BDAP's Director of Treatment, in writing, within five days, if the SCA discontinues or limits authorization for admission to any LOC or type of service, for any reason, including lack of funding.

## 10.10 CONFIDENTIALITY OF INFORMATION

The drug and alcohol system in Pennsylvania was developed in 1972 with the advent of the Governor's Council on Drug and Alcohol Abuse. This Council was subsequently reorganized and its responsibilities and administrative authorities transferred to the Department of Health. During the same time that Pennsylvania was forming its drug and alcohol system, the federal government enacted two laws to protect confidentiality, one relating to alcohol abuse and the other relating to drug abuse. Subsequently, these statutes were amended and consolidated into one law covering both alcohol and drug abuse. The regulations authorized by this statute appear as 42 C.F.R. Part 2. In addition to 42 C.F.R. Part 2, drug and alcohol information is protected in a number of ways that include the following:

- Act 63 71 P.S. § 1690.101 et seq. - established the Pennsylvania Advisory Council on Drug and Alcohol Abuse in 1972 whose authority was transferred to the Department of Health and addresses confidentiality requirements
- 28 Pa. Code Chapter 709 - standards for licensing freestanding treatment facilities to include adherence to confidentiality requirements
- 42 CFR Part 2 - 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
- Act 126 42 Pa. C.S.A. § 6352.1 - state law clarifying what information may be exchanged between children and youth agencies, the juvenile justice system, SCAs and treatment providers.

Client confidentiality has become the principle cornerstone guiding the treatment of substance abuse 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 client;
  - 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 client's right to revoke consent (must allow verbal and written revocation);
  - Expiration date of the consent;
  - Dated signature of client;
  - Dated signature of witness; and
  - Copy offered to client

- The information to be released must relate to the purpose of the consent;
- HIPAA, under 45 C.F.R., contains confidentiality requirements that may supercede the requirements of 42 C.F.R.; and
- BDAP often reviews the SCA and/or their provider consent forms; however, they are only approved by BDAP if the forms meet the state and federal drug and alcohol confidentiality requirements. If SCAs or their contracted treatment providers identify themselves as HIPAA-covered entities, they are required to obtain appropriate training from their agency regarding whether or not the consent forms meet HIPAA requirements.

The SCAs are required to have written procedures associated with the adherence to all federal and state confidentiality regulations. The procedures must include the following information and be signed off by all staff:

- exchange of client-identifying information;
- storage and security of client records, to include computer security;
- completion of required confidentiality training;
- staff access to records;
- progressive 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.

## **10.11 ANOTHER LEVEL OF CASE MANAGEMENT RESOURCE COORDINATION**

The only functions of case management mandated by BDAP for adolescents are screening and assessment. ICM is not mandated for adolescents. BDAP recognizes that many SCAs have been providing a variation of ICM services that is less intensive in nature. This type of case management service, hereinafter referred to as Resource Coordination (RC), is not required; however, the SCA may design RC services to meet their local needs. If RC services are provided, the SCA must have a written description of how the services will be made available.

Regardless of how RC is designed, BDAP will monitor client files for the following:

- adherence to federal and state confidentiality regulations
- client sign-off on the SCA's grievance and appeal policy

In addition, the staff person providing this type of case management must meet the same staffing qualifications required of individuals providing assessment and/or ICM services (see Staffing Qualifications, Part 10.06). Training requirements, at a minimum, must include Addictions 101, Confidentiality, Practical Application of Confidentiality Laws and Regulations, and Case Management Overview. If staff persons providing RC are also providing other case management functions, they must also meet all applicable training requirements for those functions.