



pennsylvania
DEPARTMENT OF HEALTH

Bureau of Drug and Alcohol Programs
TREATMENT MANUAL

July 1, 2010 – June 30, 2015

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TREATMENT MANUAL

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PART I. Purpose and Use of the Treatment Manual

BDAP has developed this manual to provide SCA personnel with information to assist in implementing the necessary requirements for the provision of treatment, treatment-related and case management services. This manual includes sections describing the Recovery-Oriented Systems of Care (ROSC); Treatment Needs Assessment process; SCA Treatment Plan; Special Populations; Client Placement; Performance Measures; Training for Contracted Drug and Alcohol Treatment Providers; Case Management and Recovery Support Services. Because all aspects of the SCA's Grant Agreement with BDAP are not included in the Treatment Manual, it is not intended to be all-inclusive.

The requirements, policies, procedures, and instructions in this manual are official and are to be adhered to by the SCAs. **Any requirements that are passed down to a subcontracted provider must be adhered to as prescribed in the Treatment Manual.** Questions from SCAs regarding applicability of specific parts of this Manual may be directed to the Division of Treatment.

Any additions or updates to the Treatment Manual will be sent to the SCA Administrator. The date of any new issuance will appear at the bottom of each page. Upon receipt of these pages, the SCA is required to substitute the new pages in place of the existing pages.

PART II. Recovery Oriented Systems Of Care

Overview

Historically, drug and alcohol treatment has been delivered in an acute care model rather than a chronic care approach that addresses a person's needs across the lifespan of recovery. 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.

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. BDAP supports the concept of Recovery-Oriented Systems of Care (ROSC) and the shift from an acute care model to a recovery management model. The foundation of this approach includes: accessible services; a continuum of services rather than crisis-oriented care; culturally competent care that is age and gender appropriate; and where possible, is embedded in the person's community and home using natural supports. This movement is known as ROSC. Creating recovery-oriented systems of care requires a transformation of the service system as it shifts to becoming responsive to meet the needs of individuals and families seeking services.

Recovery-oriented systems support person-centered and self-directed approaches to care that build on strengths and resilience. Individuals, families, and communities take responsibility for their sustained health, wellness, and recovery from alcohol and other drug related issues through the various life phases of recovery. This system refers to the larger cultural and community environment in which long-term recovery is nested and offers a complete network of formal and informal resources that support long-term recovery of individuals and families.

Elements of a Recovery-Oriented System of Care

- **Person-centered** – Recovery-oriented systems of care are person-centered. Each problem area is individually addressed; offering a wide range of interventions to help each individual achieve his or her specific goals.
- **Family and other ally involvement** – A recovery-oriented system of care acknowledges the important role that families and other allies can play. Family and other allies will be incorporated, with the permission of the individual, in the recovery planning and support process. They can constitute a source of support to assist individuals in entering and maintaining recovery.
- **Inclusion of the voices and experiences of recovering individuals and their families** - The voices and experiences of people in recovery and their family members contribute to the design and implementation of recovery-oriented systems of care. Recovering individuals and family members are prominently and authentically represented on advisory councils, boards, task forces and committees at the federal, state and local levels.

- **Promoting access and engagement** – Each person who seeks services should be afforded every opportunity to access appropriate addiction treatment and recovery support. A recovery-oriented system promotes access to care by facilitating swift and uncomplicated entry into services. Engagement involves making contact with the person, building trust over time, attending to the person’s stated goals and needs and, directly or indirectly, providing a range of services in addition to clinical care.
- **Individualized and comprehensive services across the lifespan** – An array of comprehensive services that adapts to the needs of individuals, rather than requiring individuals to adapt to them. They are designed to support recovery across the lifespan.
- **Systems anchored in the community** – A recovery-oriented system of care is nested in the community for the purpose of enhancing the availability and support capacities of families, social networks, community-based institutions and other communities in recovery. Systems establish and maintain effective formal and informal linkages throughout the state to connect individuals and families to clinical, community-based and recovery support services.
- **Ensuring continuity of care** – A recovery-oriented system of care offers a continuum of care, including pre-treatment, treatment, continuing care and recovery support. Individuals should have a full range of stage-appropriate services from which to choose at any point in the recovery process.
- **Partnership-consultant relationships** – A recovery-oriented system of care is a network of people and services with one no more important than the other. Individuals are empowered to manage their own recovery with the support of community based services.
- **Strength-based** – A recovery-oriented system of care emphasizes strengths, assets and resiliencies.
- **Culturally responsive** - A recovery-oriented system of care is culturally sensitive, competent, responsive and aware of recovery specific language. There is recognition that beliefs and customs are diverse and can impact the outcomes of recovery efforts.
- **Responsiveness to personal belief systems** – A recovery-oriented system of care respects the spiritual, religious and/or secular beliefs of those they serve and provide linkages to an array of recovery options that are consistent with these beliefs.
- **Commitment to peer recovery support services** – A recovery-oriented system of care provides opportunities for ongoing participation of peers in the planning, implementation, and delivery of peer support services throughout the full continuum of care.
- **Integrated services** – A recovery-oriented system of care coordinates and/or integrates efforts across service systems to achieve an integrated process that responds effectively to the individual’s unique strengths, desires and needs.

- **System-wide education and training** – A recovery-oriented system of care ensures that concepts of recovery and wellness are foundational elements. Training, at every level, will reinforce the tenets of recovery-oriented systems of care.
- **Ongoing monitoring and outreach** – A recovery-oriented system of care provides ongoing monitoring and feedback with assertive outreach efforts to promote participation, motivation and reengagement in order to continually improve the system.
- **Outcomes driven** - A recovery-oriented system of care is guided by outcomes that are measurable and include benchmarks of quality of life changes.
- **Research-based** – A recovery-oriented system of care is informed by research which is supplemented by the experiences of people in recovery.
- **Adequately and flexibly financed** – A recovery-oriented system of care should be adequately financed to permit access to a full continuum of services.
- **End stigma and discrimination** – A recovery-oriented system of care works toward the eradication of stigma and discrimination.
- **Promote the highest level of autonomy** – A recovery-oriented system of care recognizes that individuals may need to learn new skills to survive in the larger society. Success at an expanding array of life tasks and the assumption of new or enhanced roles in the community as they are defined by the person in recovery over time-- both derive from and contribute to sustained recovery.

These guidelines were adapted from Center for Substance Abuse Treatment, *National Summit on Recovery Conference Report* (2005) by the Recovery-based Issues Subcommittee of the Pennsylvania Drug & Alcohol Coalition.

REQUIREMENTS

To initiate the transformation of Pennsylvania’s system of care, each SCA must provide a plan for the development and incorporation of Recovery Oriented Systems of Care (ROSC). This information must be included in the SCA’s Treatment Plan, which is defined in Part Four. The SCA must show which elements of a ROSC are being incorporated into the plan. In addition, the plan must identify the use of specific recovery-based services supported by the SCA.

PART III. Treatment Needs Assessment

It is the intent of the Bureau of Drug and Alcohol Programs (BDAP) to further enhance and improve substance abuse treatment policies and practices throughout the Commonwealth. 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 treatment resources. An estimate of a community's substance use prevalence, incidence and treatment demand (otherwise called a needs assessment) can be used to efficiently match available treatment resources with projected demand and to plan for the development of new treatment 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.

In late 2002, BDAP convened a workgroup comprised of representatives of the Divisions of Treatment, Program Monitoring, Prevention, Statistical Support, the Office of Mental Health and Substance Abuse Services, as well as representatives from the Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA), Pennsylvania Community Providers Association (PCPA), Drug and Alcohol Service Providers of Pennsylvania (DASPOP), Pennsylvania Recovery Organization Alliance (PRO-A), and the Clinical Standards Committee. The workgroup was charged with the development of a standardized local needs assessment process to be utilized by the Single County Authorities (SCAs) in identifying and reporting their treatment needs to BDAP.

The Treatment Needs Assessments using the new standardized format were due to BDAP November 30, 2005. After reviewing and approving these Needs Assessments and subsequently the SCAs' Treatment Plans, BDAP began to consider refining the Treatment Needs Assessment process. In April 2007 BDAP convened a workgroup consisting of the Division of Treatment, the Division of Program Monitoring and the Division of Prevention, SCAs and a representative from the Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA) to discuss and make further recommendations for improvement to the Treatment Needs Assessment. The workgroup has developed this process to further enhance the efforts of the SCAs to determine the treatment needs in their local communities.

SCAs will be conducting their Prevention Needs Assessments during the same time period, and will be encouraged to coordinate the processes used to prepare both documents, as much as possible. This will allow the SCAs to utilize staff, providers, community members, county personnel, etc. in the most efficient manner possible. These stakeholders can be involved in both Needs Assessment processes at the same time, thus eliminating the need to convene separate workgroups or meetings and streamlining the entire procedure. Since many of these individuals are involved in both prevention and treatment initiatives, this coordination of processes would be a tremendous convenience to all parties involved.

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 Commonwealth relies on the SCAs to obtain the critical information needed to manage at the state level. This project will yield information that the state needs, in standard categories where possible, in numbers that will add up to a state total.

It is understood that SCAs are different in their geography, economics, population demographics and density. Consequently, there would be no basis for BDAP 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 BDAP's Division of Treatment will review SCA responses.

Role of the Single County Authority (SCA)

Historically, the SCA has had two roles in Pennsylvania. One has been to plan and coordinate all substance abuse services in its local area. The other has been to provide and manage substance abuse services, which it pays for with funds from various sources, including the Pennsylvania Department of Health.

The first role was formulated in the early 1970's when large areas of Pennsylvania lacked any substance abuse services, and few services existed anywhere in the state. Today, the situation is much different. The Department of Health is still an important source of support for substance abuse services, particularly as a source of funds of the last resort; but it has long since ceased to be the largest funding source, while Medicaid, the corrections system, and private insurance have grown, and the Veterans Administration and private practice physicians have provided services outside the system financed by the Department.

In this more complex system, it has become more difficult for the SCA to be fully cognizant of all aspects of need for substance abuse services, and the extent to which that need is met in its area. In a real sense, it is impossible for the SCA to coordinate these services. Accordingly, the treatment needs assessment process described in this document will relate mostly to the second role of the SCA, that of manager of the services which it funds. The minimum requirements spelled out in this document will focus on that demand which is appropriate for the SCA to address, as the funding source of last resort.

However, it is neither desirable nor possible for drug and alcohol services funded with Department of Health money to be managed without participation in joint efforts with the other service systems impacting on the local area. Where it is relevant to refer to activities and practices of the other service systems, in providing an explanation of demand and of patterns of service provided by the SCA, please do so. Where cooperation with other service systems or participation in their planning activities has added to the knowledge or resources of the SCA, please include that information in your needs assessment response. 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 the SCA Treatment Needs Assessment

The SCA Treatment Needs Assessment will be due in accordance with the BDAP Report Schedule.

Treatment Needs Assessment Overview

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

Part One – DOH will provide the SCA data identified in **Table 1 – “SCA Estimates of the Prevalence of Substance Abuse Disorders”**. These numbers may be used by SCAs to describe the possible need (as distinguished from demand) and the extent of the problem, where local data is not available or conflicts with state and federal data (pages 3.01.5-3.01.9).

Part Two - DOH will provide web links for data that is available at the state/local level for Table 2. The SCA will collect and report other data identified in **Table 2, “Local Special Population Need Data”** to estimate local special population need data. The SCA response should include Table 2, and a narrative, as described on pages 3.01.9-3.01.12.

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

The SCA should provide a narrative response, as described in “Directions for the SCA” on page 3.01.13-14.

Objective 3: To identify local, state, and national trends that may impact the SCA.

The SCA should provide a narrative response, as described in “Directions for the SCA” on page 3.01.14.

Objective 4: To identify the demand for substance use disorder treatment.

Case Management Resource Report (CMRR) Data – DOH will provide a standard cumulative report, based on data from the CMRR for each SCA to review. The SCA should provide a narrative response, as described on page 3.01.15.

Client Information System (CIS) Data - DOH will provide the data identified in **Table 3 “Recruitment Strategy”, Table 4 “Clients Paid for by SCAs And Not Referred by a Provider (Non-Voluntary Proportion)”, Table 5 “Service Strategy for SCA”, and**

Table 6 “Demand for Service by Primary Substance of Abuse” for each SCA to review and respond to, as described in “Directions for the SCA” (pages 3.01.14-3.01.22).

Objective 5: To identify and quantify the resources necessary to meet the estimated treatment demand and any emerging trends (identified in Objective 3) that impact on current demand (the difference between existing resources and demand).

The SCA should provide a narrative response, as described in “Directions for the SCA” (page 3.01.23).

Objective 6: To identify issues and systems barriers that would impede the ability to meet the assessment and treatment demand.

The SCA should provide a narrative response, as described in “Directions for the SCA” (page 3.01.23).

Objective 7: To identify assets or resources available in the county or region to help respond to treatment demand.

The SCA should provide a narrative response, as described in “Directions for the SCA” (page 3.01.24).

Objective 8: To identify recovery support services that the SCA needs in developing a Recovery Oriented System of Care (ROSC) and to identify recovery support services that are currently available the county or region.

The SCA should provide a narrative response, as described in “Directions for the SCA” (page 3.01.25).

Treatment Needs Assessment Objectives

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

Definitions:

Estimate: A quantitative 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 with a diagnosable condition at a given time.

Substance use disorder: A condition of substance abuse or dependency as defined by DSM IV-TR.

Single County Authority (SCA): The agency designated by local authorities in a county or joinder to plan, fund, and administer drug and alcohol activities in a county or joinder.

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

OBJECTIVE 1, PART ONE

Prevalence of substance dependency disorders in the total population

| Treatment Needs Assessment Table 1 Estimates of the Prevalence of Substance Abuse Disorders (Dependence or Abuse)¹ Pennsylvania, Single County Authorities and State Based on 2006-2007 National Survey on Drug Use and Health (NSDUH)² | | | | | | | | | |
|--|-----------------------|------------|---------------------------|------------|---------------------------|------------|----------------------------|------------|---------------------------|
| 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 |

Treatment Needs Assessment Table 1
Estimates of the Prevalence of Substance Abuse Disorders (Dependence or Abuse)¹
Pennsylvania, Single County Authorities and State
Based on 2006-2007 National Survey on Drug Use and Health (NSDUH)²

| 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%) |
| 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 |
| 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. Past year dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

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.

Data Sources: The Department of Health will provide data for each SCA (Table 1) based on surveys which yield valid estimates of the prevalence of substance abuse disorders. Only 7% to 10% of the estimated number of dependent people presented in this table would admit to having a substance abuse problem, but the larger number may be thought of as those whose behavior is creating personal consequences and affecting their associates. 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.

Directions for the SCA

Include Table 1 in the treatment needs assessment, so that the information is part of the document submitted to BDAP.

OBJECTIVE 1, PART TWO

Prevalence of substance abuse dependency disorders in special populations

Each SCA will be responsible for developing prevalence estimates of substance abuse disorders (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 (as distinguished from demand) 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.

The Department of Health will provide 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 are substance dependent 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 abuse 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 abuse 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).

To get similar estimates for County Jail Population and Persons on State Probation or Parole in the county, phone calls should be made to local contacts to ask: What is the annual caseload (Column 4)? Based on Department of Corrections (DOC) and national estimates, approximately 70% of all inmates are substance dependent and require some form of treatment.

BDAP will use the information to show variation among different parts of the state, and will sum the information to show levels of need reported from the local level, as an aid to justify the importance that the substance abuse program be fully funded or possibly expanded.

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 BDAP.
- Make local calls, as described above, to collect the data needed for Table 2, County Jail Population and Persons on State Probation or Parole in county. Provide any other local information desired, if available.
- List the local sources of information used, in a narrative response. Examples may include SAP information, Integrated Children's Services Plan data, Coroner's report, United Way, hospital coalitions, Advisory Boards, Task Forces, physicians who prescribe Buprenorphine, Consumer/Family Satisfaction Teams, etc.

Table 2
Local Special Population Need Data
As reported by (SCA name)

| Special Population Category (Column 1) | Source of Data and web link (Column 2) | How to Locate Data (Column 3) | (Column 4) Enter Total Number from Column 1 | (Column 5) Percent of these persons who have substance abuse problems. | (Column 6) Estimated number who have substance abuse problems =Col 4 x Col 5 for each category |
|---|---|---|--|---|---|
| 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 http://ucr.psp.state.pa.us/UCR/Reporting/Monthly/Summary/MonthlySumArrestUI.asp | 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 http://ucr.psp.state.pa.us/UCR/Reporting/Monthly/Summary/MonthlySumArrestUI.asp | 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 http://www.pbpp.state.pa.us/pbppinfo/cwp/browse.asp?a=468&bc=0&c=69783 | 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 (Continued)
Local Special Population Need Data
As reported by (SCA name)

| Special Population Category (Column 1) | Source of Data and web link (Column 2) | How to Locate Data (Column 3) | (Column 4) Enter Total Number from Column 1 | (Column 5) Percent of these persons who have substance abuse problems. | (Column 6) Estimated number who have substance abuse problems =Col 4 x Col 5 for each category |
|---|--|--|--|---|---|
| 6. Reported Substantiated Child Abuse & Neglect Cases (Total) | Pennsylvania Department of Public Welfare http://www.dpw.state.pa.us/Resources/Documents/Pdf/AnnualReports/2007/ChildAbuseReport.pdf | 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 http://www.pacourts.us/T/AOPC/ResearchandStatistics.htm 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, e.g. MISA

Objective 2: To 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 dealt with. 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, then tracked over time that now requires a response impacting service delivery.

Directions for the SCA

- **Provide a narrative** that identifies emerging treatment needs in the SCA.
(For example: Increase in heroin use and/or deaths, increase in methamphetamine labs, identification of new drugs of abuse, increase in number of inmates released from state/county probation and parole, the use of heroin by children of middle/upper class.)
- **Include a succinct description** of the information relied upon to identify the emerging need, and include supporting data.
(For example: Review CIS, CMRR data; anecdotal information obtained from treatment providers, police, probation/parole officers or human service staff, MH case managers, children & youth case workers; other data source information, such as emergency room deaths, increase in HIV/AIDS, D&A-related arrests, SAP info, Integrated Children’s Services Plan data, Hepatitis C data, etc.)
- **Describe your plans** to track or address the emerging need.
(For example: Depending on the issue, the SCA has several options available that may include:
 - 1.) Immediately attempting to address the need through changes in service delivery, training, capacity or funding,
 - 2.) Recognizing the need and desiring to make a change, but does not given political or funding factors that influence the SCA’s ability to make changes,
 - 3.) Tracking the information to determine if there is any change over time that would impact the annual SCA Plan or other planning documents.)

SAMPLE SCENARIO (Objective 2):

Heroin use has increased to the point that it has overtaken cocaine as the second leading drug of choice by substance abusers. This information is based on CIS and SCA assessment data (included in a table), as well as anecdotal information obtained through regular treatment provider meetings over the past two years. This increase over time has resulted in a need to add a new goal to the SCA Plan that would increase capacity within the local methadone program as a way to meet the increased need of individuals appropriate for this type of service.

Objective 3: To 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, 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

- Describe the trends that may influence the business practices of the SCA.
- Provide any objective data or descriptions of trends that may impact the SCA.

Objective 4: To 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: Data from the CMRR 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. The CMRR information can be supplemented with data from CIS, which will show the recruitment patterns and service strategy in use by each SCA. This will reflect the decisions each SCA is making about which individuals they serve.

The Department of Health will develop standard cumulative reports, based on aggregate data from CMRR and CIS to feed back to each SCA to review and respond to.

Directions for the SCA (CMRR Data)

Review the CMRR data for the SCA and discuss any issues identified in a narrative response that addresses the items listed below.

If an SCA is having any difficulty in meeting the CMRR requirements, this narrative allows an opportunity to explain why.

If an SCA is not having any difficulty providing timely access to assessments or the recommended type of service, simply explain that the items below do not apply.

- **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 response should provide as much detail as possible, to elaborate on responses already provided in the monthly CMRR reports.
- **The number of individuals recommended for treatment that had to wait longer than two weeks to access the recommended type of service,** broken down by type of service. Discuss the reasons why individuals had to wait longer than 2 weeks to access treatment.

Use of CIS Data

The Department of Health (DOH) will prepare and provide the following data (Tables 3-6) for each SCA to review and respond to. Additional background information and sample tables are provided on the pages that follow in this section.

- **SCA Pattern of Referrals into Treatment** - Table 3 will present the number and percentage of all first admissions for SCA-paid clients (referring SCA) for the previous year, broken down by each referral source (except juveniles, which would be identified by age). The percentages for each individual SCA and the state as a whole will be displayed side by side, for comparison.
- **Non-Voluntary referrals/SCA clients paid for** – Table 4 will provide an example based on CIS criminal justice referrals (not referred by a provider) to show the differences among SCAs in their strategies for recruiting criminal justice clients into treatment.

- **Service Strategy for each SCA** – Table 5 is slightly different from the referral source tables. It is limited to SCA clients as defined by the “Referring SCA” item in CIS. It will count treatment admissions that began during the year, rather than individual clients. This report is expected to identify differences in the pattern of services provided by each SCA, compared to the statewide pattern.
- **Demand for Service by primary Substance of Abuse** – Table 6 is also limited to SCA admissions as defined by the “Referring SCA” item in CIS. It will count treatment admissions that began during the year, rather than individual clients, based on the primary drug of choice at admission.

Directions for the SCA (CIS Data)

Prepare a 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 3-6 (use the categories in tables). The explanation should reference the 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. It should reference the 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. Include a discussion of any issues for the management of your program which may be associated with demand for services from users of specific substances. The narrative should identify the most critical areas of need into which new resources are needed, or would be applied. To the extent that CIS data are rendered invalid by reporting issues, describe the issues and what the SCA is doing to correct them.

Table 3 - DOH will provide this data (SCA Pattern of Referrals into Treatment) based on CIS:

| Table 3 | | | |
|---|--------------------------|----------------------------------|--------------------------------|
| CIS Pattern of Referrals for SCA (name) | | | |
| SCA Paid Unique Clients | | | |
| Referral Source for New Clients | Number of Clients | Percentage of SCA clients | Percentage of Statewide |
| Criminal Justice/Non-Voluntary | | | 35% |
| Social Service Agencies | | | 15% |
| Drug & Alcohol Abuse Providers | | | 15% |
| Employers | | | 5% |
| Religious Organizations | | | 5% |
| Self, Friends | | | 20% |
| Primary Care (Physicians, Emergency Rooms) | | | 5% |
| Total: | | | 100% |
| Below is the percentage for juveniles only | | | |
| Juveniles | | | 15% |

This table will present the number and percentage of all first admissions for SCA-paid clients (referring SCA) for the previous year, which came from each referral source (except juveniles, which would be identified by age and total number from all referral sources). The percentages for the individual SCA and the state as a whole will be displayed side by side for comparison.

Table 4 - DOH will provide this data (Non-Voluntary referrals/SCA clients paid for) based on CIS:

| Table 4 | | | |
|--|---|----------------------|------------------------------|
| Clients Paid for by SCAs | | | |
| And Not Referred by a Provider (Non-Voluntary Proportion) | | | |
| Referring SCA | Criminal Justice/Non-Voluntary Clients | Total Clients | Percent Non-Voluntary |
| 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 4 is a display of the number of criminal justice/non-voluntary clients, total clients, and percentage of criminal justice/non-voluntary clients for selected SCAs. It shows that there are great differences among SCAs in their strategies for recruiting criminal justice clients into treatment. It may be of assistance in describing the manner in which the SCA's recruitment strategy involves the criminal justice system.

Table 5 - DOH will provide this data (SCA Service Strategy) based on CIS:

| Table 5 | | | |
|---|-----------------------------|--------------------------|--------------------------------|
| Service Strategy for SCA (name) | | | |
| Level of Care Usage for Treatment Admissions | Number of Admissions | Percentage of SCA | Percentage of Statewide |
| Hospital Detox | 649 | 5% | 15% |
| Hospital Rehab | 52 | 0% | 15% |
| Non-Hospital Detox | 1263 | 9% | 15% |
| Short-term Non-Hospital Rehab (30 days or less) | 1794 | 13% | 5% |
| Long-Term Non-Hospital Rehab | 932 | 7% | 5% |
| Halfway house | 807 | 6% | 10% |
| Partial Hospitalization | 1807 | 13% | 5% |
| Intensive Outpatient | 1767 | 13% | 7% |
| Outpatient drug free | 3773 | 28% | 20% |
| Methadone Maintenance | 598 | 6% | 3% |
| Total Admissions paid by SCA | 13442 | 100% | 100% |

Table 5 is slightly different from the referral source tables and will be specific for each SCA. Sample SCA data is provided in this example. Again, the table is limited to SCA clients as defined by the Referring SCA item in CIS. However, what are counted are treatment admissions which began during the year, rather than individual clients. We would expect to see differences in the pattern of services provided by individual SCAs, compared to the statewide data, since we know that some SCAs simply do not utilize certain levels of care.

Table 6a and 6b - DOH will provide this data (Demand for Service by Primary Substance – under age 18 (6a) and age 18+ (6b)):

| SFY 2005-2006 | | | |
|---|--|--|--|
| Treatment Needs Assessment Table 6a | | | |
| Demand for Service by Primary Substance of Abuse | | | |
| SCA Paid Admissions (Under Age 18) for: | SCA (name) | | |
| Primary Substance of Abuse | Number of Admissions (Under Age 18) | Percentage of SCA Admissions (Under Age 18) | Percentage of Statewide Admissions (Under Age 18) |
| Marijuana / Hashish | 500 | 74.52% | 63.38% |
| Alcohol | 79 | 11.77% | 21.22% |
| Cocaine / Crack | 19 | 2.83% | 4.93% |
| Heroin | 47 | 7.00% | 3.93% |
| Other Opiates / Synthetics | 17 | 2.53% | 2.06% |
| Other | 3 | 0.45% | 1.66% |
| Benzodiazepine | 2 | 0.30% | 0.62% |
| 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% |
| Barbiturates | 3 | 0.45% | 0.11% |
| Non-Prescription Methadone | 1 | 0.15% | 0.09% |
| Other Stimulants | 0 | 0.00% | 0.09% |
| PCP | 0 | 0.00% | 0.07% |
| Other Tranquilizers | 0 | 0.00% | 0.07% |
| Total paid by SCA | 671 | 100.00% | 100.00% |

| SFY 2005-2006 | | | |
|---|---------------------------------------|---|---|
| Treatment Needs Assessment Table 6b | | | |
| Demand for Service by Primary Substance of Abuse | | | |
| SCA Paid Admissions (Age 18+) for: | SCA (name) | | |
| Primary Substance of Abuse | Number of Admissions (Age 18+) | Percentage of SCA Admissions (Age 18+) | Percentage of Statewide Admissions (Age 18+) |
| 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% |
| Benzodiazepine | 55 | 0.43% | 0.62% |
| Other | 67 | 0.52% | 0.58% |
| Methamphetamine | 19 | 0.15% | 0.46% |
| PCP | 6 | 0.05% | 0.17% |
| Non-Prescription Methadone | 30 | 0.23% | 0.16% |
| Other Sedatives / Hypnotic | 15 | 0.12% | 0.16% |
| Other Amphetamines | 5 | 0.04% | 0.10% |
| Other Hallucinogens | 9 | 0.07% | 0.08% |
| Barbiturates | 10 | 0.08% | 0.08% |
| Over-the-Counter | 3 | 0.02% | 0.05% |
| Other Tranquilizers | 12 | 0.09% | 0.04% |
| Other Stimulants | 3 | 0.02% | 0.03% |
| Inhalants | 3 | 0.02% | 0.03% |
| Total paid by SCA | 12770 | 100.00% | 100.00% |

Tables 6a & 6b are also limited to SCA clients as defined by the “Referring SCA” (paying SCA) item in CIS. It shows the 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 18 and age 18+.

Please discuss any issues for the management of your program which may be associated with demand for services from users of specific substances. 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.

Additional background information and sample tables - Objective 3 (CIS Data):

Use of CIS data in needs assessment: CIS data reflects admissions. With the use of comparisons, and with additional information supplied by the SCA, CIS data can greatly add to the understanding of the need, demand, and the response to demand in the SCA's service area. It must be recognized that, although each SCA has a different pattern of need in its community, need can be classified in common categories. For example, juveniles exist in all SCAs. The need for services on the part of juveniles may differ greatly from SCA to SCA. Each SCA also operates in the context of multiple service systems, which differ from SCA to SCA. In one SCA a certain kind of need may be responded to by another system. In another SCA, no other services may be available to meet that need. Finally, SCAs are charged with deciding how best to shape the service system within their areas. They are also charged, within limits, the responsibility of deciding how best to respond to the needs and demands of their areas, with limited resources.

Understanding these things, it will be very useful to think of SCAs as having strategies for recruiting individuals into treatment (Pattern of Referrals), and as having Service Strategies, which are captured by CIS data. CIS data from one SCA can be compared with that from another SCA or with the state as a whole. With the benefit of those comparisons, SCAs can explain how the data reflect recruitment and services strategies, which are appropriate to the situation in their area, and how they reflect decisions made about how best to use the limited resources available. This explanation would be a statement of how the SCA management understands what need in its community is met by other systems, what need is being met with SCA resources, and what need remains unmet. SCAs can go beyond that, and explain what further services would be provided if additional resources were available, and how those additional services would benefit the community.

Information of this nature from forty-eight SCAs would greatly improve BDAP's ability to detect patterns of unmet need, and to explain to funding agencies what needs to be done at a state strategic level, to improve the drug and alcohol treatment service system.

Objective 5: To identify and quantify the resources necessary to meet the estimated treatment demand and any emerging trends (identified in Objective 3) that impact on current demand [the difference between existing resources and demand].

Definitions:

Resources: money, staff, providers, Drug Courts, Buprenorphine eligible physicians, intersystems 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

In response to Objective 4, the SCA has now identified unmet demand for assessment services and services in specific levels of care, using data from the CMRR. The SCA has also reviewed data from the CIS identified specific populations, and specific levels of care, which are emphasized and not emphasized, by its recruitment strategy and by its service strategy. Additionally, the SCA has identified emerging trends in Objective 3 that may need to be addressed.

Prepare a narrative response discussing any areas where the demand for assessment and treatment services is unmet or where there are emerging trends that need to be addressed. The SCA must identify and quantify what specific resources would be necessary to address such needs or trends. The SCA must explain the basis for any estimates provided.

Objective 6: To identify issues and systems barriers that impedes 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, location, language, zoning restrictions, payment for co-occurring services outside of managed care, parental resistance to permitting SAP assessments, interface with county systems, to include confidentiality issues (i.e., courts, CY&F), 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, state-wide implementation of HealthChoices, SCA protocols/policies & procedures, etc.

Directions for the SCA

- Describe the “systems barriers” that impede or prevent the SCA from meeting assessment and treatment demands.

Provide any objective data or descriptions of “barriers” that support the SCA’s position.

Objective 7: To 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, 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

Identify assets or resources that enable, or could enable, the SCA to meet demand such as through cooperation with other health and human services organizations.

Objective 8: To identify recovery support services that the SCA needs in developing a Recovery Oriented System of Care (ROSC) and to identify recovery support services that are currently available in the county or region.

Definitions:

Resources: money, staff, recovery centers, recovery houses, transportation, tutoring, volunteers, community agencies, support groups, etc.

Recovery Oriented System of Care: A recovery management model of care, also known as a chronic care approach to recovery. The foundation of this approach includes: accessible services; a continuum of services rather than crisis-oriented care; culturally competent care that is age and gender appropriate; and where possible, is embedded in the person's community and home using natural supports. Creating a ROSC requires a transformation of the service system as it shifts to becoming responsive to meet the needs of individuals and families seeking services. Recovery-oriented systems support person-centered and self-directed approaches to care that build on strengths and resilience. Individuals, families, and communities take responsibility for their sustained health, wellness, and recovery from alcohol and other drug related issues through the various life phases of recovery. This system refers to the larger cultural and community environment

in which long-term recovery is nested and offers a complete network of formal and informal resources that support long-term recovery of individuals and families.

Directions for the SCA

The SCA must identify what specific recovery resources would be necessary to support the development of a ROSC. In addition, the SCA must identify recovery resources that are currently available to support the development of a ROSC. Examples of recovery resources may include, but are not limited to 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.); and recovery housing.

PART IV. 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 most 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 Commonwealth relies on the SCAs to obtain the critical information needed in order for the Bureau of Drug and Alcohol Programs (BDAP) to manage the substance abuse system at the state level.

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 BDAP to review the deficiencies identified by SCAs regarding programs, services, and support needs, as well as corresponding plans of action, to correct such deficiencies. In addition, BDAP will utilize this information to identify trends and manage the substance abuse system from a statewide perspective.

SUBMISSION OF SCA TREATMENT PLAN

The SCA Treatment Plan will be due in accordance with the BDAP Report Schedule.

I. Background

Describe the SCA's strategy to accomplish the development of the treatment plan. 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 they deem necessary. At a minimum, the following information must be included in this section:

- Highlights of the Treatment Plan and Needs Assessment; and
- A description of the trends and issues that were identified through the needs assessment process.

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: To obtain an estimate of the prevalence of substance use disorder in the total population of an SCA.

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

Objective 3: To identify local, state, and national trends that may impact the SCA.

Objective 4: To identify the demand for substance use disorder treatment.

Objective 5: To identify and quantify the resources necessary to meet the estimated treatment demand and any emerging trends (identified in Objective 3) that impact on current demand (the difference between existing resources and demand).

Objective 6: To identify issues and systems barriers that would impede the ability to meet the assessment and treatment demand.

Objective 7: To identify assets or resources available in the county or region to help respond to treatment demand.

Objective 8: To identify recovery support services that the SCA needs in developing a Recovery Oriented System of Care (ROSC) and to identify recovery support services that are currently available the county or region.

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 support services.

The plan should also discuss the impact the action plans, described in Section III of the Treatment Plan, may have on their budget.

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, if at all, the SCA evaluates the quality of services provided. Describe how, if at all, 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 will use to ensure that its providers will be able to meet state and national outcome measures.

VI. Eligibility and Access

This section of the Treatment Plan looks at how the SCA defines 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.).
- If, within the past two years, the SCA had a waiting list for having clients assessed beyond the requirements delineated in BDAP's Treatment Manual,

describe how many clients waited for an assessment, the level(s) of care referred to, and the average wait time. The SCA must also describe any extenuating circumstances related to clients being placed on a waiting list for an assessment. The SCA must include any current waiting list protocols.

- If, within the past two years, the SCA had a waiting list for admission to treatment beyond the requirements delineated in BDAP's Treatment Manual, describe how many clients waited for admission, the level(s) of care referred to, and the average wait time. The SCA must also describe any extenuating circumstances related to clients being placed on a waiting list for treatment admission. The SCA must include any current waiting list protocols.

PART V. Special Populations

5.01 Priority Populations

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

- Pregnant injection drug users;
- Pregnant substance users;
- Injection drug users; and
- All others.

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;
- 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 (7) days from those programs that treat individuals for injection drug use upon reaching 90 percent (90%) 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 client until admission into treatment occurs. Tracking of the client 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. 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 (*Note: the SCA-Provider monitoring tool does not include a component to review outreach. If the SCA chooses to provide oversight of the outreach project via provider monitoring, the SCA will need to add such a component to their monitoring tool.*);

- 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 to identify a provider for each service listed above.

PART VI. Placement

In order to ensure placement in the proper level of care, the SCA and its contracted providers must use the PCPC for adults and 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 BDAP Operations Manual, section 7.03.

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)
- The SCA shall contract with a licensed and approved methadone maintenance provider and refer adult clients for its service as indicated by the PCPC for Adults.
 - SCAs are not required to contract with providers of Medically Managed Inpatient Detox, Medically Managed Inpatient Residential services, and Adolescent Halfway House services. However, before the SCA expends Department of Health funds for Medically Managed Inpatient Detox, Medically Managed Inpatient Residential treatment, or Adolescent Halfway House services a contract with the provider must be fully executed. Rate determinations will be established by the SCA where the facility is located.
 - 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 BDAP funds, the SCA must:

- Only contract with BDAP 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 BDAP. 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 DOH 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 clients 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 client);

- 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 Health
 Bureau of Drug and Alcohol Programs
 Division of Treatment
 2 Kline Plaza
 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.

BDAP 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 Bureau of Drug and Alcohol Programs 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 BDAP.

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 Contractor shall ensure that when providing the services outlined in this Paragraph, funds awarded under this Agreement 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. Clients 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 to clients must be in writing and clients 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 BDAP review. Any client receiving recovery house funding from the SCA must be screened, and if appropriate, receive a level of care assessment. The client'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 BDAP 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 regarding resident use of alcohol and/or other substances;
- Have safeguards in place to ensure the safety and protection of each resident;
- Be in compliance with all local municipal ordinances;

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

6.05 Medication Assisted Treatment (MAT)

When an SCA pays for MAT, individuals must concurrently be enrolled in substance abuse counseling. 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 clients receiving this service are notified of this and any other limitation on funding for MAT. Notification to clients must be in writing and clients 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 client 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 BDAP 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 Health
Bureau of Drug and Alcohol Programs
Attention: Director of Treatment
Division of Treatment
02 Kline Plaza
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

7.01 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. SCAs must meet BDAP established benchmarks, as follows:

- Fiscal Year 2010-2011: 9% or less wait longer than 7 days for assessment;
- Fiscal Year 2011-2012: 8% or less wait longer than 7 days for assessment;
- Fiscal Year 2012-2013: 7% or less wait longer than 7 days for assessment;
- Fiscal Year 2013-2014: 6% or less wait longer than 7 days for assessment; and
- Fiscal Year 2014-2015: 5% or less wait longer than 7 days for assessment.

- Fiscal Year 2010-2011: 10% or less wait longer than 14 days for admission to treatment*;
- Fiscal Year 2011-2012: 9% or less wait longer than 14 days for admission to treatment*;
- Fiscal Year 2012-2013: 8% or less wait longer than 14 days for admission to treatment *;
- Fiscal Year 2013-2014: 7% or less wait longer than 14 days for admission to treatment*; and
- Fiscal Year 2014-2015: 7% or less wait longer than 14 days for admission to treatment*.

*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

8.01 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:

- BDAP approved Pennsylvania Client Placement Criteria
- BDAP approved Practical Applications of PCPC criteria
- BDAP approved or PCB approved Confidentiality
- BDAP approved Practical Applications of Confidentiality Laws and Regulations

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

- Most recent edition of the ASAM Patient Placement Criteria
- BDAP approved, or PCB approved Confidentiality
- BDAP approved Practical Applications of Confidentiality Laws and Regulations

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

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

PART IX. Adult Case Management

9.01 The Functions Of Adult Case Management

BDAP 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. Assessment includes 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.

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.

Due to differences in service delivery systems, BDAP 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 BDAP 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

BDAP 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. If an individual is referred to detox prior to completion of a LOC assessment, the assessment must be completed in its entirety before the individual can be admitted to another level of care.

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 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 (if appropriate); 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 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 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, 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 client, must complete the assessment tool. 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 individuals who have never engaged in treatment after being assessed or who have been discharged and are seeking to reinstate services. 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 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 can be found in Appendix D.

| | |
|---|--|
| <p>Level 1 A Outpatient B Intensive Outpatient</p> | <p>Level 3 A Medically Monitored Detox B Medically Monitored Short-Term Residential C Medically Monitored Long-Term Residential</p> |
| <p>Level 2 A Partial Hospitalization B Halfway House</p> | <p>Level 4 A Medically Managed Detox B Medically Managed Inpatient Residential</p> |

***pharmacotherapy 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:

| | |
|---|-----------------------------------|
| Mental Status | Women with Dependent Children |
| Cultural/Language Considerations | Women's Issues |
| Gay/Lesbian Issues | Impairment e.g. hearing, learning |
| Pharmacotherapy (e.g. methadone, buprenorphine) | |

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.

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.

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. 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 (e.g., DOT)
- **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);
- **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

Case Coordination is a function of case management through which the SCA ensures that the individual's treatment and non-treatment needs are addressed. 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 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 must provide Case Coordination for each individual receiving services paid for by the SCA. The SCA shall design Case Coordination to meet their local needs. The SCA must develop a Case Coordination policy which delineates the following:

- how and when non-treatment needs are initially identified;
- how identified non-treatment needs are documented;
- At a minimum, non-treatment needs must be re-evaluated according to the following timeframes:
 - Detoxification: not applicable
 - Outpatient: every 90 days
 - Intensive Outpatient/Partial Hospitalization: every 60 days
 - Inpatient Residential (Short-term, Long term) and Halfway House: prior to discharge
- how identified non-treatment needs are addressed (i.e. resource list);
- how the delivery of services paid for by the SCA is tracked and documented;
- how continued stay review PCPCs are reviewed and approved or disapproved; 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., intervention/discussion groups, 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 BDAP, 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), clients 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.

Continued Stay Review

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, discharge and referral. The PCPC must be completed by the clinical staff person working directly with the individual. Continued stay reviews must be conducted within the parameters of the following process:

| LOC | CONTINUED STAY PROCESS |
|----------------|---|
| Detoxification | Pre-approved detoxification treatment may occur for up to five days. Treatment beyond the fifth day requires the completion of a continued stay PCPC Summary Sheet that must be forwarded to the SCA for approval. The summary sheets must also be maintained in the individual's file. |
| Outpatient | Following completion of the LOC assessment and the application of the PCPC, 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 PCPC Summary Sheet was completed and maintained in the individual's file. |

| | |
|--|--|
| <p>Partial Hospitalization / Intensive Outpatient</p> | <p>Following completion of the LOC assessment and the application of the PCPC, 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 PCPC Summary Sheet was completed and maintained in the individual's file.</p> |
| <p>Inpatient Residential; Short-term</p> | <p>Following completion of the LOC assessment and the application of the PCPC, short-term inpatient residential treatment may be approved for up to 14 days. Treatment beyond the 14-day period requires that a continued stay PCPC Summary Sheet be completed and forwarded to the SCA for approval. The summary sheets must be maintained in the individual's file.</p> |
| <p>Inpatient Residential; Long-term to include Halfway House</p> | <p>Following completion of the LOC assessment and the application of the PCPC, long-term inpatient residential and halfway house treatment may be approved for up to 30 days. Treatment beyond the 30-day period requires that a continued stay PCPC Summary Sheet be completed and forwarded to the SCA for approval. The summary sheets must be maintained in the individual's file.</p> |

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 data to identify individual's needs; and
- Action to be taken to meet a individual'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. 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.

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 sign-off on written documentation, to include, at a minimum, the LOC assessment and PCPC Summary Sheets must continue until the case manager has received all appropriate training.

9.07 Staffing Qualifications

Required Qualifications of Staff Providing Case Management Services 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 provide 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 provide 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 provide 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.

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 BDAP-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 BDAP. SCA Administrators are not permitted to exempt themselves from training requirements. Any staff that previously conducted screening and assessment and had the BDAP-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 BDAP 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 BDAP 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 BDAP certificate)

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

- Case Management Overview – 6 hours (requires BDAP 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 BDAP 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-R for substance abuse disorders and cultural competency will be addressed.

- Pennsylvania Client Placement Criteria – 6 hours (requires BDAP 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 BDAP certificate)

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

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*, clients 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 a client 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 BDAP of the outcome within seven days via the BDAP-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 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 individual and BDAP of the outcome within seven days via the BDAP-approved Grievance and Appeal Form found in Appendix C. 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 individual must sign-off with signature and date 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

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

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. Section 1690.108), the Public Health Service Act (42 U.S.C § 290dd-2), Federal Confidentiality Regulations (42 CFR Part 2), In addition, 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 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 individual

- The information to be released must relate to the purpose of the consent; 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 Health Information Portability and Accountability Act (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:

- exchange 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

BDAP 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. Assessment includes 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.

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.

Due to differences in service delivery systems, BDAP 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 BDAP 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

BDAP 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.

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 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 (if appropriate); 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 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 American Society of Addiction Medicine (ASAM) Patient Placement 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, 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 prior to referring the adolescent to the appropriate level of care. The assessor, not the adolescent, must complete the assessment tool. 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 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 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 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 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 |

Currently, BDAP 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.

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.

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.

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. 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.

9.04 Case Coordination

OVERVIEW

Case Coordination is a function of case management through which the SCA ensures that the individual's treatment and non-treatment needs are addressed. 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 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 must provide Case Coordination for each individual receiving services paid for by the SCA. The SCA shall design Case Coordination to meet their local needs. The SCA must develop a Case Coordination policy which delineates the following:

- how and when non-treatment needs are initially identified;
- how identified non-treatment needs are documented;
- At a minimum, non-treatment needs must be re-evaluated according to the following timeframes:
 - Detoxification: not applicable
 - Outpatient: every 90 days
 - Intensive Outpatient/Partial Hospitalization: every 60 days
 - Inpatient Residential (Short-term, Long term) and Halfway House: prior to discharge
- how identified non-treatment needs are addressed (i.e. resource list);
- how the delivery of services paid for by the SCA is tracked and documented;
- how continued stay review PCPCs are reviewed and approved or disapproved; 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., intervention/discussion groups, 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 BDAP, 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), clients 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.

Continued Stay Review

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, discharge and referral. The PCPC must be completed by the clinical staff person working directly with the individual. Continued stay reviews must be conducted within the parameters of the following process:

| LOC | CONTINUED STAY PROCESS |
|----------------|---|
| Detoxification | Pre-approved detoxification treatment may occur for up to five days. Treatment beyond the fifth day requires the completion of a continued stay PCPC Summary Sheet that must be forwarded to the SCA for approval. The summary sheets must also be maintained in the individual's file. |
| Outpatient | Following completion of the LOC assessment and the application of the PCPC, 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 PCPC Summary Sheet was completed and maintained in the individual's file. |

| | |
|--|--|
| <p>Partial Hospitalization / Intensive Outpatient</p> | <p>Following completion of the LOC assessment and the application of the PCPC, 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 PCPC Summary Sheet was completed and maintained in the individual's file.</p> |
| <p>Inpatient Residential; Short-term</p> | <p>Following completion of the LOC assessment and the application of the PCPC, short-term inpatient residential treatment may be approved for up to 14 days. Treatment beyond the 14-day period requires that a continued stay PCPC Summary Sheet be completed and forwarded to the SCA for approval. The summary sheets must be maintained in the individual's file.</p> |
| <p>Inpatient Residential; Long-term to include Halfway House</p> | <p>Following completion of the LOC assessment and the application of the PCPC, long-term inpatient residential and halfway house treatment may be approved for up to 30 days. Treatment beyond the 30-day period requires that a continued stay PCPC Summary Sheet be completed and forwarded to the SCA for approval. The summary sheets must be maintained in the individual's file.</p> |

10.04 Case Coordination

Overview

Case Coordination is a function of case management through which the SCA ensures that the adolescent's treatment and non-treatment needs are addressed. 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 individual'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 attend other health-related appointments. 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 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 must provide Case Coordination for each adolescent receiving services paid for by the SCA. The SCA shall design Case Coordination to meet their local needs. The SCA must develop a Case Coordination policy which delineates the following:

- how and when the SCA identifies non-treatment needs (see Appendix B for a check-list of non-treatment need categories);
- how the SCA documents the identified non-treatment needs;
 - At a minimum, non-treatment needs must be re-evaluated according to the following timeframes:
 - Early Intervention: not applicable
 - Outpatient: every 90 days
 - Intensive Outpatient/Partial Hospitalization: every 60 days
 - Inpatient Residential (Short-term, Long term) and Halfway House: prior to discharge
- how identified non-treatment needs are addressed (i.e. resource list);
- how the SCA tracks and documents the delivery of services paid for by the SCA;
- how the SCA reviews and approves or disapproves continued stay review ASAMs; 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., intervention/discussion groups, 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.

The staff person providing Case Coordination must meet the staffing qualifications outlined in Part 10.07 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.

Continued Stay Review

Placement decisions and length of stay need to be reconsidered throughout the course of an adolescent'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 adolescent. Continued stay reviews must be conducted within the parameters of the following process:

| LOC | CONTINUED STAY PROCESS |
|---|---|
| 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 adolescent's 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 adolescent's file. |
| Residential/Intensive Inpatient Treatment Includes halfway house | 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 adolescent's file. |

10.05 Case Management File Content

Case Management files must, when applicable, include:

- screening tool,
- assessment tool,
- documentation of interim services (if applicable),
- ASAM Summary Sheets (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 individual 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 data 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. 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.

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:

- 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.

10.08 Core Training

The SCA is required to ensure that those persons providing case management functions and their supervisors complete all required and applicable BDAP-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 BDAP. SCA Administrators are not permitted to exempt themselves from training requirements. Any staff that previously conducted screening and assessment 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.

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 - 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
- Screening & Assessment – 6 hours
- ASAM Patient Placement Criteria – 6 hours

Case Coordination function – 21(27*) total training hours

- Addictions 101 – 6 hours
- Confidentiality – 6 hours
- Practical Application of Confidentiality Laws and Regulations – 3 hours
- Case Management Overview – 6 hours
- *ASAM Patient Placement Criteria – 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 BDAP 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 BDAP 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 BDAP certificate)

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

- Case Management Overview – 6 hours (requires BDAP 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 BDAP 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.

- American Society of Addiction Medicine Patient Placement Criteria – 6 hours (requires BDAP certificate)

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.

10.09 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*, clients 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 a client 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 BDAP of the outcome within seven days via the BDAP-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 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 adolescent and BDAP of the outcome within seven days via the BDAP-approved Grievance and Appeal Form found in Appendix C. 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 adolescent 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 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

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

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. Section 1690.108), the Public Health Service Act (42 U.S.C § 290dd-2), Federal Confidentiality Regulations (42 CFR Part 2), In addition, 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 adolescent;
 - 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 adolescent's right to revoke consent (must allow verbal and written revocation);
 - Expiration date of the consent;
 - Dated signature of adolescent;
 - Dated signature of witness; and
 - Copy offered to the adolescent

- The information to be released must relate to the purpose of the consent;
- 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:

- exchange 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 BDAP understands that the list of RSS is extensive, the SCA may utilize BDAP 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.

12.01 APPENDIX A

BDAP 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? _____

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 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 Methadone/LAAM/Buprenorphine 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
 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) _____

12.02 APPENDIX B

NON-TREATMENT NEEDS CHECKLIST

| DOMAINS | Is the individual in need of assistance in the following areas? |
|--------------------------------------|---|
| EDUCATION /VOCATION | i.e., GED, job training, resume writing, tutoring, etc. |
| EMPLOYMENT | i.e., job search assistance, etc. |
| PHYSICAL HEALTH | i.e., medication management, pressing medical issues needing attention, pregnancy testing, pre-natal care, TB assessment, HIV/AIDS, Hepatitis, etc. |
| EMOTIONAL/MENTAL HEALTH | i.e., mental health referral, psychotropic medication management; co-occurring referral, etc. |
| FAMILY/SOCIAL | 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. |
| LIVING ARRANGEMENTS / HOUSING | i.e., assistance with getting client into a healthy recovery environment, referral to housing agencies, etc. |
| LEGAL STATUS | i.e., referral for legal assistance, communication skills when dealing with probation/parole, etc. |
| BASIC NEEDS | i.e., assistance with meeting basic needs such as food, clothing, and transportation, etc. |
| LIFE SKILLS | 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:
BDAP Director of Treatment
02 Kline Plaza
Harrisburg, PA 17104
Or Fax to 717-787-6285

12.04 APPENDIX D

PCPC Summary Sheet

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

Circle One: **ADMISSION** **CONTINUED STAY** **DISCHARGE/REFERRAL**

2. 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 program or facility referred to: _____

| | <u>Level of Care</u> | <u>Criteria Indicated</u> |
|--------------------------------|----------------------|---------------------------|
| 1. Intoxication/Withdrawal | _____ | _____ |
| 2. Biomedical Conditions | _____ | _____ |
| 3. Emotional/Behavioral | _____ | _____ |
| 4. Treatment Accept/Resistance | _____ | _____ |
| 5. Relapse Potential | _____ | _____ |
| 6. Recovery Environment | _____ | _____ |

3. A brief comment about the client's progress or status is required in each dimension. For detox admissions, include in Dimension 1 amount, duration, and last use for each substance.

Dimension 1: _____

Dimension 2: _____

Dimension 3: _____

Dimension 4: _____

Dimension 5: _____

Dimension 6: _____

12.05 APPENDIX E

Adolescent Placement Summary Sheet

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

Circle One: ADMISSION CONTINUED STAY DISCHARGE/REFERRAL

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 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 | _____ | _____ |
| 3. Emotional/Behavioral or Cognitive Conditions and Complications | _____ | _____ |
| 4. Readiness to Change | _____ | _____ |
| 5. Relapse, Continued Use or Continued Problem Potential | _____ | _____ |
| 6. Recovery Environment | _____ | _____ |

3. A brief comment about the client's progress or status is required in each dimension. For detox admissions, include in Dimension 1 amount, duration, and last use for each Substance.

Dimension 1: _____

Dimension 2: _____

Dimension 3: _____

Dimension 4: _____

Dimension 5: _____

Dimension 6: _____

12.06 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.

AODT: Alcohol and Other Drug Treatment

American Society of Addiction Medicine Patient Placement 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.

BDAP: Bureau of Drug and Alcohol Programs

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.

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 AOD 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.

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 (MET's): 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.

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.

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

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

Recovery Oriented Systems of Care (ROSC): Recovery-oriented systems of care support person-centered and self-directed approaches to care that build on strengths and resilience. Individuals, families, and communities take responsibility for their sustained health, wellness, and recovery from alcohol and other drug related issues through the various life phases of recovery.

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.

12.07 Appendix G

ACRONYM LIST

APSS: Adolescent Placement Summary Sheet

ASAM: American Society of Addiction Medicine

BDAP: Bureau of Drug and Alcohol Programs

C.F.R.: Code of Federal Regulations

CRS: Certified Recovery Specialist

CSR: Continued Stay Review

D&A: Drug and Alcohol

DOH: Department of Health

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

ROSC: Recovery Oriented Systems of Care

RSS: Recovery Support Services

SCA: Single County Authority

TB: Tuberculosis