COUNCIL ON CHEMICAL ABUSE

CASE MANAGEMENT
POLICIES AND PROCEDURES

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I. DEFINITION OF PHILOSOPHY OF CASE MANAGEMENT

Chemical dependency is a chronic and progressive disease that has an enormous impact on individuals, families and society. As a chronic illness, in most cases effective and appropriate treatment is required to arrest the disease process and to enhance the opportunity for the individual to achieve sobriety and on-going recovery. Long term recovery is the ultimate goal for those entering the Berks County SCA treatment system. However, not all individuals who access and receive drug and alcohol treatment are successful in their attempt to achieve sobriety. Identifying the nature and extent of an individual's chemical dependency and matching them to the most appropriate treatment is essential. Many times an individual's lack of success can be attributed to their inability to access the most appropriate drug and alcohol treatment service to address their addiction. In addition to their addiction, many chemically dependent individuals also suffer from other life stress problems that can impede their ability to complete treatment and/or achieve and maintain long-term sobriety. For these individuals, it is crucial to learn and incorporate into their daily lives the necessary skills to achieve and maintain overall self sufficiency and sobriety from chemical dependency.

In Berks County drug and alcohol case management is designed to help addicted individuals access treatment and address other life stress problems that could impede the recovery process. In order for case management to be successful, it must be a collaborative effort with the individual's achievement of overall wellness and self-sufficiency being the ultimate goal. As such, the primary focus of case management is the individual. While clients may require assistance from a drug and alcohol case management professional, services must be client driven and the client must be an active and willing participant. It is also imperative that those who deliver case management services be qualified in the services they provide.

II. STRUCTURE OF BERKS COUNTY'S CASE MANAGEMENT SYSTEM AND ACCESS

In Berks County, case management consists of those treatment and recovery supports that assist individuals to effectively address their chemical dependency disorder. While not treatment, case management includes those activities that facilitate the process for individuals to access appropriate levels of care and that assist individuals to address other life-stress areas that could impede the individual's treatment and/or recovery process. Through a comprehensive and coordinated system of case management, clients will be afforded an opportunity to experience a positive and effective treatment episode and attain an adequate level of self-sufficiency in order to achieve and maintain long-term sobriety. The case management system in Berks County will entail three primary functions: screening, level of care (LOC) assessment for adults and adolescents, case coordination, and intensive case management (ICM) for adults only.

Screening will determine the drug and alcohol client's need for acute care; this could include the need for detoxification, pre/peri-natal medical care and/or psychiatric services. All individuals to be funded for drug and alcohol treatment by Berks County SCA must first be screened upon accessing treatment services. Screenings shall be conducted by all contracted providers which serve as access points into the Berks County SCA funded treatment system; this includes but is not limited to: the Berks County Central Intake Unit, outpatient treatment programs, and local detoxification units. Berks County Jail and the Berks County Reentry Center, which serve as a treatment access points, are exempt from the screening requirements as a similar function is provided upon an individual's entry into the prison.

Level of Care (LOC) Assessment will ascertain the nature and extent of the individual's substance use disorder and match, as well as refer, the client to the appropriate mode of treatment. LOC assessments shall be conducted by all contracted providers which serve as access points in the Berks County SCA funded treatment system; this includes: the Berks County Central Intake Unit, outpatient treatment programs, local detoxification units, the Berks County Jail and the Berks County Re-Entry Center.

Case Coordination is a vital component of the case management process and addresses both the treatment and non-treatment needs of an individual. The treatment needs are directly related to treatment authorization and continued stay reviews. This directly impacts the level of care and duration of treatment the Berks SCA is willing to fund for the individual. The non-treatment needs, while not directly related to the individual's treatment, is concerned with those life areas that will directly affect an individual's ability to participate in treatment as well as to provide needed recovery support.

Intensive Case Management will identify the individual's life stress problems, link the client with available supportive services and monitor progress. ICM is offered to all chemically dependent individuals who suffer from a substance use disorder and who experience other life stress problems (i.e., medical, employment, housing, etc.). By addressing the individuals various problems through the provision of ICM services, chemically dependent individuals will be afforded a greater opportunity to attain and maintain sobriety and to ultimately reach a greater level of self-sufficiency and support the overall recovery process. Access to ICM services can be accomplished directly through a Berks SCA contracted ICM provider or through any of the contracted LOC assessment sites.

As the Berks SCA does not provide any direct treatment or ancillary treatment services to clients, all case management services are provided through contracts with local drug and alcohol service providers. The framework by which Berks County's case management services are provided will be in accordance with the guidelines set forth by the Department of Drug and Alcohol Programs (DDAP). However, the particular policies and procedures for the provision of these services will be determined locally according to the needs of the residents of Berks County. It shall be the responsibility of each contracted case management provider to establish policies and procedures with regard to the case management services they provide.

III. CONFIDENTIALITY OF INFORMATION FOR DRUG AND ALCOHOL CLIENTS

The Berks 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 Berks SCA shall make adequate provisions for system security and protection of individual privacy. The Berks 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 regulation governing patient records

Act 126.42 PA C.S.A § - state law clarifying what information may be exchanged between children and youth agencies, the juvenile justice system, SCA's and treatment providers.

Client confidentiality has become the principle cornerstone guiding the treatment of substance abuse disorders. It is the ethical and legal responsibility of drug and alcohol services providers to maintain client confidentiality. 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 elements as required by all state and federal regulation and statute;
- The information to be released or received must relate to the purpose of the consent; just because you can have the information, does not mean you should based on the purpose of the consent; and

- If service providers identify themselves as HIPAA-covered entities, they are required to obtain appropriate training from their agency regarding whether or not they meet HIPAA requirements.

Contracted providers are required to have policies associated with the adherence to all federal and state confidentiality regulations. The policies must include the following information and be signed-off by all staff:

- the process for the exchange of client-identifying information;
- storage and security of client records, to include computer security;
- acquisition of required confidentiality training, if applicable;
- staff access to records;
- progressive disciplinary protocols for staff violating confidentiality regulations;
- revocation of consent to include how it is documented on the consent form; and,
- notification of that re-disclosure is prohibited without proper consent.

IV. SCREENING

Screening is the first step in identifying the presence or absence of alcohol or other drug use whereby information is collected about either an adult or an adolescent in order to make initial decisions concerning his or her emergent care needs. Although screening may include gathering demographic and other information to determine eligibility, for the purpose of this manual screening is specifically defined as the determination of the need for a referral to emergent/acute care services.

All individuals to be funded for drug and alcohol treatment by Berks County SCA must first be screened upon accessing treatment services. Screenings shall be conducted by all contracted providers which serve as access points into the Berks County SCA funded treatment system; this includes but is not limited to: the Berks County Central Intake Unit, outpatient treatment programs and local detoxification units. Screening is not required for individuals accessing treatment services at Berks County Prison, as these individuals would have already undergone medical screening as part of their intake into the prison. Screening can be conducted by telephone or in person.

<u>Requirements</u>

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

The purposes of screening are:

- to obtain information to ascertain if emergent care is needed in the following areas:
    - Detoxification
    - Prenatal Care
    - Perinatal Care
    - Psychiatric Care
- to motivate and refer, if necessary, for a LOC assessment or other services.

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

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

- **Option 2:** Support staff may conduct screening in conjunction with skilled medical or human service professionals if they utilize a tool that contains the components of DDAP's screening tool, including trigger questions, which prompt the support staff to transfer the client to a skilled professional who is able to determine the need for an emergent care referral. This tool can be found in **Appendix A**; or

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

    - psychiatric (identification of suicide and homicide risk factors);
    - perinatal and prenatal (identification of alcohol and other drug use effects on the fetus); and
    - detoxification (pharmacology, basic addiction, identification of drug interactions).

Contracted providers should provide adequate training for staff that perform screening. The provider may choose to make training in the appropriate areas available to staff in a variety of ways, including: in-service, in-house, DDAP -sponsored, etc. If a contracted provider chooses the option of support staff conducting screenings on their own, those staff must attend DDAP -sponsored trainings regarding addiction and screening, when such trainings are available.

Referral for Care

If as a result of the screening it is determined acute care is necessary for either detoxification, medical and/or psychiatric care, an immediate referral shall be made for appropriate medical and/or psychiatric care. Depending on the situation and the client's history, referrals could be made to, but not limited to, the following: emergency care unit, private physician, mental health crisis unit, detoxification unit or local health clinic. Specifically, if an adult is in need of detox, the client 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 client file. If a client is referred to detox prior to completion of a LOC assessment, the assessment must be completed in its entirety before the client can be admitted to another level of care. Whatever the outcomes of a referral, the results and outcomes of the screening must be documented in the client file. This includes: acute need(s) identified, referral(s)

for acute care, outcome of any referral and whenever possible, follow-up results of referral for acute care.

If as a result of the screening it is determined acute care is not necessary, but that a drug and alcohol disorder may exist, a drug and alcohol level of care assessment is immediately completed or an appointment for such an assessment is scheduled. The assessment appointments must be scheduled to occur within seven (7) days of the screening. If this timeframe is not met, the reason must be documented on the screening instrument.

If as a result of the screening it is determined acute care is not necessary and that drug and alcohol usage issues do not exist, no referral or scheduling of an appointment is necessary. The results and outcomes of the screening must be documented in the client file.

Other than those clients seen at Berks County Jail or Berks County Reentry Center, there may be times when an individual is assessed but not screened. In these situations, the contracted provider must document the reason that a screening was not conducted and the date of initial contact in the client file.

Screening Tool

The DDAP screening tool was developed to ascertain the need for emergent care. If the contracted provider chooses to develop their own screening tool, the tool must include areas to gather the following information:

- date of initial contact;
- client demographic information;
- appointment date for LOC assessment; and
- questions to determine the need for emergent care in the above identified areas.

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

Client File

At a minimum, the completed client screening, referral information and any other consent or authorization form signed by the individual must be included in the client file. The Screen may be maintained as part of the LOC assessment if provided by the same facility. As part of the contract monitoring, the Berks SCA shall review client screenings for completeness and adherence to the information requirements.

V. LEVEL OF CARE ASSESSMENT

The activities encompassed in the function of assessment serve to coordinate all aspects of the client's involvement in the drug and alcohol service delivery system. This function, which is primarily focused on the determination of needed resources, includes a LOC assessment that identifies the need for drug and alcohol treatment as well as a care coordination assessment that determines the need for non-treatment services.

Requirements

The function of assessment includes a number of activities that will be done by the Berks SCA's contracted assessment providers and will consist of the following assessment activities:

- LOC assessment and placement determination;
- Non-treatment needs determination;
- TB Screening and Referral Services; and

LOC assessment and placement determination

LOC assessment is defined as a face-to-face interview with the client to ascertain treatment needs based on the degree and severity of alcohol and other drug use/abuse through the development of a comprehensive confidential personal history, including significant medical, social, occupational, educational, and family information. A LOC assessment must be completed within seven calendar days from the date of initial contact. The assessor must document if this time frame is not met. A LOC assessment must be completed in its entirety prior to referring the client to the appropriate level of care, except when the client is in need of detoxification. Once an assessment is completed, it will be valid for a period of six months. The 6-month time frame does not pertain to active clients. This applies to clients who have never engaged in treatment after being assessed or who have been discharged and are seeking to reinitiate services. If a client requests to reinitiate 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, for an adult, a new PCPC must be completed; and for an adolescent, a new APSS must be completed using the ASAM Placement Criteria.

The Berks SCA does not limit the number of LOC assessments or admissions to treatment offered to either an adult or adolescent with the following exceptions:

- ...A client will be funded through Berks SCA funds no more than two (2) times per fiscal year (July 1st to June 30th) for detoxification services. Allowances beyond two admissions for a fiscal year may only be made on a case by case basis depending upon the particular needs of the client, and must be approved by the Berks SCA or its designee.

- ...The Berks SCA will not continue to pay for Medication Assisted Treatment services for individuals who are non-compliant with treatment/counseling recommendations.

Those clients receiving the above services will be notified in writing of this limitation. **These restriction do not apply to pregnant women**

For adults, 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. The PCPC Summary Sheet can be found in **Appendix B.** The PCPC Summary Sheet in the STAR Treatment Data system may be used in lieu of the PCPC Summary Sheet

Level 1 **A** Outpatient **B** Intensive Outpatient	**Level 3** **A** Medically Monitored Detoxification **B** Medically Monitored Short-Term Residential **C** Medically Monitored Long-Term Residential
Level 2 **A** Partial Hospitalization **B** Halfway House	**Level 4** **A** Medically Managed Detoxification **B** Medically Managed Inpatient Residential

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)	

For adults, additional treatment related services are available: pre-treatment groups and early recovery support services. Pre-treatment groups are strongly recommended for those who have a scheduled admission date of more than five

(5) days from the date of LOC assessment. Additionally, clients assessed and referred for treatment are offered an opportunity to attend pre-treatment groups as they await admission into treatment. These groups not only prepare clients for their treatment experience, but clients are also offered assistance in connecting to appropriate and necessary non-treatment services.

Early Recovery Support Service (ERSS) is a post-treatment service that will provide the necessary guidance, assistance and encouragement to clients as they transition from treatment and become established in their personal recovery program. It is believed that the longer individuals remain connected with drug and alcohol supportive services, the likelihood of long term sobriety increases. Participants are expected to be actively involved in an external recovery support program (ex: 12-Step program) while involved with ERSS. Also, as relapse can be a natural occurrence during the early stages of recovery, ERSS can provide timely intervention for clients who relapse and need to be readmitted into appropriate drug and alcohol treatment services. Early Recovery Support Services is a professionally directed group education/discussion activity and is <u>not</u> a treatment service. ERSS is not to be offered in lieu of appropriate drug and alcohol treatment services nor is it intended to be a "pre-treatment" service.

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

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

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

Use of LOC Assessments in Developing Psychosocial Evaluations

A LOC assessment provided by TASC or any licensed treatment provider must be forwarded to the outpatient facility to which the client is referred for treatment. As is allowed by Department of Health Licensing Alert 01-07, licensed treatment providers are allowed to use this assessment as the basis for developing a client's psychosocial history. The Department of Drug and Alcohol Program recognizes that the LOC assessment may provide the framework for the required assessment; however, it may not meet all of the regulatory requirements for a psychosocial history. Therefore, it is the responsibility of the licensed facility that will provide treatment to ensure that it is in compliance with the corresponding requirements at 28 Pa. Code.

According to the above-noted Licensing Alert, the following conditions must be satisfied in order for the LOC assessment psychosocial history to be utilized:

> (1) the psychosocial history must have been developed within the last six months;
>
> (2) the psychosocial history, with the client's informed written consent, must have been obtained AT or BEFORE the client's admission from LOC assessment provider; and
>
> (3) upon receipt of the psychosocial history, the receiving project/facility must review it for completeness and accuracy with the client and document such review by dated signature of both the facility staff conducting the review and the client.

If the psychosocial history is incomplete, the receiving project/facility is responsible for further development of the historical data. The receiving project/facility is then responsible for the development of the psychosocial evaluation, treatment plans and all other components of the clinical record.

The use of this assessment document is voluntary and at the discretion of the treatment provider. However, the Berks SCA will only pay a single LOC assessment per treatment access. As such, the treatment facility which receives a LOC assessment shall not be authorized for payment or reimbursed by the Berks SCA to develop a new psychosocial history. The treating provider will be allowed an Admission Session to review the LOC assessment, develop a psychosocial

evaluation and complete any other intake documentation required. Any treating provider that receives a previously completed LOC assessment shall reimburse the Berks SCA for any Berks SCA funded treatment sessions used to develop a new psychosocial history.

Admission to Treatment

All clients must be offered admission to the most appropriate level of care available within 14 days of the assessment. Clients 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 client file.

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

Identification of Non-treatment Needs

In addition to gathering the information necessary to determine the most appropriate LOC, the assessment is also utilized to identify other needs that an individual may have, such as: education/vocation, employment, physical health, emotional/mental health, family/social, living arrangements/housing, legal status, basic needs (food, clothing, transportation), and life skills. This requirement is further expounded upon in Section VI.

TB Screening and Referral Services

In accordance with the Department of Drug and Alcohol Programs, the Berks SCA ensures that any provider performing LOC assessment services:

- Assess the client to determine whether or not the client would be considered high risk for TB as follows:
    - Have you traveled extensively (more than 4 weeks) outside the U.S. in the last five years to high TB incidence areas (Asia, Africa, South America, Central America)?
    - Are you a recent immigrant (within the past 5 years) from a high TB risk foreign country (includes countries in Asia, Africa, South America, and Central America)?
    - Have you resided in any of these facilities in the past year: jails, prisons, shelters, nursing homes and other long-term care facilities such as rehabilitation centers? (*If residents of any of these facilities were tested within the past three months they don't need to have their risk for TB reassessed.)

- Have you had any close contact with someone diagnosed with TB?
- Have you been homeless within the past year?
- Have you ever been an injection drug user?
- Do you or anyone in your household have the following symptoms such as a sustained cough for two or more weeks, coughing up blood, fever/chills, loss of appetite, unexplained weight loss, fatigue, night sweats?

- Any client that responds with a "yes" to any of the above questions is considered high risk for TB. With regard to TB screening and referral, the assessment provider shall adhere to the following:
  - Refer all the clients identified as high risk to the County's Public Health TB Clinic and document such referral in the client file;
  - Attempt follow-up contact with all clients referred to the County's Public Health TB Clinic to determine if the client reported to the health clinic. Any attempted follow-up contact and any information gathered from the contact must be documented in the client file.
  - Establish a Qualified Service Agreement (QSA) and/or obtain client consent to allow for the disclosure of communicable disease reporting to the County's Public Health TB Clinic. Any client consent must be maintained in the client file.

<u>Client Liability</u>

All Level of Care Assessment providers and Treatment providers must abide by the policies for Liability Assessment for Drug and Alcohol Services as set forth in Part Seven of the Department of Drug and Alcohol Program Fiscal Manual. These requirements include policies as well as the necessary Berks County client liability payment amounts by service, "Client Liability Form" and the "Request for Liability Reduction or Elimination Form." In addition to the DDAP policies, the Berks SCA has established the following policies and requirements related to the client liability process.

1. The provider of the Level of Care Assessment is responsible to determine client liability. If inpatient detoxification, the Community Re-Entry Center or the Berks County Jail treatment services is the client's entry point into Berks SCA funded drug and alcohol treatment, the detoxification unit, and the contracted treatment provider at the Community Re-Entry Center and the Berks County Jail shall determine the client's liability prior to referral to a subsequent level of Berks SCA funded treatment.

2. A copy of all client liability determinations and re-determinations must be sent to the TASC Authorization Unit within two (2) business days of the liability determination or re-determination.

3. All adult clients regardless of their liability assessment will be financially responsible for a portion of their treatment experience. The Berks SCA requires minimum co-pay for all clients not exempted from the liability provision. This minimum co-pay applies to those adults whose liability is assessed as zero. The minimum co-pay for outpatient, intensive outpatient and partial hospitalization services shall be one dollar ($1.00) per hour for each group session and two dollars ($2.00) per hour for each individual and/or family session. The minimum co-pay for residential and halfway house services shall be five-dollars ($5.00) per day. The exception to the minimum co-pay policy is for clients receiving outpatient methadone or buprenorphine services, who at this time have a separate liability determination process.

4. Clients failing to provide income verification during the liability determination assessment must present appropriate verification to the treatment provider within thirty (30) days of admission into treatment. The treatment provider shall review and compare the verification documentation with the original ”Client Liability Form”. If necessary, a Re-determination of the client liability must be completed and sent to the TASC Authorization Unit. A copy of the verification documentation must be maintained in the client file.

5. Clients claiming no income must be referred to the Berks County Assistance Office to apply for Medical Assistance benefits within thirty (30) days of admission into treatment. A copy of the client’s letter indicating his or her Medical Assistance eligibility must be maintained in the client file.

6. In accordance with the DDAP Fiscal Manual, all requests for reduction or elimination of liability shall be completed and submitted by a drug and alcohol professional. All such requests shall be submitted using the “Request for Liability Reduction or Elimination” form as found in the DDAP Fiscal Manual. The “Request for Liability Reduction or Elimination” form must be sent to the Berks SCA Program Administrator. The envelope containing the request shall be clearly marked with “Client Liability Reduction or Elimination”. The Berks SCA will render a decision regarding the elimination or reduction of client liability within ten (10) business days of receipt of the request. The Berks SCA’s decision regarding reduction or elimination of client liability is final and non-appealable.

7. The Berks SCA will not reimburse any uncollected client liability or co-payment.

Assessment Components

The following are the required level of care assessment 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**: Adults: literacy, degree to which the alcohol/drug problem has interfered with education. Adolescents: 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 (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**: Adults: child custody/visitation, childcare arrangements, sexual orientation. Adolescents: 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;
- **abuse**: history of any abuse yes/no, issues that might impact placement
- **legal**: Adults: probation/parole status, conviction record to include disposition, current charges. Adolescents: 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, LOC determination/PCPC, ASAM 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.

VI. CASE COORDINATION

Case Coordination is a function of case management through which the Berks 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 contracted LOC assessment and treatment provider may utilize **Appendix D** (Non-Treatment Needs Checklist) to assist in identifying non-treatment needs. If the contracted LOC assessment and/or treatment provider chooses not to use the Non-Treatment Needs Checklist, the instrument they do use 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 Berks SCA contracted LOC assessment and treatment providers will provide Case Coordination to each individual receiving services paid for by the Berks SCA. This includes identifying and referring clients for non-treatment needs, other treatment related support services and treatment continued stay review.

Non-Treatment Needs

Non-Treatment needs will be initially identified during the level of care assessment process. Following the assessment, the case manager/evaluator shall review the Non-Treatment Needs Checklist with the client and together shall determine whether a problem or issue exists.

The identification of problem/issue and whether appropriate resources where made available shall be documented on the Non-Treatment Needs Checklist. Additional action taken on behalf of the client with regard to non-treatment needs shall be documented in the client file. Clients shall have their non-treatment needs

re-evaluated while engaged in treatment. The treatment provider shall review and complete the Non-Treatment Needs Checklist with the client at those intervals as required by the Department of Drug and Alcohol Programs. The re-evaluation intervals for the various levels of care are as follows:

- Detoxification: not applicable
- Outpatient: every 90 days
- Intensive Outpatient/Partial Hospitalization: every 60 days
- Inpatient Residential and Halfway House: prior to discharge

The Berks SCA will make available to assessment and treatment providers a Guide to Local Resources and Services. Each client that has an identified non-treatment need shall be offered this guide with those resources/service areas highlighted. Any additional resource/service need not listed shall be noted for the client on the Guide. Non-Treatment needs services are generally other services available in the county and are not funded by the Berks SCA.

Other Supportive Services

In addition to Non-treatment needs services, the Berks SCA also funds some treatment related services which help individuals increase their level of self-sufficiency. These include Pre-Treatment groups, Early Recovery Support groups, Intensive Case Management and Recovery Housing.

Pre-Treatment groups are designed to both prepare a client for treatment while he or she awaits admission and to assist the client in accessing services to address other life issues (i.e., housing, medical, etc.). The

Early Recovery Support (ERS) groups assist clients to transition from treatment to local addiction support resources. ERS groups also present important topics to assist clients address issues and challenges faced in the early phases of recovery (i.e., budgeting, nutrition, health & wellness, parenting, anger management, etc.). Intensive Case Management will identify a chemically dependent individual's life stress problems, link them with available supportive services and monitor their progress. ICM is discussed in further detail in Section VI. A Recovery House is a safe and supportive environment where residents in recovery live together as a community. Recovery Houses are discussed in further detail in Section XIV.

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 for adults and the ASAM criteria for admission, continued stay, discharge and referral adolescents. The applicable PCPC or ASAM 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 criteria:

LEVEL OF CARE	INITIAL STAY MAXIMUM APPROVAL	CONTINUED STAY MAXIMUM APPROVAL
Detoxification - Drug Free	3 days	2 days
Detoxification – Medication Assisted	5 days	2 days
Inpatient Residential; Short-term	14 days	7 days
Inpatient Residential; Long-term	30 days	30 days
Halfway House	30 days	30 days
Partial Hospitalization – Drug Free	6 weeks	2 weeks
Intensive Outpatient – Drug Free	8 weeks	2 weeks
Outpatient – Drug Free	26 weeks	4 weeks
Methadone Maintenance - Outpatient	26 weeks	26 weeks
Dual Diagnosis – Outpatient	26 weeks	13 weeks

Following completion of the LOC assessment and the application of the PCPC (adults) and ASAM (adolescents) the above services may be approved up to the initial maximum approval amount. Treatment beyond the initial maximum approval amount requires the treatment provider to document that the case was clinically staffed and that a continued stay PCPC (adults) or APSS (adolescents) Summary Sheet was completed and maintained in the individual's file.

The authorization unit at the Treatment Access and Services Center (TASC) is designated as the entity to make LOC placement decisions and lengths of stay for Berks SCA managed funds. All Berks SCA funded treatment services must be pre-authorized through the TASC authorization unit. The exceptions to this are those who access acute detoxification services at local detoxification units or those accessing outpatient treatment services at Berks County Jail or the Berks County Reentry Center. In these particular instances treatment funding will be retroactively authorized. The treatment management process is more fully described in Section XVII of these guidelines.

VII. INTENSIVE CASE MANAGEMENT

Intensive Case Management (ICM) is offered to all individuals who suffer from a substance use disorder and who experience other life stress problems (i.e., medical, employment, housing, etc.). ICM services will be provided in accordance with the guidelines found in this policy and procedure manual. Through the provision of ICM services, chemically dependent individuals will be afforded a greater opportunity to attain and maintain sobriety and to ultimately reach a greater level of self-sufficiency.

The Berks SCA contracts with the Treatment Access and Services Center (TASC) as the primary provider of ICM services. The Berks SCA also contracts with local organizations to provide specific ICM services for pregnant women/women with children. Additionally, those who reside in any of the Berks SCA's transitional houses, will be provided ICM services by the facility where the client resides.

Referral To ICM

Potential ICM clients will be primarily identified and referred for ICM services by Berks SCA contracted LOC assessment and/or treatment providers. However, referrals to ICM can also be made by a variety of other sources to include but not limited to: court personnel, case workers, hospitals or any other agencies working with individuals who meet the criteria for ICM services
At the time of the LOC assessment, providers will refer individuals for ICM who meet criteria as evidenced by the Non-Treatment Needs Checklist). While this may be the primary means of referring individuals to ICM, referrals for ICM can occur any time prior, during or following drug and alcohol treatment. An appointment will be scheduled for the initial contact between the client and the ICM provider. With proper consent, the LOC assessment or treatment provider will forward to the ICM unit a copy of the Non-Treatment Needs Checklist .

It should be noted that there are no direct referrals for ICM services to the Berks SCA transitional houses. Individuals residing at one of these houses will be offered ICM services following their admission into the house.

When a referral for ICM services is made, a face-to-face contact must be made within 14 days of receipt of the referral. Failure to meet this time frame must be documented in the client chart. Under no circumstance should the initial face-to-face contact occur more than 30 days from receipt of the referral.
If a client is placed on a waiting list for ICM services, a face-to-face contact must be made within 14 days of when the client comes off the waiting list. Failure to meet this time frame must be documented in the client chart. Under no circumstance should the initial face-to-face contact occur more than 30 days from when the client comes off the waiting list.

The Berks SCA is not mandating caseload size, however, caseloads must not exceed an intensive case manager's ability to meet the needs of the clients and services must adhere to both the DDAP and the Berks SCA Intensive Case

Management requirements. Each ICM provider shall establish a case manager to client ratio. However, it is suggested that caseloads not exceed 30 clients per each full-time equivalent intensive case manager.

Waiting List

If the ICM service provider reaches their client-to-staff ratio, a waiting list will be created. A waiting list will be developed in the chronological order in which clients are referred for ICM services. Clients with six or more identified domains on the Non-Treatment Needs Checklist must be given priority on the waiting list. The ICM units will make every effort to keep the client engaged while on a waiting list. This could be through regular phone contacts to determine the status of the client or by allowing the client to report to the ICM unit to discuss any acute services they may require. Any contact and/or services provided to a client while on an ICM waiting list shall be documented in the client's pending chart. The waiting list shall be monitored on a no-less than weekly basis by the ICM supervisor

Admission to ICM

The admission process is designed to: orient the client to the ICM process, identify the client's needs and develop a plan for addressing the various needs. Admission to ICM services is voluntary and is not restricted based on the client's level of care, type of service or the treatment reimbursement funding stream(s) through which the client is eligible. Clients must participate in drug and alcohol treatment or must have recently completed drug and alcohol treatment and is engaged in a program of recovery in order to be involved in ICM. Admission to treatment does not need to occur prior to admission to ICM. A client is admitted to ICM once a Service Plan has been completed.

The criteria for admission into ICM services include: resident of Berks County, evidence of a substance abuse disorder and documented need for ICM services. Those clients included with the Health Choices project are subject to the criteria that Community Care Behavioral Health (CCBH) establishes for ICM services with the local provider network.

The admission intake must be conducted through a face-to-face interview between the client and the case manager. The two primary components of the admission process are the completion of DDAP's Inventory of Support Services – ISS (**Appendix E)** and development of an individualized service plan (**Appendix F**). The case manager must explain to the client that the ISS instrument is being used to identify his/her specific support service needs and that a service plan will be developed incorporating this information. The individualized service plan constitutes the core of the ICM effort and is viewed as a road map to assist the client in addressing service needs. Case managers and clients must work together to develop individualized service plans that include realistic and measurable goals

The individualized service plan must be completed within fourteen (14) days of each administration of the ISS. A client is considered admitted for ICM services once a service plan has been completed.

The contracted ICM provider must have a written policy that describes the protocols for admission. The following items must be completed as part of the admission process:

- An agreement to participate form;
- Description of ICM services;
- Discharge criteria;
- Grievance and appeal procedure;
- Follow-up requirements;
- Appropriate consent to release information forms;
- Administration of ISS; and
- Development of an individualized service plan.

There must be client sign-off to verify that the above items have been reviewed in the admission process. This documentation must be included in the client's ICM chart.

Inventory of Support Services Tool

The Inventory of Support Services (ISS) is the initial and ongoing tool used to identify the client's level of self-sufficiency for each of the twelve domains. A set of scores is associated with each level of self-sufficiency ranging from 0 (Self-Sufficient) to 10+ (In Crisis), thus the higher the score the greater the need. This Self-Sufficiency Matrix can be found in **Appendix G**.

The ISS will be administered during a structured face-to-face interview. It is intended that the ISS instrument will be administered in its entirety during one interview session with the client. However, if extenuating circumstances do not allow for the ISS interview to be completed during one session, the ICM case manager can perform the ISS over two (2) sessions. The need for more than one session must be documented in the client file.

The ISS will be completed in accordance with the following requirements:

- Upon entry into ICM services in order to determine the appropriateness of the referral and to establish a baseline;
- 1st Update 60 days following the initial ISS;
- Updates every 90 days thereafter during the 1st year of ICM enrollment;
- Updates every 6 months following one year of ICM enrollment; and
- Upon discharge from ICM. (if possible)

Individualized Service Plan

The overall purpose of the service plan is to establish a well-documented plan of action for meeting goals. After identifying areas of need, the client and case manager will determine how to best utilize the client's strengths and assets to identify actions steps and goals in each of the areas of concern. Clients will be encouraged to take an active role in service planning so as to be empowered and invested in working on the goals developed in conjunction with the case manager. The ICM case manager must encourage, assist, and support clients in identifying their strengths and needs and to act as a resource to help clients access appropriate services.

The intent of the individualized service plan is not to replace or duplicate a treatment plan. It serves as an adjunct or supplement to a treatment plan and the focus will be on accessing and utilizing services available to meet a client's needs. It is not appropriate for a service plan to dictate a specific level of care especially since a level of care could change prior to the development of a new service plan. (A typical goal of the AODT domain may be "client will address substance abuse issues," followed by action steps such as "comply with all recommended treatment" or "attend a self-help group daily".)
Minimally, the service plan must be written legibly and must include the following:

- Client strengths;
- ISS scores and identified areas of need;
- Status codes to indicate areas of need to be addressed;
- Goals that correspond to the areas of need;
- Action steps with target dates;
- The client's name on each page of the service plan;
- Dated signatures of the client and the case manager (dated signature of case management supervisor is optional); and
- Checkmark to indicate the client received a copy of the service plan.

The client and case manager will work together to develop a new service plan within 14 days of each ISS administered. The ISS results will be scored, placed on the front sheet of the service plan, and then used as the foundation for the service plan development. The domains to be initially addressed will consist of those with the highest score.

The needs to be addressed will be prioritized in order of those that the client and the case manager agree. If there are certain areas the client is unwilling to address, the client and case manager can agree to defer addressing the particular area. The case manager must document all instances in which an identified need is being deferred due to client unwillingness to address such need.

The scores from each domain of the ISS will be documented on the first page of the service plan in conjunction with three of the client's strengths. The case manager will assist the client in identifying goals, especially those required to stabilize immediate needs. The case manager will assist in the process of needs identification to ensure the client does not develop counterproductive goals. The service plan must be developed in such a manner as to identify opportunities to empower the client in accessing community resources.

The case manager's responsibility for an activity in the action step is limited to specific functions such as linking, monitoring, advocating, or coaching.
The case manager will not be a resource to meet the client's needs directly, but function strictly as a support to increase the client's self-sufficiency.

The service plan will be reviewed at each scheduled meeting with the client to ensure that progress is being made on identified goals. Each time the plan is reviewed during a scheduled face-to-face ISP meeting the client and case manager shall initial and date the service plan. The service plan may need to be amended due to significant changes in life circumstances or a crisis situation occurring for the client. Documentation is required to demonstrate the circumstances and the resolution of the crisis situation.

Discharge From ICM

The decision to discharge a client from ICM will be based on the progress of the client as defined by the service plan. There will be objective information that will give direction for when discharge would be appropriate. It is anticipated that a client's average length of stay in ICM services will range from three months to one year; however, the service plan must drive a client's length of stay in ICM services. If a client's length of stay in ICM services exceeds one year, an explanation for an extended length of stay must be noted in the client ICM file. However, due to the nature of the services provided, those involved with the pregnant women/women with children ICM will have an average length of stay of nine to eighteen months. For those involved with this service, any length of stay beyond eighteen months, an explanation for an extended length of stay must be noted in the client ICM file. A client should be discharged from services when the short-term objectives and goals of the service plan have been achieved and there are not any other service needs that can or should be addressed through case management services. The Discharge form can be found in **Appendix H,** must be completed in its entirety for each client at the point of discharge from ICM.

Definitions of Reasons for Discharge

A client is deemed to have completed ICM services when he/she has achieved completion of the goals on the service plan and no other needs have been identified. The following is a list of possible reasons for discharge:

- Completed ICM: Client has completed ICM e.g. support service needs have been adequately addressed and client is no longer in need of additional ICM services;

- Institutionalized/Incarcerated: Client is currently committed to a long-term psychiatric facility or has been incarcerated (either sentenced or pending disposition of his/her criminal case) for more than thirty days;

- Voluntary Discharge: Client indicated that he/she did not want the ICM services or support services that were being offered;

- Administrative Discharge: Client does not adhere to his/her commitment to the ICM process. This could include continued failure to keep schedule appointments or refusal to comply with agreed upon action steps in the ISP. The client file must include documentation of efforts made by the ICM case manager to keep a client engaged in the ICM process.

- Transfer: Client has moved to another county within Pennsylvania and wishes to continue receiving ICM services; and

- Other: Any other reasons for discharge that do not fit the above categories.

A discharge form is to be completed for each client at the point of discharge from ICM. The primary areas included in the discharge form will be:

- Reason(s) for discharge;
- Client's name;
- Date of admission to ICM, date of discharge, and date of last contact: In some cases the date of last contact may be the discharge meeting. However, in cases where discharge does not occur as part of a face-to-face meeting, the date of last contact should be the last time the case manager has had any direct contact with the client, either face-to-face or via telephone;
- Level of self-sufficiency: This must be based on the ISS administered at the point of discharge. If the ISS is not administered at the point of discharge, a client's level of self-sufficiency will be based on the last ISS administered; and
- The ICM Discharge Form must be completed and appropriately signed. If the client has completed ICM services, then only the ICM case manager need sign the ICM Discharge Form. If the client has not completed ICM services, then both the ICM case manager and the ICM case management supervisor are required to sign off on the ICM Discharge Form.

Regardless of the reason for a client's discharge from ICM services, clients can have the opportunity to re-engage in ICM services. The ICM case manager will make the client aware, through written documentation, that the client may request to re-engage in ICM services at any time and how the client can become re-

engaged in ICM services. The ICM provider will have an ICM re-engagement policy and procedure

Client Satisfaction Survey

The Berks SCA requires ICM units to develop policies and protocols to survey their clients' satisfaction with intensive case management services. These policies, protocols and satisfactions surveys must be submitted to the Berks SCA for review and approval. Client Satisfaction Surveys must be completed by clients anonymously and independently of the intensive case manager. The clients must be provided an addressed and stamped envelope to mail the survey to the case management office and/or a designated drop-box for the surveys should be established at the case management unit. Each time the ICM provider surveys client satisfaction it must document the number of surveys distributed, the number surveys completed and returned as well as the overall results of the survey.

The Berks SCA shall annually conduct a client satisfaction survey to be administered by each ICM unit. The ICM provider shall distribute the survey to all active ICM clients and assure the completed surveys are returned to the Berks SCA.

ICM Transfer

The Berks SCA may accept ICM transfer cases from other SCA's and where appropriate will transfer ICM cases to other SCA's. Berks County will accept ICM transfers from another county if the client was originally identified as having needs in six (6) or more domains on the ISS, one of which is in the alcohol and drug domain. Cases transferred to Berks County:

- Will be processed as new referrals
- Will not be given priority on a waiting list unless one or more levels of Self Sufficiency on the discharge ISS from the original county of residence has a score of eight (8) or above.

If a Berks County ICM client moves to another county that offers ICM and the client is agreeable, the ICM case will be transferred to that SCA's ICM unit. Appropriate consents to release information will be obtained in order to transfer necessary client information to the new ICM unit.

VIII. CASE MANAGEMENT FILE CONTENT

Case Management files must, when applicable, include:

- screening tool,
- assessment tool,
- documentation of interim services (if applicable),
- (Adults)PCPC Summary Sheets (admission, continued stay, and discharge). (Adolescents) ASAM Summary Sheets (admission, continued stay, and discharge),
- consent to release information forms,
- acknowledgement of receipt of the Grievance and Appeal policy (**Appendix I)**,
- acknowledgement of receipt of treatment limitations (if applicable),
- acknowledgement of receipt of housing limitations (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 Berks SCA (i.e., discharge form, case note, etc.).

Intensive Case Management files must, when applicable, include:

- documentation of interim services (if applicable),
- valid consent to release information forms.
- acknowledgement of receipt of the Grievance and Appeal policy,
- Inventory of Support Services - ISS,
- Individualized Service Plan - ISP,
- case notes
- Discharge form.

Case Notes

All contacts related to a client must be documented in the client file. While notes should be as concise as possible, they 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 the individual's needs; and
- Action to be taken to meet a client'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. It is strongly encourages that 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.

IX. GRIEVANCE AND APPEALS

The primary objective of the grievance and appeal process is to promote a step-by-step effort at reconciliation between an aggrieved client and the Council on Chemical Abuse. The Council on Chemical Abuse's contracted treatment and treatment related service providers are required to have their own separate grievance and appeal protocols arising from the client's direct involvement with those particular programs. This process is intended to resolve those issues where the Council on Chemical Abuse's administrative or financial decisions are in dispute. The Council on Chemical Abuse intends to have an expeditious, accessible, fair, and uniform process in place for resolving grievances and appeals.

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

- denial or termination of services;
- level of care determination;
- length of stay in treatment;
- length of stay in ICM; and
- violation of the client's human or civil rights.

An appeal is defined as a request for reconsideration of a Council on Chemical Abuse's decision at progressive stages until the grievance is resolved.

The Council on Chemical Abuse's review process includes the following:

The first level of appeal of grievance decision shall be made in writing to the Council on Chemical Abuse's Executive Director or his/her designee who is not directly involved in the dispute. Access to client records shall be in accordance with state and federal confidentiality regulations.

The second level of appeal to a grievance decision shall be made to an independent review board or hearing panel that is comprised of an odd number of members, no less than three, who have no financial, occupational or contractual agreements with the Council. This may include any of the following: care and/or case management or other administrative staff from another Single County Authority(ies), treatment facility staff, staff of other human service agencies, or former clients who have knowledge of care and case management practices. Access to client records shall be in accordance with state and federal confidentiality regulations. Any member of the second level appeal who has financial, occupational or contractual ties to the Council on Chemical Abuse or any other agency involved in the grievance or appeal shall disqualify himself or herself.

A decision shall be rendered within seven days for each level of appeal to a grievance decision upon receipt of the written appeal and a written client

consent to release confidential information to any and all individuals reviewing the appeal. The Council on Chemical Abuse shall inform the client and DDAP of the outcome by means of the Grievance Reporting Form **(Appendix J)**, within seven days of the decision for both the first and second level of appeal to a grievance.

A signed consent form must be attained from the client so confidential client information relating to the appeal can be provided to the first level of appeal and to an independent review board for the purpose of rendering a decision on the appeal

The client shall have the right to access to all documentation pertaining to the resolution of the grievance within the confines of state and federal confidentiality regulations.

The client shall have the right to be involved in the process and have representation by means of a client advocate, case manager, or any other individual chosen by the client at each level of appeal.

The Department of Drug and Alcohol Programs (DDAP), the Department of Public Welfare nor the members of the Berks SCA's governing body (County Executive, County Commissioners or governing Board of Directors) may serve on the independent review or hearing panel at any level of the grievance and appeals process.

Clients shall be notified of the Berks SCA's grievance or appeal policy and procedures upon accessing services of any Berks SCA funded treatment and/or treatment related service. The client must acknowledge with signature and date that they have been notified about the following areas:

- the grievance and appeal policy that outlines the five areas that a client can grieve with the Berks SCA;

- the need for a signed consent form from the client so confidential client information relating to the appeal can be provided to the first level of appeal and to an independent review board for the purpose of rendering a decision on the appeal;

- the right to have access to all documentation pertaining to the resolution of the grievance within the confines of state and federal confidentiality regulations; and

- the right to be involved in the process and have representation by means of a client advocate, case manager, or any other individual chosen by the client at each level of appeal.

X. MIMINUM STAFFING QUALIFICATIONS

In order to assure that capable individuals provide case management services, anyone providing such services must meet minimum qualifications. Required Qualifications of Case Management Staff Providing LOC Assessments and/or ICM Services are as follows:

- Staff employed by a contracted, non-treatment provider who provides the functions of case management must meet the qualification 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. The minimum educational and training requirements for these positions are listed in **Appendix K.**

- Staff employed by a contracted drug and alcohol treatment provider who provides the functions of case management must meet the DDAP licensing requirements for either Counselor or Counselor Assistant. Supervisors of these staff persons must meet, at a minimum, the DDAP licensing requirements for Clinical Supervisor or Lead Counselor.

XI. CORE TRAINING REQUIREMENTS

The contracted treatment and/or case management providers are required to ensure that those persons providing treatment and/or case management functions must complete all required and applicable DDAP approved case management core training within 365 days of hire. Proficiency in each function will be documented by providing Pennsylvania Department of Drug and Alcohol Programs approved certificates of completion for the required core competency courses. All Provider staff certificates from required trainings must be maintained by the Provider.

Exceptions may be made at the discretion of the Berks SCA Executive Director, for the Addictions 101 and Screening and Assessment courses, provided that comparable training and educational requirements have been met. In order for the Berks SCA to exempt any of the contracted provider staff from the required trainings, the contracted provider must be able to provide written documentation to justify the exception.

All persons providing case management, intensive case management or treatment direct service or supervision must complete an approved Motivational Interviewing training and any necessary follow-up training as directed.

<u>Case Management Providers</u>

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 Adult and 33 Adolescent total training hours For both Adult and Adolescent providers unless otherwise specified

- 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 (Adult Assessments)
- Practical Application of PCPC Criteria – 3 hours (Adult Assessments)
- ASAM Patient Placement Criteria – 6 hours (Adolescent Assessments)

Case Coordination Function – 21(30*) Adult and 21(27*) Adolescent total training hours For both Adult and Adolescent providers unless otherwise specified.

- Addictions 101 – 6 hours
- Confidentiality – 6 hours
- Practical Application of Confidentiality Laws and Regulations – 3 hours
- Case Management Overview – 6 hours
- *PCPC – 6 hours (Adult Services)

- *Practical Application of PCPC Criteria – 3 hours (Adult Services)
- *ASAM Patient Placement Criteria – 6 hours (Adolescent Services)

*If conducting continued stay reviews

Individuals that previously conducted screening and assessment and had the DDAP-required Core Trainings prior to November 2003 is not required to take the Case Management Overview course, Addictions 101, and Screening and Assessment. In addition, staff that completed Confidentiality and PCPC training courses prior to November 2003 are not required to take the related practical application courses.

Intensive Case Management Providers - 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
- ISS, Service Planning and Record Keeping – 6 hours

Treatment Providers

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

- DDAP approved Pennsylvania Client Placement Criteria
- DDAP approved Practical Applications of PCPC criteria
- DDAP approved or PCB approved Confidentiality
- DDAP 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
- DDAP approved, or PCB approved Confidentiality
- DDAP 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.

XII. SUPERVISION.

Supervision of staff providing case management, intensive case management and/or treatment services should be designed to ensure the adequate provision of those services. Supervision procedures are at the discretion of the provider. The provider will develop policies and procedures regarding supervision. However, the supervision of new staff performing treatment and/or 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, PCPC Summary Sheets (for adults) and APSS or ASAM Summary Sheets (for adolescents) must continue until the treatment counselor and/or case manager has received all appropriate training.

As Motivational Interviewing (MI) is required as part of service delivery, supervision documentation must include supervision methods used and steps taken to assure that MI is be being utilized in the delivery of services.

<u>Requirements of Case Management Supervision</u>

1. In order to ensure the adequate provision of case management, intensive case management and treatment services, supervisory staff must have a working knowledge of all information and responsibilities required of case management staff; therefore, case management supervisors must, at a minimum, complete all required case management core trainings;

2. In order to ensure timely and effective delivery of services, completion of appropriate paperwork, and proper documentation, each contracted provider shall develop policies and procedures which shall detail the following information:

    - The manner and frequency of supervision for both case management specialists/treatment specialist/counselor as well as case management specialist trainees/treatment specialist trainees/counselor assistants.

    - The manner in which supervision and chart reviews will be documented; and

    - The process for allowing new staff to perform case management and/or intensive case management functions without having received required/related core trainings, which must include a combination of job shadowing and direct observation of LOC assessment, ISS administration, and Service Plan development. Close supervision and supervisory sign-off on written documentation, to include, at a minimum, the LOC assessment, PCPC Summary Sheets, ISS, Service Plans, and ICM discharge forms must continue until the case manager has received all appropriate training.

XIII. REPORTING

The Berks SCA is required to submit reports as per the Department of Drug and Alcohol Programs (DDAP) Report Schedule and manuals (Treatment, Fiscal, Prevention, Operational and Gambling). The Berks SCA's Executive Director, or his/her designee, shall notify DDAP's Director of Treatment in writing, within five (5) days, if the Berks SCA discontinues or limits authorization for admission to any level of care or type of service, for any reason, including lack of funding. When treatment limitations are removed, the Berks SCA will notify DDAP's Director of Treatment, in writing, within five days.

All Berks SCA contracted case management and treatment providers shall submit reports to the Berks SCA as required by both DDAP and/or the Berks SCA. The following are some of the reports currently required:

- The Case Management Resource Report (CMRR) **Appendix L** is required from all case management providers (assessment and ICM) on a monthly basis. This report is due to the Berks SCA within fifteen (15) days following the end of the month to be reported.

- The Intensive Case Management Activity Report **Appendix M** is required from all intensive case management providers on a monthly basis. This report is due to the Berks SCA within ten (10) days following the end of the month to be reported.

- Reports related to specific funding or programs (i.e., HAP, HSDF, RIP, Drug Court, Transitional/Recovery Housing, etc.) at those intervals as specified by the Berks SCA.

- Client Satisfaction surveys at those intervals as specified by the Berks SCA.

XIV. Performance Measures

The assessment and treatment provider must adhere to the following performance measures related to timely access to assessment and admission to treatment as established by the Department of Drug and Alcohol Programs. Individuals are expected to be assessed or admitted to treatment within established timeframe requirements. SCAs must meet DDAP established benchmarks, as follows:

Maximum of Clients who have to wait seven (7) days or longer for an assessment.:

Fiscal year 2010 – 2011	9%
Fiscal year 2011 – 2012	8%
Fiscal year 2012 – 2013	7%
Fiscal year 2013 – 2014	6%
Fiscal year 2014 – 2015	5%

Maximum of Clients who have to wait fourteen (14) days or longer for admission to treatment:

Fiscal year 2010 – 2011	10%
Fiscal year 2011 – 2012	9%
Fiscal year 2012 – 2013	8%
Fiscal year 2013 – 2014	7%
Fiscal year 2014 – 2015	7%

XV. PRIORITY POPULATIONS

This section contains various polices related specifically to the Department of Drug and Alcohol Programs (DDAP) Treatment Manual.

The Berks 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 Berks SCA chooses to restrict access to assessment and/or admission to treatment such restrictions shall not apply to pregnant women. All such limitations will be expressed in written policy and all individuals must sign off to indicate that they have been notified of the limitations in writing.

Pregnant Women

The Berks SCA and all of its contractors that serve women shall provide preference to pregnant women and shall publicize such preferential service. The Berks SCA will provide services to 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 then;
- 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 pregnant 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.

If the client is deemed eligible for Interim Services, the assessor will offer the client a listing of various resources in the local community that address the above issues. **Regardless whether or not the client accepts interim services, on a monthly basis the treatment provider to whom the client has been referred shall attempt telephone contact with the client until admission into treatment occurs. All such telephone contacts shall be documented in the client file**

The LOC Assessment provider must document in the Assessment file the offering of Interim Services to pregnant women unable to access treatment services.

Injection Drug Users

Service Providers that treat individuals for injection (IDU) substance abuse are required to notify the Berks SCA by letter or electronic mail within seven (7) days upon reaching ninety percent (90%) of its capacity to admit individuals to the program. Upon receipt of this notification, the Berks SCA's Executive Director, or his/her designee, shall notify the Utilization Management Supervisor in writing regarding the IDU program reaching 90% capacity.

Note: The following only pertains to non-pregnant IDU. The Berks 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.

If the client is deemed eligible for Interim Services, the assessor will offer the client a listing of various resources in the local community that address the above issues. **Regardless whether or not the client accepts interim services, on a monthly basis the treatment provider to whom the client has been referred shall attempt telephone contact with the client until admission into treatment occurs. All such telephone contacts shall be documented in the client file**

The provider must document in the Assessment file the offering of Interim Services to injection drug users unable to access treatment services.

Injection drug users who cannot be offered a treatment admission within 14 days of the assessment will be given a treatment admission date within 120 days of the assessment. The Utilization Management Unit will track such clients until the date of the scheduled admission.

The Berks SCA shall develop a plan, which is updated yearly, to ensure outreach activities are carried out for injection drug users who have not yet entered treatment. The Berks SCA shall have written outreach procedures that include the following:

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

<u>Women With Children</u>

All contracted treatment providers who serve pregnant women and women with dependent children, including women who are attempting to regain custody of their children, shall provide or arrange for the provision of ancillary services. These ancillary services include, but are not limited to:

- Primary medical care for women, including a referral for prenatal care and, while the women are receiving such services, child care;
- Primary pediatric care, including immunization, for their children
- Gender sensitive 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;

- Sufficient case management and transportation to ensure that women and their children have access to the services provided in this paragraph;
- Therapeutic interventions for the children in the custody of the women receiving treatment services pursuant to this paragraph, which may address, among other things, the children's developmental needs, issues of sexual and physical abuse, and neglect.

The Berks SCA shall maintain a current resource list to identify a provider for each the services listed above.

The provider must document in the client treatment chart that ancillary services had been provided or arranged.

XVI. TRANSITIONAL/RECOVERY HOUSING

A transitional/recovery house is a safe and supportive environment where residents in early recovery live together as a community. The Berks SCA contracts with several organizations that provide transitional/recovery services. The various populations served in the contracted transitional/recovery houses include: criminal justice (male/female), homeless (male/female), women with children (female) and dually diagnosed (male/female).

The Berks SCA shall only contract with and use DDAP funds for transitional/recovery houses that meet the following requirements:

- 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 handicap accessible;
- Be in compliance with all local municipal ordinances.

The transitional/recovery house shall submit such policies, procedures and documents which attest that they are in compliance with the above requirements. These policies, procedures and documents shall be reviewed by the Berks SCA prior to contracting with the transitional/recovery house as well as each year during contract monitoring. Prior to final approval, the Berks SCA will conduct a site visit. Results of the site visit will be documented and will be available for DDAP review.

Any client receiving transitional/recovery house funding from the Berks SCA must be screened, and if appropriate, receive a level of care assessment. The client's referral to recovery housing must come from the Berks SCA or one of its level of care assessment providers.

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

XVII. CLIENT TREATMENT MANAGEMENT PROCESS

The Berks SCA is responsible to coordinate a continuum of drug and alcohol treatment services for Berks County residents who required public funds in order to receive such services.

The following are the policies and procedures to be followed for all treatment services funded through the Berks SCA.

A. Client Eligibility

The Berks SCA's treatment funding is intended for Berks County residents who do not have any other behavioral health coverage to offset the cost of drug and alcohol treatment services. Those not eligible for this drug and alcohol treatment funding include individuals with drug and alcohol treatment coverage through a Private HMO, Private Health Insurance[1], Medical Assistance [2,3], or Health Choices.

[1] There are two exceptions to the private health insurance exemptions. First, the Berks SCA may pay for treatment if an individual's private health insurance does not include drug and alcohol treatment coverage. Second, the Berks SCA may authorize outpatient and/or non-hospital detoxification services for individuals who have exhausted their drug and alcohol treatment coverage. Documentation is required that the client's insurer does not or will not cover the specified drug and alcohol treatment service.

[2] The Berks SCA does receive funding to reimburse Act 152 services, which are eligible only to Medical Assistance clients.

It is the policy of the Berks SCA that prior to issuance of authorization of Berks SCA treatment funds, clients must have documentation that he/she has applied for Pennsylvania Medical Assistance benefits and has submitted all required documents related to the application. An exception to this policy may be allowed if:

- The client is to be funded for treatment through specific grant funding which the Berks SCA deems that application for Medical Assistance benefits is not necessary; or
- It is obvious that the client is not eligible for Medical Assistance benefits. The person making such a determination must document in the client file the reason Medical Assistance application was not pursued.

While any individual may access treatment through the Central Intake Unit at TASC, all mandated referrals must access treatment through this unit. Mandated clients include those referred by the Courts, Adult County Probation/Parole and Children and Youth Services.

B. Residency Requirement

1. It is the policy of the Berks SCA that an individual must have a minimum of three (3) months of established residency in Berks County in order to be funded by the Berks SCA for drug and alcohol services.

2. Individual's accessing Berks SCA funds must be able to furnish proof of Berks County residency. Acceptable proof of residency includes:

    a. valid PA drivers license
    b. rent receipts or utility invoices addressed to the individual from the 3 previous months
    c. verification from a Berks County emergency shelter as being a guest or accessing their services a minimum of 3 months prior to the access date
    d. other satisfactory documentation that indicates that the client has at least 3 months of Berks County residency prior to treatment access.

3. Residing in an institutional setting within Berks County does not constitute the establishment of Berks County residency. Institutions include but are not limited to the following:

    a. prisons/early release centers
    b. drug and alcohol treatment programs
    c. general/psychiatric hospitals
    d. transitional houses/group homes

4. An individual residing in an institution is eligible for Council funding if he or she can demonstrate 3 months of established Berks County residency prior to his or her admission/commitment into the institution.

5. Exception to the residency requirement may be made for those individuals with emergent care needs (i.e., detox).

C. Authorization/Re-Authorization

All treatment services funded by the Berks SCA must be authorized by the Berks SCA's Authorization Unit (TASC). The Berks SCA will not reimburse the treatment provider for assessment or intake nor will any treatment services be reimbursed if not authorized by the Berks SCA's Authorization Unit.

<u>Initial Authorization</u>

The LOC evaluator must adhere to the following when requesting treatment-funding authorization:

- Enter the necessary information into the STAR system. Non drug & alcohol facilities making an authorization request should fax the necessary information to the TASC Authorization Unit (610-375-4712)
- Fax a TASC consent to release information form allowing the TASC Authorization Unit to disclose information to the treating facility.

The TASC Authorization Unit will contact the LOC assessors within one (1) working day regarding the level of care for which funding is authorized. An authorization for funding will be issued which will include the effective from and the effective to dates of funding authorization.

Continued Stay (Treatment Extension)

Request for an extension of treatment stay must occur prior to the expiration of the current treatment authorization. The Berks SCA is not responsible for any continued stay treatment units not pre-authorized. The treatment provider must adhere to the following when requesting a continued stay (treatment extension) funding authorization:

- Enter the necessary information into the STAR system.
- Residential treatment providers must call TASC for pre-authorization of a continued stay at 610.988.0699.

The TASC Authorization Unit will contact the treatment provider within one (1) working day regarding the continued stay request. An authorization for funding will be issued which will include the effective from and the effective to date of funding authorization. If continued stay-funding authorization is not approved, the TASC Authorization Unit will discuss level of care transfer options with the treatment provider.

Level of Care Transfer

Request for a level of care transfer must occur prior to the expiration of the current authorization. The Berks SCA is not responsible for any treatment units not pre-authorized. The treatment provider must adhere to the following when requesting a level of care transfer funding authorization:

- Enter the necessary information into the STAR system.
- Fax a consent to release information form TASC Authorization Unit (if applicable) to disclose information to the allowing the new treating facility.

The TASC Authorization Unit will contact the treatment provider within one (1) working day regarding the level of care for which funding is approved. An authorization for funding will be issued which will include the effective from and the effective to date of funding authorization.

D. Encounters/Claims (Utilization/Billing)

1. Providers are to submit appropriately completed monthly encounters/claims by the 10th of the month following the provision of services. Those program encounters/claims not submitted by the 10th of the month may not be processed during that particular month.

2. All Berks County treatment providers must submit encounters/claims via entering information into the "Encounter" Screen in the STAR System*.

3. Providers will be sent an exception report of those services rejected and a revised encounters/claims report.

4. If approved by TASC's Authorization Unit corrected encounters/claims entries previously rejected may be re-submit with the following month's encounters/claims. The exception to this is June's submission, which is the final encounter/claims report for the fiscal year. This must be reconciled with TASC's Authorization Unit by a specific date in July, which will be designated each year by the Berks SCA.

E. Discharge

1. The treatment provider must enter discharge information into the appropriate Discharge Screen ("Detox Discharge" for clients being discharged from detoxification units or "Discharge" for clients being discharged from all other levels of care.) in the STAR System*****, within five (5) working days following the discharge.

2. No encounters/claims will be accepted for any services provided after the discharge date.

**** Until such time that the STAR System is fully operational and all functions are mandated by the Department of Drug and Alcohol Programs, the Berks SCA's Web Connect System will be utilized to accomplish this client management process.***

XVIII. STAR Treatment Information System

All drug and alcohol assessment and/or treatment contracted providers are required to utilize Pennsylvania Department of Drug and Alcohol Program's Strengthening Treatment and Recovery (STAR) Data System and adhere to all requirements and procedures as set forth by the Pennsylvania Department of Drug and Alcohol Program and the Berks SCA. The SERVICE PROVIDER is required to use the STAR Data System for all Berks SCA funded treatment and treatment related services including, but not limited to, client screening, client liability assessment, funding authorization, admission, service encounters, continued stay reviews and client discharge.

Until such time that the STAR is fully operational and mandated by DDAP, the Berks SCA's Web Connect System will be used to complete authorization and billing of client services.

The provider assumes full responsibility and liability for any breech in client privacy as a result of the provider's (or any of it's personnel's) inappropriate usage and/or managing of the client information viewed and/or inputted into the DDAP STAR and Berks SCA Web Connect systems.

XX. APPENDICIES