Section:	A.	DDAP Case Management and Clinical Services Manual
Section:	B.	Blair County Monitoring Requirements Screening Assessment Case Coordination
Section:	C.	ICM Referral Process
Section:	D.	CRS Referral Process

Section 5A: See DDAP Website for most current copy of the Case Management and Clinical Services Manual

DDAP website: https://www.ddap.pa.gov/Professionals/Pages/For_SCAs.aspx

Section 5B: Blair County Case Management Monitoring Requirements

Screening

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

Requirements Screening must be provided 24 hours a day, seven days a week. Screening can be conducted by telephone or in person. Initial referrals may come from many different entities including intake units, emergency departments, 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.
Whenever possible, screening must be done by speaking with the individual who may be in need of services. Screening by a contracted provider must be completed by utilizing the Intake and Screening Tool in PA Web Infrastructure for Treatment Services (PA WITS). Purposes of screening include:

1) To obtain information to ascertain if emergent care is needed in the following areas:
   a. Withdrawal Management
   b. Prenatal Care
   c. Psychiatric Care

2) To motivate and refer, if necessary, for a LOC assessment or other services. After-hours screening does not require the ability to schedule a LOC assessment.

3) To identify individuals being referred by an emergency room or urgent care facility following an overdose.

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

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

Option 2: Support staff may conduct screening in conjunction with skilled medical or human service professionals. And if needed, transfer the individual to a skilled professional to determine emergent care services; OR

Option 3: Support staff may conduct screening if the provider is able to demonstrate, through documentation to be provided during the onsite monitoring visit or upon DDAP

request, that the individual determining the need for a referral for emergent care services has a combination of education, training, and experience in the following areas:

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

The Contracted Provider must have written referral procedures to address emergent care services available during business hours and after-hours. If procedures are updated at any time by the contracted provider, the most current dated version of the policy must be signed off by all staff.
If the individual is in need of emergent care, those needs must be addressed at the time they are identified. All priority populations must be offered admission to treatment immediately.

All other individuals in need of withdrawal management at the time of screening, must be admitted to this level of care within 24 hours. If this timeframe cannot be met, the reason must be documented in the individual's file.

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

Assessment

Assessment Overview: DDAP defines assessment as the gathering of clinical and non-clinical information which is used to determine the most appropriate level of care (LOC) and any additional non-treatment needs that may impact placement and the recovery process. The contracted assessment providers must utilize PA WITS system to complete the requirements delineated below.

The SCA has discretion in determining whether SCA staff and/or contracted staff provide the following assessment activities:

1) LOC assessment using the Treatment Assessment Protocol (TAP)
2) Tuberculosis (TB)/Hep C/HIV Screening and Referral Services utilizing Miscellaneous Notes;
3) The Problem Gambling Screening and Referral Questions utilizing Miscellaneous Notes;
4) Case Management Service Plan or Recovery Plan as it is known in PA WITS; and
5) Placement Determination utilizing the most recent version of the ASAM Criteria and Guidance for Application of ASAM in PA's Substance Use Disorder (SUD) System of Care LOC Assessment and Placement Determination:

LOC assessment is defined as a face-to-face interview with the individual to ascertain treatment needs based on the degree and severity of alcohol and other drug use/abuse through the development of a comprehensive confidential personal

history, including significant medical, emotional, social, occupational, educational, and family information.

A LOC assessment must be completed within seven calendar days from the date of initial contact with the individual. The assessment must be completed in its entirety in one session prior to referring the individual to the appropriate LOC, except when the individual is in need of withdrawal management. If either of those timeframes are not met, the reason must be documented. A client who is admitted directly into withdrawal management without an assessment, cannot be admitted into any other LOC until the assessment is completed.

Once a LOC assessment is completed, it will be valid for a period of six months. The six-month timeframe does not pertain to active clients. This applies to individuals who have never engaged in treatment after being assessed or who have been discharged and are seeking to reinitiate services. An exception to this timeline may be made for individuals who were incarcerated during this six-month time period.
Specifically, time prior to being in the controlled environment may be considered. If an individual requests to reinitiate services prior to the end of the six-month period, the case manager may complete a follow-up TAP in lieu of a new one; however, a new ASAM Summary must be completed.

In order to determine the appropriate LOC, the individual conducting the LOC assessment must apply The ASAM Criteria. The ASAM Summary in PA WITS must be used to record and exchange client information necessary in making or validating placement determinations. The contents of the ASAM Summary must comply with state and federal confidentiality regulations. The ASAM Summary must reflect the LOC the client needs whether or not funding is available for a specific LOC.

In addition, the ASAM Summary should not be solely based on the LOC requested by the individual or referral source. If the level of care received is different than the level of care recommended, case notes should document attempts to engage the individual into clinically appropriate services. In addition, the ASAM requires the following areas be considered prior to placement in order to determine, and maximize retention in, a particular type of service:

1) Withdrawal Management may be considered for all levels of care, not only inpatient
2) Medication Assisted Treatment may be provided in concert with any LOC
3) Co-Occurring Disorders
4) Cultural/Ethnic/Language Considerations
5) Sexual Orientation and Gender Identity
6) Women with Dependent Children
7) Women’s Issues
8) Impairment (e.g. hearing, learning)
9) Criminal Justice Involvement

Level 0.5 Early Intervention
Level 1 Outpatient Services
Level 2
2.1 Intensive Outpatient Services
2.5 Partial Hospitalization Services
Level 3
3.1 Clinically Managed Low-Intensity Residential Services (e.g., Halfway House)
3.5 Clinically Managed High-Intensity Residential Services (Adult) / Clinically Managed Medium Intensity Residential Services (Adolescent)
3.5 Clinically Managed Highest-Intensity Residential Services (Adult) / Clinically Managed High Intensity Residential Services (Adolescent)
3.7 Medically Monitored Intensive Inpatient Services (Adult) / Medically Monitored High Intensity Inpatient Services (Adolescent)

Level 4 Medically Managed Intensive Inpatient Services

Referral and Admission to Treatment

All individuals must be referred to and admitted to the most appropriate LOC available within 14 days of the assessment excluding previously mentioned Priority Populations identified the DDAP Treatment Manual for whom admission must be immediate.

Individuals in need of withdrawal management must be admitted to treatment within 24 hours. If these time frames cannot be met, the reason must be documented in the individual's file. DDAP considers admission to treatment as the first attended appointment with a provider after the LOC assessment has been completed. A treatment episode is a combined service provided to an individual during a period of treatment and begins with the admission to treatment.
The substance abuse treatment episode should be assumed to have ended if the client has not received a treatment service in three days, in the case of inpatient or residential treatment or 30 days in the case of outpatient treatment.

TB/Hep C/HIV Screening and Referral Services DDAP collaborated with the Department of Health, Bureau of Communicable Diseases to develop questions in reference to assessing the need for referrals to appropriate TB services. These questions must be completed by contracted assessment providers by utilizing the Miscellaneous Note in PA WITS.

Coordination of Services Overview

DDAP defines Coordination of Services as a function of case management through which the SCA establishes an organized approach to coordinating service delivery to ensure the most comprehensive process for meeting an individual's treatment and non-treatment

needs throughout the recovery process. Through Coordination of Services, the SCA ensures that individuals with complex, multiple problems receive the individualized services they need in a timely and appropriate fashion. The process of Coordination of Services is intended to promote self-sufficiency and empower the individual to assume responsibility for his or her recovery.

Coordination of Services is a collaborative process that includes the following activities: engagement, evaluation of needs, establishing linkages, arranging access to services ensuring enrollment in the appropriate healthcare coverage, advocacy, monitoring, and other activities to address client needs throughout the course of treatment. Coordination of Services includes communication, information sharing, and collaboration, and occurs regularly with case management and/or provider staff serving the client within and between agencies in the community. The ASAM criteria should be applied throughout the course of treatment to ensure individualized person-centered care throughout the individual's course of treatment. The Contracted provider will comply with the Appendix E: Section 14 Coordination of Services policy and Section 16 Central Point of Contact.

Case Management File Content

Contracted assessment providers are required to have a complete record for every client to include the following in PA WITS:

1) Client Profile
2) Intake
3) Screening Tool
4) TAP
5) Miscellaneous Note for TB/Hep C/HIV Screening
6) Miscellaneous Note for Gambling Screening
7) ASAM
8) Admission
9) Program Enrollment
10) Case Management Service Plan / Recovery Plan
11) Discharge
12) Documentation of interim services using miscellaneous notes, if applicable
13) Case Management Notes, including admission and discharge notes, will be completed utilizing the encounter notes.

Notes must adequately describe the nature and extent of each contact to include the following:

a. Information gathered about the individual,
b. Analysis of the information to identify the individual's treatment and non-treatment needs,
c. Action to be taken to meet the individual's treatment and non-treatment needs, and
d. Case manager's signature or initials and date.

In addition, to the documentation required in PA WITS, the contracted providers must include the following information as part of a client's file:

a. Signed consent to release information forms
b. Acknowledgement of receipt of grievance and appeal policy
c. Acknowledgement of any limitations

Files that are maintained electronically must contain all required components, and a hard copy must be available upon request. Information maintained in a paper file, including signed consent to release information forms, acknowledgement of any limitations, and liability forms, must be made available for review upon request. All data must be entered into PA WITS within 7 days of the date the service was delivered.

Section 5C: Blair County Intensive Case Management Referral Process

Overview

What is Resource Coordination and Intensive Case Management?

The RC/ICM service can be a valuable resource for those individuals who have multiple and complicated needs due to their alcohol and substance use. By understanding the value of this resource, your agency will be better prepared to inform the individual of this resource and encourage engagement into the RC/ICM service. Depending on the extent of the individuals, it will determine which level of case will be provided

The primary activities of RC/ICM are:

- **Engagement - This is the process of establishing rapport between the case manager and the client.** The primary goal of this activity is to reduce the barriers that may stand in the way of the client entering or remaining in treatment/recovery activities. This step is essential in that it creates a foundation for working together. Clients who are experiencing difficulties need to feel confident and comfortable in expressing their concerns to a case manager. Engagement goes beyond informing clients about the available community resources, it is intended to identify and meet the client's immediate needs. Maintaining rapport with the client is critical in order to keep the client focused on addiction education and recovery.

- **Evaluation of the Client's Strengths and Needs – This is the process by which a client's needs are examined through the administration of the Determination of Needs Form (DON).** The role of the case manager is to encourage a client to recognize his/her own assets and how he/she can apply them in positive ways to attain the goals set forth in the service plan. It is also important to help the client identify those behaviors that may create barriers to obtaining his/her goals. The DON is formally reviewed every 60 days. Generally, clients are believed to support, and are motivated by, an approach through which he/she can identify his/her own strengths and abilities and take an active role in addressing specific domains.

- **Service Planning and Goal Setting - This includes the development of a client-driven service plan to address the specific needs identified.** The case manager will assist the client in developing a written service plan and in determining the sequence in which to address the areas of need. Service plan goals should be realistic, measurable, and mutually acceptable. The action steps are designed to work toward achieving goals and must be observable and time limited. This will help to ensure that a client does not become overwhelmed, especially during periods of transition or stabilization.

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

- **Monitoring – The process by which the case manager evaluates the progress toward the completion of goals identified in the service plan.** Monitoring can include regular review and adjustment of the service plan, and the assessment of available community resources.

- **Advocacy – The process of being a proponent for the client in helping to remove any obstacles that may prevent the client from obtaining necessary services.** Advocacy is geared toward, but is not limited to; achieving the goals identified in the service plan and may include acting as an intermediary between the client and another agency or entity.

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

- **Disengagement – A progressive process that occurs over the course of a client's involvement in ICM/RC services**. The client will begin to rely less on the case manager and more on his/her own abilities.

Resource Coordination/Intensive Case Management Referral Guidelines:

Adults/Adolescents

Blair County subcontracted agencies for assessment and treatment are required to screen individuals for non-treatment needs at the time of the initial assessment and ongoing during each level of treatment (if the client is not currently receiving RC/ICM services). The agency is responsible for the following steps:

1. Complete the Non Treatment Needs Initial Screening form. If the individual meets three or more of the domains or is a pregnant woman, the client must be offered a referral to RC/ICM services.

2. The agency will provide the individual with information concerning intensive case management. (The RC/ICM Case Management Overview, ensures staff are educated on this service)

3. If the individual refuses the service, the agency will document on the Non Treatment Needs Initial Screening form how identified needs were addressed. The agency will maintain these forms in the individual's chart.

4. If the individual accepts Case management services, the agency will have the individual sign a release of information for the Case Management Unit at the Blair County Drug and Alcohol Program, Inc. The agency will also complete and fax (814-381-0922) the following documents to the Case Management Unit:

    - Blair Co. Drug & Alcohol Program RC/ICM CM Referral Form-**Attachment 5Ca-ICM-RC Referral Form**
    - Blair Co. Drug & Alcohol Program Non Treatment Needs Initial Screening Form-**Attachment 5Cb-Non Treatment Needs Screening Form**

The Case Management Unit will make contact the individual within the appropriate times frames for identified RC/ICM services. The Case Manager will follow up with the agency on the outcome of this referral.

Section 5D: CRS Services

Overview

Certified Recovery Specialists will be individuals who have received the Certified Recovery Specialist credential from the Pennsylvania Certification Board (PCB). They will offer peer support and guidance to Blair County SCA and MA-eligible adults struggling with addiction issues or co-occurring substance abuse and mental health issues in need of outreach, mentoring and peer support at all stages of the recovery process.

The CRS will be responsible for outreach, support, and guidance for individuals in the identified target population. CRS services are not treatment in the clinical sense of the term; rather, CRS services are intended to extend and enhance the drug & alcohol treatment continuum. This occurs by assisting individuals in overcoming barriers and diminishing the gaps between their needs and available community resources, helping to prevent relapse, and promote sustained recovery. If relapse occurs the CRS will assist in minimizing the negative effects through early intervention, and when identified as appropriate compete a timely referral to treatment. Individuals involved with CYS, the criminal justice system, and those re-entering the community after release from jail may also benefit from this service.

Recovery Specialist services will be made available through face-to-face meetings and additionally by phone contact if needed. The Recovery Specialist will meet with eligible individuals on a one-on-one basis at various locations throughout the area, such as local restaurants or libraries, as well as at treatment facilities in and out of the county. Travel time is not a reimbursable service under this service description. Services offered by the Recovery Specialist will include outreach, mentoring, peer support and guidance, as well as resource information and referral. The Recovery Specialist will work closely with individual before, during and after their treatment experiences to support and assist them in their recovery, in understanding and navigating the system of care, as well as to encourage and guide any necessary connections with other service systems.

Individual-focused Recovery Plans will be developed by the individual and the Recovery Specialist within one month of enrollment, and reviewed every six (6) months thereafter. The Recovery Plan will be signed by both parties, and will specify individualized goals and objectives pertinent to the individual’s recovery and community integration in language that is outcome oriented and measureable. This plan will also identify interventions directed at achieving the individualized goals and objectives, as well as specify the Recovery Specialist’s role in relating to the individual, involved others, and the frequency the services will be delivered. The Recovery Specialist will work with the individual’s family, service and treatment providers, other programs, and natural supports to assist in the achievement of these goals.

Certified Recovery Specialist Services Referral Guidelines:

Adults

Blair County subcontracted agencies for assessment and treatment screen individuals for the need of recovery support treat at the time of the initial assessment and ongoing during each level of treatment (if the client is not currently receiving CRS services). The agency is responsible for the following steps:

1. The agency will provide the individual with information concerning CRS services. (The CRS Overview, ensures staff are educated on this service)

2. If the individual accepts CRS services, the agency will have the individual sign a release of information for Blair County Drug and Alcohol Program, Inc. The agency will also complete and fax (814-381-0922) the following documents to the CRS Supervisor:

    - Blair Co. Drug & Alcohol Program CRS Referral Form-Attachment 5Da

The CRS Unit will make contact with the individual within the appropriate times frames for identified CRS services.