



Pennsylvania
Department of Drug and
Alcohol Programs

CASE MANAGEMENT & CLINICAL SERVICES MANUAL

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PART I: GENERAL INFORMATION

1.00 Purpose and Use of the Manual

The mission of the Department of Drug and Alcohol Programs (DDAP) is to engage, coordinate and lead the Commonwealth of Pennsylvania's effort to prevent and reduce substance use disorders (SUD) and to promote recovery, thereby reducing the human and economic impact of the disease. This work is carried out in conjunction with the Single County Authorities (SCAs), their contracted providers, and the community at large. The SCAs have flexibility to develop their service delivery system in response to community needs.

DDAP has developed the Case Management and Clinical Services Manual (CMCSM) to comply with and convey the requirements of the [Substance Use, Prevention, Treatment and Recovery Services \(SUPTRS\) Block Grant](#) and [4 Pa. Code§ 257.4](#). The CMCSM provides guidance to SCAs and their contracted providers in delivering services to individuals with SUD and their families.

The SCA Grant Agreement takes precedence over the Prevention, Case Management and Clinical Services, Fiscal and Operations Manuals issued by DDAP, unless otherwise specified by DDAP or the Commonwealth, such as in Policy Bulletins or Management Directives. In addition, it may be necessary to issue temporary instructions, which will take precedence over material in this Manual. Any temporary instructions will clearly state the exception and include an expiration date.

PART II: SCA NEEDS ASSESSMENT AND PLAN

2.00 SCA Needs Assessment and Plan

To adequately plan for services most needed, SCAs must complete a Needs Assessment to identify any demographic changes that must be considered, current service use including capacity and access issues, and any other areas of concern, gaps or needs that should be addressed. The SCA Needs Assessment and subsequent Plan provide the opportunity for SCAs to present information to DDAP on how the SCA is providing services related to SUD in the most efficient and effective manner and at the most appropriate level of care to individuals in need of services. The information provided by the SCAs will significantly contribute to DDAP's ability to detect patterns of unmet need and provide strategic insight to improve the service delivery system.

SCAs are different in their geography, economics, population demographics, and density. Substance use trends and vulnerable populations change over time and across communities. These changes impact prevalence, incidence, and treatment demand estimates, which SCAs can use to match available resources with projected demand and plan for the development of new resources based upon needs. The Needs Assessment is a process through which the SCA uses reliable data to estimate the prevalence of SUD for people in its area. The Needs Assessment further identifies emerging SUD trends that may impact demand for treatment and services, methods to address SUD, and potential barriers to providing effective treatment and services.

The SCA should apply the information gathered, compiled, and analyzed through the Needs Assessment process to the development of the SCA Plan for the Delivery of Treatment & Services (SCA Plan). The SCA Plan is designed to assist SCAs in defining needs and developing the resources necessary to meet those needs.

The SCA Plan must:

- A. Describe trends and issues that were identified through the needs assessment process and how they will be addressed.
- B. Address outcomes separately with a plan of action to meet each objective.
- C. Describe the steps used for developing the plan, including the process for stakeholder input.
- D. Describe the fiscal impact of each plan of action and how the SCA will allocate funding to meet the need.
- E. Describe the SCA's quality management initiatives.
- F. Describe the manner through which individuals access services.

The SCA Needs Assessment and Plan must be completed and submitted according to the DDAP Report Schedule, and in accordance with the directions and any accompanying documents provided by DDAP.

PART III: SPECIAL POPULATIONS

3.00 Priority Populations

- A. The SCA and its contracted providers who serve an injection substance use population and who receive SUPTRS funds shall give preference to treatment as follows in the order outlined below.
 - 1) Pregnant women who inject drugs
 - 2) Pregnant women who use substances
 - 3) Persons who inject drugs
 - 4) Overdose survivors
 - 5) Veterans
- B. All individuals in these priority populations must have a level of care assessment (LOCA) and be offered admission into the recommended level of care. If the SCA or contracted provider cannot ensure admission to the recommended level of care immediately, the individual must be offered case management services as well as admission to another level of care. Any individuals in need of emergency care should be treated as outlined in Section 5.00.
- C. An SCA may not restrict access to admissions to treatment for priority populations even if it applies restriction to others.

3.01 Pregnant Women

Both the SUPTRS and CMCSM identify pregnant women who inject drugs and pregnant women who use substances as priority populations. The SCA and its contracted providers must adhere to the following steps:

- A. Screen the woman for emergent care needs.
 - 1) If emergent care needs are identified, make an immediate referral to the appropriate service.
- B. If no emergent care needs are identified and a LOCA is necessary, then conduct a LOCA to determine the need for treatment.
- C. If treatment is indicated, refer the woman to a treatment provider that has the capacity to provide treatment services to the woman immediately.

DDAP has provisions for narcotic treatment programs (NTP) that are at capacity but need to admit a pregnant woman for treatment of an opioid use disorder (OUD).

[28 Pa. Code § 715.29. Exceptions. \(pacodeandbulletin.gov\)](#) allows NTPs to request exceptions. NTPS may request an exception to admit a pregnant individual in writing to ra-licensuredivision@pa.gov and DDAP's Division of Program Licensure will review exception requests to increase capacity for any NTP on a case-by-case basis. If there are any questions regarding this process, contact DDAP's Bureau of Program Licensure at 717-783-8675.

- 1) If no treatment facility has the capacity to admit the woman immediately, then;
 - (a) Make support services such as case management or recovery support services available within 48 hours after the LOCA, and
 - (b) Make interim services available to the woman within 48 hours after the LOCA.
- 2) Interim Services are defined as services that are provided until an individual is admitted to a substance use treatment program. The purpose of interim services is to reduce adverse health effects of substance use, promote the health of the woman, and reduce the risk of transmission

of a disease until the woman is admitted to a treatment program. Interim services for pregnant women must include:

- (a) Counseling and education about Human Immunodeficiency Virus (HIV) and tuberculosis (TB);
 - (b) Counseling and education about the risks of needle sharing;
 - (c) Counseling and education about the risks of transmission to sexual partners and infants;
 - (d) Counseling and education about the steps that can be taken to ensure that HIV and TB transmission do not occur;
 - (e) Referral for HIV and TB treatment services, if necessary;
 - (f) Counseling on the effects of alcohol and drug use on the fetus; and
 - (g) Referral for prenatal care.
- 3) The SCA must maintain a resource list that clearly identifies, by physical address, phone number, and if applicable, website link, providers for each interim service. The title of each type of interim service must appear on the resource list exactly as written in the above list.
 - 4) The SCA must have written procedures that include the mechanism to maintain contact with the pregnant woman until admission into treatment occurs. Tracking of the pregnant woman must occur by the SCA or its contracted provider regardless of whether the woman is receiving interim services.
- D. The SCA must publicize the availability of preferential treatment services to pregnant women. The SCA may use street outreach programs, ongoing public service announcements on radio or television, regular advertisements in local or regional print media, posters placed in targeted areas, and frequent notification to the local network of community-based organizations, health care providers, and social service agencies.

Under the Taxpayer-Funded Transparency Act, [Act 2015-90](#), all DDAP-funded media advertisements, except media that is funded through the Compulsive and Problem Gambling Treatment Fund, must include the statement “Paid for with Pennsylvania taxpayer dollars.” Print ads must visibly display these words and broadcast advertisements must clearly have the statement read aloud during the ad. If the advertisement is broadcast or published free of charge, it does not need to include the statement.

Act 2015-90 applies to broadcast advertising such as television, radio, and other audiovisual advertising, as well as print advertising such as; print and electronic newspaper and magazine advertising, and billboards. Paid advertising includes media in formats such as; newspaper ads, paid digital media, radio ads, TV ads, billboards, shopping cart ads, etc. in which a third party is being paid to disseminate, broadcast, publish, or post the media. Paid advertisements do not include media in formats such as brochures, newsletters, flyers, posters, magnets, stickers, etc. where funds may be spent on printing/creation of the material/item, but not to disseminate, broadcast, publish or post the media.

If the SCA is utilizing a TikTok account for advertising, ads cannot contain live links to any DDAP or other Commonwealth websites or systems. The advertising must still include the statement “Paid for with Pennsylvania taxpayer dollars.”

3.02 People Who Inject Drugs (PWID)

The SCA must address the needs of PWID as follows:

- A. Screen all PWID for emergent care needs.

- 1) If emergent care needs are identified, make an immediate referral to the appropriate service.
- B. If no emergent care needs are identified and a LOCA is necessary, conduct a LOCA to determine the need for treatment.
- C. If treatment is indicated, refer all PWID to a treatment provider that has the capacity to provide treatment services immediately.
 - 1) If no treatment facility has the capacity to admit the individual, then;
 - (a) Make support services such as case management or recovery support services available within 48 hours after the LOCA, and
 - (b) Make interim services available to all PWID within 48 hours after the LOCA and arrange for admission to treatment 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.
 - 2) The definition for “Interim Services” is outlined in Section 3.01 of the CMCSM. At a minimum, interim services for PWID must include:
 - (a) Counseling and education about HIV and TB;
 - (b) Counseling and education about the risks of needle sharing;
 - (c) Counseling and education about the risks of transmission to sexual partners and infants;
 - (d) Counseling and education about the steps that can be taken to ensure that HIV and TB transmission do not occur; and
 - (e) Referral for HIV and TB treatment service, if necessary.
 - 3) The SCA must maintain a resource list that clearly identifies, by address, phone number, and if applicable, website, providers for each interim service. The title of each type of interim service must appear on the resource list exactly as written in the above list.

The SCA must have written procedures that include the mechanism to maintain contact with the individual until admission into treatment occurs. Tracking of the individual must occur by the SCA or its contracted provider regardless of whether the individual is receiving interim services.
- D. Ensure outreach activities are carried out for PWID who have not yet entered treatment. These outreach activities must be identified as Activity 7200 – Intervention for contracting and expenditure reporting. All activities are further defined in DDAP’s Fiscal Manual.
 - 1) The SCA must have written outreach procedures that identify the following:
 - (a) The specific staff responsible to oversee outreach activities and the oversight process.
 - (b) The SCA staff or contracted provider responsible to perform outreach;
 - (c) The training provided to outreach workers;
 - (d) The specific outreach activities;
 - (e) The process to contact and follow up with PWID;
 - (f) The process to inform PWID of the relationship between injection drug use and communicable diseases like HIV;
 - (g) The process to inform PWID of methods to prevent the transmission of such diseases; and
 - (h) The process to encourage entry into treatment.

- E. Require contracted providers who treat PWID to notify the SCA within seven days upon reaching 90 percent of its capacity to admit individuals to the program.
 - 1) The SCA must have a policy and procedure in place that include:
 - (a) The process for treatment providers to notify the SCA;
 - (b) The individual responsible for notifying the SCA;
 - (c) A method for the SCA to track the information received from the provider; and
 - (d) The process for the SCA to inform other contracted providers.

3.03 Women with Children

- A. The SCA shall ensure that contracted providers who deliver services to pregnant women, women with dependent children, and women who are seeking custody of their children treat the family as a unit, when appropriate, and provide or arrange for the provision of the following services:
 - 1) Primary medical care for women, including a referral for prenatal care, as well as childcare while the women are receiving medical care;
 - 2) Primary pediatric care, including immunization, for their children;
 - 3) Gender-specific substance use treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, and parenting, as well as childcare while the women are receiving these services;
 - 4) Family therapy, nutrition education, and education to GED level;
 - 5) Therapeutic interventions for the children in the custody of the women receiving treatment services which may address, among other things, the children's developmental needs, issues of sexual and physical abuse, and neglect; and
 - 6) Case management and transportation to ensure those women and their children have access to the services provided in all items listed above.
- B. The SCA must maintain a current resource list that identifies, by address, phone number, and if applicable, website, a provider for each service listed above.
- C. DDAP is required to as a condition of the SUPTRS federal block grant to expend an amount equal to the amount expended by the Commonwealth during FFY 1994 on programs designed for the Pregnant Women With Children (PWWWC) population. The objective is to improve and expand SUD services to this priority population, either directly or through arrangements with other public or non-profit entities.

DDAP allocates SUPTRS funding for the PWWWC population to all SCAs under Appropriation 70-963 through their grant agreements. SCAs are required to provide treatment through a continuum of care (including MAT), as well as to provide or facilitate ancillary services (such as shelter, health services, case management services, day-care, peer supports etc.) to assure the holistic wellness for this population. The client must have custody or be in the process of regaining custody of their children for the SCA to use PWWWC dollars.

SCAs that do not meet the expenditure amount for the previous SFY dedicated to their SCA will be required to complete an outreach and referral plan focusing on PWWWC. The outreach and referral plans will be submitted to DDAP for approval prior to implementation. SCAs must report on their outreach efforts at least every 60 days for 12 months to ensure continued efforts. SCAs can submit reports to the Treatment Resource Account at: RA-DATREATMENT@pa.gov

3.04 Overdose Survivors

DDAP defines an overdose as a situation in which an individual is in a state requiring emergency medical intervention as a result of the use of drugs or alcohol.

DDAP is identifying individuals who have overdosed as an additional priority population to better facilitate access to care directly following an overdose event.

- A. Admission to treatment for individuals who have overdosed must be considered in conjunction with the requirements delineated in Part III - Special Populations in the CMCSM.
- B. Warm Handoff Policy (WHO):

To ensure expedient, appropriate, and seamless care for all individuals who have overdosed from any substance or who have been admitted into a hospital for other reasons and identified as needing SUD treatment services, SCAs must develop, implement, and maintain a plan for screening, assessing, referring to treatment, and tracking individuals. The SCA must coordinate with local hospitals to address the needs of individuals who have experienced an overdose or who are hospitalized and identified as needing SUD treatment services to develop a policy and procedures, which must be approved by DDAP's Treatment Section and include the elements below:

- 1) Details or process by which an individual who experienced an overdose or who are hospitalized will be offered a 24/7 direct referral from the Emergency Department (ED) to treatment by one or any combination of models noted below;
- 2) The hospital(s), the SCA and provider(s), as applicable, must have on file any Memorandum of Understanding (MOU) or Letter of Agreement (LOA) that may apply;
- 3) Timelines for the referral processes;
- 4) A mechanism for tracking referrals or refusals for treatment; and
- 5) Completion of DDAP's warm handoff monthly report in accordance with DDAP's Report Schedule.
- 6) Identify situations in which telehealth-only services would be used and what procedures would be in place.

The warm handoff policy and procedures must include one or more of the following models:

- 7) **SCA Agency Model:** The SCA staff provides LOCA services for local healthcare facilities and EDs. The SCA must establish procedures for referral to treatment during evenings, weekends and holidays.
- 8) **Contracted Provider Model:** The SCA contracts with one or more providers such as case management units, treatment providers, or crisis intervention providers to perform the following services within area hospital EDs:
 - (a) screening
 - (b) LOCA
 - (c) referral to services
- 9) **Certified Recovery Specialist (CRS) Model:** CRSs provide screening and referral to a provider qualified to conduct the LOCA and referral to treatment. The CRS can be employed by the SCA or a contracted provider. The CRS cannot complete a LOCA.
- 10) **Treatment Provider Model:** The SCA contracts with a local treatment provider and monitors to ensure staff are performing the following services within hospital EDs:
 - (a) screening

- (b) LOCA
- (c) referral to services

This may already be occurring as a courtesy or referral source by treatment providers to local healthcare facilities and EDs. In some instances, the treatment provider may be hospital owned/affiliated.

- 11) **Direct Referral to Treatment by Hospital Staff Model:** The hospital Social Worker, withdrawal management personnel, or other hospital staff assists a patient with referral directly to SUD treatment. This may occur through a special arrangement that the SCA has with the hospital or by the hospital staff, independent of the SCA. It is expected when necessary, that the SCA would be engaged in some level of relationship/arrangement with the hospital or receiving treatment provider as it relates to warm handoff reporting and authorization of funding, when necessary.
- 12) **DDAP Approved Model:** The SCA can present another alternative not otherwise mentioned in this Section, or a combination of any of the above for DDAP approval.

3.05 Veterans

The SCA and contracted providers are required to address the needs of veterans as follows:

- A. Provide the full continuum of treatment services to veterans;
- B. Conduct screening and LOCA services;
- C. Use the ASAM Criteria, 2013 to determine the appropriate level of care;
- D. Make a referral to treatment; and
- E. Provide additional case management services as appropriate.
- F. If the facility operated by the U.S. Department of Veterans Affairs (VA) is determined to be the most appropriate facility to provide treatment for the veteran, the SCA or contracted provider must directly connect the individual to the admitting provider, and the SCA or contracted provider must confirm that the veteran was admitted as planned. The SCA must do more than provide contact information to a veteran. The SCA may continue to provide Case Management Services while the veteran is in the VA facility.
- G. The SCA cannot deny funding to a veteran based on eligibility for VA benefits. The SCA must offer the recommended level of care to the veteran regardless of the funding source.

PART IV: SERVICE CONTINUUM

4.00 Continuum of Care

- A. To ensure placement for all individuals in the proper level of care, the SCA and its contracted providers must use The ASAM Criteria, 2013 and offer the full range of SUD treatment and services described in the full continuum of care. SCAs must ensure that the SUD providers in its network comply with program standards in the ASAM Criteria, 2013 included but not limited to, admission criteria, discharge criteria, interventions/types of services, hours of clinical care, and credentials of staff as set forth in the [ASAM transition requirements](#).
- B. The development of a provider network must include the full continuum of care as outlined below:
 - 1) Early Intervention (adult, adolescent);
 - 2) Outpatient (adult, adolescent);
 - 3) Intensive Outpatient (adult, adolescent);
 - 4) Partial Hospitalization (adult, adolescent);
 - 5) Clinically Managed Low-Intensity Residential Services (e.g. Halfway House) (adult, adolescent);
 - 6) Withdrawal Management (adult);
 - 7) Clinically Managed High-Intensity Residential Services (adult);
 - 8) Clinically Managed Medium-Intensity Residential Services (adolescent);
 - 9) Medically Monitored Intensive Inpatient Services (adult);
 - 10) Medically Monitored High-Intensity Inpatient Services (adolescent);
 - 11) Medically Managed Intensive Inpatient Services (adult, adolescent).

4.01 Halfway House Treatment Setting

- A. A substance use disorder halfway house is a licensed treatment program at the ASAM 3.1 LOC. The halfway house setting must provide a home-like atmosphere within the local community, be accessible to public transportation, and provide opportunities for independent growth and responsible community living. Mutual self-help, assistance in economic and social adjustment, integration of activities of daily living and development of a sound recovery program are requirements of halfway houses.
- B. New halfway house programs must work with DDAP's Licensing Division to obtain an Inpatient Non-Hospital Residential Treatment license and complete the halfway house application process with DDAP's Treatment Section before it is approved and is to accept residents into the 3.1 LOC.
- C. The process to establish a halfway house is:
 - 1) An applicant requests a halfway house information packet by emailing the Treatment Section RA-DATREATMENT@pa.gov.
 - 2) The applicant submits the [Request for Licensing Application Packet](#) to the licensing division in accordance with instructions on the form. The box for inpatient non-hospital halfway house must have a checkmark.
 - 3) Licensing Division sends an email to the Treatment Section's RA account (RA-DATREATMENT@pa.gov) to notify the Treatment Section.

- 4) Treatment Section staff contact the applicant to begin the halfway house application process and provide a checklist of required documents for the application. Correspondence from the applicant notifying the SCA where the county in which the facility is located indicating its intent to open a halfway house. The application will include:
 - (a) Facility full name, facility number, address, telephone number, and director;
 - (b) Halfway house capacity including total beds, male/female ratio, and focus on any special populations;
 - (c) A copy of the DDAP License for inpatient non-hospital residential treatment;
 - (d) A description of frequency and length of:
 - i. Individual Therapy
 - ii. Group Therapy
 - iii. Peer Groups
 - iv. Community Meetings
 - v. Educational Groups
 - (e) A description of the following Support Services and how individuals will access them at the facility or in the community:
 - i. Public transportation
 - ii. Transportation provided by the facility to employment and appointment
 - iii. Educational services
 - iv. Employment opportunities
 - v. Job training
 - vi. Vocational services
 - vii. Healthcare
 - viii. Recreational activities
 - ix. Life skills
 - x. Social services
 - xi. Mental health services
 - (f) A copy of the floor plan and description of the physical structure to include the following:
 - i. Independent physical structure;
 - ii. Independent food preparation and dining area;
 - iii. A description of how the facility promotes self-sufficiency and independent living; and
 - iv. Job descriptions and proposed staff composition and qualifications.
- D. Submit completed halfway house applications to The Pennsylvania Department of Drug and Alcohol Programs via email at RA-DATREATMENT@pa.gov with a copy to the SCA where the facility is located.
- E. Staff from the Treatment Section will review the halfway house application and contact the halfway house provider if any additional information or clarification is necessary. Treatment Section staff will conduct a site visit within 30 business days of receipt of the halfway house application to determine whether the facility meets all definitions, programmatic, and funding requirements. A representative from the local SCA must also be present at the site visit.
- F. If the location of a halfway house changes, the provider must submit a new request for approval within 90 days of the location change.
- G. DDAP will send a letter of notification approving or denying the application to the local SCA and treatment facility. If the application is denied, the provider must submit a written appeal to the

Director, Bureau of County Program Oversight within ten business days of the mailing date of the denial to RA-DATREATMENT@pa.gov.

- H. A halfway house that seeks to increase its capacity above 30 beds should obtain written approval from DDAP's Bureau of Program Licensure, and DDAP's Treatment Section, within the Bureau of County Program Oversight within the Division of Prevention, Treatment, and Recovery. Requests to DDAP must be sent to the RA Account listed in Section 4.01, D.
- I. Halfway houses should notify DDAP of changes to contact personnel at the facility and respond to biannual outreach efforts from DDAP's Treatment Section to confirm and update facility information.
- J. The SCA may use DDAP funds only for a halfway house that:
 - 1) Has an inpatient non-hospital residential treatment license for the specific facility where the halfway house activity is provided;
 - 2) Is an independent physical structure containing no more than 30 beds;
 - 3) Provides no other licensed treatment activity within the same physical structure; and
 - 4) Has been approved as a halfway house by DDAP.
- K. The SCA may not establish a rate for a new halfway house or enter into a contract prior to receiving written approval by DDAP.

4.02 Emergency Housing Services

- A. The SCA may provide emergency shelter and housing services to homeless or near homeless individuals who agree to participate in SUD treatment, self-help groups, or other recovery support services.
- B. The SCA shall ensure that DDAP funds are used only when housing assistance from other agencies is not available.
- C. SCAs may authorize housing services for up to seven days prior to the LOCA being completed; however, the SCA may not make payment until the individual has had a LOCA by the SCA or one of its contracted providers.
- D. Use of DDAP funds is limited to 60 days per individual per state fiscal year. The SCA must give written notice of the time limit and obtain the individual's signature on the notice to verify receipt of the information.
- E. An individual who is determined to need SUD treatment, self-help groups, or other recovery supports must agree to participate in such services and follow all recommendations in order for the SCA to continue to pay for emergency housing services. The SCA must give notice of the requirement to participate in services to the individual. The individual's signature must be obtained to verify receipt of the information.

4.03 Recovery Housing

[Act 59 of 2017](#) defines a drug and alcohol recovery house as housing for individuals recovering from drug or alcohol addiction, which provides those individuals with a safe and supportive drug and alcohol-free environment that may include peer support and other recovery support services.

- A. SCAs may contract with or make referrals only to licensed recovery houses. In addition, SCA-funded treatment facilities will be permitted to make referrals only to licensed recovery houses.

- B. Any individual receiving recovery house funding from the SCA must be screened and, if appropriate, receive a LOCA. The individual’s referral to recovery housing must come from the SCA or one of its contracted providers to be eligible for SCA funding.

4.04 Medications for Substance Use Disorders

Medication-assisted treatment (MAT) is the use of medications combined with [counseling and behavioral therapies](#), to provide a “whole-patient” approach to the treatment of substance use disorders. [Medications](#) are approved by the Food and Drug Administration (FDA) and are clinically driven and tailored to meet each patient’s needs. Retrieved from [Medications for Substance Use Disorders | SAMHSA](#)

- A. The coordination of care between therapeutic and pharmaceutical interventions is critical. Individuals with SUD who have a disorder for which there is an FDA-approved medication treatment must have access to those treatments based upon their individual needs and preferences. SCAs must:
 - 1) ensure the availability of FDA-approved medication and assist with payment for medication;
 - 2) educate individuals about MAT options;
 - 3) ensure medication and clinical therapeutic interventions are available in all levels of care, even if the SUD treatment provider is not the prescriber of the medication;
 - 4) ensure that the individual’s needs are met directly or through an appropriate referral to a prescriber;
 - 5) ensure that treatment and non-treatment providers do not exclude individuals on MAT from being admitted into services;
 - 6) ensure coordination of care, with proper consent occurs in situations where a prescriber and the SUD treatment provider are not the same;
 - 7) ensure contracted providers admit and provide services to individuals who use MAT for SUD;
 - 8) ensure provider capacity is sufficient to treat individuals who use MAT for SUD;
 - 9) provide information and referral regarding access to MAT to individuals who can obtain medications through other resources, such as medical assistance or third- party insurance.
- B. All treatment, including medication, must be individualized. SCAs may not place limits on a type of service or medication or restrict the length of service.
- C. DDAP will identify state or federal funds that are available only to providers that permit use of FDA-approved medications in the treatment of SUD. Contracted providers that restrict admission based upon medication use may not receive those funds to treat any individual or provide any type of prevention, intervention, treatment, or treatment- related service.
- D. An SCA may only use DDAP funds to pay for MAT, other than methadone, for individuals who have either:
 - 1) Had a LOCA and are in the process of placement into licensed SUD treatment;
 - 2) Enrolled in licensed SUD treatment; or
 - 3) Successfully completed licensed SUD treatment.

4.05 Recovery Oriented Systems of Care

DDAP supports the concept of Recovery-Oriented Systems of Care (ROSC). The foundation of this approach includes: accessible services; a continuum of services rather than crisis-oriented care; culturally competent care that is age and gender appropriate; and is embedded in the person’s community and home using natural supports. According to social belonging and inclusion are parts of the foundation for recovery and

should not be seen as a benefit of participating in recovery activities.¹ Creating recovery-oriented systems of care requires a transformation of the service system as it shifts to becoming responsive to meet the needs of individuals and families seeking services.

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

SCAs are encouraged to implement these strategies throughout their practices and the practices of their providers.

Elements of a ROSC

- A. Person-centered
- B. Family and other ally involvement
- C. Inclusion of the voices and experiences of recovering individuals and their families
- D. Promoting access and engagement
- E. Individualized and comprehensive services across the lifespan
- F. Systems anchored in the community
- G. Ensuring continuity of care
- H. Partnership-consultant relationships
- I. Strength-based
- J. Culturally responsive
- K. Responsiveness to personal belief systems
- L. Commitment to peer recovery support services
- M. Integrated services
- N. System-wide education and training
- O. Ongoing monitoring and outreach
- P. Outcomes driven
- Q. Research-based
- R. Adequately and flexibly financed
- S. End stigma and discrimination
- T. Promote the highest level of autonomy

These guidelines were adapted from Center for Substance Abuse Treatment, National Summit on Recovery Conference Report (2005).

¹ *Recovery-Oriented Systems of Care: A perspective on the past, present, and future | Alcohol Research: Current reviews.* (2021b, July 22). <https://arcr.niaaa.nih.gov/volume/41/1/recovery-oriented-systems-care-perspective-past-present-and-future>.

4.06 Harm Reduction

Harm Reduction is an approach that uses person-centered, evidence-based public health strategies to assist people who use drugs (PWUD) in minimizing the negative consequences associated with substance use. Harm reduction operates on the individual's terms without coercive measures or linking access to services with treatment or abstinence requirements by embracing the philosophy of "meeting people where they are at." It celebrates "any positive change" as a successful intervention.

SAMHSA's [Harm Reduction Framework](#) is a roadmap of principles and pillars that SCAs can incorporate into their work. This framework conceptualizes harm reduction as:

- A. A set of services that help people reduce the risks of harmful drug use, that includes everything from naloxone distribution to evidence-based treatment.
- B. An approach that encompasses the principles and pillars of harm reduction (as outlined in SAMHSA's framework). A harm reduction approach can be applied across the full continuum of SUD services and is a way to make SUD services more accessible for marginalized communities; and
- C. A type of organization. Community-based harm reduction programs (CHRP) are organizations where people with lived and living play a significant role in directing the organization's harm reduction initiatives, programs, and services. CHRPs also offer the core practice areas, as permitted by law. Harm reduction activities may be integrated into a comprehensive, person-centered program of care that includes treatment services and meets the specific needs of the community in which the program is housed.

Any organization that engages with PWUD is encouraged to adopt and apply practices and principles outlined in SAMHSA's framework to enhance the services they offer and integrate a harm reduction approach to the spectrum of SUD services.

Applying a harm reduction approach will help SCAs and their contracted providers fulfill their requirements as outlined below, including:

- 1) **Outreach Activities:** SCAs must conduct outreach activities to people who use substances who have not yet entered treatment.
 - (a) Outreach activities should center the needs of people who currently use substances.
 - (b) Staff conducting outreach services should have a working understanding of the current, dynamic, and rapidly changing landscape of substance use in their community.
 - (c) Harm reduction-oriented outreach emphasizes kindness and autonomy in the engagement of people who use drugs.
 - (d) Outreach should be proactive in offering people who use drugs support to access health and social services, including additional SUD prevention, treatment, and recovery services.
- 2) **Interim Services:** Services provided until an individual is admitted to a substance use treatment program.

Counseling and education provided as interim services are an opportunity to share harm reduction strategies with people who use substances that include safer injecting strategies, safer sex strategies, provision of harm reduction supplies (e.g. condoms, naloxone and drug testing strips), overdose prevention education, and, if available, referral to local harm reduction providers.
- 3) **Resource Lists:** The SCA must maintain a resource list that clearly identifies providers for interim services.
 - (a) SCAs can include local harm reduction providers on their resource list.

- (b) These lists should also include services that provide culturally appropriate services to subsets of the community including Black, Latino, American Indian and Alaska Native persons, Asian Americans, and other persons of color; members of religious minorities; LGBTQI+ persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely impacted by persistent poverty or inequality.

SAMHSA’s framework includes a compilation of additional best practices and specific services, with descriptions and citations of evidence. SCAs should use this framework to allocate resources to support harm reduction practices (within the limits of current state and federal law).

D. SCAs may use DDAP and SAMHSA funds for harm reduction strategies including:

- 1) Access to low-barrier services, including use of mobile and street outreach programs to connect with people where they are at.
- 2) Overdose prevention education and distribution of overdose prevention supplies including opioid reversal medication and personal drug testing strips.
- 3) Education about health issues such as HIV, STIs and viral hepatitis and distribution of safer sex kits and FDA-approved home test kits.
- 4) Distribution of safer smoking and injection supplies to reduce infections and transmission of infectious diseases such as wound care supplies, sharps disposal containers, and/or written materials about safer injecting and smoking practices. This does not include sterile needles, syringes, pipes and drug paraphernalia.
- 5) Navigation and referral to public health services such as infectious disease screening, treatment, and prevention.
- 6) Navigation and referral to medications for substance use disorders.

Harm reduction approaches, initiatives, programs, and services support individuals on their journey towards positive change, as each person defines it for themselves. Support is based on what each person who uses substances identifies as their personal needs and goals (not what SCAs or providers think they need), offering people tools to thrive. Ideally, people in need of support in the SCA should have access to low-barrier treatment services that offer a whole-person approach and rapid re-initiation, if needed.

PART V: CASE MANAGEMENT

5.00 Case Management Overview

[SAMHSA's Tip 27: Comprehensive Case Management for Substance Abuse Treatment](#) describes case management as a coordinated approach to the delivery of health, substance use, mental health, and social services, and linking individuals with appropriate services to address specific needs and achieve stated goals. Case management offers the individual a single point of contact, is individual-driven and driven by individual need, community-based, pragmatic, anticipatory, culturally sensitive, involves advocacy, must be flexible, and requires particular knowledge, skills, and attitudes.²

According to The ASAM Criteria, 2013 case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes.³

- A. The SCAs and its contracted providers must offer case management as a separate and distinct service from treatment that addresses all relevant aspects of an individual's path to recovery. Case management includes screening, LOCA, assessment of treatment-related needs, coordination of services, continued stay reviews, and ongoing management of an individual's needs throughout treatment and recovery.
- B. If the SCA contracts with a treatment provider to perform case management, the two services must be conducted either by two separate staff members or at two separate times. The treatment provider may not perform both treatment and case management services during a therapy session.
- C. All individuals who present for SUD services must be screened and, if appropriate, referred for a LOCA.
- D. When an individual comes to the SCA office from outside the county, the SCA will provide assistance regardless of the county of residence and should coordinate with the home SCA.
- E. The SCA must offer ongoing case management services to all individuals with SUD and may choose to offer case management to families. The SCA must coordinate and track services it funds even for individuals who do not accept case management services.
- F. The SCA and their providers must offer case management services within the community. Some examples of places to provide community-based case management include:
 - 1) Individual's home
 - 2) Library
 - 3) Restaurant
 - 4) Park
 - 5) Recovery Center
 - 6) Treatment Provider
 - 7) Correctional Facility
 - 8) Hospitals/Doctor's offices
 - 9) County Assistance Offices

² Levin, Saul M. M.D., M.P.A., Greene, Jeanie Ahearn, M.S.W. Case Management for Substance Abuse Treatment: A Guide for Administrators Desk Reference Based on Treatment Improvement protocol (TIP) 27. DHHS Publication No. (SMA) 00-3396. Printed 2000

³ The ASAM Criteria, 2013" used throughout this document is referencing the full ASAM text: Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, eds. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies®, 2013.

10) Schools

5.01 Low Barrier Models of Care

According to [SAMHSA's Advisory: Low Barrier Models of Care for Substance Use Disorders \(samhsa.gov\)](https://www.samhsa.gov), low barrier care is a model of treatment that seeks to minimize the demands placed on individuals and makes services readily available and easily accessible. This model provides a non-judgmental and welcoming environment which ultimately can encourage individuals to seek help without the fear of stigma or discrimination. Aspects of the low barrier model can be seen in case management services.

A. Some examples of approaches for the low barrier model are:

- 1) Multidisciplinary care teams;
- 2) Integrating SUD screening & assessment;
- 3) Involving those with lived experience;
- 4) Educating primary care physicians and other providers;
- 5) Developing collaborative care protocols;
- 6) Offering flexible treatment options;
- 7) Eliminating service engagement preconditions;
- 8) Addressing stigma;
- 9) Establishing referral networks and evaluating.

SCAs are encouraged to implement these strategies throughout their practices and the practices of their providers. This flexible, person-centered approach has been shown to improve recovery-based outcomes for individuals and communities affected by substance use and use disorders.

5.02 Social Determinants of Health (SDOH)

The US Department of Health and Human Services [defines social determinants of health \(SDOH\)](#) as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

SDOH provides a person-centered perspective that gives insight into the interrelated aspects of health and wellbeing as well as how an individual may respond to substance use disorder treatment based on their strengths and weaknesses.

Addressing SDOH can accelerate progress towards [health equity](#), which the World Health Organization defines as the absence of unfair, avoidable, or remediable differences among groups of people. Health equity includes the right of all individuals to access high quality and affordable health care, services, and support⁴. Addressing SDOH is crucial for achieving health equity for individuals to reach their highest potential. When case management staff assess a person's SDOH needs they are focusing on holistic care that can bolster treatment engagement and retention. SCAs are encouraged to address SDOH in their case management practices increasing the chance of positive health outcomes.

Completing an SDOH screening is helpful in identifying individual needs. Those needs must be identified and monitored using the Case Management Service Plan (CMSP) along with what interventions and referrals are used to assist the individual in goal attainment. The SCA shall use the SDOH screening tool located in Appendix D to assist with coordination of services which is described in section 5.06.

⁴ World Health Organization: WHO. (2021, July 7). *Health equity*. https://www.who.int/health-topics/health-equity#tab=tab_1

5.03 Screening

- A. Screening is the first activity provided to an individual who seeks to access services. Screening evaluates the need for emergent care services including withdrawal management, prenatal, and psychiatric services.

The purposes of screening include:

- 1) To obtain information to determine the need for emergent care in the following areas:
 - (a) Withdrawal Management
 - (b) Prenatal Care
 - (c) Psychiatric Care
 - 2) To motivate and refer, if necessary, for a LOCA or other services. After-hours screening does not require the ability to schedule a LOCA immediately;
 - 3) To identify individuals being referred by an emergency room or urgent care facility following an overdose.
- B. SCAs must make screening available 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, EDs, 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.
- C. Whenever possible, screening must be done by speaking with the individual who may need services.
- D. Screening must be completed using the Intake and Screening Tool in [PA Web Infrastructure for Treatment Services \(PA WITS\)](#).
- E. SCAs and contracted providers may conduct screening in the following three ways.
- 1) Option 1: Individuals conducting screening are skilled medical or human service professionals (e.g. ED triage nurse, crisis intervention caseworker, SCA case manager, counselor) proficient in identifying the need for a referral for emergent care services through a combination of education, training, and experience; or
 - 2) Option 2: Support staff 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
 - 3) Option 3: Support staff conduct screening if the SCA is able to demonstrate, through documentation 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:
 - (a) Psychiatric (identification of suicide and homicide risk factors);
 - (b) Prenatal (identification of alcohol and other substance use effects on the fetus); and
 - (c) Withdrawal Management (pharmacology, basic addiction, identification of drug interactions).
- E. The SCA must have written procedures for referrals to emergent care services during business hours and after-hours. The SCA must date and have all staff sign all updates.
- F. The SCA must meet emergent care needs at the time they are identified. If this timeframe cannot be met, the reason must be documented in the individual's file.

- G. Any time a screening is not completed for an individual, the SCA or the contracted provider must document the reason in the individual's file.

5.04 Assessment and Placement Determination

DDAP defines an assessment in accordance with The ASAM Criteria, 2013 as an evaluation of an individual's strengths, resources, preferences, limitations, problems, and needs and determines priorities for an individual's treatment.

A LOCA is a face-to-face interview to ascertain the treatment and treatment-related needs of an individual based on the degree and severity of substance use and the treatment and treatment-related needs of the individual based on the six dimensions of The ASAM Criteria, 2013.

- A. Individuals shall be referred to the appropriate LOC indicated through the completion of a [LOCA tool](#), [ASAM Summary](#), and [Risk Rating](#).
- B. The SCA and its contracted providers must assess individuals and meet their individualized treatment and treatment-related needs through the SCA provider network.
- C. Contracted providers who complete LOCAs must maintain neutrality when referring individuals into a specific level of care, a specific facility, or provider.
- D. The SCAs and its contracted providers must use a tool that includes the following components:
 - 1) education: literacy, degree to which substance use has interfered with education;
 - 2) employment: degree to which substance use interferes with employment; current employment, length and placement of employment, employment history;
 - 3) military: eligibility for VA benefits, combat experience/potential trauma issues, injuries related to military service;
 - 4) physical health: chronic and current acute medical conditions; past and present medications, are medications taken as prescribed, pregnancy, and TB questions;
 - 5) substance use history: type and frequency, date of first and last use, amount, and route of administration, length, patterns and progression of use, impact on behavior and relationships with others; treatment history;
 - 6) abstinence and recovery periods: recovery support systems, periods of abstinence; periods of active recovery;
 - 7) behavioral health: cognitive functioning; mental health symptoms, current and past treatment; hospitalizations, suicidal/homicidal ideations or attempts; psychotropic medications;
 - 8) family/social/sexual: child custody/visitation, childcare arrangements, risky behaviors; relationship status; family supports;
 - 9) spiritual: spiritual identity;
 - 10) living arrangements: current living arrangements, supportive recovery environment;
 - 11) abuse: history of abuse, issues that might impact placement;
 - 12) legal: probation/parole status, conviction record to include disposition, current and pending charges;
 - 13) gambling: lack of control in frequency of betting, lack of control over amount bet, lying about how much is bet;
 - 14) potential barriers to treatment: other areas that may impact treatment (i.e. transportation, cultural/language, childcare needs);

15) assessment summary: clinical impressions, strengths, needs, special considerations.

E. Telehealth Assessments

To remove barriers and assure widespread accessibility for services, the SCAs and contracted providers who perform LOCAs may use telehealth services. The SCA and providers must develop policies and procedures around the implementation of telehealth LOCAs.

Policies must address various components to include security, privacy, and confidentiality components specific to telehealth, including private space for services for the SCA or contracted provider and the client; network security; when is it clinically appropriate or not appropriate to do telehealth; informed consent of individual for telehealth and an in person option for LOCAs; releases of information whether signed in-person or electronically; staff training on use of equipment; on-going staff training on regulations/guidance, crisis situations, cultural considerations, accommodations via interpreter or electronic communication device.

- 1) Technology used for telehealth should be capable of presenting sound and image in real-time and without delay. Telehealth equipment should clearly display the practitioners' and participants' faces to facilitate the assessment. Smartphones with video on would be acceptable. Audio only (telephone) should only be used after all other options have been considered and deemed not possible. The reason for audio only assessments must be documented in the individual's file.
- 2) Individuals receiving assessments should receive education and training on the telehealth process and technology platform. Training should include security, privacy, and confidentiality components specific to telehealth such as private space for services.
- 3) Specific consent must be obtained from the individual to record the session.
- 4) The SCA should collect no show rates for both telehealth and in-person for comparison purposes.
- 5) The SCA should conduct satisfaction surveys with telehealth services on a regular basis.

F. The individual conducting the LOCA must apply The ASAM Criteria, 2013 to complete the ASAM Summary and Risk Rating. The ASAM Summary is a multidimensional assessment of the strengths and needs of the individual and the Risk Rating addresses the individual's severity and level of function. Risk Rating is not meant to indicate the level of services required for an individual. Additional information regarding risk can be found in The ASAM Criteria, 2013 book and online training modules.

G. The ASAM Summary and Risk Rating must be completed in PA WITS to record and exchange information necessary in making or validating placement determinations. The information documented on the ASAM Summary and Risk Rating must comply with state and federal confidentiality regulations.

- 1) The ASAM Summary and Risk Rating must reflect a multi-dimensional approach to determining the appropriate level of care an individual needs regardless of whether funding is available for a specific level.
- 2) The ASAM Summary should not be solely based on the level of care requested by the individual or referral source.
- 3) If the level of care received is different than the level recommended, the ASAM Summary as well as the case notes must document attempts to engage the individual into clinically appropriate services.

H. The ASAM Criteria, 2013 requires consideration of the following areas prior to placement in order to maximize retention in the appropriate level of service:

- 1) Withdrawal Management for all levels of care, not only inpatient;
 - 2) Medication Assisted Treatment in 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.
- I. A LOCA must be completed within seven calendar days from the date of initial contact with the individual. The LOCA must be completed in its entirety in one session prior to referring the individual to the appropriate level of care.
- 1) When the individual needs withdrawal management the LOCA does not need to be done prior to admission into withdrawal management but must occur before the individual is referred to the next level of care.
 - 2) If either the seven-day timeframe or the completion of the assessment in one session cannot be met, the case manager must document the reason in the individual's record.
- J. Once a LOCA is completed, it will be valid for a period of six months. This applies to individuals who have never engaged in treatment after being assessed or who have been discharged and are seeking to reinstate services.
- 1) The six-month timeframe does not pertain to individuals actively engaged in treatment. An exception to this timeline may be made for individuals who were incarcerated during this six-month period. Specifically, time prior to being in the controlled environment may be considered when determining the LOC.
 - 2) If an individual request to reinstate services prior to the end of the six-month period, the case manager may complete a follow-up assessment in lieu of a new one; however, a new ASAM Summary and Risk Rating must be completed.

5.05 Referral and Admission to Treatment

- A. Priority Populations identified in Part 3.00 must be admitted to the appropriate level of care immediately. All other individuals must be referred and admitted to the appropriate level of care available within 14 days of the LOCA. Individuals in need of withdrawal management must be admitted to treatment within 24 hours. If these time frames cannot be met, the case manager must document the reason in the individual's file.
- B. The SCA must identify specialty funding sources such as State Opioid Response grants prior to the initiation of services to ensure compliance with the requirements of these sources [e.g. entering the Government Performance and Results Act (GPRA) into WITS].
- C. An individual is admitted to treatment at the first attended appointment with a provider after the LOCA 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 misuse treatment episode should be assumed to have ended if the individual 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.

D. The levels of care are:

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) (adult, adolescent) 3.5 Clinically Managed High-Intensity Residential Services (Adult) / Clinically Managed Medium-Intensity Residential Services (Adolescent) 3.7 Medically Monitored Intensive Inpatient Services (Adult) / Medically Monitored High-Intensity Inpatient Services (Adolescent)
Level 4	4.0 Medically Managed Intensive Inpatient Services

E. Upon notification of discharge from a SUD treatment facility, SCAs must follow-up with the individual who has accepted case management services within 3 business days and schedule a follow-up case management appointment within 2 weeks after the discharge.

5.06 Communicable Disease Screening and Referral Services

A. Tuberculosis (TB)

DDAP collaborated with the Department of Health, Bureau of Communicable Diseases to develop questions that assess the need for referral to appropriate TB services.

- 1) The SCA must ensure that any entity providing a LOCA determines whether the individual is at high risk for TB. The following questions must be asked at the time of the LOCA, and the responses documented, prior to admission to treatment:
 - (a) 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)?
 - (b) Are you an immigrant from a high TB-risk foreign country (includes countries in Asia, Africa, South America, and Central America)?
 - (c) 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 an individual was a resident of any of these facilities and tested within the past three months, they do not need to be reassessed.)
 - (d) Have you had any close contact with someone diagnosed with TB?
 - (e) Have you been homeless within the past year?
 - (f) Have you ever injected drugs?
 - (g) Do you or anyone in your household currently have the following symptoms, such as a sustained cough for two or more weeks, coughing up blood, fever/chills, loss of appetite, unexplained weight loss, fatigue, night sweats?
 - (h) Do you currently have or anticipate having any condition that would decrease your immune system? (Examples: HIV infection, organ transplant recipient, treatment with TNF-alpha antagonist (e.g. infliximab, etanercept, others), steroids (equivalent dose of Prednisone 15mg/day for one month or longer) or any other immunosuppressive medications)

- (i) Any individual that responds with a “yes” to any of these questions is considered high risk for TB.
- 2) Written procedures must be in place to address how individuals identified as high risk will be referred to the County or nearby Public Health TB Clinic and how the individual’s acceptance or rejection of the referral is documented.

B. Viral Hepatitis

Since there is a strong association between substance use and viral hepatitis risk, DDAP has collaborated with the Pennsylvania Department of Health (DOH), Bureau of Communicable Diseases and Bureau of Epidemiology, to develop standards to address the need for viral hepatitis services, including vaccination, education, testing, and linkage to care. These standards are informed by guidelines from the Centers for Disease Control and Prevention, the American Association for the Study of Liver Disease, and the Infectious Disease Society of America. The SCA shall ensure that all DDAP-funded providers within their jurisdiction implement these guidelines and/or seek technical assistance from DDAP to address areas that need improvement.

1) Education

- (a) All clients shall be offered trauma-informed and culturally responsive educational materials at the time of LOCA. These materials shall include information covering:
 - i. General information about viral hepatitis
 - ii. Information about vaccines for hepatitis A and B
 - iii. Prevention and harm reduction strategies
 - iv. Test result interpretation
 - v. Information about local providers who offer services for prevention and treatment of viral hepatitis
- (b) All staff shall be offered education and training on viral hepatitis, including information covering:
 - i. General information about viral hepatitis
 - ii. Information about vaccine for hepatitis A and B
 - iii. Prevention and harm reduction methods
 - iv. Test result interpretation
 - v. Information about local providers who offer services for prevention and treatment of viral hepatitis

Providers may access education materials at [Hepatitis | Department of Health | Commonwealth of Pennsylvania](#) and request online training by contacting STATEOPIOIDRESPONSE@lists.psu.edu

2) Hepatitis C Testing*

- (a) The SCA and/or its contracted providers shall ensure that universal opt-out hepatitis C testing is available at time of LOCA. This testing shall occur on-site or through a referral to improve access to hepatitis C services for all people receiving a LOCA.
 - i. Universal opt-out testing differs from risk-based screening assessments to determine who shall be tested or referred for an HCV test.
 - 1. In universal opt-out testing, an individual is informed that an HCV test will be completed as a part of routine screening unless they decline the test.
 - ii. An individual’s acceptance or rejection of opt-out testing shall be documented in their files.
- (b) In addition to testing at time of LOCA, more frequent testing is appropriate and shall be offered to individuals who, at any point during treatment, report:

- i. Current or past injection drug use
 - ii. Current or past intranasal drug use
 - iii. That they are living with HIV
 - iv. A history of incarceration
- (c) Providers shall use current testing technologies, specimens, and practices for accurate identification of HCV infection.
 - i. Hepatitis C testing shall be initiated with a FDA-approved HCV antibody test.
 - 1. An HCV antibody test, when reactive, indicates an exposure to HCV
 - ii. Sites performing phlebotomy should order reflex testing from the lab so that a positive antibody test triggers an automatic RNA confirmatory test.
 - 1. Sites that use rapid testing without immediate blood draw shall refer individuals for a confirmatory test if the rapid test is reactive.
 - iii. Any HCV antibody positive/reactive test shall always be followed by an FDA-approved nucleic acid test (NAT) for detection of HCV RNA.
 - 1. This is a confirmatory test to detect HCV RNA which, when positive, indicates active and current HCV infection.
 - iv. If blood draw or rapid testing is not possible on site, arrangements shall be made for referrals and warm handoff to off-site testing programs.
 - v. Whenever possible, integrated or coordinated service models are recommended to increase continuity of services.
 - vi. Whenever possible, coupling rapid HCV testing with rapid HIV testing is encouraged.
- 3) Hepatitis B Testing*
 - (a) Everyone without documentation of hepatitis B status shall have blood drawn for hepatitis B testing.
 - i. If blood draw is not possible on-site, arrangements shall be made for a warm handoff to an off-site blood draw.
- 4) Viral Hepatitis Treatment
 - (a) Everyone who tests positive for hepatitis B and/or C shall receive treatment.
 - i. If on-site treatment is not available, arrangements shall be made for individuals to receive treatment off-site.
 - ii. Facilities may request resources and information about providers treating hepatitis B and/or C via the Department of Health by visiting [Hepatitis Map-Copy 5\) Vaccination](#)
 - (a) Both hepatitis A and B viruses are vaccine-preventable illnesses.
 - (b) Everyone shall be offered hepatitis A and B vaccine upon admission to treatment if they do not have documentation of immunity.
 - i. If the facility is not equipped to administer vaccinations, arrangements shall be made for individuals to receive vaccine through primary care providers, retail pharmacy chains, or Pennsylvania State Health Centers.
- 6) Written Procedures
 - (a) Written procedures shall be in place to address how education, testing, vaccination, treatment, and referral for viral hepatitis services will be delivered. The procedures shall address:

- i. How people will be provided with educational materials.
- ii. How people will be given access to opt-out testing on-site or via referral.
- iii. How people's' acceptance or rejection of the opt-out test and/or offer of or referral to prevention services are to be documented in their files.
 - 1. A sample Viral Hepatitis Prevention/Treatment Referral Acceptance/Declination form can be found in Appendix E and utilized for documentation of opt-out testing/referrals.
- iv. How documentation of an individual's reason(s) for declining testing and/or referral for viral hepatitis care and prevention services are documented.
- v. The protocol for linkage to care and prevention services, including vaccines, either on site by staff, on site by mobile provider, or via referral.

Providers may access a directory of hepatitis C and B testing resources [Hepatitis Map-Copy](#).

C. Human Immunodeficiency Virus (HIV)

DDAP collaborated with the Pennsylvania Department of Health Bureau of Communicable Diseases and Bureau of Epidemiology, to develop standards to address the need for education, testing, and linkage to care for HIV services. These standards are informed by guidance from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention.

The SCA shall ensure that all DDAP funded providers within their jurisdiction implement these guidelines and/or request technical assistance from DDAP to address any areas that need improvement.

1) Education

- (a) Everyone shall be offered trauma-informed and culturally responsive educational materials at the time of LOCA. These materials shall include information covering:
 - i. HIV basics
 - ii. HIV testing options and procedures
 - iii. Test result interpretation
 - iv. Methods of HIV prevention, including PrEP
 - v. Information about local providers of HIV prevention and care services
- (b) All staff shall be offered education and training on HIV, including information covering:
 - i. HIV basics
 - ii. HIV testing options and procedures
 - iii. Test result interpretation
 - iv. Methods of HIV prevention, including PrEP
 - v. Information about local providers of HIV prevention and care services
 - vi. Provision of trauma-informed, culturally responsive HIV prevention and care

Providers may access education materials at [HIV Resources and Support | Help Stop the Virus](#) and request online training by contacting STATEOPIOIDRESPONSE@lists.psu.edu

2) HIV Testing

- (a) The SCA and its contracted providers shall ensure that universal, opt-out HIV testing is offered at time of LOCA. This testing shall occur on-site or through a referral to improve access to HIV services for all.
 - i. Universal opt-out testing differs from risk-based screening assessments to determine who shall be tested or referred for an HIV test.

1. In universal opt-out testing, people are informed that an HIV test will be completed as a part of routine screening unless they decline the test.
 - ii. People's acceptance or rejection of opt-out testing shall be documented in their files.
- (b) In addition to testing at time of LOCA, more frequent testing is appropriate and shall be offered to individuals who, at any point during treatment, report recent potential exposure to HIV based on any of the following:
 - i. Unprotected sexual activities with persons living with HIV or unknown HIV status, or anybody who has multiple sex partners
 - ii. Sharing needles, syringes, or other drug preparation equipment with persons living with HIV or unknown HIV status
 - iii. Being diagnosed with, or recently treated for viral hepatitis or sexually transmitted infections (STIs) such as syphilis, gonorrhea, or genital herpes
- (c) The SCA and/or its contracted providers shall use current testing technologies and specimens that allow them to detect HIV infection.
- (d) Integrated and/or coordinated service models are recommended to increase continuity of services, and HIV testing shall be integrated into service delivery to the highest degree possible.
- (e) Whenever possible, pairing rapid HIV testing with rapid HCV testing is encouraged.
- (f) SCAs and/or their contracted providers shall follow CDC guidelines for ensuring that appropriate measures are taken if the HIV rapid/point-of-care test is reactive. In this scenario, people will need an HIV confirmatory test.
- (g) If the test is negative, PrEP education shall be provided.

Providers may access a directory of HIV testing resources at: [Find a Testing Site](#).

3) HIV Treatment

- (a) All HIV positive individuals shall receive treatment.
 - i. If on-site treatment is not available, arrangements shall be made for people to receive treatment off-site.
- (b) Cooperation of providers conducting HIV testing is required under the Disease Prevention and Control Law of 1955 (35 P.S. § 521.1, et seq.) and the regulations promulgated thereunder (See 28 Pa. Code ch. 27).
 - i. All positive HIV test results will be followed-up by the local Department of Health or County/Municipal Health Department Disease Intervention Specialists (DIS) to ensure access to partner services and linkage to care.

Providers may access a directory of HIV medical resources at [PA DOH HIV Services](#)

4) Written Procedures

- (a) Written procedures shall be in place to address how education, testing, treatment, and referral for HIV services will be delivered. The procedures shall address:
 - i. How people will be provided with educational materials.
 - ii. How people will be given opt-out testing either on-site or via referral.
 - iii. How the acceptance or rejection of opt-out HIV testing and/or referrals for HIV care and prevention services are to be documented in peoples' files.

1. A sample HIV Testing/Treatment Referral Acceptance/Declination form can be found in Appendix F and utilized for documentation of opt-out testing/referrals.
- iv. How documentation of individuals' reason(s) for declining testing and/or referral for HIV care and prevention services are to be documented.
- v. The protocol for linkage to care and prevention services, including on-site by staff, on-site by mobile provider and/or via referral.

5.07 Coordination of Services

Coordination of Services is 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 treatment-related 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 manner. 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 which includes engagement, evaluation of needs, establishing linkages, arranging access to services, ensuring enrollment in the appropriate healthcare coverage, advocacy, monitoring, and other activities to address the individual's treatment-related needs throughout their course of treatment. Coordination of Services includes communication, information sharing, and collaboration, and occurs regularly between the case manager, contracted provider, and individual receiving services.

- A. In addition to providing services to meet the treatment-related needs of the individual, the SCA and contracted providers are required to complete continued stay reviews for the individual's treatment. The ASAM Criteria, 2013 must be applied throughout treatment to ensure individualized person-centered care is documented throughout the individual's treatment episode.
- B. The Case Management Service Plan, which is referred to as a recovery plan in PA WITS, is an assessment of treatment-related needs that must be addressed at the time of LOCA and updated no less than every 30 days throughout an individual's time in treatment. The SCA is responsible to ensure every individual has a Case Management Service Plan that has been reviewed and updated while the individual is receiving services from the SCA. A sample CMSP can be found in Appendix D.
- C. The SCA's Coordination of Services policy and procedures must include:
 - 1) A mechanism to coordinate and track all individuals whose treatment is paid for by the SCA;
 - 2) How the SCA or contracted providers will assist with arranging access to services and ensuring enrollment in the appropriate healthcare coverage, such as the Medical Assistance application process;
 - 3) How continued stay reviews are completed;
 - 4) How the Case Management Service Plan is documented;
 - 5) A mechanism to attempt to re-engage individuals who do not appear for treatment or leave treatment prior to discharge;
 - 6) A mechanism to ensure direct contact is made from one level of care to another, including follow-up contact to ascertain whether the individual was admitted as planned; and
 - 7) Documentation of the time and reason when an individual is no longer receiving services from the SCA.
- D. The SCA is responsible to:

- 1) Ensure Coordination of Services is offered to every individual receiving services paid for by the SCA;
- 2) Develop a policy which delineates the procedures used for the Coordination of Services;
- 3) Distribute its policy and procedures to contracted providers of Coordination of Services.

5.08 Independent Peer Review

In accordance with [45 § CFR 96.136 -- Independent peer review.](#), any SCA and/or provider that receives Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) block grant and/or SOR funding may be selected and required to be a part of the independent peer review process to assess the quality, appropriateness, and efficacy of treatment services provided throughout the Commonwealth.

The purpose of independent peer review is to review the quality and appropriateness of treatment services. The review will focus on treatment programs and the substance use services system, rather than on individual practitioners. The intent of the independent peer review process is to continuously improve the treatment services to those with substance use disorders.

- A. "Quality" for the purpose of this section, is the provision of treatment services which, within the constraints of technology, resources, and individual circumstances, will meet accepted standards and practices which will improve individual health and safety status in the context of recovery.
- B. "Appropriateness" for the purpose of this section, means the provision of treatment services consistent with the individual's identified clinical needs and level of functioning.

The independent peer reviewers shall be individuals with expertise in the field of substance use disorder treatment. Independent peer reviewers must also be knowledgeable about the modality being reviewed and its underlying theoretical approach to substance use treatment and must be sensitive to the cultural and environmental issues that may influence the quality of the services provided.

As part of the independent peer review, the reviewers shall review a representative sample of individual records to determine the quality and appropriateness of treatment services, while adhering to all Federal and State confidentiality requirements, including 42 CFR part 2.

The reviewers shall examine the following:

- A. Admission criteria/intake process;
- B. Assessments;
- C. Service/Treatment planning, including referral, e.g., prenatal care, TB, HIV and Hepatitis services;
- D. Documentation of implementation of treatment services;
- E. Discharge and continuing care planning; and
- F. Indications of treatment outcomes.

Independent peer review will not involve providers/practitioners reviewing their own programs, or programs in which they have administrative oversight, and that there be a separation of peer review personnel from the funding decisionmakers.

Independent peer review is not conducted as part of the licensing/certification process and will not result in any findings or corrective action.

5.09 WITS Case Management Requirements

- A. The SCA and its contracted providers are required to complete the following components in PA WITS for every individual receiving case management services, including a LOCA:
 - 1) Client Profile;

- 2) Intake;
- 3) Screening Tool;
- 4) ASAM;
- 5) Program Enrollment [for individuals receiving ongoing case management, other than screening & assessment, and also for State Opioid Response (SOR)-funded case management];
- 6) An encounter note to explain the reason an individual is discharged from case management services; (The case in WITS must be closed via the “Save & Close the Case” portion of the Intake page.)
- 7) Documentation of interim services using miscellaneous notes, if applicable;
- 8) SOR GPRA for individuals with an OUD, receiving SOR funded treatment or treatment-related services;
- 9) Case Management Notes, including admission and discharge notes, to 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 treatment-related needs;
 - (c) Action to be taken to meet the individual’s treatment and treatment-related needs; and
 - (d) Case manager’s signature or initials and date.

Items 1-7 must be entered into PA WITS within 7 days of the date service was delivered. Timeframes for entry of the SOR GPRA are outlined in the [SOR GPRA FAQ](#).

- B. In addition to the documentation required in PA WITS, the SCA and its contracted providers must include the following information as part of an individual’s file:
 - 1) Signed consent to release information forms;
 - 2) LOCA;
 - 3) Acknowledgement of receipt of grievance and appeal policy;
 - 4) Liability forms;
 - 5) Case Management Service Plan.
- C. Files that are maintained electronically in a system other than PA WITS must contain all required components, and a hard copy must be available to DDAP staff upon request. Information maintained in a paper file, including signed consent to release information forms, and liability forms, must be made available to DDAP upon request.

5.10 Supervision

Supervision of staff providing case management services should be designed to ensure the adequate provision of those services.

- A. The SCA must have policies regarding supervision.
- B. The supervision of new staff performing case management functions without having received required core trainings must include a combination of job shadowing and direct observation of LOCAs.

- C. The case management supervisor must document close supervision and review of written documentation, to include the LOCA and ASAM Summary Sheet, until the case manager has received all required trainings.

5.11 Staffing Qualifications

- A. Staff delivering case management services must meet the minimum education and training (MET) requirements established by the State Civil Service Commission for one of the following classifications:
- 1) D&A Case Management Specialist;
 - 2) D&A Case Management Specialist Trainee;
 - 3) D&A Treatment Specialist; or
 - 4) D&A Treatment Specialist Trainee.
- B. Supervisors of staff delivering case management services must meet the MET requirements established by the State Civil Service Commission for the Case Management Supervisor or Treatment Specialist Supervisor.
- C. If case management services are being performed by a contracted and licensed drug and alcohol treatment facility, staff delivering services must meet either the MET requirements for the classifications referenced above or the staffing regulations for either a Counselor, 28 Pa. Code § 704.7 or Counselor Assistant, 28 Pa. Code § 704.8.
- D. An individual who meets the qualifications of a counselor or counselor assistant but is providing case management services, must deliver the services separately from treatment or therapy services.
- E. Supervisors of case management staff in a contracted and licensed facility must meet either the MET requirements for the supervisory classifications referenced above or the staffing regulations for Clinical Supervisor, 28 Pa. Code § 704.6, or Lead Counselor, 28 Pa. Code §§ 704.6(d), 704.11(f)(3).
- F. With the implementation of the utilization of The ASAM Criteria, 2013 qualifications for case managers, case manager supervisors, counselors, counselor assistants, and clinical supervisors can be found here: [Guidance for the Application of ASAM for Adults - 2/22](#)
- G. Staff hired on or after July 1, 2021, who are completing LOCAs or Continued Stay Reviews need to be licensed or credentialed. If they are not, then they need to be working towards licensure or credentialing and must document the steps that are being taken towards this achievement.
- H. Case Managers conducting level of care assessments hired before July 1, 2021, do not need to be licensed or certified as long as they remain employed by the same SCA or contracted provider.
- I. The following case management certifications will be acceptable to meet the requirements listed above:
- [Commission on Case Management Certification \(CCM\)](#)
 - [Breining Institute – Certified Case Manager Interventionist \(CCMI\)](#)
 - [America Case Manager Association – Accredited Case Manager \(ACMI\)](#)
 - [National Association of Social Workers – Certified Social Work Case Manager \(C- SWCM\)](#)
 - PA Certification Board – [Community Health Worker](#) / [Certified Allied Addiction Practitioner](#)

In addition to the resources listed above, the SCAs should work with their project officers regarding other accrediting bodies or certifications the SCA would like DDAP to consider.

5.12 Core Training

- A. The SCA is required to ensure that staff providing case management services and their supervisors complete all case management core trainings within 365 days of hire.

- B. The SCA and contracted provider must maintain certificates of completed trainings.
- C. The SCA Administrator may permit an exemption for Addictions 101 and Screening and Assessment to SCA and contracted provider staff who have already had comparable education and training. If the SCA Administrator chooses to exempt any staff from the above trainings, there must be written documentation to justify the exemption.
- D. An SCA Administrator who is a case management supervisor and wishes to be exempted from the above training requirements may submit a written request and supporting documentation to the SCA's Project Officer in DDAP's County Program Oversight (CPO) Section. SCA Administrators are not permitted to exempt themselves from any training requirements without first obtaining approval from DDAP.
- E. Staff who have already conducted screening and assessment and have completed the DDAP-required core trainings are not required to take Addictions 101, and Screening and Assessment trainings.
- F. Case Management staff and their supervisors are required to complete the following DDAP approved courses:
 - 1) Addictions 101;
 - 2) Substance Use Disorder Confidentiality;
 - 3) Case Management Series (Both courses are required for staff who did not complete the previous Case Management Overview curriculum.) The online Case Management Overview training must be completed before the Case Management Skills training.
 - (a) Case Management Overview. All Case Managers and Case Management Supervisors must complete the Online Module by December 29, 2023, regardless of their date of hire and even if they completed the previous versions of Case Management Overview through TRAIN PA.
 - (b) Case Management Skills Training; available in-person or virtual.
 - 4) Screening & Assessment; (Screening & Assessment is required only for case managers who perform screening and assessment.)
 - 5) Motivational Interviewing, Advancing the Practice; (Required for staff hired on or after July 1, 2020; however, it is recommended that all case managers complete training in Motivational Interviewing.)
 - (a) Supervisors & Clinical Supervisors must complete the motivational interviewing training.
 - 6) The ASAM Criteria, 2013: Under ASAM Criteria, 3rd Edition, 2013, staff should have training to understand signs and symptoms of mental health disorders.
 - (a) Clinical supervisor must acquire co-occurring education/training by December 29, 2023, Counselors, Counselor Assistant's, Case Managers, and Case Manager Supervisors must acquire co-occurring education/training by 7/1/2024.
 - (b) Education/training can be either formal instructor led or self-paced e-Learning.
 - (c) Training topics include signs and symptoms of mental disorders, information regarding psychotropic medications and their interactions with substance related disorders.
 - (d) Training may be provided by external sources, including: DDAP, SAMHSA and its affiliated Addiction Technology Transfer Centers (ATTC), National Institute of Health (NIH), National Institute on Drug Abuse (NIDA), ASAM or any of its training affiliates, accredited colleges and universities, and other recognized behavioral health associations.

- (e) Providers may train internally under the following conditions: the provider has a structured internal training and development program, Co-occurring curriculum meets the minimum content requirements listed above, and staff attendance is recorded.
- (f) Structured training and development programs include but are not limited to the following features: employee learning led by staffed facilitators, internal development of training materials and course assessments, access to a functional training venue, and a mechanism to register and record staff attendance.
- (g) Training conducted prior to July 1, 2023, will be accepted if the training meets the minimum guidelines outlined in this section.

Training courses and descriptions are:

- 1) **Addictions 101** (requires DDAP certificate or exemption) This course includes basic information about the disease concept, characteristics of common drugs of misuse, pharmacology, assessment, withdrawal management, treatment, and recovery.
- 2) **Substance Use Disorder Confidentiality** (requires DDAP certificate) This course provides participants with information needed to comply with applicable laws and regulations for the confidentiality of drug and alcohol treatment services in the Commonwealth of Pennsylvania.
- 3) **Case Management Series** (requires DDAP certificate) The online Case Management Overview training will provide a foundation from which case managers will build skills and gain a comprehensive understanding of case management, and guide participants through what case management is, how it came about, the core roles of case managers, and provide resources to assist in the delivery of case management.
- 4) **Case Management Skills** This training can be completed in-person or virtually and will build on the information provided in the online training and provide participants with the opportunity to practice case management skills. Participants will also be provided with tools to assist in identifying resources within their network and community to assist the individuals they serve.
- 5) **Screening & Assessment** (requires DDAP certificate or exemption) This course will provide an understanding on how to conduct an effective assessment and determine emergent care needs. The required components of screening and assessment tools, emergent care issues, screening options, interview techniques and a review of the DSM- 5 Criteria for Substance Use Disorders and Addictive Disorders will be covered.
- 6) **Motivational Interviewing, Advancing the Practice** (requires DDAP certificate) Motivational Interviewing (MI) is an evidence-based treatment that addresses ambivalence to change. MI is a conversational approach designed to help people identify their readiness, willingness, ability to change and make use of their own change-talk. Participants will learn the theory/concepts of MI and will practice MI in an experiential setting.
- 7) **American Society of Addiction Medicine, The ASAM Criteria, 2013** (requires Train for Change or The Change Companies certificate) Approved courses include the two-day classroom skills course by Train for Change and/or ASAM Modules I and II by The Change Companies. These courses are designed to provide participants with the skills and understanding necessary for effective use and application of The ASAM Criteria, 2013.

Independent use and application of The ASAM Criteria, 2013 is prohibited by SCAs and contracted providers unless DDAP approved core training requirements are successfully completed.

- G. SCA Contracted Treatment Providers staff and their supervisor are required to complete the following DDAP approved courses within 365 days of hire:

- 1) Addictions 101;

- 2) Substance Use Disorder Confidentiality;
- 3) The ASAM Criteria, 2013.
- H. The SCA must ensure through provider monitoring that contracted treatment providers meet the minimum training requirements.
- I. Upon successful completion of each training course, participants must complete a course evaluation. The evaluation form can be accessed through DDAP's Training Management System. Upon completion and submission of the course evaluation, participants will have access to their certificates of completion.
- J. WITS Treatment Data System Training: In addition to the required trainings noted above, the SCA and its contracted providers are strongly encouraged to complete the online training modules for DDAP's Data System, [PA WITS](#).

5.13 Grievance and Appeal Process

The grievance and appeal process is a step-by-step effort at reconciliation between an aggrieved individual and the SCA. Contracted providers and other agencies may have their own grievance and appeal protocols for matters arising within their programs.

- A. The SCA must use its process in cases where the grievance concerns an administrative or financial decision made by, or on behalf of, the SCA. The SCA must have an expeditious, accessible, fair, and uniform grievance and appeal process.
- B. A grievance is a written complaint by an individual of the decision made by the SCA. An appeal is the process to resolve a grievance. Individuals must be able to file a grievance in at least the four areas listed below.
 - 1) Denial or termination of services;
 - 2) LOC determination;
 - 3) Length of stay in treatment; and
 - 4) Violation of the individual's human or civil rights.
- C. An SCA may choose to include additional categories that an individual can grieve. Those areas must be specific and clearly stated as part of the SCA's grievance and appeal process.
- D. In the event an individual grieves a treatment funding decision related to a reduction or termination of services or length of stay in treatment, the SCA is required to continue funding treatment services at the current level of engagement until the appeal is resolved. This applies to all treatment services, including the provision of Medication Assisted Treatment (MAT).
- E. The SCA appeal process must include a two-stage process in which:
 - 1) The first level of appeal is made to a panel consisting of SCA staff or a supervisory level staff person, none of whom is directly involved in the dispute. The SCA must issue a written decision within seven days upon receipt of the grievance.
 - (a) The SCA must inform both the individual and DDAP of the decision within seven days via the DDAP-approved Grievance and Appeal Reporting form (DDAP-EFM-1099). Identifying information may not be included or attached to this form.
 - 2) The second level of appeal is made to an independent review board or hearing panel that consists of an odd number (no less than three) of members who have no financial, occupational, or contractual agreements with the SCA. DDAP staff; Department of Human Services staff; and members of the SCA's governing body such as County Executives, County Commissioners, and SCA Board members may not serve as the independent review board or hearing panel.

- (a) The panel must issue a written decision within seven days upon receipt of the grievance. Access to confidential records must be in accordance with state and federal confidentiality regulations. At the time of the appeal, the SCA must identify the composition and number of members designated as the independent review board or hearing panel. The SCA must inform both the individual and DDAP of the decision within seven days via the DDAP-approved Grievance and Appeal Reporting form. Identifying information may not be included or attached to this form.
- F. At the time of the LOCA, the individual must acknowledge in writing that he or she has been notified of:
- 1) The grievance and appeal policy that outlines all of the categories an individual can grieve with the SCA, both DDAP's required categories as well as those added by the SCA;
 - 2) The need for a signed consent form from the individual so confidential information relating to the appeal can be provided to an independent review board for the purpose of rendering a decision on the appeal;
 - 3) The right to have access to all documentation pertaining to the resolution of the grievance within the confines of state and federal confidentiality regulations;
 - 4) The right to be involved in the process and have representation by means of an advocate, case manager, or any other individual chosen by the individual at each level of appeal; and
 - 5) The continuation of funding for service continues at the current level of engagement for appeals of termination of funding or reduction of treatment services, including MAT, until the appeal is resolved, unless the individual agrees otherwise.

5.14 Reporting

- A. The SCA must notify the Prevention, Treatment and Recovery Division Director in writing within five days after the SCA discontinues or limits authorization of any services for lack of funding. The notification must explain how the SCA will meet the ongoing treatment needs of the individuals until additional funding is available.
- B. The SCA must notify the Prevention, Treatment and Recovery Division Director in writing within five days after the SCA removes limitations.
- C. The SCA may not apply funding limitations to any Priority Populations identified in Section 3.00.
- D. All reporting is due according to the DDAP Report Schedule that is provided at the beginning of each fiscal year.

5.15 Confidentiality of Information

All persons currently or formerly screened, assessed, diagnosed, counseled, treated and rehabilitated for substance use disorders, 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 an individual's substance use information, the SCA shall make adequate provisions for system security and protection of individual privacy. The SCA, treatment providers, contracted providers, and others are subject to the confidentiality requirements of the Pennsylvania Drug and Alcohol Abuse Control Act ([71 P.S. §§ 1690.101, et seq.](#)), the Public Health Service Act ([42 U.S.C §§ 290ee-3, 290dd-2](#)), and Federal Confidentiality Regulations ([42 CFR Part 2](#)). Drug and alcohol information is protected in many ways including, but not limited to, the following:

Pennsylvania Statutes [Title 71 P.S. State Government § 1690.101](#) - established the Pennsylvania Advisory Council on Drug and Alcohol Abuse, addresses confidentiality requirements at 71 P.S. §§ 1690.108, and consent of minors at 71 P.S. §§ 1690.12.

[28 Pa. Code § 709.28](#) - Standards for licensing freestanding treatment facilities to include adherence to confidentiality requirements.

[42 CFR Part 2, Subparts A-E](#) - A federal regulation governing SUD records.

[45 CFR Part 96](#) - A federal regulation governing the privacy of health care information.

[42 Pa. C.S.A. § 6352.1](#) - A state law clarifying what information may be released by SCAs and treatment providers to children and youth agencies and the juvenile justice system.

- A. Confidentiality is one of the cornerstones guiding the treatment of substance use disorders. Staff working with individuals who have an SUD must always be conscious of where and how an individual's identifying information is discussed.
- B. Valid consent forms must include all the components of federal and state confidentiality regulations and the information to be released must relate to the purpose of the consent.
- C. SCAs and contracted providers must have written procedures for compliance with all federal and state confidentiality regulations. The procedures must include:
 - 1) Release of client-identifying information;
 - 2) Storage and security of client records, to include computer security;
 - 3) Completion of required confidentiality training;
 - 4) Staff access to records;
 - 5) Disciplinary protocols for staff violating confidentiality regulations;
 - 6) Revocation of consent, to include how this is documented on the consent form; and,
 - 7) Notification that re-disclosure is prohibited without proper consent.
- D. All staff who perform or supervise treatment and treatment-related services must acknowledge in writing that they have read the procedures.
- E. Staff who do not directly perform or supervise services must sign a statement certifying that they will keep all information acquired through their employment duties confidential. The statement must specify that disciplinary action will be taken if confidentiality is breached.

PART VI: RECOVERY SUPPORT SERVICES

6.00 Recovery Support Services

Recovery Support Services (RSS) are treatment-related services provided to individuals and their families to assist with recovery from SUD. These services complement the focus of treatment, outreach, engagement and other strategies and interventions to assist people in recovery in gaining the skills and resources needed to initiate, maintain, and sustain long- term recovery. RSS are not a substitute for clinical services.

- A. While DDAP understands that there are many RSS, the SCA may use DDAP funds for:
- 1) Mentoring Programs in which individuals newer to recovery are paired with Certified Recovery Specialists to obtain support and advice on an individual basis and to assist with issues potentially impacting recovery (these mentors are not the same as 12-step sponsors);
 - 2) Training and Education in a group setting using a structured curriculum relating to addiction and recovery, life skills, job skills, health and wellness;
 - 3) Family Programs using a structured curriculum that provides resources and information needed to help families and significant others who are impacted by an individual's addiction;
 - 4) Telephonic Recovery Support or Recovery Check-ups to individuals who can benefit from a weekly call to remain engaged in the recovery process and to help maintain their commitment to their recovery;
 - 5) Recovery Planning to assist an individual in managing his or her recovery;
 - 6) Support Groups for recovering individuals and their families that are population focused, such as HIV/AIDS, veterans, youth, bereavement, etc.;
 - 7) Recovery Housing as described in Section 4.03; and
 - 8) Recovery Centers where RSS are designed, tailored and delivered by individuals from local recovery communities.

PART VII: CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

7.00 Culturally and Linguistically Appropriate Services (CLAS)

Cultural competence is the ability to interact effectively with people of different cultures. Both individuals and organizations can be culturally competent. “Culture” is a term that goes beyond just race or ethnicity. It can also refer to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession. Cultural competence means to be respectful and responsive to the health beliefs and practices—and cultural and linguistic needs—of diverse population groups.

Being respectful means:

- recognizing and valuing cultural differences, such as the health beliefs, practices, and linguistic needs of diverse populations.
- Being responsive means:
- Knowing something about the culture of the group that programs/services focus on;
- Customizing prevention and promotion in a way that respects and fits within the group’s culture;
- Involving people from the targeted cultural group in assessing needs, developing resources, planning and implementing programs/services, and evaluating their effectiveness.

[The National CLAS Standards](#) are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and organizations to implement culturally and linguistically appropriate services.

SCAs and their contracted providers must provide services that are respectful of and responsive to cultural and linguistic needs, cultural health beliefs and practices, preferred languages, health literacy levels, and other communication needs.

PART VIII: CONTINGENCY MANAGEMENT

8.00 Contingency Management

Contingency Management is an evidence-based intervention for the treatment of SUD. SCAs are permitted to use Contingency Management to support people in meeting treatment goals.

- A. The SCA and contracted providers that utilize Contingency Management strategies are required to develop policies and procedures which include:
- 1) Target behavior;
 - 2) Choice in target population;
 - 3) Choice of reinforcer (reward-gift card);
 - 4) Incentive Magnitude (strength of the reward);
 - 5) Frequency of incentive distribution;
 - 6) Timing of incentive;
 - 7) Duration of the intervention;
 - 8) How to describe contingency management to eligible and ineligible individuals;
 - 9) Protocols to ensure continued adherence to evidence-based principles;
 - 10) Tracking individual outcomes;
 - 11) Testing methods and protocols for targeted substance use disorders and other behaviors;
 - 12) Allowable incentives to include selection, storage, distribution of incentives and how quickly the incentive will be received;
 - 13) Documentation and tracking of incentives
 - 14) Roles and responsibilities of all staff implementing contingency management activities
 - 15) Techniques for supervisor to provide on-going oversight and coaching
- C. The SCA and contracted providers are required to follow SAMHSA requirements as applicable. SAMHSA has placed a cap on all Contingency Management programs. The value of each contingency may not exceed \$15 per reward and may not exceed \$75 per patient per calendar year.
- D. SCAs or contracted treatment providers that plan to use DDAP funds for Contingency Management must be trained by an approved DDAP Contingency Management trainer. After completing the Level 1 on-line course, staff may begin to use Contingency Management. In order to remain eligible to use DDAP funds for contingency management, staff must complete all requirements of Level 1 Certification.
- E. Documentation must be kept on file at the SCA or contracted treatment provider that demonstrates progress towards and completion of Level 1 Certification.
- F. Each SCA and contracted provider utilizing Contingency Management must have procedures in place which outline the proper safeguarding of gift cards used for Contingency Management. The following internal controls must be in place and followed:
- 1) **Custody:** A single individual, preferably a fiscal or financial officer, must be the designated custodian of gift cards. This individual will be responsible for ensuring all purchasing, security, dispensing, tracking, and replenishing procedures are followed.

- 2) **Numbering and Security:** All gift cards must be numbered and secured at all times (e.g. in a locked box inside a locked cabinet or drawer).
 - 3) **Disbursement Procedures and Audit Logs:** The custodian must keep an audit log of gift card purchases and disbursements for audit purposes.
 - 4) **Lost cards:** The value of receipts and gift cards must total the authorized amount purchased and approved by the custodian and finance office. Agency employees are held responsible for any gift cards in their possession which are lost or misplaced.
 - 5) **Reconciliation:** A reconciliation of the gift cards must be conducted every time gift cards are purchased or on at least a monthly basis.
- G. SCAs are required to monitor providers who are using DDAP funds for contingency management on an annual basis.
- H. DDAP staff may review Contingency Management policies and procedures, as well as monitor audit logs, at any time.

PART IX: MISCELLANEOUS

9.00 Miscellaneous

A. Additional Case Management Activities

If the SCA chooses to provide additional activities or services, such as Intensive Case Management (ICM) or Resource Coordination (RC), individuals cannot be required to participate in these or any other ancillary services to be eligible to receive a specific level of care or type of service (e.g., Methadone, Buprenorphine). Additionally, the SCA cannot require that a specific population (e.g., pregnant women, criminal justice, adolescents) participate in ICM or RC or other ancillary services to receive a specific level of care or type of service.

B. Policy and Procedure Updates

If procedures are updated at any time by the SCA, the most current dated version of the policy must be signed off by all staff.

C. TEDS Data

SCAs are required to monitor their contracted treatment providers to ensure TEDS Data is entered in PA WITS within seven business days from the date of occurrence (admission, transfer to another level of care, discharge). SCAs are required to issue corrective action to any contracted provider who fails to enter TEDS data into PA WITS. In addition, the SCA must inform County Program Oversight of any contracted providers on corrective action.

Appendix A: ACRONYMS

AIDS - Acquired Immune Deficiency Syndrome
APSS - Adolescent Placement Summary Sheet
ASAM - American Society of Addiction Medicine
BHMCO - Behavioral Health Managed Care Organization
CHRP – Community-based Harm Reduction Programs
CFR - Code of Federal Regulations
CLAS - Culturally and Linguistically Appropriate Services
CPO - County Program Oversight
CRS -Certified Recovery Specialist
CSR -Continued Stay Review
D&A - Drug and Alcohol
DDAP - Department of Drug and Alcohol Programs
ED - Emergency Department
EI - Early Intervention
ESL - English as a Second Language
HIPAA - Health Insurance Portability and Accountability Act
HIV - Human Immunodeficiency Virus
ICD - International Classification of Disease
ICM - Intensive Case Management
IDU - Injection Drug User
LOA - Letter of Agreement
LOCA - Level of Care Assessment
MA - Medical Assistance
MAT - Medication Assisted Treatment
MET - Minimum Education and Training
MOU - Memorandum of Understanding
NTP - Narcotic Treatment Programs
OVR - Office of Vocational Rehabilitation
OTS - Opioid Treatment Services
RC - Resource Coordination
RSS - Recovery Support Services
SCA - Single County Authority
SUD - Substance Use Disorder
TB - Tuberculosis
VA - Veterans Affairs
WITS - Web Infrastructure for Treatment Services

Appendix B: GLOSSARY

Advocacy: The process of being a proponent for the client in helping to remove any obstacles that may prevent the client from obtaining necessary services.

Appeal: A request for reconsideration of an SCA's decision at progressive stages until a grievance is resolved.

Assessment: A face-to-face interview with an individual to determine an individual's strengths, resources, preferences, limitations, problems, and needs.

Barrier: An impediment to accessing treatment and/or support services.

Case Management: A collaborative process between the client and the case manager that facilitates the access to available resources and retention in treatment and support services, while simultaneously educating the client in the skills necessary to achieve and maintain self-sufficiency and recovery from substance use disorders.

Case Manager: An individual who performs screening, assessments, and/or Case Coordination, to include clinical staff at the provider level performing these functions.

Clinically Managed Low-Intensity Residential Services (Halfway House)- Level 3.1: Programs that offer a supportive living environment with 24-hour staff and integration of clinical services to include at least 5 hours per week of low intensity SUD treatment. Treatment is characterized by services such as individual, group, and family therapy; medication management; and psychoeducation. These services facilitate the application of recovery skills, relapse prevention and emotional coping strategies. They promote personal responsibility and re-integration of the individual into the network systems of work, education, and family life. Services are characterized by a live-in, work out situation.

Clinically Managed Medium Intensity Residential Services (Adolescent) and Clinically Managed High-Intensity Residential Services (Adult) – Level 3.5– Programs designed to serve individuals who, because of specific functional limitations, need safe and stable living environments in order to develop and/or demonstrate sufficient recovery skills so that they do not immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care. These programs assist individuals whose SUD is currently so out of control that they need a 24-hour supportive treatment environment to initiate or continue a recovery process that has failed to progress.

Continued Stay Review: The process for reviewing the appropriateness of continued stay at a level of care and/or referral to a more appropriate level of care.

Early Intervention: An organized screening and psycho-educational service designed to help individuals identify and reduce risky substance use behaviors. These early intervention services can include group and individual discussion (e.g. impaired driving programs).

Emergent Care: Those conditions related to detoxification, psychiatric, and prenatal that require an immediate referral for services.

Engagement: The process through which the case manager establishes rapport with a client or potential client.

Grievance: A written complaint by an individual regarding a decision made by an SCA related to denial or termination of services, level of care determination, length of stay in treatment, length of stay in ICM, determination of financial liability, or violation of the individual's human or civil rights.

Harm Reduction: A practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower PWUD and their families with the choice to live healthier, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of PWUD, especially those in underserved communities, in these strategies and the practices that flow from them. Substance Abuse and Mental Health Services Administration: Harm Reduction Framework. Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2023.

Health Equity- the absence of unfair, avoidable, or remediable differences among groups of people.

Health Insurance Portability and Accountability Act (HIPAA): Federal regulation addressing healthcare issues related to the standardization of electronic data, the development of unique health identifiers, and security standards protecting confidentiality and the integrity of health information.

Intensive Outpatient: An organized non-residential SUD treatment service provided according to a planned regime consisting of regularly scheduled treatment sessions. Treatment consists of 9 hours of structured programming per week for adults and 6 – 19 hours of service/week for adolescents (Note: IOP is licensed as an outpatient activity).

Level of Care: Intensity and types of treatment services ranging from outpatient to medically- managed residential.

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

Medically Managed Intensive Inpatient Services- Level 4: An organized service delivered in an acute care inpatient setting. It is appropriate for patients whose acute biomedical, emotional, behavioral, and cognitive problems are so severe that they require primary medical and nursing care.

Medically Managed Intensive Inpatient Withdrawal Management – Level 4WM: An organized service delivered by medical and nursing professionals that provides for 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting. Services are delivered under a defined set of physician-approved policies and physician-managed procedures or medical protocols.

Medically Monitored Intensive Inpatient Services (Adult) & Medically Monitored High-Intensity Inpatient Services (Adolescent)- Level 3.7: Programs that provide a planned and structured regime of 24-hour professionally directed evaluation and observation, medical monitoring, and addiction treatment in an inpatient setting. They are appropriate for patients whose sub-acute biomedical and emotional, behavioral, or cognitive problems are so severe they require inpatient treatment but who do not need the full resources of an acute care general hospital or a medically managed inpatient treatment program.

Medically Monitored Inpatient Withdrawal Management – Level 3.7WM: An organized service delivered by medical and nursing professionals, which provides 24-hour evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols.

Medication Assisted Treatment (MAT): FDA-approved medications, to be used in conjunction with substance use disorder treatment, designed to assist in recovery.

Minimum Education and Training Requirements (METs): Employment standards established by the State Civil Service Commission.

Opioid Treatment Services: An umbrella term that encompasses a variety of pharmacological and non-pharmacological treatment modalities including Methadone, Buprenorphine, and Naltrexone.

Outpatient: An organized, non-residential treatment service provided in regularly scheduled treatment sessions. Treatment consists of 9 - 19 hours of structured programming per week for adults and 6-19 hours of service/week for adolescents.

Overdose: A situation in which an individual is in a state requiring emergency medical intervention because of the use of any mood-altering substances.

Partial Hospitalization: The provision of a planned format of skilled treatment services delivered on an individual and group basis. Partial hospitalization is designed for those individuals who would benefit from more intensive services than are offered in outpatient treatment programs, but who do not require 24-hour care. This environment provides multi-modal and multi-disciplinary programming facilitated by an interdisciplinary team. Services consist of 20 or more hours per week.

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

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

Recovery Support Services (RSS): Recovery support services are non-clinical services that assist individuals and families to recover from alcohol and other drug problems. These services complement the focus of treatment, outreach, engagement and other strategies and interventions to assist people in recovery in gaining the skills and resources needed to initiate, maintain, and sustain long-term recovery.

Screening: The first step in identifying the presence or absence of alcohol or other drug use whereby data is collected on an individual in order to determine if a referral for emergency services is warranted.

Self-sufficiency: The point at which the client is able to maintain recovery efforts and service needs without the help of the case manager or significant support from other social service agencies.

Single County Authority (SCA): Local entities responsible for program planning and the administration of federal and state-funded grants agreements and contracts.

Social Determinants of Health (SDOH) - the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

The ASAM Criteria, 2013: Criteria used to determine the appropriate level of care and type of service.

Treatment-Related Needs: Needs that the individual may have in the following areas: education/vocation, employment, physical health, emotional/mental health, family/social, living arrangements/housing, legal status, basic needs (food, clothing, utilities), life skills, childcare, and transportation.

Withdrawal Management: Services to assist a patient's withdrawal. Withdrawal syndrome is the onset of a predictable constellation of signs and symptoms following the abrupt discontinuation of, or rapid decrease in, dosage of a psychoactive substance.

Appendix C: HIV/HEPATITIS SERVICES IN DRUG AND ALCOHOL TREATMENT FACILITIES

The Pennsylvania Department of Health (DOH) in partnership with the Pennsylvania Department of Drug and Alcohol Programs (DDAP) recommends that clients of licensed drug and alcohol treatment facilities are informed of available HIV and viral hepatitis services.

Any entity providing LOCA must also provide the following:

Educational Services

All clients seeking SUD services funded by the SCA must receive HIV and viral hepatitis educational materials.

Vaccination Services

All clients seeking SUD services funded by the SCA must be offered:

- o Hepatitis A vaccination onsite or provided referral
 - _____ Vaccine offered.
 - _____ Vaccine refused.
 - _____ Referral provided.
 - _____ Previous vaccination documented.
- o Hepatitis B vaccination onsite or provided referral
 - _____ Vaccine offered.
 - _____ Vaccine refused.
 - _____ Referral provided.
 - _____ Previous vaccination documented.

Testing Services

DOH and DDAP require, and the CDC recommends, that all adult clients seeking SUD services funded by the SCA must be tested for HIV and hepatitis C.:

- o HIV testing onsite or provided referral
 - _____ HIV rapid test provided.
 - _____ HIV blood draw performed.
 - _____ HIV testing refused.
 - _____ HIV testing referral provided.
 - _____ HIV positive status documented.
- o Hepatitis C virus (HCV) testing onsite or provided referral
 - _____ HCV rapid test provided.
 - _____ HCV blood draw performed.
 - _____ HCV testing refused.
 - _____ HCV testing referral provided.
 - _____ HCV positive status documented without subsequent treatment.

In addition, DOH and DDAP also require clients seeking SUD services funded by the SCA must also be tested for Hepatitis B

- o Hepatitis B virus (HBV) testing onsite or provided referral
 - _____ HBV rapid test provided.
 - _____ HBV blood draw performed.
 - _____ HBV testing refused.
 - _____ HBV testing referral provided.
 - _____ HBV positive status documented.

Treatment Services

All clients seeking SUD services funded by the SCA who are living with HIV, hepatitis B and/or C should receive treatment.

- o HIV
 - _____ HIV care referral provided.
- o HCV
 - _____ HCV care provided onsite.
 - _____ HCV care onsite refused.
 - _____ HCV care referral provided.
- o HBV
 - _____ HCV care provided onsite

Appendix D: SOCIAL DETERMINANTS OF HEALTH SCREENING TOOL AND CASE MANAGEMENT SERVICE PLAN

The Case Management Service Plan (CMSP), (referred to as a “Recovery Plan” in PA WITS), is an assessment of treatment-related needs that must be addressed at the time of LOCA and updated no less than every 30 days throughout an individual’s time in treatment.

SCAs will utilize the Social Determinants of Health Screening Tool below to identify an individual’s additional needs for support during the time of assessment to help identify goals for the Case Management Service Plan. If an individual identifies a need for service in any other domains, it should be reflected on the CMSP along with interventions.

Healthcare coverage: (i.e., medical assistance; healthcare marketplace; veteran’s benefits; etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Basic Needs:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Food</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Clothing</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Housing</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Transportation</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Utilities</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical Health (i.e., locating a PCP; medication management; medical issues; pregnancy testing; prenatal/postpartum care; TB/Hepatitis/HIV testing & treatment; etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Employment (i.e., resume writing; CareerLink referral; OVR, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mental Health Services (i.e., MH treatment referral; psychotropic medication management, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Substance Use Disorder Services (i.e., SUD treatment referral; MOUD referral, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Family Assistance (i.e., counseling; education; resources, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Childcare (i.e., childcare access, childcare costs, custody/visitation, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Legal Status (i.e., referral for legal assistance; coordinating with probation/parole, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Education (i.e., GED, tutoring, English as a Second Language courses, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Life Skills (i.e., cooking; cleaning; grocery shopping; budgeting; etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Social (i.e., recovery supports; social skills; developing healthy leisure activities; etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

On the following page, you will find a sample Case Management Service Plan that can be used as a template and/or for reference.

Case Management Service Plan

UCN:			
Date:			
Individual Name:			
Goal Statement: <i>(Needs identified in the individual's words; ex. 'Housing')</i>	Objective(s): <i>(What are the objectives related to the needs identified by individuals? Ex. 'Individual will obtain employment.')</i>	Action Steps: <i>(What steps will be taken to achieve the objective? ex. 'Individual will attend resume building course at CareerLink.')</i>	Target Date:

**Appendix E: VIRAL HEPATITIS PREVENTION/TREATMENT REFERRAL
ACCEPTANCE/DECLINATION**

ACCEPTANCE:

I understand there is a strong association between substance use and viral hepatitis risk. I have been offered trauma-informed and culturally responsive educational materials that included general information on viral hepatitis, information on vaccines for hepatitis A and B; prevention and harm reduction strategies; test result interpretation; and information about local providers who offer services for prevention and treatment of viral hepatitis. Based on the information I received, I am making an informed decision to accept the viral hepatitis referral(s) at this time.

DECLINATION:

I understand there is a strong association between substance use and viral hepatitis risk. I have been offered trauma-informed and culturally responsive educational materials that included general information on viral hepatitis, information on vaccines for hepatitis A and B; prevention and harm reduction strategies; test result interpretation; and information about local providers who offer services for prevention and treatment of viral hepatitis. Based on the information I received, I am making an informed decision to decline the viral hepatitis referral(s) at this time. If in the future I change my mind, I understand that I can reach out to my case manager for a referral at any time.

CHECK ONE:

I ACCEPT Viral Hepatitis prevention/treatment referral.

I DECLINE Viral Hepatitis prevention/treatment referral.

Individual Name: _____

Individual Signature: _____

Date: _____

Appendix F: HIV TESTING/TREATMENT REFERRAL ACCEPTANCE/DECLINATION

ACCEPTANCE:

I understand there is a strong association between substance use and human immunodeficiency virus (HIV). I have been offered trauma-informed and culturally responsive educational materials that included general information on HIV basics; HIV testing options and procedures; test result interpretation; methods of HIV prevention (including PrEP); and information about local providers of HIV prevention and care services. Based on the information I received, I am making an informed decision to accept the HIV testing/treatment referral(s) at this time.

DECLINATION:

I understand there is a strong association between substance use and human immunodeficiency virus (HIV). I have been offered trauma-informed and culturally responsive educational materials that included general information on HIV basics; HIV testing options and procedures; test result interpretation; methods of HIV prevention (including PrEP); and information about local providers of HIV prevention and care services. Based on the information I received, I am making an informed decision to decline the HIV testing/treatment referral(s) at this time. If in the future I change my mind, I understand that I can reach out to my case manager for a referral at any time.

CHECK ONE:

I ACCEPT HIV testing/treatment referral.

I DECLINE HIV testing/treatment referral.

Individual Name: _____

Individual Signature: _____

Date: _____