I. Purpose:

To establish protocol for coordinating service delivery to ensure the most comprehensive process for meeting an individual's treatment and treatment-related needs throughout the recovery process.

II. Policy:

The process of Coordination of Services is intended to promote self-sufficiency and empower the individual to assume responsibility for his or her recovery and must be offered to every individual receiving services paid for by the SCA.

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. **Recovery Plan**

In order to track and document the delivery of Coordination of Services paid for by the SCA, a Recovery Plan must be completed during the assessment and updated every 60 days thereafter. The initial plan and all updates must be completed in WITS. Through a collaborative process, the case management specialist/provider staff and individual shall identify needs within specific domains. Domains identified in WITS include the following: healthcare coverage; basic needs; physical health; emotional/mental health; family; child care; legal status; education/vocation; life skills; social; and employment.

B. **Access to Healthcare Coverage:**

If it is determined that an individual is in need of healthcare coverage, such as Medical Assistance, provider staff must provide, or arrange for assistance with the process to access such coverage. It is not acceptable for provider staff to direct individuals to apply for healthcare coverage on their own or refer them to another entity for these services. Provider staff shall provide assistance with any and all appropriate healthcare applications until proper enrollment has occurred based upon eligibility.

C. **ASAM and Continued Stay Reviews:**

The SCA/Provider shall utilize the ASAM criteria throughout the course of treatment to ensure that care is person-centered. An individual's treatment needs are expected to be addressed throughout the individual's treatment episode according to the guidelines above. Additionally, the individual's level of care is to be reviewed throughout their treatment episode in accordance with treatment criteria.

ASAM guidelines are clear that progress in treatment should occur at "regular intervals" relevant to the individual's severity of illness and level of function. The SCA shall utilize the continued stay guidelines as outlined in the ASAM criteria. All initial ASAM and Continued Stay Review ASAM information must be entered into PA WITS.

D. **Re-Engagement:**

The provider is required to have a mechanism in place to address re-engagement for those who do not show for their LOCA, the first treatment appointment, or who leave treatment before they are successfully discharged. In the event of any of these scenarios, provider staff shall attempt to reach out to the individual in question no less than two distinct times using any means to attempt re-engagement. All attempts at re-engagement shall be documented in the individual's file. While all means of attempt to re-engage with individuals is acceptable, case management staff are encouraged to attempt to engage with the individual by the means which may be most successful and are encouraged to look at multiple means when attempting to re-engage individuals in order to increase the likelihood of success.

Attempted re-engagement may include but is not limited to the following:

- A phone call, letter, text, or e-mail to re-engage
- With consent, an attempt to engage the individual through family/other contacts provided
- With consent, an attempt to engage the client physically at an appropriate location (IE: County CY&F, probation office, recovery house, etc.)
- Offer of resources to access if they choose not to re-engage
- Offer of YADAC's contact information

E. **Door to Door Warm Hand-Off:**

The provider is required to have a mechanism in place to ensure that direct contact is made from the LOCA to the recommended level of care and subsequent levels of care throughout the individual's treatment. This mechanism must include that a follow-up contact shall be made to ensure the individual was admitted as planned. Such contacts shall be documented in the individual's file.

F. **Documentation:**

Following termination of services, whether successful or not, the provider shall document that the individual is no longer receiving services from the SCA and a reason why services ended. (Example: the individual is no longer utilizing SCA funding) Furthermore, and with appropriate signed consents, completed documents may be shared between the SCA Case Management Staff and contracted treatment providers.

Approved By:

Audrey Gladfelter _____ 1/10/2022 _____

YADAC Administrator Date