

**PREFERRED PROVIDERS:  
SUBSTANCE USE DISORDER TREATMENT  
STANDARDS**

January 30, 2018

<http://www.healthvermont.gov/alcohol-drugs>

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## I. Introduction

The Vermont Department of Health (VDH), Division of Alcohol and Drug Abuse Programs (ADAP) in partnership with state and community-based public and private organizations aims to create an accountable, comprehensive system of services and supports that empowers Vermonters to embrace resiliency, wellness, and recovery by becoming active participants in the management of their treatment and recovery. This system includes the entire range of services from prevention, early intervention, and treatment through recovery, and is composed of a continuum of timely, interconnected and coordinated components with multiple entry points.

These ***Treatment Standards*** are subject to change. The Vermont Department of Health (VDH), Division of Alcohol and Drug Abuse Programs (ADAP) will institute a formal process to send out notice of changes with the effective date and to track changes to Preferred Providers' Executive and Clinical Directors Notification of changes will be posted to the VDH/ADAP website.

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## II. Summary of Updates

Date	Section Information	Section Number
	Changed title of document from “Guidelines” to “Standards”	N/A
	Changed “substance abuse” or “addiction” to substance use disorder	Throughout
	Changed organization to provider	Throughout
	Removed many references to written policies and procedures and added a definition of policy to specify that it is written.	Throughout
	Changed individual to person served	Throughout
	Changed “will” to “must”	Throughout
	Added definitions for: <ul style="list-style-type: none"> <li>• American Society of Addiction Medicine Criteria</li> <li>• Culturally and Linguistically Appropriate Services (CLAS) Standards</li> <li>• Critical incident</li> <li>• Grievance</li> <li>• Medication</li> <li>• Office-based Outpatient Treatment</li> <li>• Preferred Provider</li> <li>• Prescribing Professional</li> <li>• Publicly Available</li> <li>• Standard</li> <li>• Substance Use Disorder</li> </ul>	Definitions
	Changed “Clinician” to “Counselor”	Definitions
	Clarified definitions for long term residential and short term residential length of time	Definitions
	Clarified definition for medication assisted treatment	Definitions
	Clarified definition for procedure	Definitions
	Clarified definition for Residential Withdrawal Management Services	Definitions
	Timeframe for policies and procedures	1.3
	Moved language regarding cancellation of program of services	1.4
	Strategic plan must be publicly available.	3.2
	Removed requirement for providers include analysis of treatment needs in their geographic service area within the strategic plan.	3.2
	New requirement to have a written plan to address the national standards for Culturally and Linguistically Appropriate Services (CLAS).	3.2.3
	Specified that background checks are to be aligned with Medicaid regulations.	5.4
	Specified that personnel policies and procedures must also include code of ethics	5.5.1
	The Provider has a job description for each staff position that contains performance criteria.	5.7.1
	Specified that policies and procedures must require supervision of clinical or direct service personnel that provides substance use disorder services by a qualified licensed professional.	5.10.1

	Changed from “annual report” to “procedure” of utilization management activities.	6.1
	Removed general language regarding healthy, safe, and clean environments due to greater specificity outlined in subsequent sections.	9.0
	Removed “Use of seclusion and/or restraint”	9.3.4
	Removed the requirement for the quality improvement plan to be reviewed by multiple stakeholders within the organization.	10.5.1
	Removed requirement regarding referral to legal entities for representation	11.2.6
	Specified that policies and procedures must include the use of person served labor and employment	11.6
	Changed “Program” to levels of care”	Throughout 12.0
	Removed “case management” as a level of care.	12.1
	Staffing requirements to be in accordance with ASAM Criteria depending on level of care provided.	12.2
	Removed requirement regarding review and update of description of services.	12.3
	Removed “payer sources.”	12.4.1
	Removed language that services must “enhance the quality of life of the persons served.”	12.6
	Specified that staff should demonstrate the skills and abilities necessary for delivering the applicable service modalities to the persons served.	12.7
	Changed “human service” to “social service.”	12.12
	Removed instructional language regarding cross outs, checklists and time records.	13.0
	Included credentials in the requirements of clinical notes.	13.2.9
	Removed mention of credentials within signature and incorporated within section 13.2.9	13.11
	Moved admissions preference language.	14.1.1.3
	Admission timelines for people who use substances intravenously to align with Substance Abuse Prevention and Treatment Block Grant requirements.	14.2-14.3
	Outlines the groups that interim services should have special attention per the Substance Abuse Prevention and Treatment Block Grant requirements.	14.5.4
	Removed waiting list requirement.	14.6
	Publicizes the availability of services for pregnant women per the Substance Abuse Prevention and Treatment Block Grant	14.8
	Orientation policy for individuals not continuously in treatment.	14.9
	Removed “intent to treat” from client orientation policies.	14.9
	Removed the requirement for the client orientation to include the purpose and process of the assessment	14.9.3
	Barriers for treatment participation and necessary accommodations must be assessed in all populations.	15.1.1.7

	Changed “behavioral” to “substance use disorder and mental health”	15.2.6
	Added cultural considerations to required components of assessment.	15.2
	Changed “ages” to “dates of birth”	15.2.8.1
	Updated timelines to accept assessments from preferred providers and licensed professionals for up to 12 months.	15.5
	Changed from “mental status exam” to “mental health exam.”	15.5.2
	Person-centered treatment plans are based on the assessment; the persons’ strengths, needs, abilities, and preferences; and cultural considerations.	17.1.2
	Specified that person-centered treatment plans for OTPs must be completed by the end of the fourth (4th) visit	17.2
	Added language so that there are treatment objectives that are specific to the person served and realistic.	17.3.2
	Aligned supervisor requirements with OPR licensing rules.	17.7
	Specified that Provider must offer a copy of the treatment plan to the client.	17.9
	Replaced “physician” with “prescriber.”	19.5
	Replaced “mental health” with “physical and behavioral health”	20.1
	Replaced “opiate dependence” with “opioid use disorder”	21.0
	Replaced client “problems” with “needs”	22.3
	Replaced “overall plan” with “treatment plan”	22.15.3
	Replaced “in the program” with “at all times”	22.17.6
	Specified that documentation of annual training around medical management and supervision of withdrawal management from alcohol and other must be retained in personnel file.	22.17.7
	Removed “adequate” when referencing personal space for privacy.	24.11.3
	Specified “dietary needs” and removed “restraint and seclusion.”	24.12
	Specified section title “Children and Adolescent Residential Programs.”	25.0

### III. Definitions

**ADMISSION CRITERIA:** Written specifications, which guide the need for, and placement of, persons served within a continuum of treatment services.

**AFTERCARE:** Services supportive of therapeutic gains to persons served who have completed a level of treatment.

**ASSESSMENT:** A process of evaluating and documenting an individual(s) social, mental and physical history and current status to determine if the person(s) has a diagnosable condition and is in need of treatment services.

**AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) CRITERIA:** set of guidelines for placement, continued stay and transfer/discharge of patients with substance use disorders and co-occurring conditions.

**BUDGET:** An itemized listing of expected expenses and revenues for a given period of time.

**CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) STANDARDS:** a set of fifteen (15) action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

**CONTINUING CARE:** Care that is on-going through different phases of treatment.

**COUNSELING:** The interaction between a clinician and a person served intended to result in a positive change in a person served social, mental and/or physical status.

**CLINICIAN:** An individual who is deemed qualified by the Preferred Provider to provide counseling services.

**COUNSELOR APPROVAL REGULATIONS:** The administrative rules V.S.A. Title 3, Chapter 8 that define the standards and criteria for licensed alcohol and drug treatment counselors.

**CRITICAL INCIDENT:** any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a person.

**DIAGNOSIS:** The process of identifying the specific nature and type of disease and/or problems of an individual(s) based on an assessment of the person's social, mental, and physical history and current status, and of documenting the opinion using the criteria and format of the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).

**DOCUMENTATION:** A written record acceptable as evidence to demonstrate compliance with these standards.

**EMERGENCY CARE:** The provision of immediate diagnosis and care, as well as appropriate referral, to persons having acute substance use disorder related problems.

**EVALUATION:** A systematic process by which treatment or program outcomes are assessed in light of identified goals and objectives.

**FOLLOW-UP:** A contact with a person served after discharge for the purposes of determining the person served post-treatment adjustment and assessing the impact of programming.

**GRIEVANCE:** An expression of dissatisfaction about any matter.

**HUMAN SUBJECT RESEARCH:** Scholarly or scientific investigation that involves the use of persons served as subjects.

**INFORMED CONSENT:** The agreement to participate in treatment based upon an understanding of the rules, expectations and procedures involved in treatment.

**INTERPRETIVE SUMMARY:** Central theme of the person served that incorporates interrelationships between sets of findings including the person's needs, strengths, and limitations. It should include clinical judgments regarding the course of treatment, the recommended treatments, and level of care, length, and intensity of treatment.

**INTENSIVE OUTPATIENT PROGRAM (IOP):** ASAM Level 2.1 states that intensive outpatient programs are 9- 18 hours (6 or more hours for adolescents) of structured programming per week, consisting primarily of individual, group, and family counseling, medication management, and education about substance-related and mental health problems. The patient's needs for psychiatric and medical services are addressed through consultation and referral arrangements if the patient is stable and requires only maintenance monitoring. (Services provided outside the primary program must be tightly coordinated.)

**INTERIM SERVICES:** Interim services include counseling and education about tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that TB transmission does not occur, as well as referral for TB treatment services, if necessary. For pregnant women, interim services also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care.

**LONG-TERM RESIDENTIAL:** A residential program whose length of stay is intended to exceed ninety (90) calendar days.

**MEDICATION:** Refers to a specific FDA-approved drug for substance use disorder treatment such as buprenorphine, methadone, or injectable naltrexone (for opioid use disorder), and naltrexone, disulfiram and acamprosate (for alcohol use disorder).

**MEDICATION ASSISTED TREATMENT (MAT) - HUB:** A regional center providing comprehensive substance use disorder treatment, Health Home, and rehabilitation services for patients receiving methadone maintenance treatment, and dispensed buprenorphine to clinically complex patients.

**MEDICATION ASSISTED TREATMENT (MAT) - SPOKE:** A team of health care professionals providing ongoing care for patients receiving buprenorphine that is comprised of a designated Provider who is the prescribing OBOT physician and the team of collaborating health and substance use disorder professionals who monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency management, and case management services.

**OFFICE-BASED OUTPATIENT TREATMENT (OBOT):** Provider practice for prescribing buprenorphine as established by the Drug Abuse and Treatment Act of 2000. In Vermont, OBOTs are often referred to as "Spokes". An OBOT may be a preferred provider, an individual provider practice or several providers practicing as a group.



**OUTPATIENT PROGRAM:** ASAM Level 1 states that an organized nonresidential treatment service or an office practice with designated substance use disorder professionals and clinicians providing professionally directed alcohol and other drug treatment that is co-occurring capable and are tailored to the individual's severity and function. This treatment occurs in regularly scheduled sessions usually totaling fewer than nine (9) contact hours per week (six (6) hours for adolescents).

**OUTREACH:** The development and implementation of a plan to interact with a community or geographic area and its organizations for the purpose of identifying persons in need of services, alerting individuals and organizations to the availability and location of services, encouraging and assisting persons to accept and enter treatment services, and developing organizational affiliations to facilitate the referral of persons served when necessary.

**PERSON SERVED:** An individual who is receiving treatment services that are governed by these standards.

**POLICY:** A written and dated statement or course of action designed to determine and govern the decisions, activities, procedures and/or operations of an organization and its employees and representatives.

**PREFERRED PROVIDER:** must have obtained Full or Provisional Certification pursuant to the Substance Abuse Treatment Certification Rule.

**PRESCRIBING PROFESSIONAL:** licensed health care professional with the authority to prescribe controlled substances.

**PROCEDURE:** A written and dated series of activities designed to implement organizational goals or policy.

**PROGRAM:** An organizational entity, which provides treatment services to persons with a substance use disorder. A program may be an identified administrative unit within a larger organization; it may also consist of more than one component.

**PROGRAM DIRECTOR:** The person responsible for the technical and programmatic aspects of the program. This person should provide direct supervision of the day-to-day aspects of program operation.

**PROGRAM EVALUATION:** A written system designed and implemented to measure both the process and outcome of a treatment program.

**PUBLICLY AVAILABLE:** posted on the organization's website and/or available in hardcopy upon request.

**REFERRAL:** The process by which a person served is directed to needed services not provided by the Preferred Provider.

**RESIDENTIAL PROGRAMS:** An organized service in alignment with ASAM Criteria 3<sup>rd</sup> edition 3.1 to 3.7 level of care that is provided by trained staff with 24-hour supervision, observation, and support to ensure the provision of treatment services to a person served who reside on the premises during the course of treatment.

**RESIDENTIAL WITHDRAWAL MANAGEMENT SERVICES:** ASAM Level 3.7 - WM: Medically Monitored Inpatient Withdrawal Management is an organized service delivered to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care by medical and nursing

professionals, which provides for 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. These programs must comply with the requirements of ASAM, Third Edition.

**RISK MANAGEMENT PLAN:** A document prepared to foresee risks, to estimate the impacts, and to create response plans to mitigate them.

**SCHEDULE OF FEES:** Maximum rate charged for specific services.

**SCREENING:** A simple test performed to identify those who are likely to have a specified disease and require further assessment.

**SHORT-TERM RESIDENTIAL:** A residential program whose initial length of stay is not intended to exceed thirty (30) calendar days.

**SPECIAL POPULATION:** A target group characterized by specific demographic, clinical and/or other unique features.

**STANDARD:** Minimum expectations related to operations, staff conduct, organizational performance, structure and/or work place environment that must be followed and enforced.

**SUBSTANCE USE DISORDER (SUD):** the clinically accurate term to describe the constellation of impairments caused by repeated misuse of a substance.

**INTERN:** An individual who, as part of a matriculation toward a formal academic degree, has negotiated to work in an approved program for a specific period of time.

**SUPERVISION:** Supervision is defined as a formal, systematic process that focuses on job skill development and integration of knowledge.

**TREATMENT:** Planned and continuing services extended to the person served.

**TREATMENT PLAN:** A written document created to guide the course of treatment that is developed with the participation of the person served, which is appropriate to meet the person's needs, and which specifies goals, activities, and services determined through the process of assessment.

**UTILIZATION REVIEW:** A process for monitoring the use, delivery, and cost-effectiveness of services.

**VOLUNTEER:** A non-paid employee.

**WITHDRAWAL MANAGEMENT SERVICES:** the provision of medical and/or social services in a facility staffed 24 hours per day to persons served who are experiencing or are at risk for experiencing physical withdrawal from alcohol or other drugs. Social setting withdrawal management services take place in a non-medical facility, a unit of which has been specifically structured and staffed to provide the above services. Medical withdrawal management services are delivered by medical and nursing professionals and the symptoms of the person served are severe enough to 24-hour inpatient care.

## IV. General Program Standards

**All Providers seeking certification must be in compliance with the General Program Standards (Sections 1-20). Population and Core Specialty Program Standards (residential, child and adolescent, IOP, etc.) must additionally comply with the standards outlined in Sections 21 through 25.**

### 1.0 Certification Procedure and Review

- 1.1 All requirements associated with the certification and application process can be found within the Substance Abuse Treatment Certification Rule.
- 1.2 A site visit of each service location must be conducted by representatives of ADAP before a certificate is issued. The site must be evaluated for its appropriateness to provide the services planned.
- 1.3 Policies and Procedures must correspond to the standards set forth in the **Treatment Standards** document and must be dated to within five (5) years from the date of the site visit.
- 1.4 In the event that the Provider must cancel their services and cease operations, it must ensure that:
  - 1.4.1 All services, including the administration of programs and activities provided hereunder must be maintained during such ninety (90) calendar day period.
  - 1.4.2 ADAP must be notified upon the start of the 90 calendar day period.

### 2.0 Leadership and Governance

- 2.1 The Preferred Provider has a leadership and governance structure.
  - 2.1.1 The Provider identifies those responsible for leadership and governance.
- 2.2 Governance is ultimately responsible for the safety and quality of care, treatment, or services.
  - 2.2.1 Governance defines in writing its responsibilities.
  - 2.2.2 Governance works with leadership to annually evaluate the Provider's performance in relation to its mission, vision and goals.
- 2.3 The governance meets at least quarterly as documented by written and dated meeting minutes that are publicly available.
- 2.4 The Provider has an organizational chart that reflects current staffing.
  - 2.4.1 The organizational chart is made available to all staff and members of the governing body.

### 3.0 Planning

- 3.1 The mission, vision and goals of the Preferred Provider support the safety and quality of care, treatment, or services.
  - 3.1.1 The mission, vision, values and goals are defined.
  - 3.1.2 The Provider develops strategic, operational, and program related plans and policies to carry out the vision and to achieve the mission.
- 3.2 There is a written, dated and publicly available strategic plan.
  - 3.2.1 The strategic plan is developed with input from persons served, personnel, and other stakeholders.
  - 3.2.2 The strategic plan must at minimum:
    - 3.2.2.1 Sets goals and priorities.

- 3.2.2.1.1** Include an evaluation process to measure all identified goals and objectives.
        - 3.2.2.2** Be reviewed and updated (as necessary).
        - 3.2.2.3** Identify the methods to be utilized to coordinate services with other service providers.
- 3.2.3** The Provider has a written plan to address the national standards for Culturally and Linguistically Appropriate Services (CLAS). This plan must be updated at least annually and include accomplishments, activities with progress to-date and next steps, and challenges.

#### **4.0 Fiscal Management**

- 4.1** The Preferred Provider must have fiscal management practices that demonstrate the following:
  - 4.1.1** Medicaid certification.
  - 4.1.2** A published fee schedule based on the federal poverty index (<http://aspe.hhs.gov/poverty/index.cfm>).
  - 4.1.3** Reliable monitoring of billing and expenditures versus revenues by person served, by staff, by service, by program, and by service provider, in accordance with generally accepted accounting principles (GAAP)
  - 4.1.4** Providers may receive funds from sources other than ADAP to carry out its duties for the population(s) whom they are certified to serve by ADAP. Funds received from such sources must be identified to ADAP.
  - 4.1.5** The Provider uses a formal written procedure to prepare a revenue and expense budget.

#### **5.0 Human Resources**

- 5.1** The Provider has a written description of its non-discrimination practices, policies, and procedures.
  - 5.1.1** The policy addresses non-discrimination on the basis of:
    - 5.1.1.1** Race.
    - 5.1.1.2** Religion.
    - 5.1.1.3** Gender.
    - 5.1.1.4** Ethnicity.
    - 5.1.1.5** Age.
    - 5.1.1.6** Disabilities.
    - 5.1.1.7** Sexual orientation.
    - 5.1.1.8** Real or perceived HIV status.
- 5.2** The Provider has a code of ethics, which governs the behavior of all staff, including business practices.
  - 5.2.1** There are procedures for investigating and acting upon violations, including reporting to authorities as warranted.
- 5.3** The Preferred Provider has policies that require staff responsible (as per their job descriptions) for substance use disorder counseling to:
  - 5.3.1** Be licensed in Vermont to provide substance use disorder treatment. If the non-licensed staff does not meet this requirement, they must cease providing direct services.

- 5.4** The Provider must have policies and procedures for conducting background checks on personnel in compliance with state and federal laws, including Medicaid regulations.
- 5.5** The Provider must have and make available to all employees a personnel policy and procedures manual.
  - 5.5.1** The personnel policies and procedures manual must include, at a minimum, information on employee:
    - 5.5.1.1** Recruitment, hiring, benefits, and promotion;
    - 5.5.1.2** Training and development;
    - 5.5.1.3** Safety and health;
    - 5.5.1.4** Assistance programs;
    - 5.5.1.5** Disciplinary systems and practices;
    - 5.5.1.6** Grievance mechanisms;
    - 5.5.1.7** Wages, hours, and salary administration;
    - 5.5.1.8** Rules of conduct;
    - 5.5.1.9** Code of ethics;
    - 5.5.1.10** Performance appraisals;
    - 5.5.1.11** Equal employment opportunity (EEO) and affirmative action policies;
    - 5.5.1.12** Confidentiality;
    - 5.5.1.13** Methods and procedures for supervision including supervision of clinical staff.
  - 5.5.2** There is written and dated documentation in the personnel record that the staff person has reviewed the personnel policies and procedures.
  - 5.5.3** There is written and dated documentation that the personnel policies and procedures are reviewed and updated (as necessary).
  - 5.5.4** There is a mechanism for notifying all employees of changes in personnel policies and procedures, which is documented.
- 5.6** Each employee must be oriented to all policies and procedures pertinent to his/her job description.
  - 5.6.1** There is written and dated documentation, signed by the employee, in the personnel file, that he/she has received this orientation.
  - 5.6.2** The orientation must include receipt of and discussion about federal confidentiality regulations, 42 CFR Part 2 and as amended.
  - 5.6.3** There is written and dated documentation, signed by the employee, that he/she agrees to abide by the federal confidentiality regulations, 42 CFR Part 2 and as amended.
  - 5.6.4** The orientation must include evidence that the staff member has completed a training on documentation policies and procedures that is inclusive of the items outlined in Section 13.0.
- 5.7** The Provider has a job description for each staff position that contains information on the:
  - 5.7.1** The written job descriptions contain information on the:
    - 5.7.1.1** Credentials and/or licensure required;
    - 5.7.1.2** Duties and responsibilities;
    - 5.7.1.3** Minimum levels of education and training required;
    - 5.7.1.4** Related work experience required;
    - 5.7.1.5** Reporting and supervisory responsibilities;
    - 5.7.1.6** Salary range of the position.
    - 5.7.1.7** Performance criteria.
  - 5.7.2** Changes in the duties and responsibilities of positions are reflected in revisions and updates of job descriptions.

- 5.7.3 There is dated documentation in the personnel file, signed by the employee, that a copy of the current job description has been provided to him/her.
- 5.8 A personnel record is maintained for each member of the staff.
  - 5.8.1 The personnel record contains documentation of the employees' credentialing documents.
  - 5.8.2 The personnel record contains signed and dated documentation of the employees' performance appraisals.
  - 5.8.3 Employees may access their own personnel records for review and comment.
  - 5.8.4 Personnel records are stored, maintained, and utilized in such a way as to protect employee confidentiality.
  - 5.8.5 There is a staff development plan for each employee which addresses training and continuing education needs.
- 5.9 Performance appraisals are conducted using pre-established performance criteria based on the specific responsibilities of the position as stated in the job description.
  - 5.9.1 Performance objectives established in the previous period must be evaluated.
  - 5.9.2 Dated performance appraisals are conducted for each staff person at least annually.
  - 5.9.3 There is dated documentation, in the personnel record, the staff have reviewed, signed, and discussed their performance appraisals with their supervisor.
  - 5.9.4 All employees must participate in an employee development plan that addresses strengths, weaknesses, and agreed upon goals for the coming period.
  - 5.9.5 Performance appraisals must document deficient performance and establish a plan to address the deficiencies.
- 5.10 The Provider has policies and procedures for the supervision of all individuals providing direct services.
  - 5.10.1 The policies and procedures must require supervision of any clinical or direct service personnel that provides substance use disorder services by a qualified licensed professional at a minimum of twice a month.
- 5.11 Ongoing supervision of clinical or direct service personnel is documented.
- 5.12 The Provider has a written and dated policy and procedure for employees who have problems that interfere with acceptable job performance.
- 5.13 Students, interns, or volunteers are to be held to the standards outlined by this section.
  - 5.14 There is a written and dated staff development plan for each employee which addresses training and continuing education needs.
    - 5.14.1 The staff development plan identifies objectives for staff development and credentialing activities.
- 5.15 The Provider makes continuing education in substance use disorder treatment and prevention services available to employees who provide the services.

## **6.0 Utilization Management**

- 6.1 The Provider has a written procedure of its utilization management activities.

## **7.0 Risk Management**

- 7.1 The Provider must implement a risk management plan.

## **8.0 Accessibility**

- 8.1** The Provider must make accommodations for clients with language barriers or with special needs per American Disability Act (ADA) Federal guidelines.

## **9.0 Health and Safety**

- 9.1** The Provider must implement an infection control policy which is in compliance with OSHA/VOSHA and Vermont Department of Health regulations that include the prevention of transmission of tuberculosis and that address the following:
- 9.1.1** Screening patients and identifying those individuals who are at risk of becoming infected.
  - 9.1.2** Testing to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment for the individual.
  - 9.1.3** Appropriate medical evaluation and treatment for individuals infected with mycobacteria tuberculosis.
  - 9.1.4** Identification of those individuals who are at high risk of becoming infected.
  - 9.1.5** Counseling individuals with respect to tuberculosis.
  - 9.1.6** Case management activities to ensure that individuals receive such services.
  - 9.1.7** Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including 42 CFR Part 2.
  - 9.1.8** For persons denied admission to the program on the basis of lack of capacity, the program refers such persons to other providers of tuberculosis services.
- 9.2** The Provider has procedures for addressing critical incidents that include:
- 9.2.1** Reporting.
  - 9.2.2** Remedial action.
  - 9.2.3** Timely debriefings.
  - 9.2.4** The following incidents:
    - 9.2.4.1** Serious Illness.
    - 9.2.4.2** Injuries.
    - 9.2.4.3** Deaths.
    - 9.2.4.4** Alleged or confirmed abuse or neglect.
    - 9.2.4.5** Medical errors.
    - 9.2.4.6** Communicable diseases.
    - 9.2.4.7** Infection control.
    - 9.2.4.8** Aggression or violence.
    - 9.2.4.9** Use and unauthorized possession of a weapon.
    - 9.2.4.10** Vehicular accidents.
    - 9.2.4.11** Bio-hazardous accidents.
    - 9.2.4.12** Suicide or attempted suicide.
    - 9.2.4.13** Unauthorized use and possession of legal or illegal substances.
    - 9.2.4.14** Sexual abuse/assault.
    - 9.2.4.15** Abduction.
    - 9.2.4.16** Other sentinel events.
- 9.3** Each Provider must define sentinel events for its own purposes and must communicate this definition throughout the organization.
- 9.4** The following critical incidents must be reported using the ADAP designated form to the ADAP Clinical Services Director within 24 hours.
- 9.4.1** Serious illness and/or injuries resulting in medical care as a result of services delivered or on the premises.

- 9.4.2 Death.
  - 9.4.3 Alleged or confirmed assault, including sexual assault by staff or by other.
  - 9.4.4 Medical errors.
  - 9.4.5 Unlawful activity perpetrated on property by staff or by other.
  - 9.4.6 Any incident, marked by seriousness or severity, that is likely to result in attracting negative public attention, or lead to claims or legal action against the State or the reporting entity.
- 9.5 The Provider's policies and procedures for addressing at a minimum for the ADAP reportable critical incidents must include:
- 9.5.1 Conducting timely, thorough, and credible root cause analysis.
  - 9.5.2 Development of an action plan designed to implement improvements to reduce risks.
  - 9.5.3 Implement improvements and monitor the effectiveness of those improvements.
- 9.6 There are policies and procedures for the handling of both licit and illicit drugs brought into the Provider by both persons served and personnel.

## **10.0 Quality Assurance and Performance Improvement**

The purpose of this section is to assure that the Provider is actively engaged in quality improvement and demonstrates the ability to use outcomes from all levels of its operations (consumer care, program effectiveness, and overall administration) to inform decision-making and improve service delivery. This includes the use of data from management and other IT reports to guide decision-making and inform managers related to daily operations as well as longer term planning.

- 10.1 The Provider has clear methods to collect data on all persons served; this data must be generated, compiled, and reported upon at least annually.
- 10.2 At a minimum, data about the persons served must be collected:
  - 10.2.1.1 At intake.
  - 10.2.1.2 At discharge.
  - 10.2.1.3 Ninety (90) days post discharge; this includes non-completed treatment episodes.
  - 10.2.2 The data must be used to inform and link to the Provider's:
    - 10.2.2.1 Strategic plan.
    - 10.2.2.2 Quality improvement plan.
- 10.3 The Provider maintains and implements a quality improvement plan and documents actions toward the areas shown to need improvement.
- 10.4 The quality improvement plan:
  - 10.4.1 Defines the quality improvement structure and procedures.
  - 10.4.2 Includes an analysis of community needs.
  - 10.4.3 Aligns with Provider's goals and objectives.
  - 10.4.4 Assigns responsibility to appropriate individuals or team for maintaining service quality.
  - 10.4.5 Is informed by data and outcomes.
  - 10.4.6 Incorporates measurable goals and objectives.
  - 10.4.7 Incorporates performance indicators:
    - 10.4.7.1 How much did we do?
      - 10.4.7.1.1 Service access.
    - 10.4.7.2 How well did we do it?
      - 10.4.7.2.1 Effectiveness.



**10.4.7.2.2** Efficiency.

**10.4.7.3** Is anyone better off?

**10.4.7.3.1** Satisfaction and feedback from:

10.4.7.3.1.1 Persons served.

10.4.7.3.1.2 Other stakeholders.

**10.5** Evidence of continuous quality improvement should be available and may include:

**10.5.1** Evidence that the quality improvement plan was reviewed by multiple stakeholders (board, managers, staff, team leaders, etc.).

**10.5.2** Evidence of decisions made as a result of improvement information or data trends identified either through the quality improvement plan review or by other teams and activities within the quality improvement structure.

**10.5.3** Evidence of recommendations made or actions taken based on Provider and key stakeholder review and input of the quality improvement plan or other relevant data.

## **11.0 Rights of the Person Served**

**11.1** Rights of the person served must be communicated to the person served:

**11.1.1** In a manner the person served understands.

**11.1.2** Prior to the beginning of service delivery or at the initiation of service delivery.

**11.1.3** When informed consent is not possible due to the inability of the person served to understand his/her rights in the treatment process, documentation of this factor appears in the client record.

**11.2** The Provider's policies promote the following rights of the persons served:

**11.2.1** Confidentiality of information.

**11.2.2** Privacy.

**11.2.3** Freedom from:

**11.2.3.1** Abuse.

**11.2.3.2** Financial or other exploitation.

**11.2.3.3** Retaliation.

**11.2.3.4** Humiliation.

**11.2.3.5** Neglect.

**11.2.4** Access to:

**11.2.4.1** Information pertinent to person served in a timely manner in order to facilitate their decision-making.

**11.2.4.2** Their record.

**11.2.4.3** Their treatment plan.

**11.2.4.4** Participate in developing their individualized treatment plan.

**11.2.5** Informed consent or refusal regarding:

**11.2.5.1** Service delivery

**11.2.5.2** Release of information

**11.2.5.3** Concurrent services

**11.2.5.4** Involvement in human subject research projects, if applicable.

**11.2.6** Access or referral to:

**11.2.6.1** Self-help support services

**11.2.6.2** Advocacy support services

**11.2.7** Adherence to human subject research guidelines and ethics when persons served are involved, if applicable.

**11.2.8** Investigation and resolution of alleged infringement of rights.

- 11.2.9 Other legal rights.
- 11.3 The Provider demonstrates:
  - 11.3.1 Knowledge of legal status of the persons served.
- 11.4 The Provider must implement procedures that conform to ADAP's grievance policy:
  - 11.4.1 Must implement a policy and procedure by which the persons served may file a formal grievance that specifies:
    - 11.4.1.1 That the action must not result in retaliation or barrier to services.
    - 11.4.1.2 How efforts must be made to resolve the grievance.
    - 11.4.1.3 Levels of review, which include availability of external review.
    - 11.4.1.4 Time frames that are prompt for consideration and result in timely decisions for the person served.
    - 11.4.1.5 Procedures for written notification regarding the actions to be taken to address the grievance.
    - 11.4.1.6 The rights of each party.
    - 11.4.1.7 The responsibilities of each party.
    - 11.4.1.8 The availability of advocates or other assistance.
    - 11.4.1.9 The provisions for secondary review of a disputed grievance.
    - 11.4.1.10 Compliance with state requirements for reporting allegations of abuse and neglect.
  - 11.4.2 Makes grievance procedures understandable and readily available to the person served.
  - 11.4.3 Must maintain documentation of the grievance, the results of the investigation and the final resolution.
  - 11.4.4 Must conduct annual reviews of the grievances to determine:
    - 11.4.4.1 Trends
    - 11.4.4.2 Areas in need of improvement
    - 11.4.4.3 Actions to be taken on noted trends and need for improvement.
- 11.5 The Provider has policies and procedures allowing persons served to review their medical record.
- 11.6 The Provider has policies and procedures regarding the use of person served labor and employment that ensure:
  - 11.6.1 The labor is directly related to treatment goals and incorporated within the treatment plan.
  - 11.6.2 The work is performed voluntarily.
  - 11.6.3 All persons served sign a statement during their admission process that all personal work requirements within the context of their treatment plan have been explained to them.
  - 11.6.4 Include guidelines for the employment of people served.
  - 11.6.5 Employment must be in accordance with local, state, and federal laws and regulations.
  - 11.6.6 Employment at prevailing fair market rates.

## 12.0 Levels of Care: Structure and Staffing

- 12.1 The Preferred Provider will be authorized to provide only the specific levels of care and associated services, at specific sites, defined within an ADAP application form and approved and certified by ADAP. Authorization will be considered for the following levels of care:
  - 12.1.1 Withdrawal management (non-medical),

- 12.1.2 Outpatient care,
- 12.1.3 Intensive outpatient care,
- 12.1.4 Residential care,
- 12.1.5 Medication Assisted Treatment (MAT), and
- 12.2 Staffing requirements are in accordance the ASAM Criteria and are determined by the level of care being provided.
- 12.3 For each level of care, there is a description of the services provided and made available to the public that includes:
  - 12.3.1 Its philosophy that includes the Provider’s belief(s) regarding people’s potential for recovery.
  - 12.3.2 Goals.
  - 12.3.3 Description of the service delivery levels/modalities used to achieve program objectives.
  - 12.3.4 Identification of ADAP priority populations and mechanisms to address their needs.
- 12.4 Each level of care:
  - 12.4.1 Documents the following parameters regarding its scope of services:
    - 12.4.1.1 Populations served.
    - 12.4.1.2 Settings.
    - 12.4.1.3 Hours and days of services.
    - 12.4.1.4 Frequency of services.
    - 12.4.1.5 Fees.
    - 12.4.1.6 Referral sources.
    - 12.4.1.7 Specific services offered.
    - 12.4.1.8 Entry criteria.
    - 12.4.1.9 Transition criteria.
    - 12.4.1.10 Exit criteria.
  - 12.4.2 Parameters regarding the scope of services are publicly available.
  - 12.4.3 Reviews the scope of services and updates as needed.
- 12.5 Service delivery models and strategies are based on accepted practice in the field and incorporate current research, evidence-based practice, peer-reviewed publications, clinical practice guidelines, and/or expert professional consensus.
- 12.6 Services must be designed and implemented to:
  - 12.6.1 Support the recovery, health, and well-being of the persons or family served.
  - 12.6.2 Reduce symptoms and needs, and build resilience.
  - 12.6.3 Restore and/or improve functioning.
  - 12.6.4 Support the integration of persons served in the community.
- 12.7 Staff must demonstrate the skills and abilities necessary for delivering the applicable service modalities to the persons served.
- 12.8 The level of care offers, either in-house or through referral of available local support, one or more of the following:
  - 12.8.1 Peer support.
  - 12.8.2 Local advocacy groups.
  - 12.8.3 Self-help groups.
- 12.9 As appropriate, families are:
  - 12.9.1 Encouraged to participate in educational programs offered by the Provider.
  - 12.9.2 Invited to participate in clinical programs or services with the person served, with consent or legal right.
- 12.10 In response to the needs of the persons served, the Provider must:

- 12.10.1** Empower each person served to actively participate with the team to promote recovery, progress, or wellbeing.
- 12.10.2** Provide services that are consistent with the needs of each person served.
- 12.10.3** Be culturally and linguistically competent.
- 12.10.4** Meet as often as needed to carry out decision-making responsibilities.
- 12.11** The Provider implements policies and procedures that address:
  - 12.11.1** The handling of items brought into the Provider by personnel and persons served that include:
    - 12.11.1.1** Illegal drugs.
    - 12.11.1.2** Legal drugs.
    - 12.11.1.3** Prescription medication.
    - 12.11.1.4** Weapons.
  - 12.11.2** The prohibition of the use of tobacco products on the facility grounds and in vehicles owned and operated by non-residential organizations.
- 12.12** The Provider has information available identifying other social service providers who offer related or ancillary services that supplement the principal services of the Provider.
  - 12.12.1** Collaborate with community elder care providers (e.g. area agencies on aging, SASH programs, home health agencies, etc.) in improving mental health and substance use disorder services for the elderly.
- 12.13** Providers providing child and adolescent substance use disorder treatment should make the necessary steps to ensure care is:
  - 12.13.1** Coordinated with family, school, community, behavioral health and physical health, and is: developmentally, cognitively, and culturally appropriate; and with a workforce knowledgeable about child and adolescent substance use disorder treatment.
  - 12.13.2** Developmentally appropriate substance use disorder treatment services that address child and adolescent treatment to effectively engage and treat these groups, and evidence based or emerging practice when possible.
- 12.14** Drug Court Programs must:
  - 12.14.1** Document the person served has been oriented to policies and procedures related to all aspects of legal and clinical services.
  - 12.14.2** Ensure persons served receive clinically appropriate treatment services of sufficient frequency and intensity, as determined by ASAM Criteria.
  - 12.14.3** Ensure that persons served are not excluded from any clinically appropriate and reasonably available treatment modalities.
- 12.15** Public Inebriate Programs must ensure that persons served are:
  - 12.15.1** Screened to determine safety of self and others with appropriate interventions and referrals to medical care as needed.
  - 12.15.2** Offered information and/or referral for care upon discharge.
  - 12.15.3** Appropriately screened for sensorium to determine incapacitation eligibility for admissions.

### **13.0 Documentation**

- 13.1** The Preferred Provider has policies and procedures that define the format and content of records for persons served.
  - 13.1.1** The record must contain:
    - 13.1.1.1** Information collected at admission that includes name, address, date of birth, and gender of the person served.

- 13.1.1.2** Name and contact information for the persons served, family, and any legal authorized representative.
- 13.1.1.3** The preferred language and any special communication needs of the individual served.
- 13.1.1.4** The reason(s) for admission for care.
- 13.1.1.5** Assessment and reassessments.
- 13.1.1.6** Allergies.
- 13.1.1.7** Diagnosis established during treatment.
- 13.1.1.8** Consultant reports.
- 13.1.1.9** Observations relevant to care.
- 13.1.1.10** The response to care.
- 13.1.1.11** Progress notes.
- 13.1.1.12** Medications ordered or prescribed.
- 13.1.1.13** Medication administered, including dose, strength, and route.
- 13.1.1.14** Adverse drug reactions.
- 13.1.1.15** Treatment plan and revisions.
- 13.1.1.16** Orders for tests and their results.
- 13.1.1.17** Advanced directives (including when appropriate for youth).
- 13.1.1.18** Informed consent.
- 13.1.1.19** Documentation of consent by the person served, guardian, or legal authority as applicable for admission, treatment, continuing care, or research.
- 13.1.1.20** Discharge summary.
- 13.1.1.21** Aftercare plan.
- 13.1.1.22** Sign-offs by the person served that is mandated by these standards.
- 13.2** The Provider has a system to protect client records from inappropriate disclosure, and the system:
  - 13.2.1** Complies with all applicable State and Federal laws and regulations, including 42 CFR Part 2.
  - 13.2.2** Includes provisions for employee education on confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosure.
- 13.3** The Provider is in compliance with data and documentation requirements outlined in any grant award from ADAP.
- 13.4** The Provider has a policy and procedure for closing, storing, and destroying person served identifying information.
- 13.5** Documentation of services provided must be legible, of sufficient clarity, and sufficient clinical content (minimum required content is specified for each service) to ensure eligibility for payment.
- 13.6** All clinical and support notes must include:
  - 13.2.1** Identification of the person served such as name, identification number, date of birth
  - 13.2.2** Date the service was rendered
  - 13.2.3** Specific title or code of the service rendered
  - 13.2.4** Location in which the service occurred
  - 13.2.5** Amount of time it took to deliver the service
  - 13.2.6** Reference to the treatment goal for the service
  - 13.2.7** Summary of the service rendered with appropriate clinical content
  - 13.2.8** Specific plan for ongoing treatment

- 13.2.9** Name, title, credentials, and signature(s) of the clinician(s). If not required by the Provider, qualifications, degrees and titles must be on file at the Provider and made available.
- 13.7** Each reimbursed service must be documented in the person's served clinical record.
- 13.8** Providers requesting and demonstrating appropriate safeguards for use of computer-generated signatures may use electronic signature technology. Policies should be in compliance with Federal law 42 CFR Part 2.

## **14.0 Screening and Access**

- 14.1** The Preferred Provider has screening/eligibility policies and procedures that:
  - 14.1.1** Define:
    - 14.1.1.1** How screening is conducted.
    - 14.1.1.2** Eligibility for services.
    - 14.1.1.3** How admissions are prioritized and conducted.
      - 14.1.1.3.1** For programs that serve people who use substances intravenously, preference to treatment is given as follows:
        - 14.1.1.3.1.1 Pregnant women who use substances intravenously
        - 14.1.1.3.1.2 Pregnant women who use substances
        - 14.1.1.3.1.3 People who use substances intravenously
        - 14.1.1.3.1.4 All other people who use substances.
    - 14.1.1.4** Exclusionary or ineligibility criteria.
  - 14.1.2** Address acceptance and refusal of referrals from outside agencies.
  - 14.1.3** Outline treatment of pregnant women through:
    - 14.1.3.1** Compliance with a forty-eight (48) hour time limit within which screening and eligibility determination for pregnant woman is identified and shared with those seeking services and/or the referring agency as clinically appropriate.
    - 14.1.3.2** Referral to ADAP when the Provider has insufficient capacity to provide services to any pregnant women who seek the services from the Provider.
      - 14.1.3.2.1** Any Provider refusing services to a pregnant woman due to insufficient capacity must refer those people to ADAP's Clinical Services Director within forty-eight (48) hours.
- 14.2** Each individual who requests and is in need of treatment for intravenous substance use is admitted to a program no later than:
  - 14.2.1** 14 days after making the request for admission to such a program; or
  - 14.2.2** 120 days after the date of such request, if no such program has the capacity to admit the individual on the date of such request and if interim services, including referral for prenatal care, are made available to the individual not later than 48 hours after such request.
  - 14.2.3** If a person cannot be located for admission into treatment or, if a person refuses treatment, such persons may be taken off the waiting list and need not be provided treatment within 120 days. For example, if such persons request treatment later, and space is not available, they are to be provided interim services, placed on a waiting list and admitted to a treatment program within 120 days from the latter request.
- 14.3** When screening is conducted the Provider must:
  - 14.3.1** Utilize evidence-based tools as clinically appropriate.
  - 14.3.2** Document each person's eligibility.
  - 14.3.3** Identify potential alternative treatment sources when services cannot be provided.

- 14.3.4** Include an interview with the person to be served or referral source.
- 14.3.5** Ensure that screening tools used are uniformly administered and personnel are trained to use the tools prior to administration.
- 14.3.6** Collaborate with community screeners to identify high-risk populations especially individuals involved with child welfare and triage appropriately.
- 14.4** When appropriate, the Provider has a policy and procedure for offering interim services that address, at a minimum, the following:
  - 14.4.1** Counseling and education about HIV and tuberculosis, the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and tuberculosis does not occur.
  - 14.4.2** Referral for HIV or tuberculosis treatment services, if necessary.
  - 14.4.3** Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women.
  - 14.4.4** That special attention is given to the following groups:
    - 14.4.4.1** Pregnant women who use substances
    - 14.4.4.2** Women who use substances and who have dependent children
    - 14.4.4.3** People who use substances intravenously
    - 14.4.4.4** People who use substances and have HIV or tuberculosis
- 14.5** If a crisis assessment is conducted:
  - 14.5.1** It is documented.
  - 14.5.2** The following are addressed:
    - 14.5.2.1** Suicide risk.
    - 14.5.2.2** Danger to self or others.
    - 14.5.2.3** Urgent or critical medical condition(s).
    - 14.5.2.4** Immediate threats.
- 14.6** The Provider utilizes procedures with written and standardized admission criteria for each level of care offered by the Provider.
  - 14.6.1** The admission criteria are publicly available to person served, staff, and community.
  - 14.6.2** The procedure includes criteria for determining that the level of care is appropriate to the needs of the person served.
  - 14.6.3** The procedure addresses acceptance and refusal of referrals from outside agencies.
- 14.7** The provider makes the availability of services and the fact that pregnant women receive preference publicly available, according to section 14.1.1.3.1.
- 14.8** All persons served receive an orientation. For individuals not continuously in treatment, providers must have a policy that discusses the frequency of which an orientation must occur.
  - 14.8.1** There is written and dated documentation signed by the person served that the orientation occurred.
  - 14.8.2** The orientation includes an explanation of the Provider's policies relating to treatment of the person served:
    - 14.8.2.1** Philosophy and goals.
    - 14.8.2.2** Confidentiality policies including 42 CFR Part 2 limitations and requirements.
    - 14.8.2.3** Consent to treatment.
    - 14.8.2.4** Rules governing conduct.
    - 14.8.2.5** Transitions between levels of care criteria and procedures.
    - 14.8.2.6** Hours of services and access to after-hour services, as appropriate.
    - 14.8.2.7** Costs, fees and payment responsibility.
    - 14.8.2.8** Mandated reporting laws.

- 14.8.3** The orientation includes an explanation of:
  - 14.8.3.1** Rights and responsibilities of the persons served.
  - 14.8.3.2** Grievance procedures.
  - 14.8.3.3** The Provider's health and safety policies regarding:
    - 14.8.3.3.1** Use of tobacco products.
    - 14.8.3.3.2** Legal or illegal substances brought into the program.
    - 14.8.3.3.3** Prescription medication brought into the program.
    - 14.8.3.3.4** Weapons brought into the program.
  - 14.8.3.4** The Provider's rules and expectations of the persons served, which identifies the following:
    - 14.8.3.4.1** Any restrictions the Provider may place on the person served.
    - 14.8.3.4.2** Event, behaviors, or attitudes and their likely consequences.
    - 14.8.3.4.3** Means by which the person served may regain rights or privileges that have been restricted.
  - 14.8.3.5** A written description of:
    - 14.8.3.5.1** How the person-centered treatment plan will be developed.
    - 14.8.3.5.2** The person's participation in goal development and achievement.
    - 14.8.3.5.3** Expectations for legally required appointments, sanction, or court notification.

## **15.0 Assessment**

- 15.1** The Preferred Provider has policies and procedures for obtaining a person served assessment and the establishment of a diagnosis.
  - 15.1.1** The policy and procedure requires that a written assessment:
    - 15.1.1.1** Be completed by qualified personnel trained in the applicable tools, tests, instruments, prior to administration, and signed off by a licensed professional.
    - 15.1.1.2** Document the risk ratings across all six dimensions in the ASAM Criteria to determine the appropriate level of care.
    - 15.1.1.3** Address use of appropriate assessment measurement tools as it applies to presenting diagnosis.
    - 15.1.1.4** Be completed, verified by dated signature, within the following time frames:
      - 15.1.1.4.1** For outpatient and intensive outpatient served programs, by the end of the third (3<sup>rd</sup>) clinical visit.
      - 15.1.1.4.2** For short-term residential or withdrawal management programs, by the end of the fourth (4<sup>th</sup>) day.
      - 15.1.1.4.3** For long-term residential, by the end of the fifteenth (15<sup>th</sup>) day.
    - 15.1.1.5** The assessment must be conducted in a manner that is sensitive to a history of possible sexual abuse or domestic violence and should not lead to retraumatization.
      - 15.1.1.5.1** Unless contraindicated, the assessment should include trauma sequelae.
    - 15.1.1.6** Family functioning and strengths must be assessed.
    - 15.1.1.7** Barriers to treatment participation and necessary accommodations must be assessed.
- 15.2** The assessment includes an evaluation of the following areas:
  - 15.2.1** Presenting problem(s)
  - 15.2.2** Mental health status including:
    - 15.2.2.1** Suicide risk.
    - 15.2.2.2** Personal Safety.



- 15.2.2.3** Risk to others.
- 15.2.3** The relationship between criminal activity and substance use disorder.
- 15.2.4** Substance use history including tobacco or tobacco-derived products.
- 15.2.5** Use of an evidence-based screening tool for pathological gambling.
- 15.2.6** Previous substance use disorder and mental health services including diagnostic and treatment histories.
- 15.2.7** Physical health information including:
  - 15.2.7.1** Health history and current health needs.
  - 15.2.7.2** Medication history and current use profile.
  - 15.2.7.3** Known allergies.
  - 15.2.7.4** Advance directives.
- 15.2.8** Family/Interpersonal history.
  - 15.2.8.1** Staff routinely follow up on questions such as ‘do you have children’ by asking about, and recording the names and dates of birth of any children;
  - 15.2.8.2** Who children are living with and who has custody;
  - 15.2.8.3** Parent’s current contact with children, including current visitation plan, if any; and
  - 15.2.8.4** Parent’s desired contact with children if contact is limited.
  - 15.2.8.5** If parent is involved with the Department for Children and Families (DCF), staff should make every effort to obtain name and phone number of the DCF social worker and explain the importance of establishing productive, ongoing partnerships with DCF, including sharing information about parental treatment, and developing shared treatment and service plans.
- 15.2.9** Spiritual beliefs.
- 15.2.10** Cultural considerations.
- 15.2.11** Educational/Employment history.
- 15.2.12** Legal history and current involvement with criminal justice system.
- 15.2.13** History of trauma that is experienced and/or witnessed.
- 15.2.14** Current level of behavioral, cognitive, and emotional functioning.
- 15.2.15** Person’s strengths, needs, abilities, and preferences.
- 15.3** Assessments for each child and adolescent must be age, gender, developmentally and culturally specific, and include information on:
  - 15.3.1** Developmental history, including developmental age factors, motor development, and functioning.
  - 15.3.2** Medical history and physical health history.
  - 15.3.3** Treatment history.
  - 15.3.4** School history, including information on special education services provided.
  - 15.3.5** Intellectual functioning.
  - 15.3.6** Family relations.
  - 15.3.7** Social functioning/interactions with peers.
  - 15.3.8** Environmental surroundings (home and community).
  - 15.3.9** Prenatal exposure to alcohol, tobacco and other drugs, and prenatal exposure to disease.
  - 15.3.10** Alcohol and drug use disorder history.
  - 15.3.11** Criminal justice involvement.
  - 15.3.12** Parental/guardian custodial status when applicable.
  - 15.3.13** When applicable, parents’/guardians’:
    - 15.3.13.1** Ability/willingness to participate in services.

- 15.3.13.2 Strengths.
- 15.3.13.3 Preferences.

15.4 The assessment process results in a written and dated document that includes:

- 15.4.1 Interpretive summary.
- 15.4.2 DSM-5 Diagnosis or ICD-10 diagnostic code.
- 15.4.3 Identification of any co-occurring disorders, including eating disorders.
- 15.4.4 Risk ratings across all six dimensions in the ASAM Criteria.
- 15.4.5 Treatment recommendations.

15.5 If the person served has received an assessment from a Preferred Provider or licensed professional in the previous twelve months and a full assessment is not clinically necessary, the treating Provider is encouraged to do an addendum. The addendum should include:

- 15.5.1 Risk ratings across all six dimensions in the ASAM Criteria.
- 15.5.2 Mental health exam.
- 15.5.3 DSM-5 diagnosis or ICD-10 diagnosis.
- 15.5.4 Changes to any section 15.2 listed above since the last assessment.
- 15.5.5 A copy of assessment from the provider or program in the medical record.
- 15.5.6 Signature of qualified professional and dated by staff completing addendum assessment and signed off by licensed professional.
- 15.5.7 Updates to treatment recommendations.

15.6 The Provider must have a policy and associated procedures stating:

- 15.6.1 How the Provider regularly screens, assesses, and treats using clinical practice guidelines for tobacco cessation including:
  - 15.6.1.1 Counseling.
  - 15.6.1.2 Utilization of FDA-approved nicotine replacement products.
- 15.6.2 How the Provider promotes no cost state resources through <http://802quits.org/> including 1-800-QUIT NOW.

## 16.0 Case Management

16.1 All Preferred Providers must provide case management services, as appropriate, that provide goal-oriented and individualized support focused on improving self-sufficiency for the person served through assessment, planning, linkage, advocacy, coordination, and monitoring. Case management must be flexible and must be driven by the unique needs of the client.

16.1.1 Based on the needs of the persons served, case management includes:

- 16.1.1.1 Outreach to encourage participation.
- 16.1.1.2 Coordination of, or assistance with, crisis intervention, as appropriate.
- 16.1.1.3 Optimizing resources and opportunities through community linkages.
- 16.1.1.4 Assistance with:
  - 16.1.1.4.1 Accessing transportation.
  - 16.1.1.4.2 Securing housing.
  - 16.1.1.4.3 Exploring employment or meaningful activities.
  - 16.1.1.4.4 Securing childcare.
  - 16.1.1.4.5 Health insurance and maintaining insurance coverage.
  - 16.1.1.4.6 Life skills education.

16.1.1.5 Case management must be carried out through a multidisciplinary team approach. The team composition must depend on the person's served needs and input but must include representatives from the various systems with

whom the person served has involvement. The goal must be to assist the person served in accessing and understanding services. It must be coordinated with:

**16.1.1.5.1** Skill development services.

**16.1.1.5.2** Social Services.

**16.1.1.5.3** Child Welfare System.

**16.1.1.5.4** Schools.

**16.1.1.5.5** Caregiver (including foster care or kin), if children are not in their birth parent's custody.

**16.1.1.5.6** Financial services.

**16.1.1.5.7** Legal services.

**16.1.1.5.8** Criminal justice system staff.

**16.1.1.5.9** Medical services.

**16.1.1.6** Care coordination with primary care provider to ensure effective planning and communication.

**16.1.2** It is the expectation that the Provider must secure and document a 42 CFR Part 2 Compliant Release of Information from the person served in order to coordinate care.

**16.1.3** When a Release of Information exists, communication is documented.

**16.2** Based on the needs of the children or adolescents served, the program must include services to support the development of:

**16.2.1** Community living skills.

**16.2.2** Social skills.

**16.2.3** Social supports.

**16.2.4** Vocational skills.

## **17.0 Person-Centered Treatment Plan**

**17.1** There is written and dated documentation that each person served receives a person-centered treatment plan that is:

**17.1.1** Developed with the person served and with the involvement of family or legal guardian of the person served, when applicable and permitted.

**17.1.2** Based on the assessment; the persons' strengths, needs, abilities, preferences; and cultural considerations.

**17.2** For those served who remain in treatment with the Provider beyond the fourth visit for outpatient and intensive outpatient programs or the fifth (5<sup>th</sup>) working day for all residential programs, the plan must be completed, dated, and signed by:

**17.2.1** The end of the fourth (4<sup>th</sup>) visit (for outpatient served and IOP programs).

**17.2.2** The end of the fifth (5<sup>th</sup>) day (for all residential and withdrawal management programs).

**17.2.3** The end of the fourth (4<sup>th</sup>) visit (for OTPs a visit is defined as a scheduled meeting with a case manager or licensed professional).

**17.3** The Plan includes the following components:

**17.3.1** The identification of the needs /desires of the person served through goals that are expressed in the words of the person served and are reflective of the informed choice of the person served that are accompanied with clinical interpretation.

**17.3.2** For each goal, there are treatment objectives that are:

**17.3.2.1** Specific to the person served.

**17.3.2.2** Measurable.

- 17.3.2.3 Achievable.
      - 17.3.2.4 Realistic.
      - 17.3.2.5 Time specific and time limited.
    - 17.3.3 Treatment objectives must identify the specific interventions, modalities, or services including:
      - 17.3.3.1 Frequency of the intervention.
      - 17.3.3.2 The staff responsible for helping to accomplish the objective.
  - 17.4 The person served must sign and date a statement, included in the treatment plan, indicating that he/she has reviewed, participated in the development of, and understands the treatment plan.
  - 17.5 The counselor must sign and date the treatment plan upon its completion.
  - 17.6 Person-centered treatment plans are reviewed and updated by the clinician and the person served as verified by a signed and dated plan no less frequently than:
    - 17.6.1 When there are significant changes in a person's life.
    - 17.6.2 When there are changes to the treatment modality, frequency and/or amount of treatment services.
    - 17.6.3 When there is a transition between levels of care.
  - 17.7 If the clinician signing the treatment plan is a non-licensed clinician, AAP, or CADC, the treatment plan must be cosigned by:
    - 17.7.1 A LADC of at least one year full-time professional experience working as such, and who is licensed and in good standing in the state of practice; or
    - 17.7.2 An independent clinical social worker, psychologist, marriage and family therapist, or clinical mental health counselor, licensed and in good standing in Vermont or a foreign jurisdiction acceptable to the OPR Director, who has completed addiction counseling training consistent with the OPR Licensing Rules (Section 5.3) and has accrued at least one year of full-time addiction counseling experience or its part-time equivalent; or
    - 17.7.3 An allopathic or osteopathic physician certified in addiction medicine by the American Society of Addiction Medicine, the American Osteopathic Association, the American Board of Psychology and Neurology, or an equivalent certifying body approved by the OPR Director.
  - 17.8 Clients must be offered a copy of their treatment plan and each update thereof.
  - 17.9 After each billable service there must be documentation supporting continued need for services based on clinical necessity, including the following:
    - 17.9.1 Dated progress notes that link to the treatment plan;
    - 17.9.2 Updates or modifications to treatment plan;
    - 17.9.3 Interventions provided and person served response;
    - 17.9.4 Printed staff name and signature or electronic equivalent.
- 18.0 **Transition/Discharge**
  - 18.1 The Preferred Provider has policies and procedures on persons served who are transitioning or are discharged from the Provider.
    - 18.1.1 The policy states that persons served must participate in the development of their aftercare plans as early as possible in the person-centered treatment planning and service delivery process.
  - 18.2 There must be entered into the person served record a discharge summary within seven (7) days following discharge signed and dated by the clinician, which includes:
    - 18.2.1 Date of admission and discharge.

- 18.2.2** Presenting condition.
- 18.2.3** Description of the services provided.
- 18.2.4** Description of progress toward treatment goals and objectives.
- 18.2.5** Reason for discharge/ transition.
- 18.2.6** Identification of unmet needs and recommended aftercare services and supports.
- 18.2.7** Medications prescribed by the Provider during the episode of care.
- 18.2.8** Final diagnosis.
- 18.2.9** Dated signature of the staff completing the discharge summary.
- 18.3** The written aftercare plan is developed and:
  - 18.3.1** Is prepared to ensure seamless transition when a person served is transferred to another level of care or prepares for a planned discharge.
  - 18.3.2** Identifies the person's need for a recovery support system or other types of service that will assist in continuing the recovery and community integration.
  - 18.3.3** Includes referral information made for additional services such as appointment dates, times, contact name, telephone number, and location.
  - 18.3.4** Includes recommendations for self-help and contact information for local peer recovery support services.
  - 18.3.5** Must include the signature of the person served and/or their legal guardian as applicable.
- 18.4** For transitions between levels of care and/or Providers:
  - 18.4.1** Counselors ensure successful transition between clinically appropriate levels of care.
  - 18.4.2** Referring Providers must provide the receiving Provider the most recent assessment upon receipt of a signed release of information.
- 18.5** Upon discharge, when person served has given documented consent, the Provider, when prescribing medications, must document coordination of care with the Primary Care Provider and/or external prescribing professional regarding, at a minimum, what medications are being prescribed and for what diagnoses.

## **19.0 Medication Monitoring and Management**

- 19.1** All medications are administered in accordance with accepted and statutory clinical practice under the authority of a prescribing professional.
- 19.2** A list of clinical staff members authorized by the Preferred Provider and by law to administer or dispense medications is maintained and updated as needed.
- 19.3** Self-administration of medication is permitted only when specifically ordered by the responsible prescribing professional.
- 19.4** Drugs and prescriptions brought into the Provider for the person served are neither administered nor made available for self-administration unless they are identified by the Provider and approved by the responsible prescribing professional.
- 19.5** Medication errors and adverse drug reactions are documented in the person served record and reported to the responsible prescriber upon discovery.
- 19.6** The Provider has policies and procedures regarding pharmaceutical practices.
  - 19.6.1** Providers will offer a pregnancy test before implementation of medication-assisted treatment.
  - 19.6.2** Treatment for pregnant women receiving methadone or other approved controlled substances from a Preferred Provider licensed to provide opioid replacement treatment will be based on up-to-date research. Women will not be detoxified during pregnancy without consideration by a physician of the impact it would have on the

mother and her fetus. In addition, all pregnant women on prescribed medications will be medically evaluated to determine the appropriateness of detoxification.

- 19.6.3** Disulfiram, naltrexone and other medications that may be contraindicated for pregnant women will not be administered without an assessment by a licensed medical professional.

## **20.0 Crisis Management**

- 20.1** The Preferred Provider has written guidelines for physical and behavioral health crisis/emergency management.

## **IV Population and Core Specialty Program Standards:**

Preferred Providers that provide services to a specific population of persons served and/or a core specialty program listed below must be compliant with those standards in addition to the General Program Standards.

## **21.0 Medication Assisted Treatment for Opioid Use Disorder**

Preferred Providers who administer medication assisted treatment for opioid use disorders must also conform to current Vermont Department of Health Opiate Addiction Treatment Rules established under the authority of 18 VSA Chapter 92.

## **22.0 Intensive Outpatient Treatment (IOP)**

- 22.1** In IOP treatment the person served and/or family members are provided at least nine (9) but not more than nineteen (19) direct contact hours a week.
- 22.2** IOP's will provide two (2) or more of the following services per week:
  - 22.2.1** Individual counseling.
  - 22.2.2** Group counseling.
  - 22.2.3** Family counseling.
- 22.3** IOP's will offer education on wellness and recovery.
- 22.4** The IOP coordinates treatment with other services when consent of the person served is documented.
- 22.5** IOP's will have the capacity to secure psychiatric and/or medical consultation by telephone within twenty-four (24) hours and within seventy-two (72) hours in person.
- 22.6** Clinical appropriateness for admission to an IOP is determined utilizing assessment protocols identified in these standards and can be justified based upon ASAM Criteria for level 2.1.
- 22.7** The Preferred Provider has a written description of the mission, policies, and procedures of its IOP.

## **23.0 Residential Substance Use Disorder Treatment Services**

- 23.1** Preferred Providers who administer residential withdrawal management services must:
  - 23.2** Be provided in a trauma-informed, gender-responsive environment that is safe, calm, welcoming and friendly.
    - 23.2.1** If a parent or guardian is in need of withdrawal management services, Providers must ensure that the children have appropriate care and supervision. Appropriate communication about the parent or guardian's well-being must be provided to children.

- 23.2.2** A pregnancy test must be offered before initiation of pharmacological intervention.
- 23.3** Establish written admission, continuing care, and discharge criteria.
- 23.4** Provide availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive needs.
- 23.5** Have the ability to arrange for appropriate and laboratory tests.
- 23.6** Assign a primary clinician who will follow the client's progress during withdrawal management. Such assignment must be documented in the clinical record.
- 23.7** Ensure availability of training and education for clinical and support staff. The training must include, but not be limited to, the following:
  - 23.7.1** Appropriate screening protocols and procedures.
  - 23.7.2** Use of ASAM Criteria to determine placement and treatment criteria.
  - 23.7.3** Medical aspects of substance use, misuse, and withdrawal.
  - 23.7.4** Pharmacology in the withdrawal management program setting.
  - 23.7.5** Early interventions for individuals at high risk during intoxication and withdrawal.
  - 23.7.6** Non-violent crisis intervention.
  - 23.7.7** Management of the individual with suicidal ideation.
  - 23.7.8** Discharge planning.
- 23.8** Have a policy to address individuals leaving withdrawal management treatment against the advice of the staff. The policy must include:
  - 23.8.1** The person served must be informed (and documented) of the risks of leaving treatment prematurely.
  - 23.8.2** The person must be provided a list of possible withdrawal danger signs particular to his or her withdrawal management protocol.
  - 23.8.3** The person must sign an "Against Medical Advice Form".
  - 23.8.4** The signature must be witnessed by a staff member.
  - 23.8.5** If the person served refuses to sign the "Against Medical Advice Form" the Provider staff must document this on the aforementioned form and sign the form.
- 23.9** Be able to justify the clinical necessity of services and:
  - 23.9.1** Include daily clinical services to assess and address the needs of each client.
  - 23.9.2** Be a range of cognitive, behavioral, medical, mental health, and other services on an individual or group basis that enhance the client's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment.
  - 23.9.3** Include health education services and services to families and significant others.
- 23.10** Provide medical specialty, psychological, psychiatric, laboratory, and toxicology services through consultation or referral.
- 23.11** Have on staff a supervising physician who has responsibility for oversight of all medical and pharmaceutical procedures.
- 23.12** Provide and have procedures for the following if the Provider manages medications for persons served:
  - 23.12.1** Compliance with all applicable laws and regulations pertaining to medications and controlled substances.
  - 23.12.2** Documentation or confirmation of informed consent for each medication prescribed, when possible.
  - 23.12.3** Integrating any prescribed medications into a person's treatment plan, including, if applicable special dietary restrictions or needs associated with medication use.
  - 23.12.4** Identification, documentation, and required reporting, including to the prescribing professional:

- 23.12.4.1** Of any medication reactions experienced by the person served.
- 23.12.4.2** Of medication errors, as appropriate.
- 23.12.5** Policies and procedures regarding medication errors and drug reactions as part of the quality monitoring and improvement system.
- 23.12.6** Actions to follow in case of emergencies related to the use of medication, including ready access to the telephone number of a poison control center by Provider staff.
- 23.12.7** Availability of the medical resources for consultation during hours of operation.
- 23.13** Coordinate services, as needed, with the physician providing primary care needs.
- 23.14** Use withdrawal rating scale tables and flowsheets (which may include tabulation of vital signs), as needed.
- 23.15** Discharge criteria must include:
  - 23.15.1** Withdrawal signs and symptoms are sufficiently resolved that the client can be safely managed at a less intensive level of care; or,
  - 23.15.2** The client signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) or other comparable standardized scoring system, such that transfer to a more intensive level of withdrawal management service is indicated; or,
  - 23.15.3** The client is unable to complete withdrawal management at the current level of care, despite an adequate trial.
- 23.16** Providers of withdrawal management services who provide ASAM Level 3.2-WM services must:
  - 23.16.1** Have procedures that are developed and supported by a physician knowledgeable in addiction medicine that outline the progress should a client's condition deteriorate and appear to need medical or nursing interventions. These procedures will include:
    - 23.16.1.1** How to determine the nature of the medical or nursing interventions that may be required.
    - 23.16.1.2** The conditions that nursing and physician care is warranted and/or when transfer to a medically monitored facility or an acute care hospital is necessary.
  - 23.16.2** Have staff that are appropriately credentialed to implement physician-approved procedures for client observation and supervision, determination of appropriate level of care, and facilitation of the client's transition to continuing care, and facilitation of the client's transition to continuing care.
    - 23.16.2.1** All clinicians who assess and treat patients are able to obtain and interpret information regarding the needs of the clients. Such knowledge includes the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the appropriate treatment and monitoring of those conditions and how to facilitate entry into ongoing care.
    - 23.16.2.2** Facilities that supervise self-administered medications have appropriately licensed or credentialed staff and policies and procedures in accordance with state and federal law.
      - 23.16.2.2.1** Staff assures that clients are taking medications according to physician prescription and legal requirements.
  - 23.16.3** Provide services that are clinically necessary and:
    - 23.16.3.1** Include a physical examination by a physician, physician assistant, or nurse practitioner as part of the initial assessment, if self-administered withdrawal management medications are to be used.



- 23.17** Providers of ASAM Level 3.7-WM withdrawal management services must:
- 23.17.1** Be staffed by physicians, who are available 24 hours a day by phone.
  - 23.17.2** Have a physician who is available to assess the client within 24 hours of admission, or earlier if medically necessary, and is available to provide on-site monitoring of care and further evaluation on a daily basis.
  - 23.17.3** Have a nurse is responsible for overseeing the monitoring of the client's progress and medication administration on an hourly basis, if needed.
  - 23.17.4** Have appropriately licensed and credentialed staff available to administer medications in accordance with physician orders. The level of nursing care is appropriate to the severity of client needs.
  - 23.17.5** Have specialized clinical consultation and supervision for medical, emotional, behavioral, and cognitive problems available.
  - 23.17.6** Have the availability of medical nursing care and observation as warranted, based on clinical judgment.
  - 23.17.7** Provide services that are clinically necessary and:
    - 23.17.7.1** Include a complete medical examination must be performed by a physician, physician assistant, or nurse practitioner within twenty-four (24) hours of admission and appropriate laboratory and toxicology tests.
    - 23.17.7.2** Include a nursing assessment on admission that is conducted by a registered nurse or other licensed and credentialed nurse.
    - 23.17.7.3** Licensed, certified, or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care, and treatment services for clients and their families.
    - 23.17.7.4** Are provided by an interdisciplinary team of appropriately trained clinicians (such as physicians, nurses, counselors, social workers, and psychologists) is available to assess and treat the client and to obtain and interpret information regarding the client's needs. The number and disciplines of team members are appropriate to the range and severity of the client's problems.
    - 23.17.7.5** Hourly nurse monitoring of the client's progress and medication administration are available, if needed.
- 23.18** The Preferred Provider has policies and procedures for the administration of its residential treatment services that address the following:
- 23.18.1** There is made available to the person served a description of the treatment services, including treatment services provided evenings and weekends.
  - 23.18.2** There is a policy and procedure made known to the person served that details the Provider's practices concerning leaving against the advice of staff.
  - 23.18.3** There is a policy and procedure that is made known to the person served that details the consequences of the use of alcohol and other drugs by the person served while in residential treatment.
- 23.19** There are policies and procedures allowing for the persons served to have:
- 23.19.1** Visitation in a space that allows for private conversation.
  - 23.19.2** The right to send and receive mail.
  - 23.19.3** Reasonable access to electronic mail.
  - 23.19.4** Telephone access with the right and capacity to conduct private telephone conversation.
- 23.20** There are policies and procedures governing the delivery of nutritional services including:
- 23.20.1** accommodating persons served that have specific dietary needs.

- 23.20.2** Daily access to nutritious meals and snacks.
- 23.21** Services are to be provided by a coordinated team that includes, at a minimum, the following professionals:
  - 23.21.1** An assigned residential staff or plan coordinator.
  - 23.21.2** A licensed behavioral health professional.
  - 23.21.3** Providers of appropriate medical support services.
- 23.22** The Provider provides treatment at least four (4) hours a day, seven (7) days a week.
- 23.23** The Provider provides face-to-face support twenty-four (24) hours a day, seven (7) days a week.
- 23.24** The Provider has telephone or in-person consultation with a prescribing health care provider and emergency services available twenty-four (24) hours a day, seven (7) days a week.
- 23.25** The Provider ensures the provisions of both medical and pharmaceutical services.
- 23.26** The Provider has at least one (1) staff member on duty immediately available at all times trained in first aid and CPR.
- 23.27** Clinical staff show competence as evidenced by professional licensure and/or specialized training in:
  - 23.27.1** Behavior management techniques.
  - 23.27.2** Biological and psychological dimension of substance use and mental health disorders and their treatment.
  - 23.27.3** Signs and symptoms of acute psychiatric conditions and their de-compensation.
- 23.28** The Provider administers the following community living components:
  - 23.28.1** A written daily schedule of activities.
  - 23.28.2** Daily meetings between the persons served and Provider staff.
  - 23.28.3** Personal space for privacy.
  - 23.28.4** Security of property.
  - 23.28.5** Separate sleeping areas for the persons served based on gender, age, and needs.
- 23.28.6** There is up to date documentation in the person served record of all medications, prescriptions, and non-prescriptions, used by the person that includes:
  - 23.28.6.1** Name of the medication.
  - 23.28.6.2** Dosage, including strength or concentration.
  - 23.28.6.3** Frequency.
  - 23.28.6.4** Instructions for use, including administration route.
  - 23.28.6.5** For prescription medications:
    - 23.28.6.5.1** Prescribing professional and phone number.
    - 23.28.6.5.2** Dispensing pharmacy and contact information.
    - 23.28.6.5.3** Policies and procedures that address:
      - 23.28.6.5.3.1** Storage, including handling of medication requiring refrigeration or protection from light.
      - 23.28.6.5.3.2** Safe handling.
      - 23.28.6.5.3.3** Packaging or labeling.
      - 23.28.6.5.3.4** Safe disposal.
      - 23.28.6.5.3.5** Maintenance of an adequate supply of the medication for the persons served.
      - 23.28.6.5.3.6** Documentation of medication use.
- 23.29** Qualified staff receives and records verbal orders for medication, laboratory test, or dietary needs.
  - 23.29.1** The Provider has identified in policy and procedures the staff that is authorized to receive and record verbal orders in accordance with law and regulation.

- 23.29.2** Documentation of verbal orders includes the date and the names of staff, who gave, received, recorded, and implemented the orders.
- 23.29.3** Verbal orders must be authenticated within seven (7) days.
- 23.30** The Provider is encouraged to maintain tobacco-free campus status, if already established, or work toward reducing smoking on campus through:
- 23.30.1** Reducing smoke breaks.
- 23.30.2** Discouraging patients, family members and other visitors from bringing tobacco products, substitutes (e-cigarettes and other vaping devices), and paraphernalia to the facility.
- 23.30.3** Supporting staff to quit or reduce tobacco use.
- 23.31** Providers of ASAM Level 3.1 residential substance use disorder treatment services must:
- 23.31.1** Have telephone or in-person consultation with a physician and emergency services that are available 24 hours a day, 7 days a week.
- 23.31.2** Have direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services.
- 23.31.3** Have the ability to arrange for needed procedures as appropriate to the severity and urgency of the client's condition.
- 23.31.4** Have the ability to arrange for pharmacotherapy for psychiatric or substance use disorder medications.
- 23.31.5** Have a team of staff that include:
- 23.31.5.1** Allied health professionals who are available on-site 24 hours a day or as required by licensing regulations.
- 23.31.5.2** Knowledgeable about the biological and psychosocial dimensions of substance use disorders and treatment, and are able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation.
- 23.31.5.3** Comprised of appropriately trained and credentialed medical, addiction, and mental health professionals.
- 23.31.6** Provide services that are clinically necessary, improve the client's ability to structure and organize the tasks of daily living and recovery, and include:
- 23.31.6.1** Planned clinical program activities constituting at least 5 hours per week of professionally directed treatment to stabilize and maintain the stability of the client's substance use disorder symptoms and to help the client to develop and apply recovery skills.
- 23.31.6.2** Addiction pharmacotherapy.
- 23.31.6.3** Random drug screening to monitor and reinforce treatment gains, as appropriate to the client's person-centered treatment plan.
- 23.31.6.4** Motivational enhancement and engagement strategies appropriate to the client's stage of readiness to change.
- 23.31.6.5** Counseling and clinical monitoring to support initial involvement or reinforcement in regular, productive daily activity and, as indicated, successful reintegration into family living.
- 23.31.6.6** Regular monitoring of the client's medication adherence.
- 23.31.6.7** Recovery support services.
- 23.31.6.8** Opportunities for the client to be introduced to the potential benefits of addiction pharmacotherapies as a tool to manage substance use disorders.

- 23.31.6.9** A physical examination, performed within a reasonable time, as defined in the program's policy and procedure manual, and as determined by the client's medical condition.
- 23.32** Providers of ASAM Level 3.3 residential substance use disorder treatment services must:
- 23.32.1** Have telephone or in-person consultation with a physician (or physician assistant or nurse practitioner) and emergency services that are available 24 hours a day, 7 days a week.
  - 23.32.2** Have direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services.
  - 23.32.3** Medical, psychiatric, psychological, laboratory, and toxicology services, available through consultation or referral, as appropriate to the severity and urgency of the client's condition.
  - 23.32.4** Have a team of staff that include:
    - 23.32.4.1** Physician or physician extenders, and appropriately credentialed mental health professionals.
    - 23.32.4.2** Allied health professionals, such as counselor aides or group living workers, on-site 24 hours a day or as required by licensing regulations. One or more clinicians with knowledge and experience in the treatment of substance use disorders are available on-site or by telephone 24 hours a day.
    - 23.32.4.3** Clinical staff knowledgeable about the biological and psychosocial dimensions of substance use and mental disorders and their treatment, and able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation.
    - 23.32.4.4** Skilled and trained in behavior management techniques.
  - 23.32.5** Provide services that are clinically necessary, improve the client's ability to structure and organize the tasks of daily living and recovery, and include:
    - 23.32.5.1** Planned clinical program activities designed to stabilize and maintain the stability of the client's addiction symptoms and help develop and apply recovery skills.
    - 23.32.5.2** Random drug screening to monitor and reinforce treatment gains, as appropriate to the client's person-centered treatment plan.
    - 23.32.5.3** A range of cognitive, behavioral, and other therapies administered on an individual and group basis, medication education and management, educational groups, and occupational or recreational activities, as appropriate.
    - 23.32.5.4** Counseling and clinical monitoring to assist the client with successful initial involvement or reinvolved in regular, productive daily activity and, as indicated, successful reintegration into family living.
    - 23.32.5.5** Regular monitoring of the client's adherence in taking any prescribed medications.
    - 23.32.5.6** Daily scheduled professional addiction and mental health treatment services, designed to develop and apply recovery skills.
    - 23.32.5.7** Clinical and didactic motivational interventions appropriate to the client's stage of readiness to change, designed to facilitate the client's understanding of the relationship between substance use disorder and life issues.
    - 23.32.5.8** A physical examination, performed within a reasonable time, as defined in the program's policy and procedure manual, and as determined by the client's medical condition.

- 23.33** Providers of ASAM Level 3.5 residential substance use disorder treatment services must:
- 23.33.1** Have telephone or in-person consultation with a physician (or physician assistant or nurse practitioner) and emergency services that are available 24 hours a day, 7 days a week.
  - 23.33.2** Have direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services.
  - 23.33.3** Have the ability to arrange for medical, psychiatric, psychological, laboratory, and toxicology services, as appropriate to the severity and urgency of the client's condition.
  - 23.33.4** Have a team of staff that include:
    - 23.33.4.1** Licensed or credentialed clinical staff who work with the allied health professional staff in an interdisciplinary team approach.
    - 23.33.4.2** Allied health professionals, such as counselor aides or group living workers, on-site 24 hours a day or as required by licensing regulations. One or more clinicians with knowledge and experience in the treatment of substance use disorders are available on-site or by telephone 24 hours a day.
    - 23.33.4.3** Clinical staff knowledgeable about the biological and psychosocial dimensions of substance use and mental disorders and their treatment, and able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation.
    - 23.33.4.4** Skilled and trained in behavior management techniques.
  - 23.33.5** Provide services that are clinically necessary, improve the client's ability to structure and organize the tasks of daily living and recovery, and to develop and practice prosocial behaviors and include:
    - 23.33.5.1** Planned clinical program activities designed to stabilize and maintain stabilization of the client's addiction symptoms and help develop and apply recovery skills.
    - 23.33.5.2** Counseling and clinical monitoring to assist the client with successful initial involvement or reinvolverment in regular, productive daily activity and, as indicated, successful reintegration into family living.
    - 23.33.5.3** Random drug screening to monitor and reinforce treatment gains, as appropriate to the client's person-centered treatment plan.
    - 23.33.5.4** A range of cognitive, behavioral, and other therapies administered on an individual and group basis, medication education and management, educational groups, and occupational or recreational activities, as appropriate.
    - 23.33.5.5** Motivational enhancement and engagement strategies appropriate to the client's stage of readiness and desire to change.
    - 23.33.5.6** Counseling and clinical interventions to facilitate teaching the client the skills needed for productive daily activity and, as indicated, successful reintegration into family living.
    - 23.33.5.7** Monitoring of the client's adherence in taking any prescribed medications and/or any permitted over-the-counter medications or supplements.
    - 23.33.5.8** Planned clinical activities to enhance the client's understanding of substance use and/or mental health disorders.
    - 23.33.5.9** Daily scheduled professional services, including interdisciplinary assessments and treatment, designed to develop and apply recovery skills.

- 23.33.5.10** Planned community reinforcement designed to foster prosocial values and milieu or community living skills.
- 23.33.5.11** A physical examination, performed within a reasonable time, as determined by the client's medical condition consistent with the Provider's policy or legal requirements.
- 23.34** Providers of ASAM Level 3.7 residential substance use disorder treatment services must:
  - 23.34.1** Have physician monitoring, nursing care, and observation available. A physician (or physician extender) is available to assess the client in person within 24 hours of admission and thereafter as medically necessary.
  - 23.34.2** Conduct a substance use-focused nursing assessment by a registered nurse at the time of admission. An appropriately credentialed and licensed nurse is responsible for monitoring the client's progress and for medication administration.
  - 23.34.3** Have additional medical specialty consultation, psychological, laboratory, and toxicology services on-site, through consultation, or referral.
  - 23.34.4** Have direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services.
  - 23.34.5** Have psychiatric services available on-site, through consultation, or referral when a presenting issue could be attended to at a later time. These services are available within eight (8) hours by telephone or 24 hours in person.
  - 23.34.6** Have be staffed by:
    - 23.34.6.1** An interdisciplinary team (including physicians, nurses, addiction counselors, and behavioral health specialists), who are able to assess and treat the client and obtain and interpret information regarding the client's psychiatric and substance use disorders.
    - 23.34.6.2** Clinicians who are knowledgeable about the biological and psychosocial dimensions of substance use and behavioral health disorders, and with specialized training in behavior management techniques and evidence-based practices. The staff is able to provide a planned regimen of 24-hour professionally directed evaluation, care, and treatment services (including administration of prescribed medications).
    - 23.34.6.3** A licensed physician to oversee the treatment process and assure the quality of care. Physicians perform physical examinations for all clients admitted to this level of care.
  - 23.34.7** Provide services that are clinically necessary and include:
    - 23.34.7.1** Daily clinical services to assess and address the client's individual needs. Clinical services may involve appropriate medical and nursing services, individual, group, family, and activity services.
    - 23.34.7.2** Planned clinical program activities to stabilize acute symptoms.
    - 23.34.7.3** Counseling and clinical monitoring to promote successful initial involvement or reinvolvement in, and skill building for, regular, productive daily activity and, as indicated, successful reintegration into family living.
    - 23.34.7.4** Random drug screening to monitor and reinforce treatment gains, as appropriate to the client's person-centered treatment plan.
    - 23.34.7.5** Regular monitoring of the client's adherence in taking any prescribed medications.
    - 23.34.7.6** Planned clinical program activities, designed to enhance the client's understanding of substance use and/or mental health disorder.

- 23.34.7.7** Health education services associated with the course of addiction and other potential health-related risk factors as appropriate.
- 23.34.7.8** Evidence-based practices, such as motivational enhancement strategies and interventions appropriate to the client's stage of readiness to change, designed to facilitate the client's understanding of the relationship between substance use disorders and life issues.
- 23.34.7.9** A physical examination, performed by a physician within 24 hours of admission, or a review and update by a facility physician within 24 hours of admission of the record of a physical examination conducted no more than seven (7) days prior to admission.
- 23.34.7.10** A comprehensive nursing assessment, performed at the time of admission.

**24.0 Children and Adolescent Residential Programs**

- 24.1.1** Staff will be on site twenty-four (24) hours a day and seven (7) days a week in residential programs.
- 24.1.2** Services provided reflect the ages, cognitive levels, interests, concerns and cultural and developmental needs of children or adolescents served.
- 24.1.3** Rooms will be available for the person served according to age, gender, and developmental needs in residential programs.
- 24.1.4** If residential services are provided, the program provides opportunities for visits, when appropriate and in compliance with applicable laws and court orders, with:
  - 24.1.4.1** Family members and significant others.
  - 24.1.4.2** Peers.
- 24.1.5** The program does not exclude children or adolescents from services solely on the basis of their juvenile justice involvement. Although specific behaviors may be identified by the Provider as exclusionary admission criteria, children and adolescents cannot be excluded from services solely because they are involved in the juvenile justice system.